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THE NATIONAL HEALTH SERVICE

GENERAL

The National Health Service Act of 1946 aimed at promoting 'the establishment in England and Wales of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'. Through the Act the Minister of Health was made responsible to Parliament for seeing that health services of every kind, and of the highest possible quality, were available to everyone who needed them. The NHS (Scotland) Act 1947 laid similar responsibilities on the Secretary of State for Scotland. Both these Acts were passed by Parliament and came into force on 5 July 1948.

Under the National Health Service (NHS), the essential freedoms have been safeguarded, for the public is free to use the service or not. The patient is free to choose his family doctor and to change to another if he wishes to do so. The doctor is free from interference in his clinical judgment, and may accept private patients while taking part in the service. The service is available free to all residents in Britain according to their medical need, except that certain small charges are made for some items. Treatment can be given under the emergency provisions of the service to any visitor from abroad who has the misfortune to fall ill during his visit, but visitors who come to Britain specifically for treatment are expected to pay for it. About 97% of the population of Britain are using the service.

ORGANISATION IN ENGLAND

From 1948 to 1974, the NHS was administered in three parts - the hospital and specialist services, the general practitioner services and the local authority services. Under the NHS Reorganisation Act of 1973 these services were unified, with just over 100 regional and area health authorities taking control in place of over 600 boards, committees and councils that had previously been responsible for them.

The new arrangements came into force on 1 April 1974, and provide for three levels of planning: central strategic planning and monitoring by the Department of Health and Social Security; regional planning and general supervision of operation by regional health authorities (RHA's); and area planning and operational control by area health authorities (AHA's).

THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY (DHSS)

The DHSS came into being on 1 November 1968, as an amalgamation of the Ministry of Health (first established in 1919) and the Ministry of Social Security. The section dealing with health has a staff of about 5,000 people, and is mainly a central supervisory department for the general organisation, planning and financing of the health and welfare services. The Secretary of State for Social Services is the head of the DHSS: this is a political appointment, as are those of the Minister of State and the Parliamentary Under-Secretary of State (Health) and the Parliamentary Under-Secretary of State (Social Security). The two senior permanent officials of the DHSS are the Permanent Secretary and the Chief Medical Officers: these are both members of the Civil Service, as are the rest of the staff of the DHSS. But none of the staff employed by regional and area authorities in the NHS are civil servants.

The Secretary of State is responsible to Parliament for the NHS and the role of the DHSS is to assist him in the following ways:

(a) Settling the kind, scale and balance of service to be provided in regions and areas.

(b) Guiding, supporting and (to the extent that this is desirable) controlling RHA's. Here it is the Department's job to help the authorities to understand the guide-lines and the reasoning behind them. It also allocates to the RHA's the necessary resources.

(c) Obtaining or developing resources which strongly influence the adequacy, efficiency and economy of the services. This requires specialist work on particular resources - personnel; finance; property and building; supply. The Department has a special responsibility in relation to staffing - for instance forecasting staff requirements, planning the number of training places, etc.

(d) Carrying out other functions which are best organised centrally, such as some types of research, standardisation and preparation of national statistics.

(e) Supporting the Secretary of State in his Parliamentary and public duties.

REGIONAL HEALTH AUTHORITIES

There are 14 Regional Health Authorities (RHA's) in England, each consisting of between 3 - 11 health areas. The RHA forms part of the chain of responsibility running from the Secretary of State to each AHA. The Chairman and members of the RHA are appointed by the Secretary of State after consultations with interested organisations, including the universities, the main local authorities, the main health professions and the TUC. Members are unpaid (but entitled to travelling and other allowances) but the Chairman may be paid on a part-time basis.

The role of the RHA is to develop strategic plans and priorities based on a review of the needs identified by the AHA's. It is responsible for allocating resources among AHA's, agreeing area plans with them and monitoring their performance. The most important of the RHA's executive functions is the design and construction of new hospitals and other health buildings. It is also responsible for identifying, in consultation with the AHA's, services which need a regional rather than an area approach and arrange for their provision.

