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"HISTORY OF THE NATIONAL HEALTH SERVICE BEFORE 1957: PROBLEMS OF HEALTH CARE"

The Secretary of State may wish to be aware that the first volume of the official history of the National Health Service is to be published on 28 April. It raises a number of issues relevant to the current review of the NHS, the most significant of which are summarised in the note at A. A copy of the Press Release which HMSO intend to use on publication day is at B and a background note on the official history of the NHS is at C.

2. The author, Dr Charles Webster, has also written an article for publication in the journal "Contemporary History" later this year. A copy is at D. This focusses on the broader issues, like the extent to which the NHS as introduced was a compromise, and the need from the earliest days of the NHS to look for cost saving measures because of pressure on resources. Less is said than in the history itself about the impact of medical interest groups on the structure of the NHS. An interesting last section examines how far issues currently being publicly discussed in the context of the review are in reality ideas which have been on the table before.

3. We have been considering the handling of the history, bearing in mind its possible implications for the:

- NHS review
- 40th Anniversary of the NHS
- current concerns about NHS financing

4. Our conclusion is that we do not need to take any special steps when the history is published. Those with a direct interest in the review will of course tend to focus on those aspects which support their case - whether it is the pressure on resources, structure of the NHS, method of financing or role of the medical profession. But this need not be unhelpful. Indeed it could be helpful in bringing out the fact that the perceived frailties of the NHS are not a new development and that many of the aspects now under scrutiny have by no means existed from the start of the NHS, unaltered or uncriticised. The history tends to confirm the view that the heart of the NHS is not in its structure, organisation, management or financing but in its comprehensive coverage, with ready access free of charge at the point of use.

5. Cabinet Office have asked for our advice on the handling of the history. We propose to respond on the general lines set out in this minute.

STRACHAN HEPPELL

A

"History of the National Health Service before 1957: Problems of Health Care

Summary of Key Issues relevant to the NHS Review

1. The early perception of the NHS

Beveridge wanted the NHS to ensure "that the best that science can do is available for the treatment of every citizen at home and in institutions, irrespective of his personal means". The author concludes that this concept of a National Health Service was popular from the beginning, and that the NHS became "sanctified .. as the inalienable foundation of the welfare state". By the 1950s a broad political consensus had developed in favour of the NHS as then perceived.

2. The Role of the Medical Profession

During the war a consensus for change had developed and the Coalition Government produced a White Paper in 1944 proposing a local authority based system of health care. The medical profession were concerned that the new Service would reduce traditional medical freedoms and attacked the proposals. The tripartite structure, with local authorities in the least significant position, introduced by the post war Labour Administration was seen by some as a capitulation to both the medical and voluntary sector lobbies. The medical profession were also seen as gaining power from the nationalisation of the hospital service, which gave them a major role in planning for the first time.

3. Finance

It was intended that a substantial proportion of NHS funds would come from National Insurance, but this never materialised, and the Exchequer had to underwrite costs from an early stage. There was concern about escalating costs and Bevan resigned in 1950 when his Cabinet colleagues proposed to introduce charges. Doubts were expressed about the prudence of maintaining a free and comprehensive system. Concern about costs continued during the Conservative administration elected in 1951, and there was an increasing perception that the demand for health care was unlimited. As a result the Gillebaud Committee
was set up in 1953 to conduct an impartial review of the Service. The Committee themselves did not produce any profound insights, but a study they commissioned from Abel-Smith and Titmuss was very influential. This study argued that costs were in fact very little increased from those pre-war and the problems arose from faulty estimating at the time of inception of the service. The author's view is that the initial level of funding was too low, although this does not come out as clearly in the History as it does in a draft article he intends to publish in an academic journal.

C

The History of the National Health Service before 1957: Problems of Health Care.

