Forty years of the NHS

Origins and early development

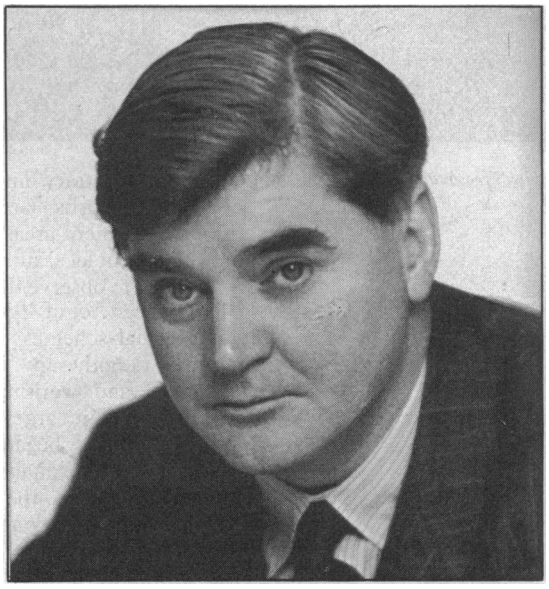
George Godber

Details of the structure and organisation of the NHS are on the record, but the reasons underlying the pattern of its development are less clear. I am concerned here, therefore, mainly with evolutionary changes in the service at work, and I shall keep mainly to the origins and the first 25 years in England and Wales.

The real NHS is the many services rendered daily by health professionals and their aides to people in their homes, in health centres, and in hospitals. Three quarters of the population use the NHS each year, and it is by their satisfaction that it should be judged.

Origins in pre-existing structures

The idea of a national health service was not produced by any one political party. Nearly all the services which were incorporated in 1948 already existed. What was needed was a system that would ensure equality of access in accordance with need, not ability to pay. That was part of a consensus in British society about its responsibility to its members, first fully expressed in the Beveridge report in 1942.



Aneurin Bevan became minister of health in the new Labour government of 1945

A medical advisory committee to the first minister of health produced an outline plan for a national health service as far back as 1920, introducing the idea of three levels of medical care approximating to region, district, and neighbourhood. Nothing was done at the time, partly because of postwar retrenchment and partly because of opposition from sectional interests.

The Poor Law had provided last resort support for the indigent in Britain for nearly a century, including what was bleakly called "medical outdoor relief." Poor law institutions included infirmary wards with a medical officer in charge, and the larger ones gradually took on the functions of general hospitals for the acutely ill. The voluntary hospitals developed specialist services first, but between the wars development was greater in municipal hospitals. Hospitals for patients with communicable diseases, tuberculosis, and mental illness and handicap had long been provided by local authorities—originally for public safety.

From 1911 personal health care for low income workers was provided through National Health Insurance. This did not cover hospital care. Other medical care by general practitioners was a matter for the individual, but there was a feature of special importance to the future of the NHS in the relationship between specialists and general practitioners, the former seeing only referred patients, save in an emergency. Local authorities also provided clinical preventive services for children and their mothers. Home nursing was a voluntary service loosely coordinated by the Queen's Institute, but home midwifery was supervised and supported by local authorities. Nurses and general practitioners worked together reasonably well, in rural areas at least, but relationships between midwives or health visitors and general practitioners could be cool or even hostile.

In hospitals the increasing pace of scientific advance required sharper differentiation of medicine into specialties and improved training in the paramedical professions. These were hampered by the fact that senior medical staff in voluntary hospitals drew their incomes largely from private practice. Only in larger centres was this sufficient to support all the specialties required. The less remunerative, such as paediatrics and anaesthetics, suffered most. Nursing staff were poorly paid, and recruitment fell behind need. Municipal hospital medical staff were paid and were either whole time or had sessional contracts. These hospitals tended to concentrate on the statutory health responsibilities such as midwifery and tuberculosis and on inpatient work. Outpatient services, which were needed to take advantage of new diagnostic services, were developed mainly at voluntary hospitals.

Hospital and specialist services in the late 1930s were unevenly distributed, inadequately funded, and lacked coordination. Most of the buildings were old, and the requirements of modern medicine were met by adaptations in inadequate space. Communicable disease hospitals were often the most modern buildings but were soon to become redundant. Yet these physical difficulties were less important than those resulting from competition, if not overt hostility, between the various district hospitals.

