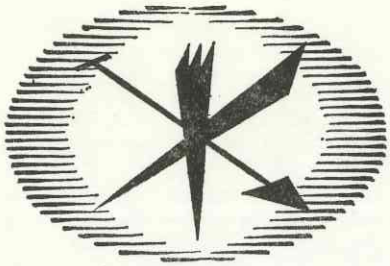

OPPOSITION
GREEN PAPER

Health Care

Report of a Working Party

LONDON
THE LABOUR PARTY
20p

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Report of a Working Party

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Foreword

This document is the eighth to appear in the now well-established series of Opposition Green Papers and I have no doubt that it will arouse as much interest and comment as earlier publications of this nature.

The health service has always been an area of policy of particular concern to the Labour Party. It was, of course, a Labour Government which established our National Health Service and we are anxious to build upon existing achievements and improve the service, especially in those areas where it has been eroded by Government policies. It is surely in the provision of preventive and curative medicine that the failings of individual as against collective provision are most evident.

The NEC publishes this document in the full expectation that it will be widely read and debated both within and outside the Party. The proposals therein are submitted on this basis and do not constitute final policy decisions (indeed those members who have worked hard to prepare the report would not each agree with every proposal made) but are a basis for debate after which decisions can be made. I hope that this Green Paper like others before it will lead to the creation of clear socialist policies relevant to the aspirations of the Labour movement and the programme of the next Labour Government.

I should like to take this opportunity to thank the Chairman and members of the working party for their valuable contribution to policy formulation within the Labour movement.

R. G. Hayward, C.B.E.

General Secretary.

Transport House,

August, 1973.

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Transport House,
August, 1973.

Health Care

Report of a Working Party

The Working Party first met in October 1972 to consider various papers submitted to the Social Policy Sub-Committee of the Home Policy Committee. Meetings continued on a very regular basis in the months following and as a consequence of discussion and papers submitted this report was produced as a contribution to debate on the issues raised.

Signed:

DR. JOHN DUNWOODY (*Chairman*)
NICHOLAS BOSANQUET
Rt. Hon. BARBARA CASTLE, M.P.
FRANK HONIGSBAUM
LAURIE PAVITT, M.P.
AUBREY SHEIHAM
Dr. SHIRLEY SUMMERSKILL, M.P.
SUE LANCASTER (*Secretary to the Study Group*)

Health Care

Report of a Working Party

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CONTENTS

Introduction

Private practice, arrangements for the drug industry, administration—these three subjects have dominated recent discussion of health in the Labour Party. These matters are important, and are dealt with in this Green Paper. But such concentration overlooks other questions of vital importance to patients and to the community. This Green Paper is about vital policy choices and priorities which have had far too little discussion within the Labour Party as in the country generally.

We begin with suggestions for action towards better health through other areas of social policy. For example, a major increase in pensions and better housing would be vital steps. For the N.H.S. our priorities are spelt out in the following sections:

Community Care. Our aims are: To arrest the fall in the share of resources going to the family doctor service; to change the overwhelming bias towards hospital medicine in medical education; to move towards integrated employment and educational structures in which all branches of medicine would have equal standing; to develop health centres, with flexible experiments in different types and sizes; and to enable certain specialties particularly pediatrics, geriatrics and psychiatry to get in better touch with the community.

Further, to provide the resources needed to make real the rhetoric of community care and to shift the emphasis in care towards rehabilitation.

Ending Neglect. Standards of health and care differ both within and between regions. We suggest a deprived areas programme for the N.H.S. to be financed directly by Central Government.

We make proposals for three particular areas of neglect: rehabilitation, waiting lists and the dental service. Services for rehabilitation will need many more staff in the remedial professions, as well as changes in community services. We think that the way to shorter waiting lists lies through improved organisation. In the dental service we would like to see much more emphasis put on prevention through flouridation. We also suggest why dentists should be given a choice between present conditions of service and a new start in a salaried service.

A Better Deal for Staff. The N.H.S. is not a good employer at present. We need an immediate review of the pay levels and pay structures of nurses and of other ancillary, technical and remedial staff. The Reports of the National Board for Prices and Incomes on Pay in the Armed Forces are the precedents here. In the longer term, we suggest reforms of the Whitley Council system so that it should operate more openly and should be able to look at pay and manpower considerations together. Finally we need new financial commitments to the training of nurses, remedial and technical staff and to the induction training of immigrant doctors.

Resources for the N.H.S. We are worried about the direction of research under present arrangements for the drug industry, as well as about levels of prices and profits. On a basis of public ownership, we advocate a search for new arrangements by which people concerned with drug research and production can work closely with clinicians as well as with scientists in universities. The conventional nationalised industry does not provide a model here. We also want to see public ownership of firms concerned with equipment for rehabilitation, and new initiatives on medical records.

In the long term, the future of private practice will depend on the standard of service in the N.H.S. But there is no reason why private practice should be encouraged. In fact, if the N.H.S. is to have the resources to provide an effective service, it must discourage private practice.

Avoiding Bureaucracy. We advocate a much simpler statutory framework of administration with the major tiers at the national and area levels. We want to see strong local authority and staff representation on the new area administration and powerful consumer councils at district level, and possibly an element of direct election.

We may unite the service in administration. But this is not a substitute for choice in policies. Such choices must be made if the men and women of the N.H.S. are to be able to make their full contribution and patients are to receive better care.

Chapter 1.—
Social Policies and Public Health

Four main forces have contributed to better health since the War: changes in social conditions, the increase in the therapeutic skill of doctors and other health staff, improvements in organisation and changes in community attitudes. Commonly developments in medical technology and in pharmacology are given pride of place. Clearly these have been extremely important, but their effect is often exaggerated. With higher real incomes has come better diet for most children; improved housing has meant much. Before the war there was a failure to bring to all patients the best possible standards of medical care then obtaining. A B.M.A. Report on fractures in 1935 showed that 37 per cent of a sample of patients being treated in ordinary hospitals were suffering permanent disability, compared with about 1 per cent of patients treated in special fracture clinics.

Our belief is that the same combination of forces will contribute to progress in the immediate future—and we would be making a great mistake to neglect any one of them. We begin by looking at action for better health through wider social policies.

Perhaps the one immediate step that would do most—in the long term—for health standards would be to raise the level of pensions substantially. At present far too often retirement is a prelude to physical and mental decay. When people retire their income drops and they become less active. Their physical and mental health worsens. They then become less able to take on part-time work, so that their income falls further while the costs of support rise. All too often they become unable to look after themselves and are forced to give up their independent lives. Through the levels of pensions and the rules on retirement associated with pensions we have created a new world—the world of the old age pensioner. It is a world of poor health, of isolation, of restricted opportunities and of low incomes. To retire is for many to move back on a time machine to the standards of incomes and expenditure of fifteen or more years ago. Research is now charting this world—not the least recent research being that on the prevalence of hypothermia among the elderly.

Some people want to retire and enjoy retirement. Others do not. We need to change rules on retirement so as to give more opportunity for individual choice. But the first step is to raise pensions substantially. This would mean that people were more able to obtain for themselves adequate food and heating and better able to enter into community life.

Another obvious priority is a decent home. The mental and physical effects of poor housing on people can be considerable. But the effects of ill planned housing—the urban steppes of some new housing estates—can be equally unfortunate. To assure for every family a decent home at a reasonable cost seems a visionary goal. But it is an aim that is essential to better health.

There are many other ways in which we can work for better health through social policies:

The level of family allowances has been miserably low. We need to give proper support to families;

We need full employment and a redistributive incomes policy. Unemployment and low pay can result in physical and mental stress and even in organic disease;

Tax policy affects the consumption of different kinds of food and tobacco. We deplore the exemption of sweets and chocolates from V.A.T.;

The diversion of heavy freight to the railways could save many lives. Recent studies show that collisions between heavy lorries and motorists have gruesome results. There are only about 123,000 lorries on the roads of over five tons unladen weight—out of 13 million vehicles. Yet they are involved in a high proportion of all fatal accidents;*

Active recreation and the opportunities for it is desirable for its own sake and would have good results for health. It would "add life to years, not just years to life";

Finally, we need new initiatives in industrial safety. The recent Report of the Chief Inspector of Factories commented: "Perhaps the greatest obstacle in the way of further improvement is the sheer indifference of some companies to the safety of their workers". For many years we have relied with some good results on an essentially voluntary approach. But much informed opinion is now coming to feel that this is no longer enough. We need stiffer penalties and more ready enforcement of them by the Courts. We agree with a recent editorial in the *British Medical Journal* that "there does now seem to be some evidence that a more forceful approach will sometimes be needed."†

These general changes in social policy could over a period of years achieve a good deal. But we also need changes in the health service itself.

What then are the priorities of better health care over the next five to ten years? We do not underestimate the difficulties involved in change. It takes time to train staff, and to alter the pattern of service. Significant improvement can only come from steady work over a number of years. The danger now is that we will lose those years in lip service to change.

We may unite the service in its administration. But this is not a substitute for choice in policies. Such choices are badly needed if we are to:

—give meaning to community care;

—improve care to neglected people and neglected regions;

—make better use of the time and concern of staff;

—improve material resources and avoid bureaucracy.

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*W. Gissane & J. Bull, *British Medical Journal*, No. 1, 1973.

†Editorial, "Buried Alive", *British Medical Journal*, No. 4, 1972.

Chapter 2.—Community Care

The Family Doctor

The first priority in community care is a better balance between the hospital and the family doctor service. Family doctors do the brunt of the work and our service is widely envied abroad. But G.P's do not have enough opportunity at present to do work of a high quality. The Family Doctor Charter has done a good deal to improve their pay; the problems of working conditions and professional standards remain. Family doctors do their work in a number of unfavourable circumstances at present:

—Spending on the G.P. service has declined as a share of total spending since the beginning of the N.H.S. In 1951–52 it amounted to 9·8 per cent of total spending in the U.K. as against 47·5 per cent on the hospital services. By 1971–72 the G.P. service was getting 6·9 per cent and the hospital service 57·1 per cent.

—The number of doctors (unrestricted principals) in General Practice has risen rather slowly. In 1949, there were 20,057 G.P's: by 1971 there were 23,252, in Great Britain. Over the period 1949 to 1971, the number of hospital doctors in England and Wales almost doubled—from 11,735 to 23,806. (The increase in numbers of U.K. trained doctors may have been rather more similar in the two parts of the service.) Between 1963 and 1970, the average size of the G.P's list in England and Wales rose from 2,327 people to 2,460.