BACKGROUND NOTE

1. In 1973 the DHSS advocated to the Official Committee on Official Histories the commissioning of a history of the evolution of the health services, in the series of histories of peacetime events initiated in 1966. In 1975 DHSS put forward a proposed synopsis which the then Prime Minister saw and approved for consideration by the Committee of Privy Counsellors on Official Histories (PCH). PCH approved the proposal and in 1978, in a Parliamentary Written Answer, the then Prime Minister announced that "the Health services since the War" was to be written by Dr Charles Webster, Director of the Wellcome Unit for the History of Medicine, Oxford.

2. It is the first volume of this Official History, describing the inception of the NHS and events up to 1957, which is now to be published on 28 April. The text has been cleared with the DHSS, and Dr Webster, with the approval of the Prime Minister and the Secretary of State, has now embarked on Volume 2, which will cover the period 1957-1979.

B

"History is past politics, and politics present history"
- Sir John Seeley (1834-1895)

The Health Services since the War
Volume I
Problems of Health Care
The National Health Service before 1957
Charles Webster

In the current great debate about the future of the National Health Service (now in its fortieth year), few things could shed more light than an incisive and authoritative analysis of its past. This, the first volume of a two-part study, looks at the politics of health care and the state of the health services from the interwar period onwards, ending with the first decade of the NHS. The second volume will take the history up to 1979.

Volume I examines the conflicts between the partners in the wartime Coalition government, and between the post-war Labour administration and medical interest groups: conflicts over what form health care should take, and over the imposition of charges in a service intended to be free (a decision which led to the resignation of the main architect of the service, Aneurin Bevan). It contrasts the high ideals and expectations of the designers of the NHS with the artificially low standards adopted and accepted in practice. Although by the tenth anniversary a consensus between the parties had emerged, the NHS was the issue which caused a fundamental split between left and right in the Labour Party - and which also divided the subsequent Conservative administration. Thus, apart from the book's obvious importance to those interested in health care, it is also a work of great relevance to the study of post-war politics.

The early history of the NHS exhibits the emergence of intractable problems, and many of these difficulties have left a permanent mark. The crisis which faced the NHS during its first decade exhibits striking parallels with the present, and many of the solutions canvassed then have been recently resurrected in the present debate. The early NHS is therefore more than just a distant echo; and this study more than just a chronicling of the dead past.

Published 28 April by HMSO on behalf of the Cabinet Office. Copies for review purposes will be available from the end of March. Please contact John Moore, P9A, Publicity, HMSO Books, St Crispins, Duke Street, Norwich. NR3 1PD.Tel.(0603) 694492
Problems of Health Care (ISBN 0 11 630942 3). Hardback, 246x156mm. 492 pages. Price £27.50.

Draft paper by
Dr C. Webster.

D

THE NATIONAL HEALTH SERVICE: LESSONS FROM HISTORY

Until recently very few aspects of health care in the present century had been the subject of reliable historical research. During its first thirty years the National Health Service attracted one short but outstanding historico-sociological study by Eckstein, and one useful medico-historical survey by Lindsay. Both were Americans, and American authors still dominate the scene. Since 1978, the thirtieth anniversary of the NHS, and coinciding with a gathering sense of crisis concerning health care, the position has been transformed. The health services have become a fashionable topic of historical research. Many able authors have written on the NHS, and especially on the origins of the service. Some have drawn on the more accessible public records. However, there are extensive opportunities for further research, and the first volume of my own official history, Problems of Health Care, the British National Health Service Before 1957 (HMSO, April 1988), although dealing with a period now largely outside the thirty-year rule, is based on documentation largely unexploited in previous studies. The next phase of this history will be concerned with the history of the service from 1957 to 1979. The second volume of the history will therefore provide a useful preview of a large body of documentation falling within the thirty-year rule, which is one of the purposes for which the peace time Official History series was intended. Access by official historians to this documentation ensures the preservation of historically important material which might otherwise be destroyed in

the course of the selection procedures currently in operation. Even if the direct results of the work of the official historians are imperfect, they enhance the quality of the documentary record available to their successors.

