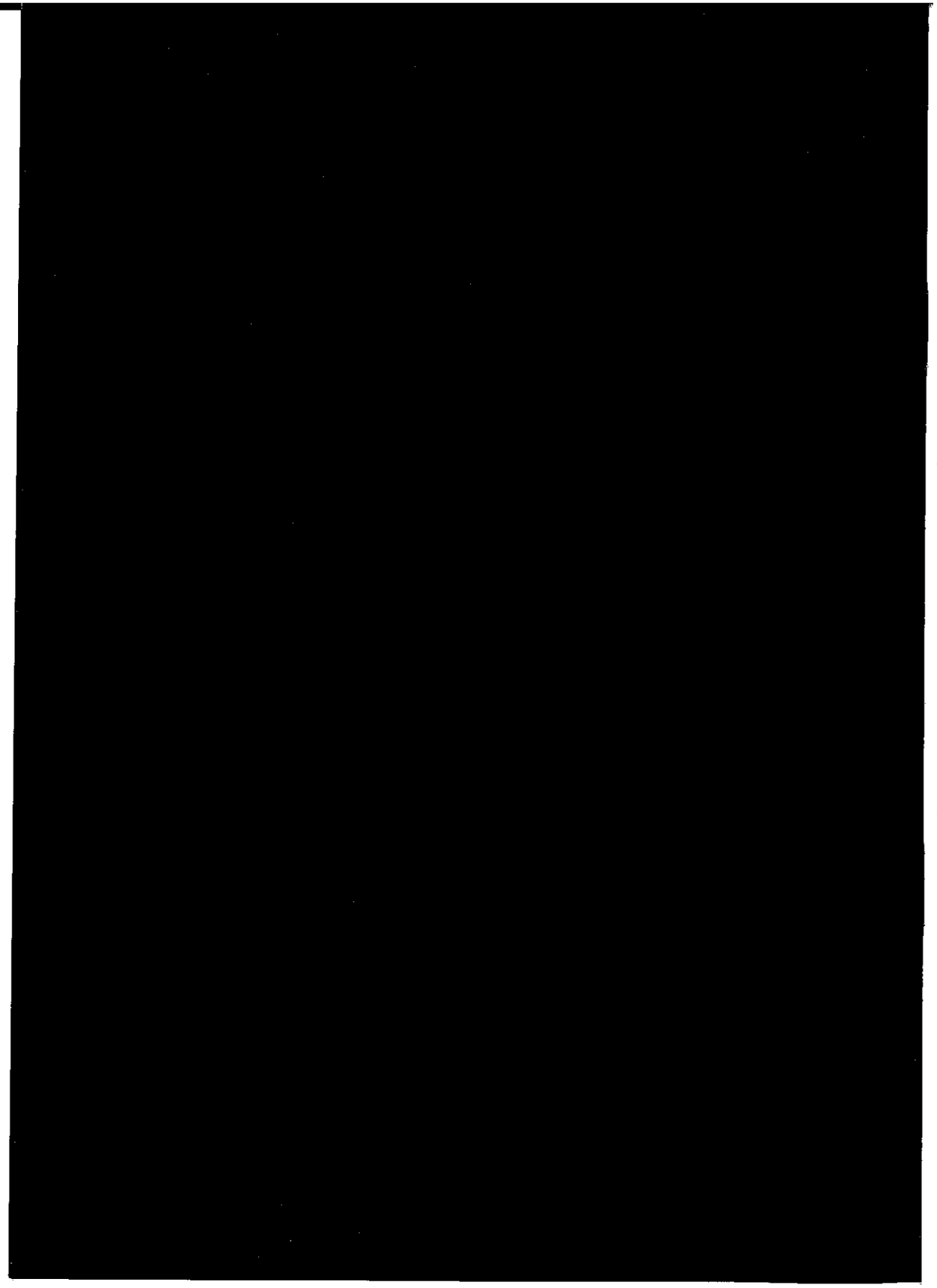

The Hebrew University of Jerusalem
The Paul Baerwald School of Social Work

The Richard M. Titmuss Memorial Lecture

"Can a Health Service be Comprehensive? The Example of the British National Health Service"

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Jerusalem, May 1997

The Titmuss Memorial Lecture: Jerusalem May 1997

"The Promise of a Comprehensive Health Service - the British Case"

John Carrier

I was fortunate to have been taught as an undergraduate by Richard Titmuss, and to have worked alongside the late Brian Abel Smith for the past 23 years. So I am grateful to you in the Paul Baerwald School and to the Hebrew University[1] for giving me the honour of an invitation to give this Annual Memorial Lecture.

I think Richard Titmuss would have approved of the title of this lecture - "The Promise of a Comprehensive Health Service - the British Case". He would have recognised the obvious challenge implied in the word 'promise': have the expectations, which were aroused at the time the British NHS was being constructed, been fulfilled? Were they reasonable expectations? I shall certainly address such questions throughout this lecture, although I have to admit now that these questions are usually asked in a more dramatic if colloquial manner, such as, can we (the UK) afford a national health service?

I have said that Titmuss would have approved of the challenge in these questions, not least because in three of his seminal works, Problems of Social Policy, (1951) Essays on the Welfare State (1958) and Commitment to Welfare (1968), he was both laudatory and optimistic about the possibility of a state-funded NHS meeting the health needs of the British population, while at the same time he remained sceptical about the claims of medical science to meet needs with the resources available, and critical of the administrative system's ability to ensure equity and accountability.

