Royal Commission on the NHS

A low-pitched scream

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Her Majesty's Stationery Office certainly does things well. The *Report of the Royal Commission on the National Health Service* has on its title page a huge regal coat of arms, on page ii a statement that the Commission spent £918 000, and on page iii a Royal Warrant, couched in swashbuckling Elizabethan phraseology and signed (By Her Majesty's Command) by Roy Jenkins. By the time he reaches the Introduction, the reader feels that any critic of the report risks being marched at halberd-point into the Tower.

At about 200 000 words (working out at £4.59p per word) the report is briefer than the Old Testament (which has 600 000 words) and easier to read. The English is beautifully clear, the tone seems balanced and objective, and there are warming traces of donnish humour. The lucid style reassures us that the authors have indeed been chosen, as we were promised in 1976 that they would be, for their "experience, expertise and wisdom." They were presumably also chosen for their stamina, since all but two survived three years' service, 2460 written submissions, and 2800 informal chats. Where, one wonders, were such exemplary people found?

Commissioners

Among the 16 commissioners were four members of health authorities, and four university professors—of economics, dentistry, nursing, and psychiatry. Beside Sir Alec Merrison (a university vice-chancellor and former physicist) were a judge, a Lloyd's underwriter, a director of social work, a TUC official, and a journalist who is now a Labour Euro-MP. An imaginative stroke was the inclusion of two doctors: one is a GP member of Liverpool city council (Labour again) and the other a retired GP member of a health authority. Six of the commissioners were women. A glance at *Who's Who* gives some hints about the commissioners' qualifications for membership. Several include previous royal commissions in their curricula vitae, and proudly advertise their membership of this one. One gives his recreation as "chairmanship" and another as "committees." ("Yoga" is among the recreations of the TUC member, who at 40 was by far the youngest man on the commission. He is a sociology graduate and former meat-porter—thus confounding those who say that none of the commissioners is accustomed to the sight of blood.)

Such apparently trivial and gossipy details are a useful background to the report. The average age of the male commissioners

The Report of the Royal Commission on the NHS was published on 18 July. The *BMJ* invited three doctors—Mr J O Drife, senior registrar; Dr P V Lippiett, trainee general practitioner; and Professor G P McNicol, professor of medicine—and one of its regular columnists, Professor Rudolf Klein, to comment, without haste, on the outcome of the three years' work by Sir Alec Merrison and his commissioner colleagues. We publish their contributions here and a leading article appears at p 817.

is around 57. It is not surprising that an old broom fails to make sweeping changes; that commissioners accustomed to working in carpeted rooms should be faintly amused at hearing evidence in a "high-pitched scream" from those of us lowly enough to work with patients' problems; that commissioners whose own jobs involve mainly paperwork (and who are so enthusiastic about committees) should find it hard to believe that the NHS has too many administrators; that commissioners at the top of their own career pyramids should feel that the Salmon ladder is the only way to organise nursing; that socialists dislike prescription charges; and that a commission so lamentably devoid of hospital experience should admiringly dismiss the acute hospital services as "generally excellent."

Again, it is not surprising that such an overwhelmingly non-medical group should "take the widest possible view of the NHS," thinking "at no time . . . that any other approach to our task would be useful, if indeed any other were possible." With such a personal phenomenon as sickness, an occasional individual close-up view is useful, if not essential. When people start taking global views of the "delivery of health care" it is time for strong men to reach for the sal-volatile and crawl under the consulting-room couch. The last time the Government took a wide view of the NHS, it gave us the epoch-making shambles of the 1974 reorganisation—which this commission is now reluctantly recommending should be re-reorganised.

Some of the evidence presented to the commission indicates that we have plenty to scream about. More than one-third of our hospital buildings date from the nineteenth century. In one survey a fifth of surgical patients had been on the waiting list for more than two years. Among hospital registrars 57% are overseas-born and in geriatric medicine the proportion is 84.6%—so that an old lady admitted to hospital has less than a one-in-five chance of meeting a junior doctor brought up in her own culture. Over the last four years the number of administra-

tors in the NHS has increased by 28%. There are nine grades of nursing administrator, each better paid than a ward sister: the lowest-paid nursing administrator earns half again more than a staff nurse. In an international league table of numbers of doctors per 10 000 people Scotland came seventh—and England and Wales thirteenth. England and Wales come eighth in an international comparison of perinatal mortality rates, and tenth in a comparison of spending on health for every inhabitant.

The commission shows enviable sang-froid in the face of these relentlessly depressing facts. Sometimes the commissioners are frankly sceptical of bad news and always they balance it with elegantly phrased optimism. For example, although a study carried out on their behalf "unequivocally supports the view that morale is low" in the NHS, the commissioners immediately add that "morale is difficult to assess" and "low morale is curiously patchy in its distribution." After giving several reasons why health workers are the best judges of the state of the NHS, the report baldly decides that health workers paint a picture that is too gloomy. With a tinge of exasperation the commissioners quote Enoch Powell's resonant opinion that we in the NHS complain too much, and indeed have "a vested interest in denigrating" the service. Like some other Powellisms, the reasoning behind this one is difficult to follow.