Legislation and the end of the Poor Law

The Local Government Acts of 1929 and 1933 ended the old Poor Law a century after its last reform. The counties and boroughs were empowered to transfer the hospital component to public health departments, where they could be developed as a health rather than a welfare service. The boundaries between cities and

Cambridge CB1 4NZ
Sir George Godber, FRCP,
former chief medical officer

Guy's Hospital, London, 1900

counties set arbitrary limits to the services available in developing suburbs. General practice and voluntary hospital catchment areas took no account of existing boundaries, but local authority hospital and preventive services had to observe them.

The Cancer Act of 1939 was intended to encourage joint regional schemes for the treatment of cancer, mainly by radiotherapy, but the only scheme formally established and working before the NHS was in Lincolnshire. The largest authorities, Middlesex and London County, began limited regionalisation of services in their hospitals, and there were service links for radiotherapy in the north west and elsewhere among voluntary hospitals. The only broader based regional programme was initiated by the Nuffield Trust in Oxford.

The concept of regionalisation fitted in with the preparations for civil defence in the event of war. Although the civil defence regions were not quite the same as the later hospital regions, they served well enough as the units for the coordination of casualty treatment. Some hospitals outside the main cities were upgraded and extended to receive staff and patients from city hospitals. That wartime experience showed that hospital services could, with advantage, be reorganised and linked in regions for mutual support and better staffing.

Plans for a coordinated service

In preparation for the expected change all the hospitals, except for those for the mentally ill or retarded, were surveyed between 1942 and 1944 under the joint auspices of the health ministries and the Nuffield Trust. I must be the last survivor of those surveying teams. The reports of the 10 teams for England and Wales and one for Scotland were later published and were surprisingly consistent. They found major deficiencies in hospital buildings which could be remedied only in the long term, though much confusion and inefficiency could be resolved in the short term by functional union of the existing hospitals at each centre with a common and strengthened specialist staff. The centres should be linked in regions so that some regional specialist services could be provided for all. Those reports provided the basis for the early work of the regional hospital boards appointed in 1947.

The coalition government had set up the Goodenough committee to review medical education and acted on its report by providing funds for reform. After accepting Sir William Beveridge's report it published its intentions for health services in a white paper in 1944. Pater has described the negotiations which followed.[1]

One vested interest after another eroded the broader concepts, and it seemed possible that we would be left with merely an extension of the National Health Insurance system, with services provided by existing hospital owners under contract. The election of 1945 was, therefore, crucial for the NHS because it produced, in Nye Bevan, a strong and committed minister of health who, with the support of Buchanan in Scotland, could carry through proposals which went beyond the 1944 white paper.

Bevan saw that the hospital problem required a radical solution—the transfer of all non-profit making hospitals to the ministries and the establishment of regional boards to plan and administer hospital services and appoint committees in each district to manage them. The service was to be available to everyone. Although private medical practice might continue, it was to do so only under controlled circumstances, and the sale and purchase of practices must end. The service would be funded predominantly from national taxation.

The NHS Bill was introduced four months after the election and passed during the first session of the new parliament. There was contention, but not enough to endanger a scheme with such widespread popular support. Most of the crises of the next two years concerned details of professional terms of service.

Many people have suggested that a unified system of administration should have been established from the beginning. This was simply not practicable; indeed, we have not achieved unification yet. There was no ready made local administrative body, nor was there any body corresponding to the essential regional component, except in Wales and Northern Ireland. The various components of the service could not be united administratively because of the size of the task. I am still uncertain whether the gains of any of the reorganisations in and since 1974 have outweighed the losses or effected any economies.

Need for flexibility

After the act was passed less than two years remained for preparatory work. Only the Public Health Laboratory Service was immediately in a position to be made permanent.

Although counties had experienced health departments they had many new responsibilities, and some of them lost outstanding medical officers of health to the

regional boards. The councils had to produce schemes for their functions under the act, consult the regional health boards about them, and secure the minister's approval. I read all these schemes and remember how concerned I was that they should not be so narrowly drawn as to inhibit later change.

Maternal and child welfare and health visiting were already established; home midwifery was under partial control; and ambulance services were derived in part from wartime services; but home nursing, home help, and after care were almost wholly new territory. Immunisation against diphtheria and smallpox were provided but needed reorganisation. Other immunisations were already available or might follow, so programmes had to be capable of prompt expansion and had to involve general practitioners. Local health authorities had to rearrange their services for the support of higher profile clinical care without diminishing the thrust of prevention. Together with the welfare services, local health authority services did more to make the NHS viable than has been recognised.