Although dealing with the more remote past, the first volume of the official history is not devoid of current relevance. Indeed, it is arguable that the nearest counterpart to the present crisis is provided by the earliest phase of the service, when the Labour government was faced by an apparent uncontrollable escalation of costs. A major crisis of confidence was precipitated concerning the viability of the service, eventually resolved by the establishment of an impartial review conducted under the Cambridge economist, Claude Guillebaud. The early history also gives an opportunity for reassessment of the factors leading to the abandonment of the mixed economy of health care in existence before the establishment of the NHS. Setting the NHS against this background is important in evaluating the increasingly strident claim that the NHS represented a fundamentally wrong turning point, breaking with deep-rooted traditions of health care built up over the previous century. This viewpoint is in fact the counterpart of the rival claim that the NHS marked a fundamental turning point for the reason that it created a system of socialised medicine in keeping with the radical social and economic programme of the Attlee administration.

NHS EMBRYOGENESIS 1918-1939

Both of the above hypotheses are open to question. As the 1944

White Paper, A National Health Service (Cmd. 6502) emphasised in its lengthy historical appendices, the pressure to consolidate and rationalise the existing health services had been rendered uncontainable by the wartime emergency. It was virtually impossible to return to the inefficient amalgam of services in situ before World War II.

It is even arguable that the starting point for the National Health Service should be located in 1918 rather than 1948. Although turning out to be something of a false start, the social reconstruction programme after World War I transformed the health services by establishing a cabinet-level ministry specifically responsible for health, and inaugurating a steady flow of legislation greatly strengthening the powers of local authorities to provide health services to specific groups. The immediate post-war effort was capped by the famous Dawson Report (1920), which contained a blueprint for a comprehensive health service with very much the same aims as the service established in 1948. Under the guiding hand of Sir Robert Morant the way was prepared for county councils and county borough councils to develop health services in parallel with the education services which they had been building up since the beginning of the century. Although, owing to the economic crisis of the time, the resultant health services materialised on a scale considerably less than was envisaged or appropriate, there was a substantial real increase in expenditure on publicly-funded health services, and this expansion escalated during the 1930s until these services constituted the largest segment in the health care

structure. The same period marked a sharp decline in the strength of the voluntary sector. The voluntary hospitals just about maintained their position, but only by such drastic measures as extending private patient accommodation, introduction of charges on patients, or new forms of contributory schemes, and finally by the injection of public funds on an increasing scale. This latter element amounted to 33% of voluntary hospital income by 1944.

The interwar period therefore constituted an important watershed in the development of health care in Britain. Notwithstanding the exercise of ingenuity in devising new means of financial support, voluntary agencies in general proved incapable of maintaining their contribution on anything like the scale required for a modern health service. The clear evolutionary trend was not towards a mixed economy of health care, but, as voluntary effort faded, the incremental replacement of private by public services. Already before World War II the term "National Health Service" was used to describe the increasingly comprehensive local authority health services.

1944 AND 1946 FORMULAE

During World War II thoughts on future planning remained consistent with Morant's blueprint. The interests of efficiency and economy seemed best served by carrying to a logical conclusion the policies pursued since the inception of the Ministry of Health. Thus, in the field of health at least, the famous planning initiatives for social reconstruction represented acceleration of an already existing

trend. The requirement for a comprehensive health service contained in Assumption "B" of the Beveridge Report seemed best met by further extensions of municipal health services, including assimilation of National Health Insurance administration by the local authorities, a possibility favoured in official circles since it was advocated in 1926 by the Royal Commission on National Health Insurance. The changes advocated in the 1944 White Paper would have expanded the scale of local authority administered health services from about £45m to about £150m per annum, including about £10m to be injected into the voluntary hospitals, which were expected to raise only £7m from their own resources. Although the White Paper included concessions made to the susceptibilities of the medical profession and the voluntary hospital lobby, the Coalition government and its Conservative Minister of Health had instituted a secular advance towards 'socialised medicine', as it was understood at the time.