—The individual G.P. still works far too much in isolation. About a quarter are still in single-handed practices; even in partnerships there may not be much contact. Most partnerships have been formed for reasons of financial and work convenience. One study in 1966 found that 40 per cent of G.P's hardly ever saw another doctor for advice and over 30 per cent not more than 5 times a month. Yet only 19 per cent of doctors in the study were in single-handed practice.*

—The G.P. is also isolated from hospital medicine. The division has become sharper since 1948. Clearly the G.P. surgeon had no future—but many other aspects of the separation have gone too far. As a former Director of the General Practice Research Unit at Guy's Hospital, Dr. R. Smith put it in 1968: "We find that the walls are going even higher at the moment and that there is an ever-increasing move to keep the general practitioner out".†

—G.P's generally lack equipment and too many are still working in poor conditions. Only ten years ago a survey showed that a third of G.P's did not even have a wash basin in their surgeries.‡ The physical conditions of surgeries may have improved considerably since 1948—more recently with the availability of loans from the General Practice Finance Corporation. But financial help has been for premises—not for equipment.

—Many G.P's do a rather limited range of work, and give short consultations. Local studies suggest that the range of work done is most narrow and consultations shortest in areas where lists are long. Some G.P's appear to keep poor records and in one study a sample of letters sent by them was thought to be

*D. Mechanic (1968) *Medical Care 6*.

†F. Honigsbaum, *Journal of Royal College of General Practitioners*, No. 22, 1972.

‡A. Cartwright & R. Marshall, *Medical Care*, No. 3, 1965.

"grossly inadequate". There is much that needs to be done to raise the standards of care in general practice—although this should certainly not be taken to imply that we think that hospital standards are above criticism or indeed always better.

—Medical education still shows an overwhelming bias towards hospital medicine. Yet a high proportion of doctors will spend their working lives in an entirely different type of work—general practice.

The recommendations of the Todd Commission on this question were modest enough. It urged that *every* undergraduate should be given an insight into general practice, although it did not specify how this was to be done. Some evidence suggests that there has been only mixed progress even towards this modest goal since 1968. The number of schools in which all students are taught general practice had increased from 8 in 1965 to 22 in 1972. The longest period of time devoted to the subject is four weeks in the final year—and the shortest eight mornings in the fifth year. A study of 89 vocational trainees in 1972, suggested that about 60 per cent of them had had some undergraduate experience in general practice—but only 37 per cent of them as a result of a required course.* The number of Chairs in General Practice at universities is one index of interest. For some years 3 have existed in Scotland and 1 in Northern Ireland—but there were none at all in England until 1972, when one each was created at the Universities of Sheffield and Manchester. At the University of London none still exists—even though it produces the largest number of medical graduates in England. There has been some increase in the number of departments of general practice—from one in 1965 to 11 in 1972.

—General practice is still far too widely seen in the medical profession as a job with lower status. The problem is not just one of resources but of mental separation between hospital medicine and general practice—a separation which adversely affects both sides. We agree with the Report of a Working Party in Scotland, chaired by Sir John Brotherston, that the time has come for change. As that Report puts it: "In the long term . . . suitable trained general practitioners appropriately equipped would not require to refer so many clinical problems to consultant general physicians as they now do and should also contribute to the hospital in-patient care of their patients."†

—Many G.P's are ill-equipped either by education or outlook to give adequate help to people in mental distress. Patients are putting increasing demands of new kinds on the service—demands which it cannot meet.

The changing balance of resources and the separation between general practice and hospital medicine has had serious consequences for patients. It has accentuated the bias in our health services towards caring for isolated episodes of illness rather than towards care for people. It has contributed to the neglect of those kinds of care which span both the hospital and the community—such as rehabilitation, the care of chronic illness, psychiatry and geriatrics. It has meant that family doctors have not been able to rise through the quality of their work to the great confidence which patients place in them. Without new initiatives the effects of separation are likely to become even more serious in the future.

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*C. K. Drinkwater, *British Medical Journal*, No. 4, 1972.

†Scottish Home & Health Department, *Doctors in an Integrated Health Service*, H.M.S.O., 1971.

Demand for the kinds of care which span both the hospital and the community are growing. Even in other kinds of care such as surgery, we are likely to see more schemes for planned early discharge which put greater responsibility on family doctors. With larger new hospitals, which are hard for many people to get to and the concentration of casualty work on special units, the G.P. may be called on more often to deal with smaller emergencies.

We turn now to remedies. In the long term the aim must be an integrated employment and educational structure, in which general practice, hospital medicine and other branches of medicine have equal standing and where doctors in training can gain experience in both hospital and in the community.

(*i*) **Resources.** We would like to see experiments quickly. For example, there could be registrar level posts in general practice for young physicians. In the longer term the service will be based mainly on health centres, where G.P's will obviously work closely with other health professions and with the social services. There are a number of steps which can be taken quickly towards these aims:

On present plans the General Practitioner Service's share of total spending is projected to fall once again. "Public Expenditure to 1976–77" shows (although on a different basis from the figures set out earlier) that spending on the Family Practitioner Service was 20·5 per cent of the total spending in 1971–72—and is planned to be 18·9 per cent in 1976–77.* While the major increase in spending on the community services, including health centres, is welcome, we find a lack of balance. In many respects the G.P. is the key figure in the community services. Yet in the present plans, there is only to be a very small increase in the number of G.P's. Even by the end of the decade at most 20 per cent of G.P's will be working in Health Centres. There is very little in the present plans which will help G.P's to do a better job. There will foreseeably be little change in their conditions of work: and in the equipment and facilities with which they do their work.

We need new financial help towards re-equipment, the employment of ancillary staff and improved conditions. The provisions under the Family Doctor Charter were a start—but they are not now enough. The new help to G.P's should concentrate not mainly on amenities but on the basic tools for the job. In the long-term, health centres will be the basis for a changed role and for greater scope in the G.P's work. But in the meantime we must do much more to help G.P's to do an effective job within the existing structure of practice. Detailed proposals for new forms of financial and professional help to G.P's would need to be worked out in close consultation with the profession, with local and with health authorities. They would involve increased resources for the kinds of care where the G.P. does often carry the main responsibility at present—rehabilitation, the care of long-term illness and the care of intermediate mental illness. But in various forms the new help to the G.P. service should be on a substantial scale. It should reverse the trend towards reduced spending on the General Practitioner Service which has been evident over so many years.

(*ii*) **Education.** The overwhelming bias towards hospital medicine in medical education must be sharply changed. For the undergraduate, we think that the Todd Commission did not go nearly far enough. It is not simply a question of students getting the flavour of general practice, through a few weeks as a medical tourist.

**Public Expenditure to* 1976–77, Cmnd. 5178, H.M.S.O. 1972.

It is a question of their learning some of their medicine in a community setting and of seeing their patients not in the highly artificial world of the hospital, but in their own homes and communities. We think that many G.P's have a good deal to offer in teaching at present, not least in the care of mental distress and in what are called—but often do not appear so to the patient at the time—minor ailments. The opportunities for undergraduate medical education in a community setting will grow even further, as a consequence of proposals we make later for the movement of certain clinical specialties which are at present hospital based towards the community. Within ten years we would hope to see a substantial proportion of undergraduate medical education being carried out in a community setting.

The proposals of the Todd Report for post-graduate training were a good deal more far-reaching than its proposals for undergraduate education. The Report called for five years of vocational training after qualification, which would put General Practice on the same footing as other specialties. There would be a Vocational Register, to be entered after an 11 year period of training, and the Report envisaged that ultimately no doctor would be allowed to practice independently as a Principal in the G.P. service until he had been admitted to this Register. In discussions since, the period of vocational training has been cut from five years to three years and the date at which such training becomes compulsory has been postponed from 1971 to 1977. Even these proposals have met with a certain scepticism. At the moment the number of places for training is very limited. Only about 160 places are available and about one third of these are not considered suitable for training post-graduates, because of the quality of the teachers. Yet by 1977 between 1,300 and 1,900 places will be needed to cope with all the potential recruits. The financial inducements both to take training and to give training have recently been improved. But these are only first steps. There is a tremendous amount to be done if we are to provide proper post-graduate training for G.P's. We think that this should have as high a priority and as great a claim on resources as undergraduate medical training.

There has been a very considerable increase in the numbers of doctors taking refresher courses, in recent years. Doctors must now attend a minimum of 37½ hours—or roughly one week every three years—to qualify for seniority payments. But many people doubt whether many of these courses are really relevant to General Practice. We feel that these courses are in principle useful. But altogether too much weight has been put on them as a means of maintaining standards and of widening horizons in general practice. Wider changes in training and new forms of association between hospital and community medicine are needed here. We turn now to our proposals for these.

(*iii*) **New Patterns of Care.** We need new patterns of care bridging both the hospital and the community. There are a number of steps which can be taken towards this:

—General Practitioners should be given new responsibilities and new roles within the hospitals. We note the recent announcement by the Secretary of State concerning a new policy for community hospitals to complement District General Hospitals. But we are still far from having defined the role of these hospitals. Clearly, they will help patients who need in-patient care but not necessarily specialist treatment. The G.P. should usually continue to have responsibility for these patients. A variety of arrangements are possible and

have been spelled out in the Brotherston Report. In some areas there is scope for the small "cottage" hospital. In others the model of the maternity services may be the right one—by which the G.P. has beds in a separate ward but adjacent to a specialist service. Another possibility is for new forms of shared responsibility by which the G.P. admits the patient and looks after him within the specialist ward. But there could also be scope for the G.P. to become involved with patients who *do* need specialist care—and not only those from his own lists. Small numbers of G.P's hold Clinical Assistantships at present, and these appointments are much appreciated where they are available. But all too often the G.P's are put into posts or specialties which are convenient to the hospital—rather than in those which would be most relevant to their main work. The experiment at the new town of Livingston in Scotland is one way of bridging the gulf. Here, G.P's were able to work five sessions per week in hospital as medical assistants by holding their list size to 1,500, and they were also given access to their own beds in a District General Hospital. Recent accounts suggest that the experiment is working well. But we need more experiments.

—Where the G.P. is taking on new responsibilities and giving new kinds of care, there will probably be a need for significant reductions in list size. Since the beginning of the N.H.S. the ratio of G.P's to patients has remained virtually static while in hospitals the ratio of doctors to patients has steadily increased. There is no magic about the ratio of 1 G.P. to 2,500 patients. There may be a case for significant reductions to allow thorough consultations and new forms of care. But the same result may be reached in some cases through better supporting services rather than through reductions in list size.

(*iv*) **The Hospital Advisory Service.** This should be extended to cover the general practitioner and community services.

Community-Orientated Specialties

One important step towards a better pattern of care would be for certain specialties to move towards the community with a base in larger health centres. This would make sense for pediatrics, for geriatrics and for psychiatry.

