Conference report

NHS: The first 40 years

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Among the events commemorating the 40th anniversary of the inauguration of the National Health Service in July 1988 was a conference at Senate House, London arranged by the Society for the Social History of Medicine, which was opened by Sir George Godber.

A question that has puzzled many people is why 5 July should have been chosen as the Appointed Day for the NHS to start, in 1948: the simple answer was that it was the middle Monday of the year. Sir George said that at that time, the objectives of the Service seemed plain – everyone should have access to care when they needed it and the existing services had to be re-constructed, since they were generally un-coordinated, irregularly distributed, and ill-equipped (particularly the former Public Assistance institutions). Hospitals were therefore reorganised on a regional basis, whilst GP and public health services had their local management changed. Until the Appointed Day, most people had to pay for at least some parts of their health care, but this need is essentially different from most others, since it is nearly always involuntary, even though ill-health is to some extent linked to lifestyle. By 1948, it was obvious that care could not be made available to everyone unless it was drastically reorganised.

Sir George emphasised that the construction of the NHS was not due to a sudden change of heart politically, nor was it part of only one party's programme; plans for a health service went back to the Dawson Report of the early 1920s. The Beveridge Report assumed that there would be a health service, since it is in society's own interest to secure the best health of the people. However, from the beginning, there were financial problems, and the NHS survived the 1950s only because new drugs greatly reduced expenditure on tuberculosis and communicable diseases – something which the Treasury failed to notice. Unfortunately, no similar change has occurred since then for other conditions. In the early 1950s, the first capital allocation of £2 million was made, but this was not accompanied by a clear policy of closing old facilities as new ones were built: that was a policy which Enoch Powell tried to introduce with the Hospital Plan. From the time of the Korean War, the obligations of rearmament (nearly 30% of national expenditure, compared with 8% for the NHS) constricted spending on the social services, but these pressures were relaxed in the 1960s.

By the late 1960s, the concept of the Health District had emerged as a potentially unifying force for the health services, but the 1974 reorganisation was less effective than had been hoped. This was partly because of the system of Areas, which was a concession to the local authorities, and partly because of the composition of the Health Authorities. The issue of low pay for ancillary workers was apparently solved, but at enormous overall cost, which resulted in great financial problems subsequently.

Sir George said that health care cannot be standardised and delivered at a fixed cost: the best outcome is not necessarily the cheapest. It might be better to put more resources into the prompter use of treatments of proved effectiveness, by foregoing some over-elaborate investigations or procedures. A better balance is certainly needed between the two, and social supports in the community can be as effective as some therapeutic interventions. No country at present provides every service for relieving illness or handicap to every citizen. There always has to be a ceiling on expenditure, even though that ceiling should be much higher than it is now.

Dr Charles Webster, author of the recently published first volume of the history of the NHS, said that following World War 1, there had been a false start towards a comprehensive health service. Lack of political will and the post-war financial crisis brought that to an end, but nevertheless, the inter-war period was a significant one for health care. The Ministry of Health was established and there was a succession of important pieces of legislation, though these were largely permissive. However, services remained very unevenly distributed, tending to be least where they were most needed; in this, they followed the pattern of the voluntary sector. Yet nationally, the quantitative increase was significant; for instance, expenditure on local authority services doubled in the 1930s – more than twice the rate of growth in the years following 1948. Both the Beveridge Report and the NHS in fact represented the continuation of an already established trend.

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To establish a first class service, Aneurin Bevan was willing to make major concessions to the medical profession; he wished to erase the Poor Law image, which had existed for over 100 years, and spoke in rather extravagant terms, e.g. of the "inalienable right of the people" to health care. Nevertheless, a political consensus about the NHS was maintained until 1979, although in 1951, the Treasury's view that there should be a massive decrease in expenditure on the NHS was accepted by the new Minister. The small reductions that were effected in 1952 caused a major revolt, though, so that further cuts were abandoned and the Minister replaced. However, so far as the national disposition of resources is concerned, the NHS' record is more questionable: many vested interests had to be conciliated, and there was a lack of central leadership from the Ministry in overcoming inequalities in resources, e.g., between teaching and non-teaching hospitals, between regions, and between social classes. Until 1960, financial retrenchment made it impossible to overcome these inequalities, but from that point, there was a growth in confidence which persisted up to 1974.

In 1956, Abel-Smith and Titmuss exploded the myth of a 'bottomless pit' of health expenditure, showing that per head of population, it had hardly changed since 1949, and in the decade to 1959, the percentage of GNP spent on health actually fell. In fact, between 1935 and 1960, there was little change in health costs. No other western health system has a comparable record to that of the UK in control of expenditure.