Life threatening diseases

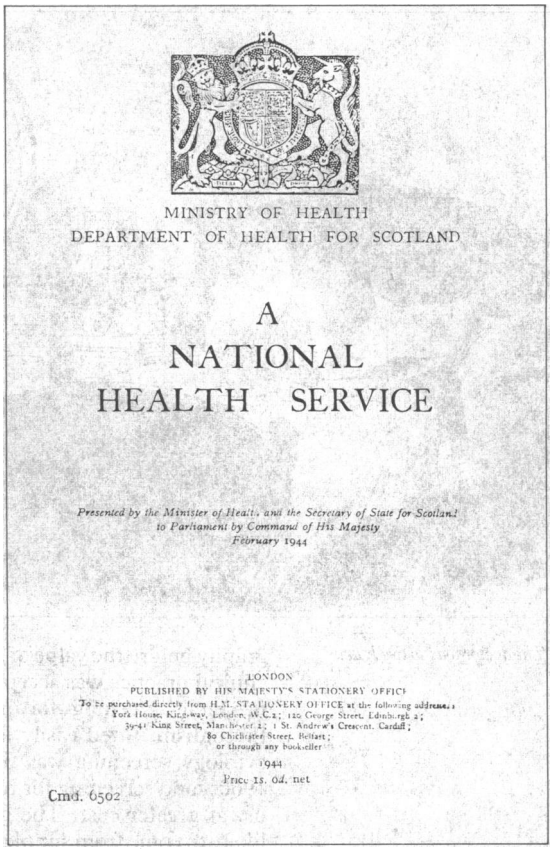
In the first two decades of the NHS most of the life threatening diseases of childhood were brought under control. In 1930 five diseases caused over 800 deaths per million children under 15 each year; by 1970 that mortality was down to five per million. This was partly because of social and environmental factors and largely because of educational work by health visitors, but immunisation also played a major part. Immunisation is far from complete even now, mainly because of the publicity given to wrong assessment of risks, but that should not obscure the gains achieved by medical officers of health and their staff.

The pioneering work on the care of the mentally ill and handicapped was done in collaboration with medical officers of health. Junior training centres for so called ineducable children and adult training centres were started by health departments and only when successful were they transferred to the education or welfare departments.

Problems of health control reminiscent of the earlier years of public health were also handled effectively. The medical officer of health was the key figure in the control of smallpox, and the virologists began to provide help in diagnosis only during the 1950s. The NHS has good reason to value the supporting work of the Public Health Laboratory Service—happily now to continue—and the skill of university laboratories. That still leaves a need for local knowledge and better regional support within the NHS. Collaboration does occur—for example, in the Medical Research Council's field trials of BCG and poliomyelitis vaccines, the clarification of the cause of retrolental fibroplasia in the early 1950s, the initiation of the confidential inquiries into maternal deaths since 1951, and local studies of perinatal deaths—but the opportunity to use the epidemiological skills of those trained in community medicine was too seldom used, despite the pioneering work of J N Morris, John Brotherston, Matthew Fyfe, Michael Warren, and Archie Cochrane.

John Ryle chose to move from clinical medicine to Oxford and the first chair of social medicine. Hiatt at Harvard and Hetzel in Melbourne made similar moves nearly 30 years later. In the interval, largely because of the work of Breslow, Morris, and others, the epidemiology of much chronic and degenerative disease was clarified and the possibility of prevention became an important new concern.

The teaching of public health had remained centred on the academic diploma in public health, which the medical officer of health was required to hold. This was


MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND

A
NATIONAL
HEALTH SERVICE

Presented by the Minister of Health and the Secretary of State for Scotland to Parliament by Command of His Majesty
February 1944

LONDON
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses:
York House, Kingsway, London, W.C.2; 120 George Street, Edinburgh 2;
39-41 King Street, Manchester 2; 1 St. Andrew's Crescent, Cardiff;
80 Chichester Street, Belfast;
or through any bookseller
1944
Price 1s. 0d. net
Cmd. 6502