At present there are four main groups of doctors concerned with the care of children; doctors working in Local Authority Child Health Services, in the School Health Service, in general practice and in hospital pediatrics. The position has been described by Dr. R. N. Chamberlain writing in the *Lancet* as one of "considerable duplication sometimes triplication of the services provided for children". She maintains that, "Many of the doctors work in isolation with little or no knowledge of either the work being done or the care being given to others".* There are rather large gaps between those parts of the care of children which have traditionally but not always accurately been labelled "preventive" and those parts which have been labelled "curative". Nor under the present system has it been easy to make up obvious deficiencies in care—such as the ascertainment and assessment of mental handicap. The present system is equally unsatisfactory from the point of view of staff as from that of patients. There is a variety of career structures and levels of status, and considerable insecurity. Training both lacks any common basis and is generally inadequate.

*R. N. Chamberlain, *The Lancet*, No. 11, 1972.

Integration gives an opportunity for a new start in the Child Health Services. In our view the essence of the new start would be a post-graduate training with shared elements as well as appropriate specialisation for all doctors who will be working with children, and a common orientation towards the community. In the longer term the school health service should, with appropriate arrangements for staffing and specialisation, become a part of general practice. Even at present there is a mixture of full time and part time staff in the service.

The current local authority child health and screening service should also become a part of general practice. The G.P. would provide these services for the families on his list. Pediatrics, which is at present almost entirely hospital based should become community orientated and close links should be forged with Health Centres. We recognise that some specialist kinds of work such as pediatric surgery will continue to be based in hospital and that all pediatricians will continue to care for in-patients and carry out much work in a hospital setting. But, increasingly, in a changing health service, with advances in pediatric care, their skills should be made more use of in the community through health centres. This will require changes in the kind of health centres built and in the role of health centres which we spell out below.

We are well aware that the hospital pediatric service is under considerable pressure. There are only 362 consultant pediatricians in the country as a whole. The changes would have to be carried out in ways which did not dislocate their service. But the difficulties of the transition have to be weighed against the rather great gains from the change for patients. Furthermore, the balance of professional opinion favours change in the direction suggested.

Geriatricians should also become increasingly community based in health centres. Again they would of course continue to look after in-patients and to have responsibilities in hospitals. But a base in the community—especially in the larger health centres—would have many advantages for patients. It would make possible much closer contact with the family doctor service and also with nursing and social services staff concerned with the elderly. Surveys have repeatedly shown that the majority of bedbound and of housebound old people live in the community and that admissions to hospitals could often be avoided if community services were more available. In the community, with close links both to hospitals and health centres, the geriatricians of the future could build a truly preventive service, and develop the work of research and practice in rehabilitation which is so badly needed.

But progress here will depend on a general improvement in the scale and standard of services for the elderly. At present the hospitals are having to shoulder the consequence of neglect elsewhere. In the community we need a much better preventive service. Physical and mental deterioration can often be halted or reversed if detected early enough. This preventive service could be greatly assisted by regular visiting of the elderly. We think that initially people over 75 should be visited at least once every year, perhaps by community nursing staff. A new community based geriatric service will also need initiatives within the hospital to help infirm and handicapped elderly patients—so called "psycho-geriatric" patients. At present we are doing little for these patients. It is hard to think of even a few places in the country where some experiment and advance is taking place. Here the need is not just for an increase in the scale of services but also for research, for enthusiasm and for the first steps towards active rehabilitation.

Care of the mentally ill today is greatly hampered by barriers and divisions in the service. G.P's, the hospital services and the local authority social services may be involved. A patient may be referred to a hospital on inadequate grounds or conversely not admitted when he should have been. The accent in the hospital service is too often on the short-term relief of symptoms, rather than on seeing how a patient's ability to cope in the wider society can be improved. The ambiguities about the very idea of mental illness and the complexities involved in referral to hospital are not faced. As a recent study of the mental health services in one part of Scotland put it: "It came to be an accepted view at Dingleton that the referral might be a cry for help from any participant in the crisis, including the family doctor, and not simply from the patient or his family".* Nor under present arrangements is it easy for staff to change their own attitudes. Many G.P's still have a rather primitive approach to mental illness. Many psychiatrists are remote figures, perhaps living in an illusion that their subject is a highly developed and technical clinical specialty. The present system is bad for patients. It repels many good medical students, who might make a fresh contribution. Some evidence suggests that psychiatry is now even less popular as an option for specialisation than it was a few years ago. The present system has also slowed down the development of day hospitals, of services for rehabilitation and of community care for the mentally ill generally.

As yet psychiatrists have shown little desire to go out into the community. As an expert American observer has put it: "Although he is more orientated to social psychiatry, the British psychiatrist, perhaps because of his hospital orientation seems more hesitant than his American counterpart to go out into the community."† A recent report *The Mental Health Service After Unification*, issued by a tripartite Committee of the Royal College of Psychiatrists, The Society of Medical Officers of Health and the British Medical Association bears out this judgment. It calls for out-patient clinics in health centres, but only on an experimental basis. By contrast it stresses the need to keep the base of the psychiatric service firmly in the District General Hospital.‡ Our emphasis would be rather different. Of course, psychiatrists would continue to have some in-patient responsibilities. But in the longer term plans must be worked out in collaboration with the profession by which the base of the new service can be in the community.

Health Centres

We turn now to the Health Centre programme. Alterations in present plans are crucial to the changes in care which we are suggesting. How do these alterations fit in with developments over the past few years? The picture has been one of rapid growth although from a very low base. In 1962 there were only 26 Health Centres and few even of these were purpose built. By the end of 1971 there were 337 Health Centres and 8·3 per cent of doctors in England and Wales, 5·5 per cent of doctors in Scotland and 18 per cent of doctors in Northern Ireland were practicing in them. It is likely that by the end of 1974, there will be some 500 health centres housing about 15 per cent of family doctors. In Northern

*D. Anderson, *British Medical Journal*, No. 4, 1972.

†C. Knight Aldrich, *The Lancet*, No. 1, 1965.

‡Royal College of Psychiatrists, Society of M.O.H's & B.M.A., *The Mental Health Service after Unification*, June 1972.

Ireland 50 per cent of family doctors will be in Health Centres by the end of 1974. Quite suddenly Health Centres have become acceptable to the professions. As Lord Aberdare, Minister of State at the D.H.S.S., put it in March 1972, there is a "continuing strong demand" from family doctors, dentists, "other community health workers" and social work staff and the "Department (of Health and Social Security) has information that the demand is increasing every year". The Department itself has changed its attitude. In 1948 following the earlier lead of the Dawson report—local authorities were given a clear duty to provide, equip, staff and maintain health centres. But the Chief Medical Officer's Report for 1948 stresses the difficult situation with building and even in 1961 "difficulties of an insuperable nature" were thought to prevent the establishment of Health Centres: only 15 had then been built. Now the mood is much more favourable. Some areas, however, have made much faster progress than others. The degree of interest shown by particular local authorities has been important. In 1969 over 65 per cent of County Councils and nearly 80 per cent of borough councils had no health centres in their areas and Devonshire and Monmouthshire still contributed over 20 per cent of operational centres. The development of health centres does not seem to be clearly related to different pressures of work, and in some places where need clearly existed, resistance by local G.P's prevented the setting up of centres.

The Todd Commission envisaged centres with twelve or more practitioners. But few are as large as this. Only 16 per cent of the 137 being built or approved in 1969 were planned for ten or more doctors. Scope varies. In 1968 all but five of the 93 existing centres provided both general practice and local authority services. But only 11 provided general dental services and seven held regular specialist out-patient clinics. We now have one or two quite large centres such as the Woodside Health Centre in Glasgow opened in June 1971, which includes full dental and physiotherapy facilities, a computer department and a research department linked to the University. There is also the Clydebank Centre opened in October 1972. 24 consultants hold regular clinics in the Clydebank Centre. More typical perhaps is the Lakeside Health Centre in Thamesmead, Bexley. This provides family doctor, nursing and dental services as well as clinics for expectant and nursing mothers and for vaccination, immunisation and family planning, a creche, and social work services. In general, new health centres are extremely popular with patients. Nine out of ten patients preferred going to health centres than to a surgery.

The picture is one of growing acceptance and is in many ways hopeful. But the pattern of growth is not at present related to need. Nor is it related to any clear concept of the balance between community and hospital medicine. Rightly there is a good deal of variety in the types and sizes of health centres. There has been no move to build very large health centres. It is sometimes argued that there is a critical limit of 10–12 G.P's above which the service becomes impersonal. Even in some centres at present there is a danger of impersonality and of the patients having to take "pot luck". However, in certain circumstances and with organisation and architecture directed to human ends, there may be a case for very large centres. But the clinical role of health centres in relation to the hospital service still remains ill-defined. The Health Centre would seem to imply that admission to hospital can sometimes be prevented, discharges take place earlier, and a fuller range of diagnostic services be provided outside the hospital

setting. It would also seem to imply a much closer link between hospital medicine and General Practice. But there is no certainty that any of these developments will come under the present health centre programme. With some exceptions, the centres represent a change in locale without a major change in the role of the doctors working in them or in the scope of their work.

Nor has the development of particular health centres been carried through in its implications for local hospital services.

We have argued for three main changes: new efforts to give the G.P. the tools to do a proper job; changes in the balance of undergraduate and postgraduate training and for the movement of certain specialties into the community. The good will which health centres now enjoy is a great advantage. But certain new initiatives are now needed. There is a danger that many health centres under present plans will be too small to provide an adequate range of diagnostic resources. They will also be too small to provide a community base for specialties. But a programme which provided centres which were the right sizes for these services, might produce services which were in some areas inaccessible. Any move towards larger health centres needs therefore to be accompanied by provision of smaller "satellite" centres in which some surgeries would be held. But it is only with such larger centres, that the changes suggested will become possible. We recommend therefore that national and local plans for the development of health centres should be established, through which the pattern of development could be more clearly related both to need and to the wider changes suggested in the role both of doctors and of other health staff. Such plans should cover both local developments in health centres and in the hospital services. They should provide both for hospital doctors to take on an increasing role in the community and for G.P's to have new roles within the hospital.

New links between hospital medicine and general practice will require new forms of training. Within larger health centres there could be posts which doctors would hold as part of a planned training programme covering both hospital medicine and the community. Posts could be offered on a rotational basis with hospital jobs or on a sessional basis—for example a Senior Registrar in General Practice and General Medicine with two years in each post or a post combining sessions in general practice and medicine. After training the doctors might choose to work either in general practice or mainly in the hospitals. These posts would be on a salaried basis and would be set up after close liaison between the Area Health Authorities and the Family Practitioner Committees.

Finally, we need new efforts to make the hospital and community services —both in their present forms and with the changes of balance described above— more accessible to patients. Particularly with larger health centres, it is vital that such transport services as are now available only to the hospital services should be made available to the community services and improved. Within the hospital services, certain specialist kinds of care are increasingly being concentrated on a regional bais. For example, in the Sheffield Region, a child from Mexborough or Grimsby may need the specialist care of the children's hospital in Sheffield. Within the hospital service we should consider the payment of fares on a non-means tested basis to visiting relatives who have to travel long distances.