The scheme introduced by Aneurin Bevan in 1946 was not quite the radical transformation sometimes imagined. In the interests of establishing a first-class service capable of capturing the confidence of all classes of medical practitioner and the whole population, Bevan offered major concessions to the critics. Even nationalisation of hospitals, the most innovative and controversial feature of Bevan's scheme, was regarded by consultants as a preferable alternative to gradual absorption by municipal authorities, which seemed the likely consequence of the 1944 scheme. The new administrative structure was attractive to hospital medical staffs because it seemed to offer a means for realistic financing

from public funds without sacrifice of their traditional freedoms, or transfer of control to remote bureaucracies. Indeed the highly devolved Regional Hospital Board - Hospital Management Committee structure adopted gave the medical profession a role in planning and administration that it had never previously enjoyed, while the other main elements on these committees were the former trustees of voluntary hospitals. As a further concession to the medical elite, thirty-six specialist and teaching hospitals were granted independence from the regional hospital authorities. General practitioners, dentists and opticians also escaped from the local authority net. Bevan recognised their status as independent contractors. For their purposes, the old NHI Insurance Committees were rechristened Executive Councils.

Instead of assuming the dominant role envisaged in 1944, the 1946 plan relegated local authorities to the least significant position in the new health service. They were left with a miscellaneous collection of clinics, and a promise of developing health centres, which never materialised, and was difficult to realise given the obstacles to liaison presented by the new service. The collapse of local authority control and perpetuation of a variety of alien features of voluntary hospital and NHI administration was offensive to the Labour Party. Consequently, although the 1946 proposals were defended for the sake of resisting further concessions, both Bevan and his colleagues recognised that the National Health Service as finally constituted would fall short of traditional socialist objectives. The tripartite structure of the NHS adopted by Bevan was

therefore not the result of deliberate socialist planning. In important respects it represented a final capitulation by the government in the war of attrition waged by effective and influential medical and voluntary pressure groups since the orginal plan for a simple and unified system of health service administration was unveiled in 1943. Simplification of health service administration evaded the Lab ur government in 1946 as it was to evade the Conservative government which devised the 1974 reorganisation, and no subsequent modification has achieved the simplicity of the original plan.

LABOUR'S CRISIS OF FINANCE

The formula worked out by Bevan had the effect of breaking with the long term trend towards local government finance of the health service. Instead of parity between rate and tax contributions envisaged in 1944, the 1946 scheme anticipated a 75% tax compared with a 4% rate contribution. The eventual burden on the exchequer was even greater than anticipated because the National Insurance Fund yielded only 10% rather than the originally intended 25% of the cost of the NHS. Although in the popular imagination the yield from the insurance stamp was supporting the entire health service, in reality it scarcely covered the dental service. The switch to exchequer funding of the health services was accepted with equanimity by the Labour cabinet, but it was perhaps not quite fully anticipated that this centralisation would elevate health service expenditure into a sensitive political issue. The dangers of this situation for the

Labour government became apparent even before the Appointed Day for the introduction of the new service on 5 July 1948. The preliminary estimates for the first nine months (July 1948 - March 1949) were considerably above the figures contained in the financial memoranda attached to the two NHS Bills (one for England and Wales, the other for Scotland), while the outcome for the first nine months was more than twice the level envisaged in the financial memoranda. Large supplementary estimates demanded for the first two years of the service resulted in adverse publicity for the government and precipitated a major crisis within the Labour cabinet. Even before the health services began, and eventually in The Cost of Health (1952), Dr. Ffrancgon Roberts argued that demand for health care and hence capacity to absorb public expenditure would be infinite, with the result that the "claims of physical health will conflict with the claims of economic health", offering the prospect that introduction of the welfare state would destabilise the economy and even precipitate the nation into totalitarianism. After 40 years of obscurity this thesis is taking on a familiar ring.