AREA HEALTH AUTHORITIES

There are 90 Area Health Authorities (AHA's) in England whose boundaries generally match those of the new non-metropolitan counties and metropolitan districts of local government. In London the health authority boundaries correspond to those of an individual London Borough in four cases, and two, three or, in one case four London Boroughs grouped together in the remaining 12 cases.

The AHA is the operational NHS authority, responsible for assessing needs in its area and for planning, organising and administering area health services to meet them. It is the employer of the staff who work at area headquarters and in the districts. It is also responsible for services such as catering and domestic, as well as for other supportive services which back up the health professions and, in so doing, contribute to patient care.

The Chairman of the AHA is appointed by the Secretary of State after consultation with the Chairman of the RHA. There are about 15 members for each AHA, four of whom are appointed by the corresponding local authority, one by the university concerned (areas with substantial teaching facilities are administered by AHAs (Teaching)) and the remaining members appointed by the RHA after consultation with the main health professions, the trade unions and other organisations. An AHA always includes doctors and at least one nurse or midwife, but otherwise the proportion of professional members is not prescribed. Members are unpaid (but entitled to travelling and other allowances) but the Chairman may be paid on a part-time basis.

HEALTH DISTRICTS

The day-to-day running of the services for which each AHA is responsible is based on 205 health districts. These usually contain a district general hospital and usually have a population of between 150,000 and 300,000. The AHA's decide the number of districts in their areas and there are between one and six districts in each area. There is no statutory authority at district level, as there is at area or region, and responsibility for the day-to-day operation of the services at district level lies with the district management team of about six senior medical, nursing, administrative and finance officers.

At district level there are also health care planning teams whose function is to determine health care needs of groups of patients (e.g. elderly, mentally ill, mentally handicapped children, etc.) or to look at particular problems (e.g. review of primary care services, re-organisation of out-patient department, etc.).

SOCIAL SERVICES

Under the new arrangements, as under the old, health service costs are met mainly through central government funds from tax revenue. Social services, on the other hand, are planned and controlled by local government authorities (sharing the same boundaries as area health authorities, in most cases) and their costs are met mainly through local government funds. Although separately financed, it is very important that health and social services should be planned jointly, particularly for the old, the mentally ill and mentally handicapped. There is therefore under the 1973 Act a statutory responsibility for area health authorities to collaborate in planning with their corresponding local government authorities. Co-operation in this field is vital to the success of the reorganised NHS.

COMMUNITY HEALTH COUNCILS

A completely new feature of the reorganised NHS is the establishment of Community Health Councils (CHC's). These CHC's represent the views of the consumer. There is one for each of an area's health districts. Half the members of the Council are appointed by the local authorities of which the area, or part of it, is included in the CHC's district, at least one-third by voluntary bodies concerned locally with the NHS and the remainder by the RHA after consultation with other organisations. The number of members varies according to local circumstances, but there are usually between 20 and 30. Members are unpaid, but entitled to travelling and other expenses. Councils appoint their own Chairmen from among their members.

The Council's basic job is to represent to the AHA the interests of the public in the health service in its district. Councils have powers to secure information, to visit hospitals and other institutions, and have access to the AHA and in particular to its senior officers administering the district services. Councils may bring to the notice of the AHA potential causes of local complaint, but their function is distinct from that of the AHA's complaints machinery and of the Health Service Commissioner.

The AHA is required to consult the Council(s) on its plans for health service developments - e.g. closures of hospitals or departments of hospitals, or their change of use. The full AHA meets representatives of all its Councils at least once a year. The Council publishes an annual report (and may publish other reports) and theAHA is required to publish replies recording action taken on the issues raised.

HEALTH SERVICE COMMISSIONER

Another new feature of the NHS is the appointment of a Health Service Commissioner to investigate complaints against NHS authorities. This is an important extension of the ombudsman principle in the public service. The necessary legislation is part of the NHS Reorganisation Act, and from 1 April 1974 his jurisdiction covers the whole of the unified NHS. He does not, however, investigate complaints which, in his opinion, relate to the exercise of clinical judgement by doctors and other staff, nor does he deal with complaints for which statutory procedures already exist (e.g. those about general medical and dental practitioners, pharmacists and opticians, which continue to be dealt with under the service committee procedure) or which he thinks the complainant could reasonably pursue through the courts of law.