Titmuss died nearly a quarter of a century ago and since then scepticism has, if anything, increased. In the final chapter of his magnum opus, Problems of Social Policy (1951 p507)

[1] I am also grateful to Professor Abraham Doron for the original invitation and for his help in editing the lecture for publication.

entitled "Unfinished Business" he remarked upon the change in public, official and professional attitudes that had occurred during the Second World War. The main change was the assumption of Government responsibility for meeting the needs of its civilian population in Great Britain - a change from providing public services to meet the needs of the poor, and hence poor quality services, towards the legitimate responsibility of Government to meet the needs of all classes of the population.

"By the end of the Second World War there was a widespread belief that it was "a proper function of Government to ward off distress and strain among, not only the poor, but almost all classes of society and, because the area of responsibility had so perceptibly widened, it was no longer thought sufficient to provide, through various branches of social assistance, a standard of service hitherto considered appropriate for those in receipt of poor relief."

Seven years later, Titmuss was to temper this approval of the expanded role of government in providing the means, (economic, administrative and philosophical) of meeting health needs with this warning, which is as true today as it was forty years ago.

"It is (however) one thing for a society to agree on the importance of good health and good medical care; quite another for it to agree on how good health may be achieved and maintained by organising and distributing its medical resources in alternative ways". (Titmuss 1958 p.135)

The long and, for the most part, noble history of British public health has settled the question of the importance of good health and good medical care, although some, such as Rudolf Klein, were, by the mid nineteen seventies, drawing attention to the climate of the NHS being one of "the increasing ideological polarisation of politics, the revolt against the values of expertise, the interest in participatory democracy and, above all, the commitment to reducing public expenditure." (Klein 1989 p 108) At the same time radical groups were launching scathing attacks on the unequal distribution of *resources* for medical care, the unequal *access* to medical care by different social classes and the unequal clinical *outcomes* for those social groups. Today the main argument is still about the responsibility of Government for the organisation and distribution of resources to provide a comprehensive medical care service.

So let us look briefly at

Firstly, the history of the NHS since 1942.

Secondly, The economic context in which the service has developed.

Thirdly, some of the legal issues raised by scarce resources, where aggrieved patients have challenged their health care provision (or lack of it) in the courts, a recent addition to the social policy/health debate.[2] So this lecture is about the difficulties of fulfilling the promise of a comprehensive health service.

For such a promise to be realised, five understandings have to be reached.

(1) The meaning of the term "comprehensive" needs to be agreed between the public, the professionals and the politicians.

(2) The promise has to be politically acceptable, giving it legitimacy over and above the ownership of the political party which happens to be in Government at any one time.

(3) The resources to fulfill the promise need to be guaranteed through a national, non arbitrary, financing system.

(4) The promise needs to be delivered through a transparent administrative system with accountability clearly marked out.

(5) In the event of a dispute the legal system must be able to enforce redress through applying procedural not substantive criteria.

How has the British NHS matched up to these understandings?

1. The history of the NHS since 1942 and the meaning of a comprehensive health service.

As plans for a NHS for the UK were being formulated, some far more dramatic events were taking place, thousands of miles away from the British House of Commons. On 10 November 1942 a father wrote to his son as follows: "this battle is really over - and I have smashed Rommel and his army - it has been great fun and I have enjoyed it". This was the Battle of El Alamein, and the writer was Field Marshal Montgomery. Meanwhile, at exactly the same time questions were being asked in the House of Commons about an obscure sounding report; "When will the Beveridge Report on Social Insurance be made available to the House"? (This enquiry was squeezed between a question about Britain returning the Elgin Marbles to Greece, and a question

[2]Later on I draw on Newdick (1995) for the legal interpretation of this debate.

about placing disabled ex-servicemen poultry-keepers in the same category as the blind in respect of supplementary rations for their chickens). The report was published in November 1942 to great public excitement and was surrounded by political conflict. A left wing MP Tom Driberg claimed the report was being "sabotaged by powerful interests", an indirect but obvious reference to the Approved Societies. These were private insurance companies who administered, under the 1911 National Health Insurance Act, 100 million insurance policies, worth £74 m per annum with 40% spent on management costs. These were sold to the poor, who lost the entire benefit if they fell into arrears. Beveridge was interviewed by the Daily Telegraph, which claimed he had said his report would "take us halfway to Moscow". This he denied.

So what was all the excitement about? As Howard Glennerster (1995) has said, the report was written in the language of Bunyan's Pilgrim's Progress. No less a task lay ahead than to slay the five giants blocking the road to reconstruction; want, squalor, idleness, ignorance and disease. For generations of students of British social policy this clarion call was the catalyst for government programmes. Want would be eliminated by a social security system based upon national insurance and national assistance; squalor by a public house building programme; idleness by a commitment to full employment through a Keynesian demand management approach; ignorance through a state education system (not a private school education) and finally disease, to be eliminated by a publicly funded and administered national health service. Beveridge based the entire programme on the acceptance of three assumptions; that there would be a system of family allowances, a commitment to full employment, and for our purposes, and here I quote the famous Assumption B - a "comprehensive health and rehabilitation service". He goes on to say, "In one respect only of the first importance, namely limitation of medical service, both in range of treatment which is provided as of right and in respect of the classes of persons for whom it is provided does Britain's achievement fall seriously short of what has been accomplished elsewhere".