Such arguments emanating from outside critics and reinforced from the Treasury undermined the self-confidence of the Labour cabinet and provoked heart-searching concerning the prudence of continuing with the development of a free and comprehensive health service. Bevan's record on the expenditure issue was unambiguous. There is no evidence that he subscribed to the fallacy that an efficient health service was likely to become progressively cheaper as it conquered disease and sickness. Bevan admitted that the new service was likely

to incur some wasteful expenditure during the teething period. He predicted that in the longer term the NHS would call on ever increasing resources as it attacked areas of neglect on a realistic scale. Bevan therefore recognised that a comprehensive health service would be expensive, but he believed that it was a realistic objective for the welfare state. Bevan's colleagues were not persuaded by this expansionist philosophy. Consequently, after other methods of restraint had failed, a cabinet committee was set up to oversee control of NHS expenditure. This committee deliberated from April 1950 until the defeat of the Labour government. Its achievements were negligible. The committee became the main cockpit for the bitter contest between Bevan and Gaitskell. Gaitskell's aim to finance all expansion in the cost of the service beyond £350m by an expanding programme of charges and cuts represented a more radical approach to health service financing than attempted by any later government whether Labour or Conservative. Bevan's humiliation and resignation from the government, although generally represented as a failure, was not without positive results for his cause. The Labour cabinet was unwilling to concede to Bevan, but it was resistant to more than minimal departure from the principles upon which the NHS was established. The ceiling for exchequer commitment to the NHS was raised to £400m. The legislation of 1949 permitting a prescription charge was not enforced, while the 1951 Act introduced dental and ophthalmic charges on the most limited basis, the anticipated yield being £9m for the first year, about half of which was collected when the Labour government was defeated in October 1951.

CONSERVATISM AND CONSENSUS

Like its predecessor, the new Conservative administration was haunted by the spectre of rising NHS expenditure. Once again an audacious attempt at retrenchment was made, on this occasion by Capt. H.F.C. Crookshank, as Leader of the House of Commons and Minister of Health. Repeating the experience of Gaitskell, Crookshank found himself out of sympathy with his Party, backbench M.P.s and cabinet colleagues. Although charges were slightly increased, extensive plans for charges and cuts were buried, and they were not unearthed again before 1979. After a few months Crookshank stood down in favour of Iain Macleod, a chief advocate of One Nation Conservatism, whose period in office saw the NHS out of the troubled waters of partisan strife and into a prolonged phase of consensus. Like Bevan, Macleod was under pressure from the Treasury for containment of health service costs. The idea of a cabinet committee was abandoned. Instead the Treasury persuaded Macleod to accept an expert review. A small team, with no health service or medical representative, and headed by an economist, was commissioned to undertake a rapid review of the problem of health service expenditure with a view to making recommendations concerning curtailment of costs. The resultant Guillebaud Committee was appointed in May 1953, but its report was not published until January 1956. This committee was frustrating to the Treasury because its existence was used by the health departments to block action on other economy initiatives. The report itself was inconsequential. The review formula had therefore not assisted the Treasury case any better than the Cabinet committee, and it wasted

nearly three years. Worse still from the point of view of the apostles of retrenchment the Guillebaud Committee had commissioned an independent economic study by Brian Abel-Smith and Richard Titmuss, which far overshadowed the Guillebaud Report in quality and effectiveness, and which strikingly demonstrated that between 1949 and 1954 there had been negligible increase in the real cost of the NHS.

Also, allowing for the effects of inflation, it emerges that the NHS was costing only slightly more than the mixed health services of 1939. Consequently the phenomenon of escalating costs turns out to be largely an artefact caused by unrealistically low costing adopted in planning documents between 1944 and 1946. Introduction of the NHS had exerted a smaller effect on health service spending than was thought at the time and there was no substantial increase in the share of the nation's resources devoted to health care. Although such epithets as "escalation" or "spiralling out of control" have entered the historical mythology they scarcely constitute an accurate representation of economic events.

The Guillebaud enquiry marks a natural turning point in the history of the National Health Service. It ended the phase of self-doubt experienced by both Labour and Conservative governments which had persisted for most of the first decade of the service. Thereafter both political parties, as well as the medical profession, came increasingly to reflect the general public satisfaction with the new service. The National Health Service was increasingly cited as one

of the major issues upon which a political consensus prevailed. Thereby the NHS became consolidated as a major British institution, the seemingly invulnerable centrepiece of a universally accepted welfare state.