The complainant has direct access to the Commissioner who, however, does not investigate a complaint until he is satisfied that the health authority concerned has had a reasonable opportunity to investigate it and reply to the complainant who, despite this, is still dissatisfied. Complaints to the Commissioner do not have to be made by the patient himself: there are some cases where the patient is unable to act for himself, and in such cases the complaint may be made on his behalf.

VOLUNTARY SERVICES

Under the new arrangements, voluntary bodies, which have always played an important part in the development of the health and welfare services, are being encouraged, in close co-operation with the area health and local authorities, to increase and extend their activities. Through their membership of the Community Health Councils they are able to influence the way in which the health services are developed. The recent growth in the number of organisers co-ordinating voluntary help in hospitals will continue and this method of co-ordination is being extended to the wider field of voluntary work in the community.

The RHA's and AHA's will be able to make grants in support of voluntary bodies which provide and promote services within the general scope of the authorities' responsibilities. Financial help for national activities continues to come from the central Department. As all this voluntary activity develops, it is important to emphasise that the role of volunteers is no longer seen as being to plug gaps in the welfare state, but rather to complement and enrich the quality of life for people in need, whether they are living in their own homes or in hospital or in any form of residential care, and also to pioneer new ideas and to develop in the hospital and its neighbourhood a real sense of community involvement in the services which as taxpayers or rate-payers they largely finance.

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HEALTH SERVICE STATISTICS - ENGLAND ONLY

The following figures are taken from Health and Personal Social Services Statistics for England, 1974.

Hospital patients	1972 Thousands	1973 Thousands
Available staffed beds (daily average)	413*	404*
Occupied beds " "	342	328
Discharges and deaths	5,223	5,132
Waiting lists	479	509
Out-patient and casualty attendances	46,290	46,674

* Of the total of 404,000 beds approximately 41% are for psychiatric patients.

Hospital staff	1972	1973
Doctors and Dentists (equivalent of whole-time)	24,413	25,573
Professional and Technical (equivalent of whole-time)	36,444	38,255
Nursing and Midwifery (whole-time)	193,564	194,929
Nursing and Midwifery (part-time)	108,847	113,617
Works, maintenance and domestic (equivalent of whole-time)	196,173	191,290
Administrative and clerical	55,190	59,142

KM/ PB

22 January 1975

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NATIONAL HEALTH SERVICE FINANCE - HOSPITALS

Expenditure of hospital authorities in England in year ending 31 March 1973
(taken from Health and Personal Social Services Statistics for England, 1974)

CAPITAL EXPENDITURE	£ thousands
Gross Expenditure	183,065

REVENUE EXPENDITURE	£ thousands	% of total hospital maintenance	
Salaries and wages:			
(i) Medical and dental	136,895	11.08)	
(ii) Nursing	368,836	29.84)	72.63
(iii) Others	391,873	31.71)	
Provisions	54,303		4.39
Staff uniforms and patients' clothing	9,252		0.75
Drugs	34,720		2.81
Dressings	8,115		0.65
Medical and surgical appliances and equipment	61,916		5.01
General services (includes power, light, heating, water, cleaning and laundry)	51,886		4.20
Maintenance of buildings, plant and grounds	38,185		3.09
Domestic repairs, renewals and replacements	19,260		1.56
Other expenditure	60,695		4.91
Total hospital maintenance	1,235,936		100.00
Blood transfusion, mass radiography, etc	19,763		
Central administration	43,076		
Total hospital revenue expenditure	1,298,775		
Less : Direct credits	36,096*		
Total net revenue expenditure	1,262,679		
Income:	16,000*		

* Note: Revenue income is derived mainly from patients in private or amenity beds, from charges for the supply and repair of certain appliances, and from payments under the Road Traffic Acts. Direct credits represent payments by staff for board, lodging, supplies and services. These direct credits are netted against expenditure in the hospital accounts.