The entire history of the post second world war British National Health Service has been one of attempting to remedy this serious shortfall in "medical service", in the face of political, legal and financial obstacles. Assumption B was spelt out as follows:

"Assumption B. Comprehensive Health and Rehabilitation Services.

(Para) 426 The second of the three assumptions has two sides to it. It covers a national health service for prevention and for cure of disease and disability by medical treatment; it covers rehabilitation and fitting for employment by treatment which will be both medical and post medical"

(Para)427 "The first part of Assumption B is that a comprehensive national health service will *ensure* that for every citizen, there is available, whatever medical treatment he requires, in *whatever* form he requires it, domiciliary or institutional, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents".

Note especially the words *'ensure'* and *'whatever'* medical treatment required and in whatever form. Clearly, if this was to be made law, an economic hostage to fortune was being given. But he also went on to recommend that the health service be organised "by Departments (of State) responsible for the health of the people and for positive and preventive as well as curative measures"; and most crucially "be provided where needed without contribution conditions in any individual case".(Para. 427) But he did not attempt to estimate the resources necessary to fulfil this commitment to provision of a comprehensive service. Beveridge makes this clear when he states that "no final detailed proposals (even) as to the financial basis of this service can be submitted in this report"; (para 437) and "the figure given for the cost of the health and rehabilitation services is a very rough estimate requiring future examination. No change is made in this figure as from 1945 to 1965, it being assumed that there will actually be some development of the service, and *as a consequence of this development a reduction in the number of cases requiring it*" (my italics)

The health proposals were supported on all sides of the House of Commons in the debate on the Report (H o C. 16-19 Feb 1943) although sharp exchanges took place on social security. The Lord President of the Council, Sir John Anderson (famous for giving his name to the widely used and domestic backyard bomb shelter) praised the report, but commented that the expenditure involved was likely to be "formidable". However, the coalition government "would not be deterred by doubts as to finance from putting our plans on a comprehensive health service into shape". By comprehensive he meant

"A service covering the people as a whole, no one left out and inclusion of institutional

treatment to be administered by the Health Department not the Ministry of Social Security...the object is to secure through a publicly organised and regulated service that any man, woman or child who wants it, can obtain easily and readily a whole range of medical advice and attention through the general practitioner, the consultant, the hospital and every related branch of the profession with up to date methods, and the co-operation of public authorities, voluntary agencies and the profession towards one common end." (House of Commons, 1943, Cols. 1655-1678)

The Chancellor of the Exchequer, Kingsley Wood, clearly set out the financial implications of implementing Beveridge and listed government post war priorities such as housing, education and civil aviation as in competition with a national health service. In a deliberate reference to a comprehensive health service he said "generous hearts do not foot bills..... the financial aspect should be considered and weighted ..... we should not hold out hopes which we are not able to fulfill..... before we come to final conclusions we must obviously have regard to the costs and other claims that will be made". So, the *economic* warnings were sounded very early on. The *political* problem was to be how to ensure that Beveridge's definition of a comprehensive health service would become a reality.

The next stage was for the Ministry of Health to draw up a White Paper, (Cmd 6502) published in February 1944. After reviewing the contributions of all the professional bodies from the beginning of the century on the question of how to provide a comprehensive health service, including a four line paragraph on the Beveridge Report, the White Paper (p.76) summarized "in very general terms the principles most frequently occurring in the presentation of plans in the political and professional literature" as follows:

(a) That there should be made available to every individual in the community *whatever type of medical care and treatment he may need.* Titmuss (1958 p.141) believed that the term "Comprehensiveness"in the White Paper meant "the creation of a new public responsibility; to make it in future somebody's clear duty to see that all medical facilities are available to all people".

(b) That the scheme of services should be a fully integrated scheme,

(c) that for certain services, particularly the hospital service, larger areas of local administration are needed than those of any existing kind of local authorities".

The General Election of 1945 produced a Labour landslide, and it is said that at the HQ of the British Medical Association cheers rang out as the news of Beveridge's defeat as a Liberal candidate was announced. But, the comprehensive principle, summarized in the White Paper under the term "scope of a comprehensive service" as having two senses- 'available to all people' and 'covering all necessary forms of health care' was on the political agenda and certainly of the highest value to the incoming Minister of Health, Aneurin Bevan.
He had three immediate concerns; to include a comprehensive *hospital* service into the ambit of a national health service, (hardly given the prominence it deserved in the White Paper) the political objective of "*universalising the best*", and the administrative task of creating a '*national*' system.

The political science literature on pressure group politics defines the period 1942-48 and the struggle between Bevan and the medical profession, as a classic example in the field, a powerful profession up against a clever, ruthless, ideological and value-driven politician. Churchill described the period as "one of party antagonism as bitter as anything I have ever seen in my long life of political conflict."

The opposition of the British Medical Association (BMA) (representing general practitioners) to Bevan's scheme was based on a number of concerns described by Eckstein(1958), Abel-Smith (1964), Webster (1988) and Klein (1989). Dominant among these was the protection of the private income of doctors, the future of the voluntary hospitals, the fear of local authority control, the fierce opposition to becoming salaried servants of the state, and an antipathy to working in health centres. Each of these was Labour party policy, and all were surrendered by Bevan as the price for getting the other half of the profession, the hospital consultants, to agree to "come into" the service- described by Bevan as "stuffing their mouths with gold". For the general practitioners there was to be remuneration based upon capitation not salary, and no compulsion to work in health centres. Administratively the NHS was to be organised through a tripartite system, with the Ministry as the central body, and the three arms of hospitals, general

medical services and public health being administered by separate bodies.