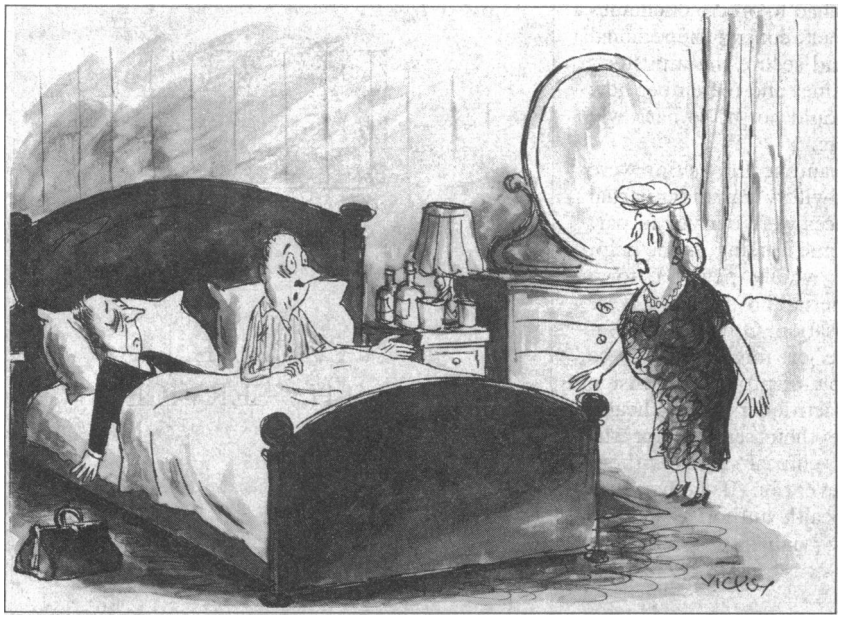
not a suitable qualification for the future specialist in community medicine, who should rank with his clinical colleagues and be able to support them in planning and evaluating their work. The reorganisation of this specialty eventually came about with the formation of the Faculty of Community Medicine in the 1970s and the report of the Hunter committee on its functions.

Now that changes in lifestyle and clinical practice are seen to be so important to health promotion the function of the community physician has changed. Health education requires communication of the right messages to the healthy and modification of factors inimical to health such as the uncontrolled promotion of unhealthy products. Education needs medical and allied knowledge and the ability to present it acceptably. Doctors, nurses, and other clinical workers do not necessarily have those skills. The Health Education Council, set up in 1967, made considerable progress before it was transmuted into the Health Education Authority last year. The Scottish Health Education Unit, with more resources, probably had a greater local impact, but funds allocated to this work were always insufficient.

Preventive health

The greatest failing, however, has been the slowness of government to recognise the need for firm regulation of the commercial promotion of tobacco, alcohol, and unsuitable foods, or to enforce that simplest and safest of preventive measures—fluoridation of drinking water. The first clear demonstration that smoking is a major cause of premature death was 37 years ago, but about 100 000 people still die prematurely every year as a result of the habit or because they have been exposed to other people's smoking. The health cost of alcohol overuse may be less in terms of premature deaths, but the social costs in other ways are probably greater. The NHS could not undo the harm that this failure of government brings.

Screening for inapparent disease is a relatively new preventive activity involving clinical and community services. It was introduced as miniature chest radio-



"The doctor was so tired, dear"

graphy before the value of screening as part of ordinary clinical practice was accepted. Other routines, such as neonatal screening for phenylketonuria and hypothyroidism, fitted easily into NHS practice. Cervical cytology screening was first introduced in the early 1960s, and screening for breast cancer is now also with us, at greater cost. The greatest gains, however, are likely to come from simpler procedures, such as checks for hypertension or glycosuria, incorporated into the routines of general practice. The foundation provided by the local health authorities in public health and community medicine has been one of the major strengths of the NHS.

The act also gave local health authorities power to provide health centres to accommodate the various components of the service. The original financial arrangements were unfavourable for doctors and local health authorities and even worse for dentists. Doctors were especially suspicious of council control. Fortunately, some experimental development began under other auspices—for example, Oxford regional hospital board at Faringdon—but real expansion only began in the mid 1960s when the general practitioner charter introduced sensible financial arrangements.