Dr Webster said that the Health District is an elusive objective whose origins go back to the 1869 Sanitary Commission. The 1943 White Paper on a future health service suggested that this should be unified and based on local authorities, which seemed to be the only possible unit. In the end, though, an extraordinarily elaborate three-part structure emerged, and in 1969, the Labour Government became paralysed over a proposed return to unified local authorities. So far as nursing was concerned, the Salmon Report was a logical outcome of the Hospital Plan and of the financial pressures which resulted from a stagnant GNP; it was, in fact, well designed for the 1974 reorganisation and consensus management.

Dr John Pickstone of the Wellcome Unit for the History of Medicine, University of Manchester, described how psychiatry was established in general hospitals in the Manchester Region, in the first years of the NHS. In the early part of this century, Lancashire – with its 17 county boroughs – had contained one-eighth of the British population. The possibility of using the general hospital model for psychiatric care, though, began with Henry Maudsley's bequest to the LCC.

By the 1920s, most large local authorities had become responsible for a considerable volume of health services in addition to asylums; for instance, related to the enormous prevalence of tuberculosis. There would have been scope, therefore, for reducing the barriers between them, but in fact this rarely happened, because asylum services were related to the Poor Law, rather than to Public Health. From 1930, it was theoretically possible for Poor Law hospitals to be placed under the local Public Health Department, but this only happened in a few places, through particular individuals.

In the discussions on the structure of the future NHS, very little consideration was given to psychiatry; until late on, it was not even suspected by most of the people concerned that the local authorities would lose control of their hospitals. The NHS was mainly concerned with extending a high quality of service rather than with integration; as a result, some of the local enterprises of the 1930s were set back. However, one of the greatest early achievements of the NHS was to spread the appointments of consultants, and this became a key factor in the process of psychiatry coming to be seen in the same terms as other specialties. However, few other innovations came from the new Regional Hospital Boards, which on the whole, spent little money in the first two years.

In the Manchester Region, though, a recommendation that the psychiatric service should continue to be based on the mental hospitals was not accepted by the Board; instead, a policy was approved that consultant psychiatrists should be appointed to districts. It was thought that this would be very expensive, and the experiment might indeed have foundered, had the first appointment not been a very successful one – that of Dr Arthur Pool at Oldham. He may be regarded as the Prophet of the movement, and established a very effective liaison with the MOH. However, there was not much evidence of the Prophet having had disciples. The scheme benefited from the strong commitment to it of the Region's Deputy Senior Administrative Medical Officer, but he came into post after it had been formulated, and had no previous experience of psychiatry.

Just before the inception of the NHS, a chair of psychiatry was established by Manchester University, and its Vice-Chancellor (Sir John Stopford) was the first chairman of the RHB, but otherwise there was no direct connection between the University and the success of the district psychiatry scheme. There is no evidence that C.P. Blacker's book of 1948 was known to the Board's SAMO. The central figures of the RHB were Stopford, Sir Harry Platt, Sir Geoffrey Jefferson (both old friends of Stopford), and Dr Norman Kletts; from the beginning, they began to distance themselves in some respects from national policies. There was a wish to find ways of easing the local problems of the 'cotton towns', in which these leaders had a long experience of medical work. Their view was that special services should be

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brought into the mainstream of medicine, rather than developed separately. Thus, no Regional Psychiatrist was appointed (the duties being split between a part-time adviser and an administrator), the Christie Hospital was not given a separate Hospital Management Committee, and specialist advisory committees were discouraged.

In Lancashire, mental hospitals had been administered before the NHS by a Mental Hospitals Board, jointly representing the county and the county boroughs; such indicators of progress as proportions of voluntary patients and out-patient clinics had been at a notably low level and the poor standards were adversely criticised by the Board of Control. Since such federal activities by local authorities had appeared to be unwieldy and useless, the RHB was very wary of further development of the mental hospitals. In any case, it proved very difficult to recruit consultant psychiatrists to be based in mental hospitals after 1948.

Lancashire was peculiar in that eight large towns each had a 'mental block' in its former Public Assistance hospital, making a total of nearly 2,000 beds, though the only specialist care came occasionally from asylum-based doctors. None of these towns was near to a mental hospital. If these units were to be upgraded, they would need supervision by consultants, like beds in other specialties – a special theme of the NHS in the 1950s; this development was strongly supported by the representatives of the towns concerned. The first proposal was for a consultant to serve two towns, as well as having some beds in the nearest mental hospital; however, the first appointee soon concentrated on one town only, and this became RHB policy by 1953. Candidates of high quality were found for subsequent appointments, and their work became more effective with the introduction of new drug treatments; otherwise, they would probably have had to continue making some use of the mental hospitals, where the new physical treatments had been of marginal significance until the mid-1940s.

This development illustrated the general situation of the NHS in its early period – though there was no money for new buildings, there was some money for new consultants. It was also a 'leapfrog' effect, in that the specialty which was most backward made the quickest progress.

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