Three major consequences followed from Bevan's negotiated deal nearly fifty years ago. The first was that control of costs for the NHS was firmly placed under Treasury, not Ministry of Health, authority; the result was to keep NHS costs as the lowest in the developed world.

The second consequence was the medical profession's victory for clinical freedom. Bevan strongly supported this, for example in his speech to the Medico-Psychological Association in 1945 he said

> "I conceive it the function of the Ministry of Health to provide the medical profession with the best and most modern apparatus of medicine and to enable them freely to use it, in accordance with their training, for the benefit of the people of the country. Every doctor must be free to use that apparatus without interference from secular organisations." (Webster 1991, p 26)

The third consequence was the rise in public expectations, based on clearing the backlog of medical need, a factor which was to continue to be responsible for future high demand. The seal of political legitimacy to Beveridge's ideal of a comprehensive service was given in Part One of the NHS Act, 1946. Under the rubric "Central Administration" the "Duty of (the) Minister" was set out thus:

1. -(1) It shall be the duty of the Minister of Health to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services...."

It is notable that the "purpose" was to provide services; nowhere is it stated what the *components* of such a comprehensive service would be. However, the later legislation (the NHS Act 1977 (Sec..3)) sets out that duty in more detail. Thus the context was prepared for future conflicts between professional discretion on the clinical components of the Service, Ministerial duties to see that such a service was freely available to the population, and Treasury control over the resources necessary to provide the professionally decided components of the service.

In summary, the principles of the new service were as follows:

1. There was to be universal entitlement for all to health care.
2. The funding of the service was to be through the system of general taxation, thus pooling individual financial risk.
3. The service was to be free at the point of use, detached from ability to pay, financial barriers and access thus being removed.
4. There was to be equality of access to a comprehensive range of primary, secondary and tertiary services, guaranteed by a geographical spread of services throughout the country.
5. There was to be an optimum standard of care for all, the service being available on the basis of need.
6. The service was to be based on the professional integrity of staff.

2. The Economic Context and Debates: Resources and Administration

Between 1948 and the present day, the NHS has changed from being *administered* to being *managed*, to being subject to *market* or quasi market criteria. Roberts (1990) has described this as being a movement from an "administrative stage" (1948-74) to a "planning phase" (1974-84) to the "management era". Economic realities tempered the mood of post-war euphoria almost from the beginning. Pinker has remarked that the British Welfare State was built at this time, but that its foundation stones were quarried and shipped from Fort Knox in the form of Lend Lease and Marshall Aid (Pinker 1979 p 60). Within the first year of operation, Bevan was forced to ask the House of Commons for a Supplementary Estimate of £50 m. Remember, this was the 'Age of Austerity'. Raw materials were rationed, there was competition for infrastructure schemes, (housing, schools etc.), the pound-sterling was devalued, the Korean war began, and Britain was trying, with soldiers on active service in the field, to disengage from Empire.

So, was Beveridge wrong? Was his prediction, that a NHS would improve the health of the population so that service costs would fall, naively optimistic, and a hostage to political and economic fortune? (Para 270 (3) Beveridge Report).

"Ah, but a man's reach should exceed his grasp. Or what's a heaven for?"
Robert Browning. Andrea del Sarto 1855.

A tentative judgement on Beveridge and Bevan, might be;

1. The administrative compromise lasted for 25 years until an over elaborate reorganisation took place in 1974, based upon a "top-down" centralised command and control model of administration, itself to be changed in 1982.
2. The Minister, with Treasury pressure, had absolute control in keeping down costs.
3. A very small percentage (3.4%) of GNP in 1948 (6.9% of GNP today) has been a remarkably low percentage of GNP for guaranteeing a comprehensive service. In the intervening years the percentage of real growth per annum on the NHS at 1988-89 prices has fluctuated between 1.1% and 3.5% per annum.
(Institute of Fiscal Studies, Election Briefing 1997) and Glennerster (1995)

Between the early 1950 s and the present day, the NHS has never been free from political controversy, mainly about the cost and the administration of the Service, and the medical "dramas" of waiting lists, postponed life saving procedures, and (in the 1960 s and 70 s) a series of spectacular patient abuse cases in long stay asylums.

The period began with charges being placed on prescriptions and later on dental and eye checks. The incoming 1951 Conservative Government immediately instituted an enquiry into the cost of the NHS (the Guillebaud Report, 1956). Richard Titmuss and Brian Abel-Smith produced an out-standing model of social and economic analysis. It demolished the argument that costs were spiralling out of control, demonstrated that the GNP going to the NHS had actually fallen in the early years of the service, and warned persistently that the future demographic and technological changes would have an inevitable cost push effect on the service.
The report also recommended an immediate capital investment programme of £20-30 m and warned about the deterrent effect of dispensing, ophthalmic and dentistry charges. Its main message was one of support; no fundamental change was necessary, the NHS was cheap, good value for money and no structural changes in administration were required.