Mental Illness and Mental Handicap

We now turn to the care of the mentally ill and handicapped. Until now they have had the rhetoric of community care—but little of the reality. In the 1960's

the main initiatives were in the care of the mentally ill. There were great hopes, starting with the 1959 Mental Health Act. During the early 1960's, predictions were made to the effect that half the mental hospitals beds would be closed by the 1970's. It was widely recognised that many people now in mental hospitals could in fact lead much more normal lives in the community. Yet little was done. In 1963 there were 1,300 hostel places for the mentally ill; by 1969 this had risen to 2,600. There had been some new developments—particularly day hospitals—but generally the pattern of care had not changed.

Now we have plans for community care of the mentally handicapped.* But they may well encounter the same obstacles as did plans for community care of the mentally ill in the 1960's. In some ways the plans are not particularly ambitious. The target is to reduce the number of mentally handicapped in-patients from 52,100 to 27,000 by 1991. The hope is that most will be able to live in hostels in the community. One difficulty is likely to be finance. The Department has made a special allocation of funds: but this seems to have been lost on numbers of local authorities. They are in any case under great pressure to develop all parts of the social services within a fairly limited budget, and there is a certain feeling of resentment that Central Government makes ambitious plans—then does not back them up with finance. Quite apart from these financial troubles, the mentally handicapped come low down the list of priorities within local government. Local councillors have not shown much interest in expenditure on health—let alone on the mentally ill and handicapped in the past. But now it is "over to them". The rapidly rising cost of land, property and construction and some degree of public opposition to the provision of services for the mentally handicapped in "their community", are additional difficulties. Another problem is likely to be with staffing. One reason why provision of care for the mentally ill has proved so difficult is that there are few trained staff for the hostels. The few also tend to turn over rapidly as one authority bids them away from the next. The new Central Council for Education and Training in Social Work is now supposed to shoulder the burden. But here again the training needs of staff dealing with the mentally handicapped are likely to come some way down a long list of priorities. Finally the services are deeply divided in attitudes, face medical apathy and, after integration, will still be seriously divided in responsibility. We turn now to recommendations.

—Services for the mentally ill will be greatly changed in the long run by our proposals for basing psychiatry in health centres. The main step is to improve the normal hospital and G.P. services so that they take more account of the needs—social as well as medical—of the mentally ill. An integrated service is the right context for new developments both generally and for the care of groups such as autistic children and those with intermediate mental illness for whom very little is done at present. The need is great. For every 10 children with psychiatric disorders, only one is receiving psychiatric care.† Within hospitals levels of staffing as between general and mental hospitals are radically different. Two hospital groups each with about 1,500 beds were compared in one study. The general teaching hospital had 120 senior specialists while the mental hospital had only five. To fill these gaps the main priority apart from the

*D.H.S.S., *Better Services for the Mentally Handicapped*, Cmnd. 4683, H.M.S.O. 1971.

†Report of the Committee on Local Authority and Allied Personal Social Services, Cmnd 3703, H.M.S.O. 1968.

changed balance between hospitals and community medicine already suggested; is an increase in the scale of the services—for rehabilitation, sheltered housing and hostel building. Better child guidance and child psychiatry services in the schools are also badly needed. But as necessary—but even more difficult to achieve—are rather general changes in attitude by society, and by the health profession, to mental illness.

A service for the mentally handicapped should start from three main premises: that most families with a mentally handicapped child want to look after him or her at home: that where it is not possible for the child to remain at home every effort should be made to provide the child with an environment as similar as possible to that of a normal home: that even the most severely handicapped child can make progress—with help. The same philosophy applies to the care of adults. Every effort should be made to create a normal social setting and normal opportunities for relationships, work and recreation. But at present the hospital services are not achieving this. It is certain that many people are becoming more handicapped rather than less as a result of their hospital stay. Most handicapped people are in large wards in large institutions. They have few opportunities for normal work or recreation and given the isolation of many of the hospitals, it is difficult for relatives to keep in touch with them. Staffing levels are inadequate; but the deficiencies are not just those of numbers but also of attitudes. Nor is it easy under present arrangements to engage the normal social and educational services in the care of the handicapped.

—The ideal is that most adults with mental handicap should live in hostels or in shared flats as part of a normal community. Residential units—particularly for children—should be small and should be very close to the areas from which the children come. The service should be much closer to the community than it is at present. Some of the severely handicapped will continue to live in hospitals. But both in hospitals and in hostels, the accent must be on a social rehabilitation. The accent until now has been far too much on a 'medical' rather than a 'social' model.

—There should be special assessment centres associated with some pediatric units, which would perform the work of diagnosis and which would be staffed by psychiatrists, psychologists, psychiatric social workers and educationalists. But in the hospitals and hostels, we need a new kind of staff—which would include after retraining most of the nursing staff working in these hospitals. These would be 'care staff', who would be trained to carry out the work of social rehabilitation. The recent report of the Briggs Committee on Nursing has pointed the way.†

The Wessex Region has shown what can be done even within the existing system. Two homes have been set up each designed to meet all needs for residential care for a total population of 100,000. One is in Southampton and one in Portsmouth. They are near the centres of the areas served and near the children's families. They carry out initial assessment on all mentally handicapped children from these towns. The children are looked after by staff with a background in child care. Medical support is provided by the local G.P's. The experience of these units suggests that in these settings children can make considerable progress and that ties with the families can be maintained. They have also been

†D.H.S.S. Report of the Committee on Nursing, Cmnd. 5115, H.M.S.O. 1972.

able to draw on the help of the local social services in a way that is impossible for hospitals.

—We want to see a service for the mentally handicapped which has a common philosophy of social rehabilitation. But we do not see how such a service can be brought about under either the present or the re-organised administrative arrangements. A National Service for the Mentally Handicapped should be set up. This would bring together the present hospital services with those of the local authorities and it would include the training and educational activities of both. It would be directly financed by central government and must be social service orientated and not operated as a sickness service. Without such a service it is difficult to see how any new 'social' rather than 'medical' approach to the care and training of the mentally handicapped can get started. It would run assessment centres and residential care. For staff, it would be able to offer training and career patterns across the range of work in hospital and in the community.

We are aware of certain dangers which would attach to setting up this service —particularly that it might be seen as a segregated service, which would be cut off from the normal community services. But we do not think that in practice this need be so. The new service could work very closely with the social services and indeed once it was fully established it might be made wholly the responsibility of the Local Authority social services. *Without* such a service we are very doubtful whether we will see much progress towards community care on the social model. The change of attitudes, the finance and the commitment to new forms of residential care—all essential—are simply not likely to be forthcoming.

Chapter 3.—Ending Neglect

I Neglected Areas and Social Groups

Standards in health differ between classes and between regions. The prospects of good health are significantly worse for children of unskilled manual background throughout their lives. They have a higher rate of death in infancy. They are shorter at school age. When they enter work they have more and longer spells of sickness. They are more likely to be admitted to mental hospitals. As they grow old they are more likely to suffer from chronic bronchitis or to become disabled. They will die younger. The main regional differences are between the older industrial areas in the North, Wales and Scotland and the rest of the country. In these areas, the chances of health are rather worse for many people from the cradle to the grave.

Geographically some of the worst areas of deprivation are quite small areas within towns—rather than regions as a whole. Medical statistics based on large areas may lead people to overlook them. A recent research study has described health conditions within a small area of Exeter—a town where standards of health and care are generally quite good:

> "Wonford Ward was the only Ward where both male and female mortality were significantly high, mortality being nearly 20 per cent above the average for the city. Wonford Ward is fairly low lying and was thus ranked unfavourably low while for social conditions Wonford was considered the worst Ward. The Ward had a high proportion of labourers and unskilled workers (three times the average for Exeter) and 55 per cent of the deceased were from social classes 4 and 5 (27 per cent for Exeter). There was considerable overcrowding with 13 per cent of the population at a density of over $1\frac{1}{4}$ persons per room in 1961."*

In so far as differences in health standards are related to class, remedies will need to be fairly general, both in terms of changes in housing and in social security benefits and in terms of change within the health service. In many practices there will be some families who need additional help. We need local initiatives to reach them. But we also need new policies for deprivation both between regions and within regions. At present many of the regions and areas with the greatest needs have the smallest resources. The Sheffield Region with its industrial character had an expenditure per head on hospital services of £13 in 1969–70: compared to £21·5 per head in the South East.† While the South East has more teaching hospitals and is thus taking a large share of the training costs of the service as a whole, the difference is far greater than can be justified rationally. In some regions, patients will have to be much sicker before they are admitted to hospital. They will have much less chance of specialist care—such as intermittent dialysis for renal disease. Regions that are badly off for hospital care also tend to be badly off for general practitioners and for local authority services. Certainly there has been—in spite of these deficiencies—a good deal of improvement since the start of the Health Service. Controls on hospital manpower have helped to establish a reasonable distribution of specialists over

*M. Griffiths, *Urban Studies*, June 1971.

†N. Bosanquet, *Inequalities in Health*, in P. Townsend and N. Bosanquet, *ed.*, *Labour and Inequality*, Fabian Society, 1972.

the country as a whole. Before the War specialists were to be found only in London and a few other large centres. Even financial inequalities have got slightly less since 1948. But we still need to get a fairer balance of budgets between regions. The new methods of distributing the budget between Regions which the D.H.S.S. has recently started may help.

Some of the worst shortages are not, however, *between* regions but *within* regions. In a region such as Sheffield standards may differ significantly between towns. Grimsby and Leicester may be particularly unfavoured while standards in Sheffield itself may be a little more acceptable. In the North West standards may be good in Manchester but much worse in the medium sized industrial towns of Lancashire. Certainly in towns such as St. Helens and Bolton, G.P's have about 3,000 patients on their lists—compared to the national average of 2,460. In general practice, there may be significant differences within towns. All this suggests that we need a "priority areas" programme *within* towns. We need to identify more clearly deprived communities or parts of communities. It is not easy to hit on the right criteria and no doubt they would have to be modified and adapted in the light of experience. However the programme is too urgently needed to wait on final research into a perfect list of criteria. They would be partly of a social and partly of a health nature and might include:

life expectancy and mortality rates,
morbidity,
consumer experience of health, including points such as the length of waiting lists,
age structure,
employment and unemployment patterns,
housing conditions.

Once the areas are selected, the next step is to work out the ways in which they are deprived. Some may suffer from a shortage of all kinds of service; in others there may be difficulties with only one service; while in others the services may exist but may be inaccessible. Once the best way of giving help has been found, there should then be a special allocation of funds from central government. We attach great importance to this special funding. Without it the programme may simply be a case of redistribution from the poor to the very poor and of government announcing high purposes—and not providing any money to make them a reality. In some places it may be possible to give help immediately through providing more staff. In others the need may be for a new health centre. We would attach particular importance to new public support for services for the mentally ill and handicapped in deprived areas.