HEALTH SERVICE COSTS AND SOURCES OF FINANCE IN THE YEAR ENDING 31 MARCH 1973 ENGLAND

COST OF SERVICE

	£ million	%
Central administration	17	0.6
Hospitals current	1,303	49.9
Hospitals capital	184	7.0
Executive councils service		
Administration	15	0.6
General medical	175	6.7
Pharmaceutical	226	8.7
General dental	112	4.3
General ophthalmic	27	1.0
Welfare foods	10	0.4
Local health authority	147	5.6
Personal social services	355	13.6
Others	41	1.6
	£2,612 million	100.0%

SOURCE OF FINANCE

	£ million	%
Exchequer	1,826	70.0
N.H.S contributions	197	7.5
Payments by persons using the services	129	4.9
Rates and exchequer grants to local authorities	452	17.3
Other	8	0.3
	£2,612 million	100.0%

National average cost of maintaining in-patients 1972/73

	£
(a) Non-teaching hospitals - weekly in-patient cost	
Acute	89.06
Maternity	95.26
Mental illness	30.34
Mental handicap	28.02
(b) Teaching hospitals - weekly in-patient cost	
Acute (London)	129.14
Acute (Provinces)	115.66

KM/PB

28 January 1975

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NATIONAL HEALTH SERVICE

Details of Medical and Dental Staff employed in hospitals in England as at 30 September 1973 (extracted from Health and Personal Social Services Statistics for England, 1974).

Grade	Staff Employed (including part-time staff expressed as whole-time equivalent)
Consultant	9,285
Senior Hospital Medical/Dental Officer	225
Medical Assistant	812
Senior Registrar	1,890
Registrar	4,514
Junior Hospital Medical Officer	2
Senior House Officer	6,377
House Officer - (Post-Registration and Pre-Registration)	2,456
Other Ungraded Staff	12
Total	25,573

General medical practitioners in the N.H.S.

	Numbers at 30 September 1973
Principals	20,341
Assistants	570
Trainees	447
	21,358

GRADES OF HOSPITAL MEDICAL STAFF

Based on extracts from Hospital Administration

by
Geoffrey A. Robinson, F.H.A., F.C.A.
(1962; rev. ed. 1966)

The following are the principal grades of medical staff employed in hospitals:

CONSULTANT - A senior practitioner who has been appointed by a statutory hospital authority, who performs clinical duties and has ultimate personal responsibility for the treatment of the patients under his care.

SENIOR REGISTRAR - Posts obtained by practitioners, normally not less than three years after full registration and held normally for three or four years.

REGISTRAR - Posts obtained by practitioners, normally not less than one year after full registration and held normally for two or three years.

SENIOR HOUSE OFFICER - A post obtained after at least twelve months post-graduate experience in hospitals. The post is held normally for one year.

HOUSE OFFICER - Normally the first post held after qualification.

MEDICAL ASSISTANT - An intermediate grade of medical practitioner capable of assuming responsibility delegated by senior staff, capable of carrying out complex diagnostic and therapeutic procedures, and giving support and supervision to the house office grades. These posts are open to practitioners who have served in the hospital service for at least three years since full registration, including at least two years in the grade of registrar or with equivalent experience. Appointments are for two years in the first instance and renewable, subject to confirmation, for an indefinite period.

New appointments to the following posts ceased in 1964, when the post of Medical Assistant was introduced:

SENIOR HOSPITAL MEDICAL OFFICER - A senior practitioner performing clinical duties who is not of consultant status but is not in the registrar grades.

JUNIOR HOSPITAL MEDICAL OFFICER - An officer who has held house appointments but is not a registrar, who has less responsibility than other hospital officers of non-consultant status, and who has been appointed for a limited or indefinite period.

KM/AC
15 January 1974

DOCTORS' PAY

Doctors working in hospitals are paid on a salaried basis, either full-time or part-time. General practitioners are paid on a more complicated basis, calculated largely according to the number of patients on each doctor's list, with a variety of special allowances and supplements. The extract below is reproduced by kind permission of the Editor, from the January 1974 issue of WHICH?, the journal of the Consumers' Association.

HOW YOUR FAMILY DOCTOR GETS PAID

GPs are paid for each patient on their list, and also allowances for being a practitioner, for practising in certain areas and types of practice, as well as fees for some treatments or visits.