The main issues of the 1970 s and 1980 s continued to be economic and administrative; how could we pay for the NHS and what were the most efficient methods of administering the service. There were policy changes, however, which although contingent upon the economic and administrative developments can be seen as having a significance in their own right. This was especially true of attempts by Central Government to establish priorities for the NHS(1976); and an emphasis upon prevention and health promotion(1976). Nonetheless, the attempt to redistribute NHS resources away from 'over-funded' to underfunded regions through the RAWP(1976) mechanism caused turbulence and the 'failed' attempt by the centre to introduce a strategic and operational planning framework once again emphasised the power of medical professionals to frustrate central direction, and the continuing spectre of scarce resources.

By the mid 1980 s therefore, although the political consensus on the place of the NHS in being the prime supplier of the country's medical care was unchallenged, the public relations image of the service was tarnished. In this the media's key role (quite legitimately) was crucial. The reports about waiting lists, overspending by health authorities, closed hospitals, children awaiting acute treatment, cancer patients on waiting lists, and patients queueing on trolleys in A & E departments all produced an air of crisis in the service and threw doubt on the scope and quality of a comprehensive service. A managerial strategy was the first of Mrs Thatcher's attempts to cope. She commissioned a report by Sir Roy Griffiths (1983), managing director of Sainsbury's, which recommended the introduction of General Managers into the NHS, with visible accountability and banishing the 1970 s ideology of consensus management,.

Nevertheless, this attempt to move from an administered to a managed service was simply a forerunner to the introduction of market discipline into the service. Reorganisation, General Management and efficiency drives were tried. The latter were exemplified by health authorities being forced, by law, to test their ancillary services in the market, especially the hospital 'hotel' services of laundry, catering and domestic cleaning (called compulsory competitive tendering). Criticisms of "privatizing" the service were voiced by the left and others, and Sir Derek Rayner, Managing Director of Marks and Spencer's was brought in by Mrs Thatcher to assess the efficiency of certain services - the so-called "Rayner scrutinies". The stage was therefore set for

a market solution.

In 1985 Alain Enthoven, an American academic health economist was in Britain on a six month sabbatical. In his brief monograph he suggested that the NHS was moving towards a New York "gridlock" and that what was required was a "solution" which would "free-up" the system. What better than a market of purchasers and providers to do this?

In 1987 *the* political crisis was the NHS, and in a pre election interview on the major current affairs television programme, Panorama, Mrs Thatcher had said, incidentally, that a working party of Ministers was examining the finances of the NHS. The Presidents of the Royal Colleges (Physicians, Surgeons, Obstetricians and Gynaecologists) had a meeting with the Prime Minister and asked for more resources to halt hospital ward closures, reduce waiting lists and alleviate the air of crisis. They wanted more resources and no reorganisation. Mrs Thatcher gave them a White Paper, Working for Patients (1989) and the market had arrived to deliver a comprehensive health service. The White Paper opens with the important statement (paragraph 1.2) that "the principles that have guided the NHS for the last 40 years will continue to guide it into the 21st Century" (Cm.555, 1989. paragraph 1.2). Could these principles sit comfortably with the market approach?

Enthoven's model was accepted - and an "internal market" (separating purchasers, health authorities and general practice fundholders, from providers, trust hospitals and community, usually mental health, trusts) was introduced through the NHS and Community Care Act 1990. For Trust Hospitals, three financial disciplines were imposed; (i) an annual balance on their income and expenditure account; (ii) an external financing (borrowing) limit; (iii) capital charging of 6% per annum on their assets, the implied rent being paid to Central Government. Local authority membership of health authorities was abolished, and hospital trusts were to be run by a hierarchy of executive and non executive directors. General practitioners were encouraged to become fundholders, and to buy services from hospitals and community trusts. In this way a commercial model of management was imposed on the NHS.

Assessments of the scheme since 1991 vary; Brian Abel Smith and Howard Glennerster (1995)

suggested that GP fundholders were succeeding in breaking the old hospital monopoly, and health authorities were disciplining hospital trusts through imposing tough "care" and "contract" specifications. But there have been problems in the immediate years following the introduction of the internal market. [3] To meet contract prices, job losses in the health service began to feature regularly; prominent trusts, especially the London Teaching Hospitals, at the cutting edge of research, with highly specialized services, expensive land and capital and high wage costs, were in trouble immediately. The Government through the Secretary of State and the new NHS Management Executive ordered a "steady state" and the internal market became the "quasi" market and some suggest, the "managed" market.

London, with its concentration of the nation's leading Teaching Hospitals, especially felt the impact of the market, and the political dilemma was one of letting the market clear at prices purchasers were willing to pay, risking closure of London hospitals, or to "downsize" in a rational manner through deliberate mergers, integrations and collaborations. All this was hastened by the publication of an influential Kings Fund Report on London (July 1992) which recommended a five year Task Force to plan the switch from hospital to primary and community care, with resources leaving the hospitals to support this reorientation of care, as well as the consolidation of London hospitals through merging the medical schools and reducing the number of students training in London and the Tomlinson Report (October 1992) which suggested mergers. The most spectacular victim of the market (and Tomlinson) was the 900 year old St. Bartholomew's Hospital.