We are suggesting fairly technical means of choosing priority areas. But health needs may also come to light through political action by people in local communities. We have to get much better information about the kinds of health problems that face ordinary people. Our proposals for representation, which we develop later, should contribute to this.

II Neglected Aspects of Care

(a) Rehabilitation

Not all neglect can be defined territorially. One particular form of care—rehabilitation—is neglected almost everywhere. The end result of the weakness and uneveness of the rehabilitation services is that both the patient and his

family suffer. In total (according to the recent Report of the Tunbridge Committee on Rehabilitation*), this adds up to a complex social and economic problem which is wasteful not simply of resources and facilities but more significantly which is destructive of the quality of peoples lives. We agree with the Government decision to start new centres at Derby and Norwich—the first of a series—but these will need to be supported by many new initiatives on staffing and on community services for the disabled. At present the objective of the service seems to be to prevent death rather than to raise the quality of life. We welcome the efforts of voluntary self-help groups such as those for cystic fibrosis and for ileostomy patients. These are the successes. But we need new effort to help people for whom much less is being done—such as people who have had strokes and people with rheumatism.

The Government's social survey has shown that there are 3 million disabled people.† More than a third live at home and are appreciably or severely disabled. Two thirds of the disabled women under 65 are unable to do most household chores. 25,000 women with children under 12 have difficulty in caring for them. The great majority of disabled people are not on local authority registers. In addition, 1 million people in Great Britain have rheumatic complaints. 50 per cent of the elderly suffer rheumatic pain; 1 in 5 of men over 45 suffer periodic and disabling pain. Every month patients who have had strokes or become incapacitated are leaving hospital to enter into a bleak world. Here is a vast misery—a darkening of life—which reflects not nature but our neglect.

Are doctors willing to take responsibility for rehabilitation? Twenty-five years ago an official Circular, R.H.B. (48) 1 blamed the "lack of medical staff interest in rehabilitation" on "insufficient training of medical students." The Piercy Report in 1956 recommended that rehabilitation should be included as an integral part of undergraduate training and postgraduate study.‡ But in the early 1970's the British Association of Physical Medicine and Rheumatology could write in its evidence to the Committee on Rehabilitation; "The main hindrance to the development of rehabilitation services at the present time is the low level of interest in the medical profession as a whole."§ The term rehabilitation is only mentioned twice in the Report of the Royal Commission on Medical Education. The Rehabilitation Committee considered it essential that a consultant should co-ordinate all rehabilitation services. But an official survey in 1969 showed that in 65 per cent of hospitals with more than 200 beds there was not one person in charge of rehabilitation.§ The G.P. has a crucial role, but according to the Committee on Rehabilitation, "many general practitioners are out of touch with the modern concepts of remedial treatment."

Medical staff responsible for physical medicine and rheumatology are not only few in number—they are distributed unequally. Of 113·6 (whole-time equivalent) consultants in these specialities, 85·6 are employed in the four Metropolitan Regions, Oxford and Wessex. The ratio of persons (aged 20 and over) per consultant varied from 1 to 122,000 in the North West Metropolitan

*D.H.S.S., *Rehabilitation*, Report of a Sub-Committee of the Standing Medical Advisory Committee, H.M.S.O. 1972.

†A. I. Harris, *Handicapped and Impaired in Great Britain*, O.P.C.S., H.M.S.O. 1971.

‡Report of the Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons, Cmnd. 9883, H.M.S.O. 1956.

§Report on Rehabilitation.

Region to 1 to 1,191,000 in Wales. Areas with the highest incapacity have the fewest consultants. We find the present Government's approach to this rather complacent. Mr. Michael Alison, while admitting in May that, "many more consultants are needed," said that the current distribution of consultants is "not a reliable indicator of regional imbalance in the provision of treatment because treatment of rheumatism is also provided by consultants in other specialities."

Rehabilitation services need remedial staff. Yet as with specialties in physical medicine, these staff are in short supply and are oddly distributed:

—In the North West Metropolitan Region there are 212 physiotherapists per million adults. In the Sheffield Region the ratio is 86 per million adults.

—In the South West Metropolitan Region there are 74·3 Occupational Therapists per million adults; in Newcastle the ratio is 24·9 per million adults.

—The Quirk Report on Speech Therapy Services* estimated that if aides were not employed, 4,038 Speech Therapists would be required. At present there are 822. 285,300 children and 38,880 adults require Speech Therapy. Less than a quarter of them receive treatment. The Report notes that the present number of speech therapists, "would have to be at least quadrupled to have a significant effect on the hidden need."

—In 1963, 142 chiropodists were employed in the hospital service; by 1970 the number had only increased to 161. We are spending little on services like these which make people more independent.

In general the present distribution of staff is not determined by need. As the Committee on Rehabilitation put it "Established posts are more likely to reflect local interest in the remedial professions rather than local needs."

Without staff to teach the disabled to use their remaining physical capacities to their full potential, to speak, to work and to care for themselves in a home environment, rehabilitation can have little meaning.

Inadequate pay, low status, poor career prospects, scattered and insufficient training facilities all conspire against remedial staff. We have proposals to make on some of these points in Chapter 4. But even when such staff are at work, their time may not be effectively used. The Committee on Rehabilitation took the view that "many of the treatments applied by the professions have a historical rather than a scientific basis . . . In our view much expensive electrical physiotherapy equipment is of limited value and could be dispensed with, without any serious loss of therapeutic effectiveness."† It is tragic that the effectiveness of the small numbers of para-medical staff is limited by inadequately researched treatment methods and a lack of authority in the treatment process.

Nurses have an important contribution to make. Nurses in hospital must be encouraged not to prolong the dependence of the disabled patient and to encourage independence. The District Nurse must be able to advise the disabled and their relatives on the use of appliances and on other problems. Yet nurse education says little about rehabilitation.

We now turn to the *Local Authority services*. A circular to Scottish Local Health Authorities in May 1972 was effective because of understatement: "In general they (local authorities) have a long way to go in meeting the needs of the handicapped people who both require and want their help."

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*D.H.S.S. & D.E.S., *Speech Therapy Services*, H.M.S.O., 1972.
†Report on Rehabilitation.

The Home: Under 6 per cent of the appreciably and severely disabled live in purpose built accommodation, 25 per cent cannot use the whole of their own homes. 61 per cent of those living in private rented accommodation do not have exclusive use of hot water, a fixed bath or an inside toilet. A recent survey in Buckinghamshire revealed that although few of the disabled living at home could use the toilet independently, ascend or descend the stairs, or bath themselves, only 2·3 per cent lived in purpose-built accommodation designed for the disabled.*

Authorities often seem more concerned to establish blame than to establish better home conditions;

"adaptations to the homes of newly disabled people are often delayed so that the patients have to be kept in hospital longer than necessary and then when adaptations have been carried out they are sometimes unsatisfactory . . ."

"In the first instance local authorities blame the hospitals for not giving enough notice of a patients discharge. In the second instance the local authorities are blamed for not ensuring that the adaptations, are tailored to the equipment that is supplied to the patient and for failure to co-ordinate building and engineering services."

Home Helps: The 1971 report by the Office of Population Census and Surveys stated that old people had home helps for an average of 4·5 hours per week. The President of the Institute of Home Help organisers, who is herself responsible for the Sheffield service, describes the provision of 4·5 hours of help to those who receive help as "in many cases totally inadequate" and states that:

"in order to satisfy the present recipients and to provide help for those who are eligible by present standards but are not currently receiving it, the size of the home help service would need to be increased between two and three times its present size. Expansion of the service is required for the chronic sick and disabled, the mentally ill, families with mentally handicapped children."

Expansion of other services, such as the home laundry service, will be required on a similar scale, as will meals-on-wheels.

Occupation and Treatment: An adequate home, and help in the home is not enough. Rehabilitation cannot be regarded as an intensive experience in a hospital which becomes unnecessary after discharge. Rehabilitation should continue at home. Frequent visits to a rehabilitation centre may be required and should be possible. The present situation of rationing visits and ending the provision of services as soon as possible, disrupts the rehabilitation process and makes it less easy for relatives to bear the burden of home care:

"Without the community facilities, much of the intensive rehabilitation of disabled people undertaken in hospital can be rendered all but useless."

"Unless there are day centres, sheltered workshops, and residential homes the discharge of some patients may be prevented or long delayed and the successful rehabilitation of others nullified."†

*T. P. Hitchsy, *Occupational Therapy Patients in their Community*, *British Hospital Journal and Social Service Review*, August 3, 1972.

†Report on Rehabilitation.

Getting Away from Home: *Transport*—The Disabled Motorists Association has condemned the design of existing three wheel cars for the disabled. There is a need to make more available suitably adapted four wheel cars.

Access—There is little point in getting away from home in your own car if you cannot get into shops and public buildings because of steps and other features that restrict access for the disabled.

Holidays—Local Authorities have the power to provide recuperative holidays, yet a recent survey in Sunderland revealed that the facility most wanted by the disabled and chronic sick was holidays.* A home can be enjoyed even more, if people have the chance of getting away. Holidays also relieve the pressure on relatives caring for the disabled.

A New Start—The Chronically Sick and Disabled Persons Act 1970 made possible a wide range of services to help the disabled to remain in their own homes. There has been only a modest increase in the government grant to Local Authorities, the implementation of the Act has been very patchy and many authorities have failed to provide the services. It is a tragedy that an Act which could do a great deal to help the disabled, remains unused.

There is particular neglect in the provision and development of appliances and equipment. A recent study in the British Medical Journal† showed that of 34 children in wheelchairs, in 29 cases the chairs were highly unsatisfactory. For some such as children with muscular dystrophy—serious consequences may arise from ill-fitting chairs. Not only were the chairs often wrong there were often long delays both for the initial order and for modification.

A Service for Rehabilitation

We welcome current progress in starting rehabilitation centres which will be central to any new service.

At the heart of a Rehabilitation Centre will be an Assessment Clinic at which staff from all the services would meet to consider a patients' needs. A survey conducted by the Department of Health and Social Services in 1969 found that 68 per cent of hospitals with over 200 beds did not have Assessment Clinics.‡ As a result patients are often discharged without adequate consultation and do not receive even those services which are available.

These centres will only become possible through national action to increase the numbers of remedial staff. Once a plan for these centres is established, problems in assessing the 'need' for such staff will become much easier. The need can only be met with changes in pay, career structures, the balance between aides and qualified staff and deployment. The work of physical medicine departments in hospitals should move into these centres while retaining flexible links with the hospitals. A Labour Government must continue the national plan for such centres and consequential plans for each of the remedial professions.