ROOTS OF CRISIS

However, the legacy of consensus should not obscure the degree to which the early NHS had planted the seeds of a longer term crisis. As demonstrated above politicians and civil servants were more successful than they thought in controlling costs. Before 1960 the expenditure of public funds on the NHS was limited to about 3.5% GNP. The major difficulty was that the arbitrarily chosen ceiling of expenditure of £400m adopted in 1951 was unrealistically low, with the result that expansion in services was largely dependent on efficiency savings, the scale of which was insufficient to deal with the major shortfalls facing the service.

The effect of this resource starvation during the first decade of the NHS is evocative of much later events. There was virtually no major capital development and even cost-effective modernisation was constrained. The state of the largely obsolete hospital stock steadily worsened. Hospitals were faced with long waiting lists, and there were shortages of staff at all levels. Because they were easier targets for economising, primary and community care were even more neglected than hospital services. Public alarm was expressed concerning conditions of the mentally sick and mental handicapped. Demoralisation set in when it became evident that the high

expectations aroused at the inception of the service would be disappointed. The stress of this situation provoked protests from leaders of the medical profession. Their letters to The Times in 1956 complained about the dereliction of British hospitals and they made unfavourable comparisons with our European neighbours, who had managed to undertake total reconstruction of their war-damaged hospitals. Strains within the hospital workforce were also evident among nurses, and medical auxiliaries such as blood transfusion and radiology technicians. In 1958 there was a 15% shortage of radiographers. The first general outbreak of industrial action occurred among nurses working in the mental and mental handicap hospitals in 1956. As in January 1988 this action spread out from hospitals the Manchester area. This may be a case of an accidental similarity, but the whole pattern of events taking place in the early years of the NHS reveals so many resemblances to the later situation that the question of their organic connection is at least worth considering.

In cases where present problems constitute a recapitulation of the past, a review of seemingly remote history may reveal the source of later difficulties, and therefore constitute a positive contribution to current thinking. It is indeed striking the degree to which seemingly unanticipated problems and apparently novel solutions turn out on closer examination to be reverberations from the past, even from the earliest history of the NHS. It remains to be seen whether the present administration will be more successful than their forebears under Macmillan in expanding the insurance principle and

reducing exchequer liability for the health service, or whether Labour will avoid recurrence of the disarray which turned the NHS into a public relations liability under the Attlee administration. It will be instructive to compare the results of present cabinet committees and "radical" reviews with their counterparts during the first decade of the NHS. Among the current nostrums finding their place in the first volume of the official history are prescription charges, limitations or charges for the dental and ophthalmic services, including consideration of the charge for dental checks, the limitation of the drug list available to general medical practitioners, and the idea of a retirement age for the latter. On this basis it is predictable that there will be a resurfacing of proposals for utilising National Insurance contributions as a basis for a system of compulsory health insurance, and for the introduction of an hotel charge for hospital in-patients. The merit award system for consultants will come under renewed scrutiny, and there will be further pressure for the more efficient use of consultants' sessions. There will be demand for the reduction in administrative and non-medical staff in hospitals. Renewed efforts will be made to devise improved methods of hospital accounting and norms for staffing in order to facilitate comparisons of efficiency. It will be impossible to refrain from thoughts of reorganisation. Among the more modest ideas will be consideration of abolition of the regional tier of administration. There is also likely to be consideration of a tighter corporate management of the hospital system, providing that community services can be hived off to local authorities, so

reversing the decline of the local authority role in the health services that has been taking place since 1948. Finally, it would also be consistent with the approach of Hugh Gaitskell and Captain Crookshank to consider exclusion of the family practitioner services from the NHS. It would be futile to pretend that the present agenda is entirely constrained by the past, but at least part of the present Government's reputation for radicalism and innovation will turn out to be illusory in the light of historical examination.