In October 1993 administrative changes were announced to manage the "new" system. The Secretary of State introduced a functional model of tasks to be performed at the local level between Hospital Trusts , general practitioners, primary care providers and health authorities. At the central level, a NHS Management Executive (NHSME) was created with Regional Offices or outposts. The policy document claimed that two objectives were at the heart of the proposed changes;

1.To maximize the responsiveness of services to local people; and

[3]Although LeGrand suggests that such problems did not materialise in the early years of the reforms, and in particular that the "equity worries" of "cream-skimming" may be no more than "theoretical issues". Robinson and LeGrand (1993)

2. To achieve the best value for money for patients and the public from the use of NHS resources. To do this, the 14 Regional Health Authorities in existence since Bevan's day, were abolished and the NHSME with a central headquarters and eight regional offices were introduced; and District health authorities and Family Health Service Authorities were merged to form new health authorities.

In practice, the NHS Executive regional offices came into existence on 1 April 1994. The Regional Health Authorities were reduced from 14 to 8. Thus a new system of "super regions" was created. This was done ostensibly for strategic purposes, setting priorities, enabling and encouraging good practice, but above all, monitoring trust/purchaser activity.

3. Legal Challenges to the Comprehensive Ideal?

During this fifty year period the NHS has moved from a professionally/medically dominated service in which professionals were responsible for defining clinical need to a service in which needs are judged against resources so that financial/manpower restraints have become as important as clinical judgements. The system has always been cost contained with rationing implicit as a consequence. In theory the new system sets priorities through the decision making of purchasers so that the rationing process is made explicit. However, the "managed" market retains the most important features of the pre 1989 system, in particular the principles of a national system, financed by taxation. Whether it is now, or ever was comprehensive in cover, scope or geographical distribution with no explicit limits on health care, is now more obviously open to question and this has been tested, at law, on several occasions.

Three cases[4] which were the result of challenges to the denial by medical staff of services to patients were the subject of legal challenges before 1989. The first, R v. Secretary of State for Social Services ex. parte Hincks 1980) was an unsuccessful challenge by four elderly men to force a hospital to complete building an orthopaedic department so that they could have the clinically recommended hip replacements. Lord Denning in the Appeal Court (as Master of the Rolls) said "it is well established that actions against health service providers.....about.....services provided and (the) financial decisions allocating resources

[4]These cases are fully discussed in Brazier (1992). Kennedy and Grubb (1994). Mason and McCall Smith (1994). Teff (1994) and Newdick (1995).

(cannot be the) subject of legal challenge."

Why not? Because "Section I of the NHS Act 1977 imposes a duty on the Secretary of State for Health to provide resources... to the extent.....he considers necessary to meet reasonable requirements". [5]

Lord Denning continued,

"I have come to the conclusion that it is impossible to pinpoint anywhere a breach of statutory duty on the part of the Secretary of State..... It all turns on the question of financial resources. If the money is not there then the services cannot be met in one particular place."

In ex. parte Walker (1987) the Judge said that he detected

"a general criticism of the decisions as to the staffing and financing of the National Health Service....this court can no more investigate that on the facts of this case than it could do so in any other case where the balance of available money and its distribution and use are concerned."

And in ex parte Collier (1988) the judgement was summarized in the following way;

"The courts of this country cannot arrange the lists in the hospital, and, if (there) is (no) evidence that they are not being arranged properly due to some unreasonableness....the courts cannot and should not be asked to intervene." Both these latter cases involved babies with "hole in heart" conditions.

The case which has caused the most debate since the introduction of the internal market, was that of ex parte B (1995). Jamie Bowen (reporting restrictions were lifted to allow charitable fund raising) had been diagnosed as suffering from non-Hodgkins Lymphoma with leukaemia. She had undergone one total body irradiation, two courses of chemotherapy and a bone marrow transplant. After a relapse the doctors treating her felt no further remedial treatment should be administered, on *clinical grounds*, but only palliative care. However, a clinical professor at the

[5]As late as March 1997 a House of Lords decision supported this view by stating that "the cost of the arrangements and its resources were a proper consideration for a local authority to take into account in assessing, under Section " (1) of the Chronically Sick and Disabled Persons Act 1970, whether a person had a need and whether it was necessary to make arrangements to meet it.....some criteria had to be provided. In the framing of those criteria the severity of a condition might have to be matched against the availability of resources... (it was) unlikely that Parliament had intended that they might all be provided regardless of the cost" R v Gloucestershire County Council and Another Ex Parte Barry, (House of Lords, Times Law Report 21 March 1997) In an earlier case Lord Justice Hoffman said "No one is under a moral duty to do more than he can, or to assist one patient at the cost of neglecting another. The resources of the National Health Service are not limitless and choices have to be made." Airedale NHS Trust v Bland (1993) 1 AER 857.

Hammersmith Hospital, London, suggested a particular combination of drugs and a further course of chemotherapy. Other experts, from the Marsden (a cancer specialist centre) and Addenbrookes Hospital, Cambridge, disagreed. Child B's father consulted a private practitioner who estimated a 10-20 percent chance of complete remission if a further course of chemotherapy were given, and the same chance of success if a further bone marrow transplant were appropriate.

As already stated, Bevan had a firm view on the clinician's right to demand resources on behalf of the patient. The 1991 reforms, and notably this case, exemplify the problem. The chemotherapy for Child B would cost £15,000 and the transplant around £60,000. Dr Zimmern, the Director of Public Health for the Cambridge Health Authority had to advise the Authority as to whether they should allocate £75,000 as an Extra Contractual Referral for this case. He advised against, on clinical grounds, and the Health Authority accepted his advice. The father went to court to force the Cambridge Health Authority to allocate the money.