In the community the Chronically Sick and Disabled Persons Act 1970 makes possible a wide range of services which would help the disabled to stay in their own homes. The priority here must be to ensure full implementation of the Act. We also need improvements in the home help service, and in all services which help the disabled to lead a normal life.

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*Survey by Sunderland Social Services Department. Reported in the *Hospital and Health Services Review*, March 1973.

†K. S. Holt, *et al.*, *British Medical Journal*, No. 6, 1972.

‡Report on Rehabilitation.

None of this will do much good, without changes in the economic position of the disabled, in jobs and income. The best hope in jobs is that we will return to full employment. The most effective incentive to employing the disabled is staff shortage. But we also need to remind firms of their legal obligations and to give more help with retraining. We should also consider a special subsidy for employing the disabled on the lines of the regional employment premium.

Income: A recent survey in Sunderland showed that 65 per cent of the sick and disabled had incomes of under £10 per week. A survey in Essex revealed that half the households of the disabled lived in poverty. The average earnings of those lucky enough to have jobs were three quarters of the national average.

The disabled face additional costs for domestic help, the telephone, travel, special diets, equipment and clothing.

We recognise that at present the financial position of the disabled may depend on the cause of disablement rather than the severity of the disability. A man injured in a road accident may be less disabled than a man who has disseminated sclerosis but there will be compensation for the victim of the accident and not for the victim of disease.

We must relate support to the degree, not the cause of disability. The Party's policy for a National Disability Income aims to do this. Finally we must work to extend the Constant Attendance Allowance.

Appliances and Equipment: Appliances and equipment can make it possible for the disabled to carry out many tasks themselves, and widen the range of employment opportunities open to them. But at present the supply of aids and appliances is complex and fragmented, General Practitioners, Local Health Authorities and hospitals all provide aids.

The Disabled Living Foundation has done an immense amount of work since its establishment in 1970, and now provides a standing exhibition of aids for disabled persons. The achievement of this research and development is impressive, but what is needed now is to make available the benefits of the research to all the disabled. The cost of many aids is far outside the financial resources of the disabled, an electric hoist may cost £100, an electrically powered bed £145, a ripple mattress £35·50.

It should be the aim of services for the disabled to provide every appliance or piece of equipment which is required—wheelchairs, walking aids, transport, clothes, sani-chairs, lifting devices, etc. Often a disabled person is provided with many appliances in hospital and the appliances are not provided when the patient is discharged. Equipment should not be regarded as belonging to the institution but to the patient who needs it.

We think that the service can only really be improved and the benefits of new appliances extended to all who need them through state ownership. Our proposals here are made in Chapter 5.

In general the difficulties of rehabilitation are increased by lack of evidence. We need more professional and other senior academic posts in Rehabilitation and research into the needs of the handicapped and the effectiveness of existing services.

(b) Hospital Waiting Lists

Long waiting lists are also evidence of neglect. Waiting lists have hardly shortened since the service started. Nor have periodic drives from Ministers to shorten them had much success. But it is not only the length of waiting lists which is objectionable but the way in which they are organised. People who may be in considerable pain even though not at risk of their lives can be put on waiting lists for indefinite periods. They may be on the list for 18 months or more. But when they come to the top of the list they may get only two or three days notice of admission. It is also highly objectionable that people can jump waiting lists through seeking private treatment. If we are serious about improving the quality of life rather than simply preventing death, we must reduce waiting lists.

In the short term there may be some waiting lists that it will be difficult to reduce. For plastic surgery or hip replacement, there simply may not be enough people to give the care. But generally we do not think the situation is so bleak. The solution need not only be the long term one of increasing resources—but the more immediate ones of making more effective use of resources and of promoting the will to improve matters. While exhortations from on high are not likely to achieve much, no one hospital is likely to make much progress alone in reducing waiting times. If it does succeed it will then be faced by numbers of patients referred by G.P's simply because waiting times have been reduced. But within an area a good deal could be done. We must encourage initiatives in the following directions:

(1) *To make more intensive use of operating theatres and wards.* This will require study of the relationship between the availability of operating theatre time, medical staff and beds. It is possible that all the available operating theatre time is not used, either because consultants are engaged on private practice or because there are not sufficient surgical beds to service the theatres. A recent experiment at Southampton has shown what can be achieved. Professor Chant and his team take the view that:—

'More efficient use of existing facilities would help to solve the waiting list problem'. They carried through special hernia weeks while maintaining emergency cover and their normal lists. Admissions were planned and a period set aside for intensive work on hernia cases. Patients were generally discharged within 48 hours. There were few complications and patients liked the method. It was also held to make for better medical teaching. In terms of workload the greatest effects were on the housemen. 'The general feeling within the surgical unit was that the exercise had been successful'.*

Another development in early discharge has been at Glasgow. An experiment was tried in two surgical units. Lengths of stay were reduced to two days for people with varicose veins, four days for appendicitis, five days for hernia and eight days for the major operation of cholecystectomy. Overall in three and a half years between June 1968 and December 1971, the number of beds was reduced from 64 to 58, the number of cases treated raised from 416 to 504 and the average length of stay decreased from 11·1 days to 7·6 days.†

*A. D. B. Chant, *et al.*, *The Lancet*, Vol. 2, 11 November, 1972.
†J. Bell & D. S. Shearer, *Nursing Times*, 5 October, 1972.

(2) *To improve admission procedures so that most people are given at least two weeks notice of admission.* Clearly it is not possible to warn people of the exact day that they are likely to be admitted, given the uncertainty of emergencies. But a hospital should have enough information about its admission patterns to give people more approximate notice. Under present arrangements it is hardly surprising that in some hospitals, about 20 per cent of people sent for from the waiting lists—with very limited notice—either fail to turn up or refuse admission. People need time to make arrangements, which at present they do not get.

If we are to achieve reductions in waiting lists there will have to be restrictions on private practice. At present a significant proportion of medical times goes to private practice. This means that the hospital service as a whole is less effective than it might be. Medical time and direction gives the main impetus to the whole team, and a reduction in time has a rather wide significance.

In some areas some allocation of new resources will be needed to reduce waiting lists. We need initiatives to establish what these are and to plan for getting them.

(c) **The Dental Service**

Neglect in the dental serice is particularly acute.

In many areas N.H.S. dentistry no longer exists; dentists no longer accept N.H.S. patients. We are training the wrong combinations of people to work in the wrong places and we have the wrong balance between preventive and remedial dental work. In the North many areas are desperately short of dentists while even in the South an increasing number of dentists are withdrawing from the N.H.S. We are not managing to prevent dental disease nor are we effectively treating disease when it does occur. We are also disturbed at the present highly bureaucratic mode of payment to dentists which does little to promote the goodwill of dentists towards the N.H.S. or guarantee the quality of care. We need fundamental change in the service and discussion should start between the profession and the next Labour Government with a view to achieving this. We would see some of the directions for change as follows:

—A greater concern with prevention. Fluoridation of the water is a first priority. We believe this can no longer be left to local prejudice and should become a central government responsibility. The evidence shows quite clearly how much misery could be avoided and at no risk. This should be accompanied by increased use of fluoride rinses for children. Periodental diseases could be greatly reduced by proper instruction to people on how to brush their teeth. Increased dental education in the schools could also help.

—On the remedial side we must encourage group practice in health centres and train many more dental auxiliaries so as to use the time of trained dentists more effectively. The advantages of group practice in teams are numerous. It means that better use can be made of paradental and secretarial staff. It is more sensible from the financial point of view, as better use can be made of equipment. It encourages continuing education and professional contact, and offers patients the varied experience of a group.

—We need both to train more dental auxiliaries and to recruit back into the service those who are already trained and have left. This will mean first of all changes in pay levels and career structures.

The career structure must cover different levels of work starting from dental surgery assistants. It must include hygienists, New Cross auxiliaries to work mainly in the public dental service on restorative work and orthodontic banding; general dental auxiliaries to do more advanced work.

—As well as a normal range of dental practice in most larger health centres, we need some specialists in a few centres. These appointments should be planned on a regional basis. Some centres would also specialise in emergency services.

—We need priority areas in the same way as we have health priority areas. There should be special grants to dentists to encourage them to work in these areas; there should also be an expansion in the number of salaried posts and special help in employing dental auxiliaries. In these areas the right balance might be one dentist to three dental auxiliaries. This would mean a change in the regulations. The development of dental care in health centres should be concentrated in these priority areas. There might also be a role for mobile dental clinics. We should also consider giving special grants to dental students who would agree to practice in priority areas for a period of five years. Finally we must improve the school dental service and the services for old people in these areas.

In priority areas, young dentists already practicing or new dentists should be given the option of service which would be partially on a salaried basis or full salaried service in a health centre with paradental personnel paid for by the Department.

—Within the general dental service the most important changes needed are to put greater weight on prevention and on in-service training. Better prevention can come about through expanding the numbers of paradental staff to give instruction in oral hygiene and to apply fluorides. Dentists must be given regular continuing education especially in prevention.

Older dentists face a good deal of insecurity at present. They should be given more opportunity for continued education. They should also have the option of changing to salaried posts and employing Dental Auxiliaries.

—The public dental service must be enlarged and improved. It must be mainly concerned with prevention and treatment for particular groups—children, the aged and the handicapped. The dentists in this service should work from health centres, in closer touch with the general dental service.

—The hospital dental service should be a consultant service. As much work as possible should be returned to the practitioner, to be supervised by the consultant. The exceptions are major oral surgery, oral pathology and oral medicine cases. The function of the hospital should not be to provide emergency services. These should be given by practitioners in health centres. The service should concentrate on training house surgeons and registrars.

Dental post-graduate education should shift more into the community. With the exception of oral surgery, oral pathology and orthodontics, there is no need for hospital consultants. The consultants will give a mainly advisory service; specialist services should increasingly be based in health centres. Dental undergraduate education should also shift more into the community and should be more closely related to its needs.

—The current method of payment for dentists is based on a fee for service principle. This tends to encourage reparative at the expense of preventive procedures. It also gives little scope to dentists who wish to take new initiatives professionally.

Dentists should have more scope for choice. They should be able to choose whether to stay with the present system of payment or to take a new alternative. The alternative would be a combination of salary with a bonus designed to encourage preventive dentistry. The bonus would be related to the amount of restorative work done and the number of preventive procedures, carried out. Dentists employed under this system would be given an allowance towards the costs of employing dental hygienists. The conditions of work and levels of remuneration under this new system should be highly attractive. Other changes needed are to revise the present payment system so that preventive procedures are rewarded and to revitalise the Local Authority dental service—which will involve a substantial increase in salaries.

Chapter 4.—A Better Deal for Staff

Our aims for the N.H.S. as a whole can only be met by making better use of the time and commitment of staff. Certainly there are some stark staffing shortages which the changing patterns of employment afford some opportunity to remedy. But a major task of the service is to make better use of the staff it has. This will mean change in pay levels, in career structures and in the ways in which pay is set.