This report will be read by thousands of "health workers" many of whom may wonder why the commission is so anxious to point out the silver lining. The man in the street—or the health worker in the corridor—fondly believes that royal commissions are set up not to congratulate governments but to give them a sharp kick in the pants. Although the commission acknowledges that we "wish to provide better services," it does not share our view that to get better service people have to complain loudly about bad service. Is this what is meant by our having a vested interest in complaining? If so, it is equally true that a commission set up by the Government has a vested interest in toning down our complaints.

Recommendations

Inevitably the 117 recommendations reflect the commissioners' background. There are 13 recommendations on dental services, compared with only four on hospital medical staff. The former include the suggestion that NHS dental treatment should be available outside working hours but the latter are much less revolutionary. We read that recruitment of doctors to shortage specialties could be enforced "by blocking expansion of other specialties"—hardly constructive, or even realistic—and that shortage specialties should be helped out by doctors in related fields developing special interests. The commission is grateful to overseas doctors for keeping the NHS going all these years but does not offer any ideas for making Britain medically self-sufficient. Instead, it recommends more training aimed specifically at overseas graduates—to help them to help us.

The new career structure for hospital doctors, diffidently outlined in an appendix to the report, does not stand up well to close examination. The commission suggests more "non-consultant" physicians (or surgeons, or whatever). This would be a career grade embracing the present senior registrar and medical assistant grades but with consultants still having ultimate clinical responsibility. A few doctors in the new grade would be promoted to consultant but most would remain in this curious limbo all their working life. Would specialists be prepared to be forever half-responsible for patients? I doubt it, and to judge from the half-hearted way the commissioners make the suggestion they seem equally dubious. If they believe that the specialties need more consultants they should have said so.

Such an academically distinguished commission is naturally keen on research and education. No fewer than 30 of its recommendations mention "research," "experiment," "education," or "training"—for everyone from dental technicians to remedial gymnasts. Three of the seven recommendations on nursing refer to expansion of research and education, and the report proposes

an Institute of Health Services Research to encourage systematic research into health care issues. Like all medical graduates, I have been brought up a devout believer in scientific method but I am unconvinced of its ability to measure tender loving care. If we turn our nurses into scientists then care of the patient on the human level will devolve still further on to unqualified nursing staff—into whose role the commission recommends "further research."

Other recommendations on nursing include the chilling idea that health departments should help to "set standards"—surely a task for the splendidly energetic Royal College of Nursing. The Salmon recommendations have not been followed far enough, says the commission: nursing administrators ought to surround themselves with more clerical staff, and nursing officers should be either managerially or clinically oriented. The clinically oriented "nurse consultant" would go round the wards being consulted on clinical problems by ward sisters. This unlikely notion is withered by a blast of cold common sense in COHSE's evidence (quoted in the report), but the commission is unabashed by what it patronisingly calls "healthy scepticism." I agree with COHSE: the commissioners' concept of clinical responsibility—medical or nursing—being shared around in a dilettantish way would not last long in a specialty where decisions matter. Even so, as the report inevitably points out, "research will assist in dealing with these issues."

On administration the commission is on firmer ground. It tersely states that more money should be found for hospital building. In response to universal clamour it agrees that an administrative tier should be abolished and recommends a loosening of the straitjacket on hospital secretaries—the number of their superiors should be "reviewed." The commissioners also have particular skill on what are called—for want of a more sensible term—"industrial relations." They quote statistics, which do not include the debacle of early this year, to show that relatively fewer strikes occur in the NHS than in the country as a whole—which is as comforting as being told that not much baby battering happens in special-care nurseries. The commission, of course, recommends urgent training in industrial relations for both staff and management representatives. What it does not recommend is a review of the policy of over-centralisation, a policy that results in men and women washing sheets or sterilising instruments in NHS factories without ever meeting the patients they are helping—or harming by industrial malevolence. The report also suggests that the TUC should work out a procedure for dealing with national disputes—an idea which, since the General Election, is of historical interest only.

An obstetrician's view

Any doctor reading this report finds himself put politely in his place. Doctors form only 7% of the NHS workforce—though consultants are "one of the best paid groups of health workers." Doctors are not always the best people to lead the health care team. The report's sardonic observation about the "patchy" nature of low morale is evidently aimed at us: the commission thinks we are upset because our status has been eroded by modern democracy. Our morale is not important for its own sake: "Doctors are important in any discussion of morale because of their effect on other health workers." When I read this breathtaking snub I had to cool off by walking round my lawns and kicking the peacocks.