Remuneration of general practitioners

Changes in general practice were necessary before care in the community could be greatly improved, and they could be effective only if they began from within. At the outset general practitioners were probably the least content with the new service. Over 95% of the population registered with their chosen doctors, and very few of these declined to take part. Since, however, payment was to be almost wholly by capitation fee the distribution of medical incomes changed abruptly. In prosperous areas, where formerly there had been most opportunities for private practice, there were more doctors but the NHS lists were small. Areas with fewer doctors became those providing the largest incomes from capitation fees. General practitioners were aggrieved by what they, with good reason, regarded as an unfair dictate on their remuneration. The Spens committee had recommended earnings above those estimated for 1939 but left this to be adjusted to 1948 values, and doctors believed that the formula used undervalued this betterment by about a quarter. There was discontent, a much needed increase in the number of doctors was impeded, and many young doctors who had been in the forces could not establish themselves. Eventually the dispute was referred to arbitration and Judge Danckwerts found for the profession. Suddenly, four years after the NHS began, there was a large sum to distribute in general practice and an opportunity to encourage group practice and new entrants through collaboration not competition.

Dissatisfaction with the state of general practice was not simply because of injustice over pay or maldistribution. Several reports had been critical of the poor quality of some practices and morale was generally low. Two things slowly changed this—the improvement after Danckwerts's arbitration and a spontaneous movement among the doctors, which led to the foundation of the Royal College of General Practitioners. An initiative from the profession contributed £100 000 a year from their own remuneration to provide interest free loans for the improvement or construction of group practice premises. The anomaly that no rent allowance was paid to doctors remained until the Pilkington royal commission in 1960. Conditions for practice development, and particularly for the health centres, were only finally made favourable in the mid 1960s when the general practitioner charter was negotiated with Kenneth Robinson.

Cooperation with other staff

In 1954, quite independently, two groups in Winchester and one in Oxford arranged for health visitors from the local health authority to work in attachment to their practices. The result was so successful that the arrangement became general in Oxford and Hampshire within a few years and by the early 1960s was copied widely elsewhere. Credit should be given to the pioneers, of whom I remember particularly Drs Gibson, Swift, and Lawrie among the general practitioners, Drs Warin and Macdougall, the medical officers of health, and Miss Hayes, the health visitor. The Cumberlege report shows there is still much to be done, but the old format of singlehanded medical practice no longer meets requirements, and in its place multidisciplinary primary care must be developed with the patients having a greater say.

I have deliberately left hospital and specialist services to the last because, despite their cost and potential for saving life, their true function is to support the caring services provided outside. A hospital should be part of the community it serves, and specialists, whether doctors or nurses, neither supplant nor control but supplement the work of their colleagues in the community.

The minister in England and Wales had completed consultations and appointed boards for 13 regions and the principality by the early summer of 1947, and the first meeting of a board took place in Sheffield in July. The independent boards of governors of teaching hospitals were appointed in the following spring. Scotland and Northern Ireland took similar action but did not have the complication of boards of governors. Regions had less than a year to collect staff, learn their jobs, plan their districts, and secure ministerial approval before consulting and appointing management committees. The emphasis was on sound representation of local people and of skill in the existing services, and we have lost too much of that emphasis in recent years. The centre recognised that local people might prefer sometimes to make their own mistakes and live with them. The development of a district service was crucial for the provision of full health care and led to a gradual lessening of old hostilities between hospitals.

Development of specialist services

The greatest early gains were made by rationalising and improving professional staff and the use of beds. Nursing schools could be broader based when they

could use the resources of more than one hospital, and nursing care improved concomitantly. Specialist medical staffing outside the main centres was improved rapidly after a painful process of consultant selection had been completed and more junior staff were recruited.

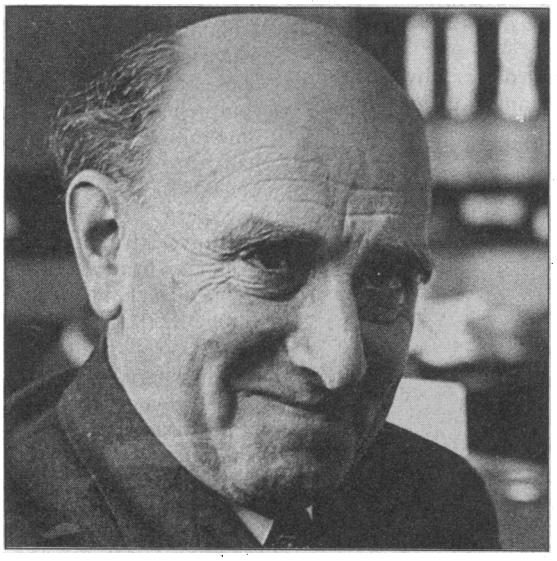
Boards had been given guidance on the development of specialist services prepared by a group of consultant advisers chaired by Sir John Charles. The Spens committee on remuneration had also laid down a pyramidal structure for specialist training, but this was interpreted wrongly as a guide to staffing, with damaging effects which still remain. Increases in consultant time and in other staff, including nurses, provided treatment for more patients, and improvements continued during the 1950s as training arrangements for the professions associated with medicine improved after a review by a committee chaired by Sir Zachary Cope. The emergence of these professions and the addition of non-medical scientists has been one of the major factors in service development.