In the High Court, Lord Justice Laws supported Child B's case. He argued that the decision to refuse the allocation had not sufficiently considered the father's view. He went on to say that the Health Authority had taken a decision which, under European law, had interfered with a fundamental human right, i.e. the right to life, without showing substantial justification for doing so.[6] The Health Authority had argued that the needs of other patients had to be considered but "merely to point to the fact that resources were infinite told one nothing about the wisdom or legality of a decision...." The Health Authority appealed, and the Appeal was heard within hours.

Sir Thomas Bingham, Master of the Rolls, disagreed. "Difficult and agonising judgements have to be made as to how a limited budget is best allocated...That is not a judgement which the court can make. In my judgement, it is not something that a health authority....can be fairly criticised for not advancing before the court....it would be totally unrealistic to require the authority to seek to demonstrate that if this treatment was provided for B then there would be a patient C

[6]"Where, however, the question was whether the life of a girl aged ten might be saved by however slim a chance the responsible authority had to do more than toll the bell of tight resources. They had to explain the priorities that had led them to decline the treatment. They had not adequately done so."

who would have to go without treatment. No major authority could run its financial affairs in a way which would permit such a demonstration... it would be unrealistic to require it (the Health Authority) to demonstrate its funding priorities by reference to specific evidence."

So the brakes on providing a comprehensive service by reason of scarce resources has a history before and after the introduction of the internal market. But the internal market has elevated the potential conflict between clinicians and managers and the purchaser/provider split has sharpened this conflict.

To return to an earlier theme, until 1983 the NHS could be said to have been administered, not managed. A managed service is one in which managers not doctors have the power to make decisions about using the organization's resources and deploying them in the most cost effective and efficient way. Managers have been an easy target for criticism for the following reasons: First, their numbers have increased from 13,000 to 17,000 between 1991 and 1994. Secondly they are associated with the pejorative term "bureaucracy", the classic Weberian "iron cage" and "disenchantment of the world." But bureaucracy is necessary in a health service of this size. Until the demise of the Soviet Union, the NHS was the second largest employer of labour (1 million) in the world after the Red Army. At best, decisions are rational, issues are seen in context, stability is achieved, decisions are recorded, and standardisation and therefore equity of approach to similar cases is the norm, with discretionary and arbitrary judgements avoided. Spheres of competence are developed and accountability insisted upon. At worst, bureaucracy can be inflexible and means elevated above, and displacing ends. It is no surprise that following Griffiths (1983) and the reforms (1991), complaints against managers are about numbers, authority and costs. So authority clashes over resources between managers and clinicians were predictable. Legislation always generates implementation costs, and the Audit Commission (1995) has estimated that in each year from 1991 an additional £70 m has had to be allocated to the health service in England and Wales, to protect the finances of authorities and trusts where contracting estimates have been inaccurate, and to provide new personnel and information. However the Audit Commission have also estimated that the total management costs (defined as those in management earning over £20,000 p.a.) are between 3.5 and 10 % of total costs.

Expectations and the Future

So, did Beveridge and Bevan promise too much? Has the UK over-reached itself as a nation capable of providing comprehensive health care? Is the NHS a victim of anti-welfare state rhetoric?

These questions often boil down to the relationship between economic theory and public spending. Whilst William Petty described economics as "the arithmetic of woe"

John Stuart Mill's advice was (1867)

" study the great writers on Political Economy, and hold firmly by whatever in them you find true, and depend upon it that if you are not selfish or hard-hearted already, Political Economy will not make you so."

The Keynesian/Monetarist debate of the 1980 s has affected the NHS. The NHS as a significant and symbolic part of public expenditure came into conflict with monetarism and market theories, and towards the end of the 1980 s monetarist/market theories exposed the NHS on four fronts;

1. A public health system has had to contend with growing public demand for health care.
2. Fiscal constraints were introduced in response to a perceived fiscal crisis (tax resistance).
3. Bureaucratic rigidity had set in.
4. The media were reporting abuse, scandal and falling standards.

However, in the British NHS because of its history, a culture of public service expenditure, recognition that markets have deficiencies, and a tradition of political compromise, the quasi market very quickly replaced the full internal market.

Early research results (two national surveys of District General Managers by the University of Bath) suggest the 1991 reforms have had the following advantages:

- The clarification of roles in the purchase/provider split;
- The focus on health needs/care has been more patient centred;
- Quality issues are emphasized more;
- Better information is available.

Provider accountability is increased;

There is some evidence on improvements in efficiency; for example "in-patient" numbers in hospital have risen by 3.5% , occupying fewer beds; and outpatient attendances have risen by 3.2%. Glennerster's research(1994) on general practice fundholders suggests that market power on behalf of patients is beginning to be wielded , but with reservations about "cream skimming" and "two tierism".

Quasi market pressure may have opened up and made visible long standing problems, especially on "hidden rationing". It has certainly resulted in restructuring the delivery system, changed provider patterns, and closed hospitals. It has concentrated upon value for money, but has had social and political costs in terms of forced closure of hospitals. Above all, it has emphasized the importance of good monitoring and audit.

What are the consequences of an internal or quasi market for a comprehensive health service?