There is almost nothing for an obstetrician in the report. The commission is keen on multidisciplinary health care teams, which the maternity services have had for years, functioning well without agonising about who should "assume a leadership role." "Audit," I gather, is a whole new ball game for the rest of the profession, but obstetricians have been indulging in formalised introspection for decades without ending up in a lemming-like rush through the upper windows of maternity hospitals. Even clinically oriented number sevens can be found in the labour ward. Perhaps the magnitude of these achievements stunned the

commission into silence, for it offers no recommendations on improving the maternity services—despite our perinatal mortality figures, with their alarming regional variations; despite mounting public concern that perinatal mortality reflects only a fraction of perinatal morbidity; and despite a rising murmur of anger from parents left to raise spastic children because of inadequate maternity facilities.

The final impression left by the report is that little is going to change. The reader who expected “blinding revelations” is gently mocked: those who thought that the NHS needed a rebore are assured that with a little oil here and there and a tightening of the occasional nut it will purr along as smoothly as ever. Already the medicopoliticians are hiding the report behind a

smokescreen of FPCs, GMSCs, HJSCs, JCCs, CCHMSs, CMCs, DMTs, DETs, and GOKs. Medical commentators are explaining the report in terms of X’s evidence being better presented than Y’s—as if the whole thing had been the medico-political equivalent of the Eurovision Song Contest. It is a great game, this business of viewing the NHS as a whole. The commission has done the job for which it was hired—Sir Harold Wilson is off the hook, and decisions are being made by a government which, whatever else it does, will ignore the advice of socialists. Meanwhile, on the shop floor miles away from Whitehall and Harley Street, exhausted and frustrated specialists head for premature obituaries by providing a service that appears—to superficial observers—“generally excellent.”

“... From the cradle to the grave”

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“There’s your National Health, friend. Look after you from the cradle to the grave.”

Ten years ago Peter Nichols’s play *The National Health* drew us medical students down the road to the Old Vic. It pointed out conflicts and contrasts we were only beginning to discern as we walked the wards. The NHS, certainly in the teaching hospitals, seemed the envy of the world. We knew no other health care system: only those with medical parents had disaffection in their blood and only our teachers’ reminiscences told of the joys and horrors of the pre-1948 era. Reorganisation came towards the end of our house jobs. You may remember the explanatory leaflets issued by the DHSS that made most other bureaucratic forms seem childish by comparison. By then our eyes had been opened to the strengths and weaknesses of the NHS. Those three initials arouse strong emotions in most Britons, particularly NHS workers—emotions often deeper-seated than reason. As far back as 1966 Enoch Powell had described the NHS as presenting “the unique spectacle of an undertaking that is run down by everyone engaged in it.”¹

The Royal Commission was announced in October 1975, a time of financial shortages, industrial disputes, and bitter arguments about pay-beds. In May 1976 the 16 Commissioners were charged with considering “in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources” of the NHS. In three years they took evidence from 2460 individuals and organisations, visited 97 places as far removed as a Moscow polyclinic and a Ballymena dental surgery, and commissioned and published research on the working of the reorganised service, the management and allocation of its resources, medical manpower, and patients’ attitudes to hospitals and primary care accessibility. They interpreted their terms of reference broadly—“we have seen our task throughout as helping the NHS to help itself.”

The report unfolds like a classical tragedy in five acts, in each of which the scene shifts from one part of the Health Service to

another. Part I gives an overall perspective, outlining objectives, assessing performance, and detailing criticisms of the Service. Part II looks at services to patients; after a discussion of health and priorities in care, it scrutinises primary care, paramedical services, and the hospitals. Part III discusses NHS staff, Part IV its relationship to outside institutions such as local government and the universities, and Part V its management and finance. Each chapter ends with conclusions and recommendations; these are brought together in a final chapter, which itself is a résumé of the whole report, and which has been published separately. There are 117 definite recommendations ranging from the general—for example, “health education should be expanded,” to the specific—“the wearing of seat belts should be made compulsory.” Obviously individuals will look critically at recommendations that concern them most and in the light of their own attitudes and experiences will praise or condemn. Running through the report, however, are some constantly recurring themes. These seem encouraging and throw light on the commission’s general attitudes to modern British health care.

Essential attitudes

The report is patient centred. The keynote is struck by the commission’s definition of the NHS as “an institution which enables human beings to offer care, and sometimes cure, to others in need of it.” The commissioners asked that the report should be judged against the criteria of the “care and comfort of patients” and they maintained these criteria throughout. For example, the early morning waking in hospital is seen as a “prime example of the hospital being run for the convenience of the staff rather than the patient,” and the argument for salaried GPs might be entertained “if it were certain that patients would benefit.” They are also concerned with the quality of life, which “becomes increasingly important as the possibilities develop of extending life for people who would in the past have died from their illnesses or injuries, and as people live longer and the chronic conditions of old age become more common.” They are brave enough to state some objectives for the NHS, pointing out that hitherto there have been none—“instead of principles there are policies which change.” Their objectives are Utopian, contentious, and some scarcely reconcilable but at least they are made to guide our thinking.

There is considerable emphasis on good health. The commission does not see the NHS as a national sickness service. It

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