Mr (later Sir) Henry Willink QC

In some specialties trained but not yet established staff were available from the forces, and some part time specialists had time formerly used for private practice now that their incomes came mainly from the NHS. But in specialties like pathology, psychiatry, radiology, anaesthetics, and paediatrics there was a severe shortage, and other new specialties were emerging, especially geriatrics. Medical staff expansion was allowed to become unbalanced by too great an increase in the senior registrar grade, especially in teaching hospitals and in the largest specialties of general medicine and surgery. When this growth was stopped in 1952 the registrar grade grew even more rapidly and the numbers of supposed trainees in medicine and surgery far exceeded the possible vacancies at consultant level. The result was only made worse by central attempts to restrain growth of the consultant grade as an economy measure. A great injustice was thus perpetrated on generations of young doctors and harm done to the NHS simply because the responsibilities of the consultant grade were too narrowly defined.

Imbalance of manpower

The situation was made worse by serious misjudgment of manpower requirements. In response to the profession's own fears the Willink committee reviewed the intake of medical schools and disastrously underestimated requirements. Our own production of doctors was cut back and many overseas doctors came in to distort further the imbalance between senior and junior grades. Most of us at the time were blind to the error until John Squire pointed it out five years later.



Sir John Charles (courtesy of the librarian, Royal College of Physicians, London)

The reaction of the Todd Royal Commission 10 years later went too far the other way.

When Sir John Charles's group produced *Development of Consultant Services*, the memorandum on which early planning was based, they described only 22 specialties, not even recognising the separation of geriatric from general medicine. Sadly, they also failed to emphasise the collective rather than the individual responsibilities of consultants to a district, and as their amanuensis I share in that failure.

Some still maintain that general medicine should include the care of the elderly, but that ignores the large social and community based component that goes far beyond the ordinary work of the general physician. Boards soon found that active development of services for the elderly required specialisation, and geriatrics, and later psychogeriatrics, became one of the fastest growing specialties. Many other developments in medicine and surgery also called for special departments, and the main increase in consultant staff—trebling in 30 years—has been in the newer specialties and in diagnostic departments rather than in the older clinical specialties.

Regional units for specialties such as neurosurgery, plastic and thoracic surgery, and radiotherapy were soon established. Nephrology, transplant surgery, and scanners of various kinds came later. But most patients need less dramatic interventions, and the district specialist services were the greater achievement of the early years. The rapid reduction of deaths associated with anaesthesia, despite the higher risk surgery undertaken, was more important than the development of cardiac surgery, but both were achieved within the system.

Psychiatry was historically the most detached specialty. In the early stages of the NHS mental hospitals were managed by their own committees, but in some places early attempts were made to reduce their isolation. Rees at Warlingham Park, Carse at Worthing, Macmillan at Nottingham, and Bierer at the Marlborough Day Hospital were all trying to restore the mentally ill, where possible, to life in the community. Short stay units and day hospitals for early cases were developed in Manchester region using converted sections of old city institutions. Improved psychotropic drugs have helped, but new social and medical policies and the growing importance of clinical psychology and psychiatric nursing have had a larger effect. The parallel change in the management of the mentally handicapped has further to go. The old custodial methods are changing, but the investment in supporting services has been insufficient. "Community care" makes a good slogan, but the real burden

is carried by families, who need far more help, and the process is not cheap.