The Medical Profession

We hope to see the medical profession move towards a common career structure for hospital doctors and for G.P's. We have suggested earlier some of the first steps towards this, such as more post-graduate training for G.P's and movement in training between posts in hospital and posts in the community. As the change in balance between medicine in and out of hospital—the need for which is implied by integration—takes place, so there will be more opportunity for integration in career structure and training.

We also need to improve the standing and training of junior doctors. The present system has a number of faults. The distribution of doctors—both geographically and between specialties—does not match the needs of the community. The existing emphasis in undergraduate training and the present post-graduate career structure for doctors worsens rather than improves the distribution. Younger doctors are at present often insecure in their prospects and they may be in their late 30s before they have a permanent post. Quite apart from personal insecurity they lack standing in their specialty and a voice in policy. Generally, too, patterns of training and status show a pronounced bias towards hospital work. The proposals in the reorganisation will do very little to give them a greater voice and are inadequate.

In the longer term we question whether the present post-qualification year is enough as an immediate post-graduate training—given the need to include some experience in general practice and a more varied experience in hospital work. Even at present many young doctors take more than two house officer posts to gain more experience. We would like to see a post-graduate experience of two years with shorter and more varied units of work. These might be four compulsory units in the first year—in acute general medicine, in acute surgery and trauma, in psychiatry and in obstetrics. In the second year there might be compulsory units in casualty and in general practice and two optional units. The aim of the first year of training would be to allow doctors to become proficient in the practice of emergency care in all areas of service. Taking the two years as a whole, they should give both a varied experience and allow a doctor to experience the specialty of his choice. In the second year there should be off-the-ward teaching and the opportunity to work for professional examinations. During these years the doctors attachments should be with the hospital rather than with particular consultants.

In post-registration training—at the registrar level—the main change required is to give people a chance of getting a permanent place in a specialty rather earlier than at present. At present a permanent position through consultant appointment comes at the age of 37 on average. There is a good deal to be said

for an assessment after 18 months of post-registration training which would amount to a preliminary acceptance or rejection from the specialty. At this point the number of successful candidates would be related to the manpower needs of the specialty in the longer term. The assessment would obviously cover both academic ability and clinical work. There is no reason why the same principle should not apply to post-graduate training in general practice. After the preliminary assessment, there should be a number of years, in which people would be moving towards full consultant status; given the expansion in the number of consultant posts this should come rather earlier than at present. But in these years the young specialists should be increasingly involved in the development of the local service. His rather more permanent standing in the specialty should help here.

Recruitment to unpopular specialties and regions remains a major difficulty—particularly recruitment to specialties. There are some signs for example that psychiatry is even less popular now than it was a few years ago. Careers advice and the prospect of a rapid rate of promotion may help to a limited extent as seems to have been the case with anaesthetics. But a fundamental change in the professional atmosphere, in the commitment to research and innovation in the unpopular areas of the health service is needed.

Our proposals for undergraduate and post-registration training will give young doctors experience in unpopular forms of work. This will emphasise the unity of medicine; we hope it will also arouse new interest.

We need changes in the training and induction arrangements for immigrant doctors who now represent about half of the junior grades in the hospital service. The present position is most unsatisfactory. Most immigrant doctors come over for training rather than to stay permanently. But they are working in hospitals in which the training element is slight. Nor is their induction adequately planned. The present system is based on a month's assessment with a consultant. The consultant is not paid for carrying this out and there may be little contact. The present system is fair neither to the doctors nor to the patients.

Two changes are essential. All doctors coming to work in the N.H.S. should go through a rigorous language assessment and a period of intensive training to make good deficiencies. Secondly, clinical attachment should include a definite programme of medical education attached to a medical school and with greater supervision in the clinical setting. Supernumary training posts might be established to alter the present situation in which immigrant doctors have to get a job quickly in order to survive financially. But it is also important that immigrant doctors should have a fairer chance of the better training posts in teaching hospitals. At present about half of British trained doctors have jobs in teaching hospitals compared to about sixth of immigrant doctors. Clearly even after proper induction courses British trained doctors are likely to be better trained. But future potential should also be taken into account in selection for these posts.

Nursing, Technical and Ancillary Staff and the Professions Supplementary to Medicine

We now turn to the training, pay and conditions of nursing staff, technical and ancillary staff and people in the professions supplementary to medicine. For some time there have been two standards in training, pay and working condi-

tions—one for doctors, the others for nurses, the remedial professions and laboratory staff.

Many of the problems can be seen in the history of nursing over the past decade. As a nation we spend little on nurse training. We spend about £10·4m in Great Britain—including the estimated cost of the time spent by Ward Sisters in teaching on the Ward—on the training of nurses compared to about £82m on the training of teachers.* In annual terms we spend about £134 a year on training a nurse in England and Wales compared to £772 on a trainee teacher and £994 a year on a university student. Nurse trainees basically learn the job by doing it—through hard work and long hours.

For quite long periods over the last decade the pay of nurses has been left behind. Over the whole period between 1960 and 1970 the pay of nurses kept roughly in line with the pay of other groups in the community, but only because of the large increase in 1970. Between 1965 and 1969 the pay of nurses rose a good deal slower than pay generally. In 1969 the real earnings of a student or pupil nurse were only 3 per cent higher than they had been in 1959—a period in which the real earnings of female manual workers rose 27 per cent. Since 1970 the pay of nurses has again risen much slower than wages and rather slower than prices. Nurses were generally caught by the more severe stage of income policy in the 1960's and have not benefited very much from the wage explosion since 1970. They now appear to have been caught by the incomes policy again. Many trained nurses—including some ward sisters—are taking home, after deductions for tax and superannuation, less than 60p an hour.†

The hours of work of nurses have been consistently longer than those of other women workers. In few jobs involving night and weekend work is such a low special rate—time and a quarter—paid.

Similar deficiencies can be found in the training arrangements, pay levels and working conditions of remedial staff, technical staff and the professions supplementary to medicine. For a work force of 35,000 people the attention paid to staffing standards, the effective use of staff, the organisation of training and to staff relations is far from adequate. Shortages in the remedial professions effect the quality of care. Remedial staff are needed for the mentally ill and handicapped and for patients in need of rehabilitation. Unless there is heavier investment in the remedial professions the welfare of patients outside th efield of acute medicine is bound to suffer. Effective action has not followed from the work of past official committees on these grades. The Quirk Report, for example, on speech therapists has led as yet to little action. But recent figures suggest that speech therapists have virtually disappeared. There were only about 170 in the entire hospital service in England and Wales. Shortages in these and similar grades are clearly related to their very low levels of pay and poor career prospects. For example speech therapists have to do a three year training at a university standard which covers areas both of medicine and of education. Yet the top of the scale in the basic grade reached after thirteen years service is £1,815 and promotion prospects are almost non-existent.

The same pattern of neglect can be found with laboratory staff and with operating theatre technicians. It would be useless to go through the almost

*N. Bosanquet & R. Clifton, *Nursing Times*, 10 May, 1973.

†N. Bosanquet & R. Clifton, *Nursing Times*, 17 May, 1973.

endless story of derelection. But fairly typical are the fortunes of operating theatre technicians. Four years ago the Lewin Report recommended a new deal in training and career structures.* Since then virtually nothing has been done. For ancillary staff there have been some improvements in career structures and training in recent years; pay levels of women ancillary workers compare fairly well with those of women in the economy generally. But pay levels of large numbers of male ancillary workers remain very low.

We turn now to remedies. Some of them lie with the Department of Health. We need a proper plan, a context in which staff numbers, career structures and training standards can all be improved. The Department must also begin to take decisions more rapidly. Its pace of action has been extraordinarily slow. In particular we hope to see rapid progress with the recommendations of the Briggs Committee on Nursing. But we also need changes in the way in which pay is set. The aim must be to ensure that justice is done and is seen to be done. We want to see change by which gaps do not appear between pay in the N.H.S. and pay generally. We also need more coherent examination of pay structure and of pay in relation to manpower considerations.

There must be great changes in the Whitley Council system. The main weakness of the system has been, first that government has had too much power. It has power both as a Government and as an employer. This has hardly been collective bargaining of an even-handed kind. Secondly, issues of pay structure have not been looked at adequately and change has come very slowly. The long delays in introducing allowances for night and weekend work in nursing are two examples. Changes are needed to bring about more even handed collective bargaining and to ensure that decisions are taken more speedily and on the basis of more adequate information.

The Whitley Councils should be reconstituted as tripartite bodies with a more independent status vis a vis the Government. They would have their own research staff and would have to publish Reports setting out the reasons for their decisions. They would be given terms of reference by which they would have to set pay.

Setting these terms of reference would be a complex task. Generally the explicit principle used in the setting of public sector pay has been that of comparability. This has been used in its purest form in the Civil Service. The Priestley Commission laid down that "the primary principle of civil service pay should be fair comparison with the current remuneration of outside staff employed on broadly comparable work taking account of differences in other conditions of service." It also recommended machinery for assessing fair comparisons—a Pay Research Unit. Elsewhere in the public sector, in the N.H.S., education and the nationalised industries—the principle of comparability has been used in less refined forms. In our view the principle of comparability is part of the basis for setting pay for groups in the public sector. This is not to suggest that the public sector can remain outside policies for prices and incomes. But public policy must work to ensure that the pay of groups in the public sector is seen to be fair. In the past there might have been difficulty about using the principle of comparability to set the pay of groups whose work has few parallels in the private

*D.H.S.S., *et al.*, *The Organisation and Staffing of Operating Departments*, H.M.S.O. 1970.
†Royal Commission on the Civil Service 1953–55 Report, Cmnd. 9613, H.M.S.O. 1955.

economy. But the use of job evaluation has now developed, so that it can now be used to assess levels of responsibility between jobs of very different content. We do not see these developments as undercutting representative organisations. Many subjects for bargaining and questions of interpretation would remain. But the new system would mean that health staffs would not suffer as they have until now from their unwillingness to take industrial action. There would be collective bargaining—but it would be better informed, guided by clearer principles and with a fairer balance of power between employer and employee.

If this new system is to get off to the right start there needs to be a once for all review of pay levels and pay structures. The Whitley Councils would have to get a right initial alignment of pay and conditions—their main job would then be to deal with rates of increase and with manpower issues as they arose. The need for such a review is particularly acute for nursing staff, as in addition to problems of pay the Briggs Report has left a number of questions about career structures which need attention.