Doctors' fees and allowances are based on recommendations by the Review Body on Doctors' and Dentists' Remuneration. Their intention is that the various payments and allowances should give GPs an average income (net of medical expenses) of £5,750.

To give an idea of how the NHS pay scheme works in practice, and how actual incomes can vary between different GPs, we set out below how the incomes of two imaginary GPs add up (for 1973–74).

Dr Newcome did three years vocational training on top of his medical training, to become a GP at the age of 28. He took over a practice of 1,500 people in Lancs. Of these, 450 are 65 or over. He employs a receptionist/secretary at £1,000 a year. Last year he did 50 night visits (between 11pm and 7am) and attended to three temporary residents. He has started a cervical smear programme – he's examined 40 women. He dispenses medicines from his surgery. This year he did a postgraduate training course on the *Early Diagnosis of Cancer.* He works from his home, rented for £500 a year.

His income works out at:	£
Basic practice allowance	1,815
Vocational training	400
1,050 patients under 65 @ £1.50	1,575
450 aged 65 or over @ £2.10	945
Payment for out-of-hours responsibilities	350
500 patients over 1,000 @ 28p	140
Payments for dispensing	800
Postgraduate training allowance (lump sum)	140
50 night visits @ £3	150
40 cervical smears @ £1.50	60
4 temporary residents @ £1.50	6
Payment for rent	150
Payment for receptionist's income	700
	£7,231

Medical Expenses (which can be set off against tax)	£
Receptionists' income	1,000
Practice expenses – including rent, heating, cleaning and so on	350
Car	650
Medical supplies	400
Other expenses	400
Locum while on holiday	200
	£3,000
Dr Newcombe's net income is	**£4,231**

Dr Longstay has been practising for 35 years. He works as a partner in a group of five doctors in London, and has 2,800 patients on his own list, of whom 600 are over 65. He is on duty one night in the week – 50 night visits a year. He vaccinates the schoolchildren in his practice – and provides maternity medical services. He treated 30 temporary residents. The group has a trainee practitioner learning the ropes – they get a grant for this. The five doctors employ four receptionists/secretaries (£1,400 each). Each partner pays £300 a year towards the maintenance of the practice building, bought some years ago (but which they get a payment for).

His income works out at:	£
Basic practice allowance	1,815
Group practice payment	270
Seniority payment	910
2,200 patients under 65 @ £1.50	3,300
600 aged 65 or over @ £2.10	1,260
Out-of-hours responsibilities	350
1,800 patients over 1,000 @ 28p	504
50 night visits @ £3	150
100 vaccinations @ 50p	50
28 births @ £21.75	609
30 temporary residents @ £1.50	45
Share of trainer's grant (£850)	170
Notional rent payment	150
Share of payment towards receptionists' income	784
	£10,367

Medical expenses (which can be set off against tax)	£
Practice expenses – including rent, heating, cleaning and so on	300
Share of receptionists' salary	1,120
Car	500
Medical supplies; other expenses	350
	£2,270
Dr Longstay's net income is	**£8,097**

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NATIONAL HEALTH SERVICE - DISTRICTS & AREAS

England (14 regions)	No. of Areas	No. of Districts	No. of areas with 1	2	3	4	5	6 districts
Northern	9	16	6		2	1		
Yorkshire	7	17	1	4		2		
Trent	8	18	3	1	3	1		
East Anglia	3	8		1	2			
N W Thames	7	18	1	3	1	2		
N E Thames	6	17		3	2		1	
S E Thames	5	16	1	1	1	1		1
S W Thames	5	14	2		2			1
Wessex	4	10	1	1	1	1		
Oxford	4	7	1	3				
S Western	5	13	1	2		2		
W Midlands	11	22	7		2	1	1	
Mersey	5	12	1	3			1	
N Western	11	17	9	1				1
Total	90	205	34	23	16	11	3	3
Wales	8	17	3	3		4		
	98	222	37	26	16	13	3	3
Scotland (Health Boards)	15	34	5	4	4	1	1	
	113	256	42	30	20	14	4	3

(Source : Hospitals Year Book 1974)