Obstetrics and paediatrics were in transition in 1948. James Spence had been in the first chair of child health at Newcastle only a few years and Dugald Baird in Aberdeen was showing how an obstetric department was responsible for all the pregnant and parturient women of a district. These were the models on which the NHS needed to build. Domiciliary deliveries gradually gave way to hospital deliveries for almost all women, by 1960 in Scotland and by 1970 in England. There is still debate about the justification for this, but it would have been less embittered if hospital staff had learned earlier to be less rigid in their handling of women going through a normal physiological process. The safety record is attested to by a maternal mortality rate among the lowest in the world, but human and interprofessional relationships could still be improved. The Abortion Act 1967 put a strain on obstetrics at a time when contraceptive services were becoming a new element in general practice, and the development of antenatal diagnosis complicated the service for both specialties. Paediatric surgery emerged as a regional specialty towards the end of the first decade. Neonatology became an important new element in paediatrics. Mary Sheridan's work on developmental abnormalities gave a new dimension to hospital and community paediatrics which was to emerge fully in the Court Report.

Sir James (Calvert) Spence

It has become fashionable to look for competition as the spur to progress. Incentives are needed in the NHS as in any other human endeavour, but the professional ethos of service to patients should be more important than financial gain. Nevertheless, financial disadvantage can be a damaging disincentive, as in the pre-Danckwerts era and again before the general practitioner charter. The merit awards system for consultants helped in hospital medicine, but it tended to be too biased toward scientific rather than service contribution, and tenure for life can be soporific.

Reviews of practice

The unglamorous specialties are as important to the NHS as the popular miracles. The Royal College of General Practitioners' campaign for quality review has made considerable progress, but it does not cover the whole of general practice. Reviews of practice should become part of the generally accepted professional obligation and will not be ensured by some kind of price list. The three reports of the cogwheel working parties between 1966 and 1973 were aimed at the development of review of medical work in hospitals and the outcome of specialist medical care. Despite much individual effort there is still no general system. Yet such activity is even more necessary now than it was 20 years ago.

Progress will not be obtained by individual competition, which may be manifest mainly through private specialist work, parasitic on every district in the NHS. Increased specialisation is necessary, but it requires closer integration of the specialties, not extra opportunities for profit in some of them. Moreover, specialist work in hospital and generalist work outside require better organised exchange between them, not competition. Medicine is not a singlehanded job. Raymond Hoffenberg's Rock Carling monograph[2] gave us the best analysis of and justification for medical audit yet published.

Professor (later Sir) Dugald Baird

To achieve its full potential the NHS depends on the work of the districts. Two things are important—continuing education in the professions with involvement of all and the sensible development of community medicine as a specialty with a supportive and coordinating role for all the others. The idea of a general practitioner shopping around for a hospital place for his patient is an anachronism forced on us only by inadequate development at district level.

Medical education is collateral to my theme, but one consequence of medical progress is a greater need for postgraduate training and continuing education for all the professions in the health service. A Green College conference in 1986 was critical of postgraduate medical education in England, and a meeting last year suggested major reforms. The Nuffield sponsored Christ Church conference, chaired by George Pickering in 1961, was followed by an eager response from the profession which gave us postgraduate centres in every district. That episode was one of the most heartening in the first 20 years of the NHS. Without it there might have been nothing to reorganise now.

Pharmacy, dentistry, and ophthalmic optics have all been important parts of the service, though recent economies have reduced NHS dental and ophthalmic provision. There is no space to discuss these, but this does not mean that I undervalue the part they play in a comprehensive health service. Indeed the provision of nine million pairs of spectacles in the first two and a half years of the NHS may have been one of its larger benefits to society, and the dental service is one of the few parts of the NHS of which it can be said unequivocally that it has promoted health in a way that would not have occurred otherwise.

The development of the NHS was not planned wholly by the central health departments. The act set up a central health services council with standing professional committees, with the object of ensuring an informed contribution which would act as a check on central bureaucracy. To an extent the council and committee did this, but they were less effective than some had hoped. Advisory committees need to be asked the right questions, and their capacity for initiation is less than many people think.

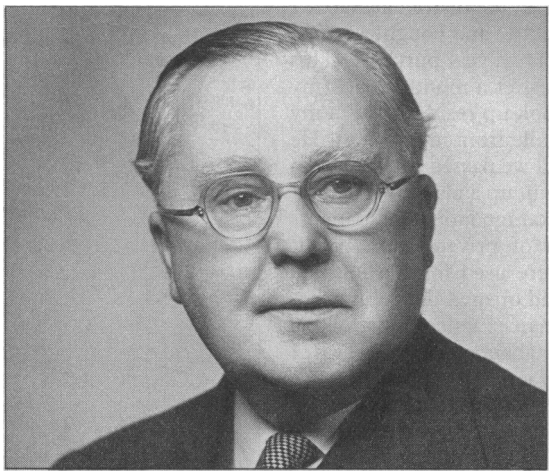
Sir George Pickering (Portrait by John Ward, Pembroke College, Oxford)

Special committees, such as the Platt committee on the welfare of children in hospital, have had a lasting effect on practice in this and other countries. Others include the Gillie committee on group practice, the committee on the nursing day, the Tunbridge committee on occupational health care in hospitals, and the Cohen committee on proprietary medicines. Many people gave much time and effort over many years and have had too little recognition for it.