The first consequence is explicit rationing, for example whereas in Oregon (USA) services were to be included or excluded by democratic referendum, in Berkshire (UK) a saving of £7 m was planned by the Health Authority eliminating unnecessary procedures such as tattoo removal, buttock lift, rhinoplasty, and infertility treatment. The NHS will cost nearly £35 bn. in 1997/98 (Financial Statement and Budget Report 1997/98 - 26 November 1996 HMSO) a considerable sum of money. However in relative terms consumer spending on tobacco and alcohol last year was £35 bn, and £46 bn on food. (Alcohol and tobacco account for nearly 9% of total household expenditure and food nearly 12%.)

Perhaps the only way to meet the demands for comprehensive health care is to raise the money by additional general taxation. All alternatives to taxation have problems, of collection, fairness and administrative cost, and compulsory private insurance, charges, top-up fees, and lottery money are uncertain and inequitable.

Is additional taxation a possibility?

Much depends upon the perception of the "tax burden" and the purpose of revenue raising.

Using Richards and Madden's paper "An International Comparison of taxes and social security contributions (1984-1994)" the evidence shows the UK is a relatively low tax society. If we take total taxes and social security contributions as a percentage of GDP the figure for the UK in 1994, was 34 %; in 1984 it was 37 %. In Germany in 1994 it was 43% up from 41% in 1984 (Chart 1 Economic Trends, Nov, 1996 HMSO) Over the same period direct taxes on households and social security contributions as a percentage of total personal income (including employers contributions) rose from 27% to 28% in Germany and fell from 20% to 15 % in the UK (Chart 6 as above) In 1994 taking total taxes and social security contributions as a peercentage of GDP, based on national accounts, the UK was thirteenthh out of fifteen developed countries, at 33.4%. Only Switzerland at 33.1% and Australia at 30% were in lower positions, (Table B Economic Trends, November 1996, as above). Occupying the first rank was Denmark, at 51.6%. It is therefore possible on this evidence to state that the UK is not "overtaxed" in comparison with other developed countries. .

The message is obvious. A comprehensive health service as defined in this paper can only be delivered if the resources of political purpose and economic leverage are used. In the UK 1 p on the standard rate of income tax raises £2 bn. Two per cent of £35 bn. is £700 m, the resource to meet the needs of the elderly, innovation, and legitimate public expectations. To make a reality of the 1940's vision means paying for it. The economy is growing between 2½ - 3% per annum so it should be possible to fund the 2% required with some additional taxation.

Looking Ahead

The UK is a frugal spender compared with other countries. Our own consumer expenditure could be subject to deterrent taxation on health damaging products. New technology would be evaluated by audit and the results published and openly debated. We should give the current system time to settle down and be evaluated, even if the idea of a quasi market is unacceptable. Eight major changes in 50 years is too many. (This is written during a British General Election Campaign). We could re-emphasise the purpose of the NHS as defined by Jenny Lee, widow of Aneurin Bevan, at a twentieth anniversary NHS conference:

"To ensure that everybody in the country irrespective of means, age, sex or occupation, should

have equal opportunity to benefit from the best and most up to date medical and allied services available. We were going to provide for all who wanted a comprehensive service covering every branch of medical and allied activity, and we were to encourage the provision of early advice and the prevention, not merely the treatment, of ill health. That still stands. (DHSS 1968, p 10).

Richard Titmuss' main theme in his writings on the NHS was that it is one of the most civilized institutions in the world (Titmuss, 1958 p 135). The "comprehensive promise", properly funded and administered in an accessible manner, has been responsible for this civilising effec

In the current climate of "crisis" in the NHS it is important that Beveridge is not rewritten in the following way:

> "A comprehensive NHS might, if resources are available, be offered to those who can prove they are citizens of the UK in the form judged most appropriate by the medical profession after considering all other calls upon scarce resources; the definition of comprehensive medical care will be allowed to fluctuate year by year depending on public expenditure decisions. Responsibility for organising the service, funding the service and employing health service staff shall be the legal duty of the Treasury whilst the Chancellor of the Exchequer can, if he deems it necessary, veto any policy of the Minister of Health.

Although the NHS shall be funded out of general taxation, charges for non-life threatening episodes requiring medical advice and treatment shall at the discretion of the DHA, Trust Hospitals or GP fundholders be levied and enforceable at law. Self-induced ill-health, injury, disease or disability through health-threatening activities for example smoking, excessive drinking, unsafe sex, dangerous sport, overdosing, driving accidents where fault is proved, shall be paid for by an additional levy on the NI contributions of the individual concerned, until the cost is paid off; or if not paying those contributions, by a charge which shall be enforceable at law. The local Director of Public Health shall have the responsibility to assess on behalf of the DHA, the Trust and the GP Fundholders which individuals shall be so charged. Individuals will be allowed to top up health care with additional contributions. Such topping up once agreed will be reflected in different

waiting times for treatment, and facilities, for top up and non top up patients." I sincerely hope not.

The NHS may have its faults. As Raymond Chandler said in another context, "The second floor was lighter and cleaner but that didn't mean it was clean and light."(p 190) There have also been stunning successes and progress since 1948 has been remarkable by any standards. It is probably the most popular British institution, referred to as such by many politicians in the recent General Election.

Let me end by quoting TS Eliot,

"We shall not cease from exploration,
And the end of all our exploring,
Will be to arrive where we started
And know the place for the first time."

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