The precedent is that of the Review carried out by the National Board for Prices and Incomes of the principles that should underline setting the pay of the Armed Forces and of their pay levels.* Clearly the work in the N.H.S. is rather different. But some of the problems in setting pay are similar. One question in the armed forces was that of differentials between grades and of setting pay roughly in line with jobs of comparable responsibility outside. Another problem was that of producing a more unified salary structure—rationalising the pattern of allowances. A third question was that of the weight to be attached to the special conditions of service life. The N.B.P.I. carried out a large exercise in job evaluation. It succeeded in doing this not only for jobs which had close analogues outside—such as those of fitter—but for those of officers which did not have such close analogues. The health professions, too, need proper studies of internal relativities and of the content of different jobs, comparisons of their skills and responsibility with jobs elsewhere in the economy and an evaluation of their special factors—such as the liability to work at socially inconvenient hours. These enquiries should be a first task for the reconstituted Whitley Councils. Clearly the solutions have to be fitted in, however, with political decisions on improving the lot of low paid workers generally.

*N.B.P.I. Standing Reference on the Pay of the Armed Forces. First Report. Report No. 70, Cmnd. 3651, H.M.S.O. 1968. Second Report, Report No. 116. Cmnd. 4079, H.M.S.O. 1969

Chapter 5.—Resources for the NHS

The Drug Industry

The N.H.S. could give better service to patients through new initiatives towards the drug industry. The recent Monopolies Commission Report on valium and librium has provided further substantiation for the earlier and more general findings of the Sainsbury Report about the level of prices charged and profits earned by numbers of firms in the industry. These are excessive. But high prices and excessive profits are not the only or even the main reason for advocating public ownership. We have two other grounds for suggesting this. First we are very worried about the direction of research under present arrangements. At present commercial criteria set the main direction. There is duplication of research, expansive ballyhooing of drugs which are labelled as new but which are really only minor modifications of old ones and neglect of possible lines of development which would help less common diseases. In a recent survey *Innovative Activity in the Pharmaceutical Industry* published by the Chemicals E.D.C., 22 per cent of new compounds introduced by British firms in 1958–70 were thought to offer little or no advantage over previously available therapies.* One part of the tragedy of thalidomide was that it was developed because it was profitable—not because it was really needed. But we are also worried about whether drug firms are able to attract the most able and imaginative scientists into their service. A system which allowed much greater contact both with the N.H.S. and with the Universities would offer many advantages.

The 1950's saw a therapeutic revolution with new drugs of great clinical significance. Since then really significant innovations have been much fewer. Now that major breakthroughs are proving hard to come by there is an even greater need than there was in the past for a high standard of imaginative scientific work. But the problem is not just one of how best to move forward into an unpromising terrain. We also need to work out how to avoid the American experience. America spends far more on research than any other country. The American industry can also draw on the resources of laboratories run by foreign subsidiaries. Yet the American industry has a much worse record of significant innovation than the British industry or the industries of a number of other European countries. 63 per cent of new compounds first marketed in the U.S. between 1958 and 1970 offered only marginal or no advantages over existing therapies. 8 per cent represented really significant clinical advances—compared to 20 per cent of new compounds first introduced in Britain.† The evidence of the E.D.C. survey seem to us fairly clear—that the American industry is much the most inefficient in terms of advance for patients. We are also worried by the finding of the Report that there is a rather weak relationship between market performance and therapeutic usefulness. The most useful drugs are not necessarily those that do the best in market terms. Finally we are worried about the distance between the development of drugs and patients. There are far too many adverse reactions being suffered by patients.

The N.H.S. will be handicapped while such an important part of its work as the development and production of drugs is carried on outside driven by alien

*Chemicals E.D.C., *Innovative Activity in the Pharmaceutical Industry*, N.E.D.C., H.M.S.O. 1973.

†Innovative Activity in the Pharmaceutical Industry.

energies. We need to make new arrangements which will allow close connections between pure science, applied pharmacology and clinicians. The actual form of these arrangements should be a matter for discussion and negotiation with all concerned. There is much that can be learnt from the experience of the Medical Research Council, which has been in some ways outstandingly effective in organising research.

There are other features of the present situation which worry us. We think it wrong that pharmacology departments in universities should be so dependent on drug companies. We are alarmed by the massive volume of medical advertising literature distributed under various guises to doctors by drug companies. The growth of controlled circulation journals financed by drug firms and the heavy dependence of the old established firms on drug advertising, is a matter of great concern. But our main worries are not here but about the sound directions for future research. We recognise the difficulties involved in the extension of public ownership here, arising from the international nature of the industry and from the importance of patents. We recognise the need for something very different in organisation from the traditional nationalised industry. Our advocacy of public ownership is not on doctrinaire grounds—but because we think that, even taking into account the difficulties of the transition, it could bring great benefits to patients. Public ownership would be accompanied by compensation to the existing owners.

We also advocate public ownership for firms making equipment for rehabilitation. Under current arrangements, there has been far too little development of equipment and appliances for rehabilitation—such as wheelchairs. The recent survey of children in chairs showed that out of about 34 children, 29 were in ill-fitting chairs. Here a much closer connection between clinical work and production would be of benefit to patients. We would also wish to see a greater public stake in other activities such as the making of surgical equipment.

Medical Records

We see a great need for improvement here. The standard of patient care is being adversely affected at present by the standard of medical records. Records have never been given a high priority in the National Health Service. This is illustrated by the grading of Medical Records Officer. In many large groups the Medical Records Officer is paid a maximum of £2,565, while taking responsibilities for the collection and storage of patient records, admission and discharge procedures, the collection of statistics and the control of a large number of clerical and secretarial staff.

One of the advantages of reorganisation is that an individual's health care should be set out in a continuous record. But in fact medical records are once again relegated to a very subordinate role. If we are to improve records and to make progress towards continuous records we need to make the following changes:

—a substantial improvement in the grading of posts;

—a determined attempt to recruit able officers;

—allocation of resources to experiments in methods of record collection, storage and linkage.

Private Practice

Our concern with private practice stems not only from abuses such as queue jumping but from its impact on the overall effectiveness of the service. Studies have shown that much expenditure in the hospital service is on overheads. A certain minimum is essential—but after that point increased spending does not increase the number of patients treated. To increase the number of cases treated, increases are needed in medical time. If a certain proportion of the time of senior doctors is taken out of the service, this is not only a loss in itself—it reduces the effectiveness of the whole service. We do not think that all service to private patients represents time and energy which would only be available to them.

The long term future of private practice will depend on the standard of service in the N.H.S. and on whether we can through discussion arrive at sensible reforms of the career structures for hospital doctors. If the N.H.S. is not providing a satisfactory service, private practice would probably grow even if the regulations were strongly against it. We attach great importance to the steps discussed earlier to reduce waiting lists. If rapid and humane treatment is open to all through the N.H.S. private practice will become a rich man's whim. We also see a need for reform in the career structures of hospital doctors. The pay of G.P's has risen further relative to hospital doctors, and this has had a disturbing influence on morale. There are many problems in the distribution of hospital doctors between regions and between specialities. There are a great many criticisms to be made of the present distinction award system.

While in the long run the future of private practice will depend on the standard of service and the appropriateness of staff conditions in the N.H.S., we do not see why in the immediate future the service should in any way encourage private practice. A Labour Government should act to stop queue jumping; until a total separation of private practice from the N.H.S. is possible, a full economic rental should be charged for all private beds which continue to exist in N.H.S. hospitals. In addition the Government should also end the indirect subsidy which private practice receives by means of the tax relief at present enjoyed by employers on group subscriptions for medical insurance. All new appointments of a consultant status should be on a full time basis and the present system of merit awards be replaced by a new system of special responsibility payments.

It is generally recognised that the N.H.S. provides a much better service for people with serious illness than does private practice. The quality of nursing and the range of help and services is much greater. But the N.H.S. is falling down in two ways at present. It is not providing enough privacy for those who want it and it is not providing a good service for people who, although they may be in severe pain, are not suffering from conditions which are threatening to life. In planning new hospitals we obviously need to provide greater privacy. But above all we need to use the resources of the N.H.S. to provide a better service, and we should make sure that private practice is not in a parasitic relationship to the N.H.S.

Chapter 6.—Avoiding Bureaucracy

In recent years, a great deal of time has been spent in the service on proposals and schemes for administrative reorganisation. We are now in the grip of it. We see two great dangers in this. The first is that administrative reorganisation will be seen as a substitute for choice in policies and priorities. Part of the case for integration has always been that it would mean a better development of community care. But this will not be so unless choices are made. The second danger —which is great in current schemes for reorganisation—is that it will lead to a rapid growth of bureaucracy.

We oppose current proposals not on narrow grounds of party politics but because we think that their effects on the service—on the people working in it and on their patients will be unfortunate. Current plans are based on a hierarchical concept of management by which an appointed few direct—or where they do not direct, "monitor" the work of the many. The few will be selected for rather nebulous qualities of management. The element of appointment is rather great. The Secretary of State appoints all the members of each Regional Authority and all the Chairmen of the Area Authorities. The regional authorities appoint all the members of the Area Authorities except four who will be appointed by local Government. The hierarchy will be complicated. There will be four levels of management—at the Department of Health, at the Regions, at the Areas and at the Districts. Responsibility is likely to be even more diffused than at present, and (if that were possible) the incapacity of the Department of Health to take decisions increased. Even quite simple decisions will have to go to a large number of committees.

We are suspicious of the strange jargon which invests the new system, and its pseudo-scientific cast-arising from an outdated philosophy of management.

We do not wish to subject the N.H.S. to another major upheaval—with all the insecurity and the diversion of energy from questions of care to questions of administration, which it would involve. For this reason we did not favour a change to local authority control immediately. However, there are certain changes that could be made quite simply within the administrative structure which would improve it.

—At the centre there should be a parliamentary select committee on the Health Service. At present there is far too little democratic discussion of national choices.

—The power and responsibilities of regional authorities should be kept to a minimum, being those functions which for practical reasons cannot be successfully performed at the area level.

—Substantial improvement to the area and regional bodies can be made by revising their membership. This should be done as soon as a Labour Government is returned to power and should not await the times at which members will come up for appointment.

Essentially, the regional and area authorities should be made accountable to the people who use and provide these services. At the area level a majority of the membership might comprise representatives of the community as a whole and the remaining members be representatives of the staff of the service. While we would welcome experiments in direct election; initially we feel that community

representatives could be nominated by local authorities. Staff representatives could be nominated by relevant unions or be directly elected by health workers as a whole. Discussions with staff will be needed to determine this. The regional bodies should become federal bodies of the areas by recruiting their membership from these areas, three members from each area—two public and one staff representative.

Membership of community health councils, established on a district basis, should comprise half local authority and half directly elected representatives. They should have an independently organised secretariat which will provide the local health councils with information and research support.

All these changes could be carried through without major disturbance. The aim of them is to reduce bureaucracy and to give people who are actually doing the work a greater voice in how it is done and to give consumers more say. We want to release initiative and to encourage a better service to the public.

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