In addition to the formal advisory machinery, there were also regional and local committees and, at the centre, many ad hoc conferences, committees, and working parties contributing on special subjects from the Guillebaud committee on the cost of the NHS to the Sainsbury committee on prescribing. They were effective because the health professionals and members always seemed ready to give extra time to promote improvement in the NHS in subjects varying from the highly technical fields of haemodialysis and organ transplantation to human relationships in midwifery or housekeeping problems like the use of central laundries. The Medicines Commission would have been needed whether the NHS existed or not, but its predecessor, the Committee on the Safety of Drugs was yet another example of a great voluntary effort by Derrick Dunlop and his colleagues through which controls were put in place voluntarily long before legislation.

Service at risk

This is not the occasion for a detailed exposition on the funding of the NHS, nor am I the person to give it, but a brief comment is necessary. The first estimates could be based only on incomplete information and were too low. The first complete year was 1949-50 and ended with Cripps, as chancellor, setting a fixed ceiling for the future, which was immediately broken. During the 1950s we were spending less than 4% of the gross national product on health care, but in that decade there was an unrepeatable bonus to the NHS as a result of the control of infections, especially tuberculosis. In real terms the costs of all the other government services except defence were growing faster than those of the NHS. During the 1970s, when the relative decline in professional earnings was remedied, the rate of increase was sharply reduced and the period of real shortages and cuts affecting welfare services began.



Sir Harry Platt

Geographical disparities were first tackled seriously by Dick Crossman, who also set up the Health Advisory Service, and were far from being remedied during the years of relative plenty. Total uniformity is probably an illusion because of unquantifiable variables which the RAWP formula cannot adjust for, and Scotland and Northern Ireland, funded through separate budgets, were far more generously treated than England and Wales.

The past decade has been one of worsening shortages despite more efficient use of a budget which has not kept pace with demographic change or technical progress. The protest by the three presidents earlier this year was fully justified for this government's parsimony has put the first principle of the NHS—equity of access to health care—in jeopardy for the first time in 40 years.

Assessing future priorities

The NHS is one of the greatest social innovations this country has produced. Andrew Jessiman of Harvard recently called it "the finest bit of social legislation since Magna Carta." Richard Titmuss said much the same, and I would add only that, unlike Magna Carta, it has been for all the people and not for some latter day baronage. It is imperfect and has often achieved less than one hoped it would. It still does not have inbuilt review of quality. It is underfunded and too much focused on reducing costs. Yet it has achieved more for the resources invested in it than any of the other services that I know. It has one great advantage in its firm basis of multidisciplinary primary care. It has been restricted by lack of funds, savagely in the 1980s, but no country can have all the resources that could be used to advantage, and at least in the NHS we share in accordance with need and, so far, not in accordance with ability to pay.

All countries must face difficult choices as to the best use of available resources, but the nearest approach to a market system there is, in the United States, does not suggest that we should emulate them if we really believe in fair shares. If there is one contribution the medical profession could make which would be of greatest value to the NHS I suggest it might be a collective assessment of priorities. That might lead to the conclusion that doing promptly and effectively the things that will bring relief, if not cure, is more important than straining after the unattainable for the very few at great cost in resources and time. The scope of medical and allied technology is now so great that it cannot all be used. Anyone achieving some extra resource for one small field needs to reflect on who goes without. In the famous words of an elderly black American who spent his life shining shoes, "There is no such thing as a free lunch." It is our duty as a profession to present our assessment of the most that can be done for the greatest number of people, and then the people must choose.

This article is based on a Green College lecture given in January 1988.

1 Pater JE. *Making of the NHS*. London: King's Fund, 1981.
2 Hoffenberg R. *Clinical Freedom*. London: Nuffield Provincial Hospitals Trust, 1986. (Rock Carling Monograph.)