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”

PETER V LIPPIETT

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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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usefully categorises health care into that exercised by a healthy person to keep himself fit; the self-treatment exercised by the slightly ill; care for the sick provided at home; and care for the sick provided in hospital. Since three of these activities happen outside hospital there is much about community care and the commissioners "think it right that the emphasis should be on the development of community services." In this context they grasp two large nettles. Firstly, "improving the quality of care in inner-city areas is the most urgent problem which NHS services in the community must tackle"; secondly, "meeting the health needs of the elderly is one of the major problems facing the NHS." Sensible suggestions are made for both problems but in each case additional resources are requested. This highlights a further problem. The commission was well aware that resources are limited and they quote David Owen approvingly: "We must be prepared to say, if we want priority for one sector, where the money should come from."²

FLEXIBILITY

A recurrent and welcome theme is the need for flexibility. Common-core training schemes are advocated for many health workers, as is retraining to meet new needs; over-rigid demarcation is deprecated. This criticism is made of medicine and nursing: overspecialisation "involves loss of flexibility"; post-graduate medical education should have "a wider and more flexible base"; there is a need "to encourage flexibility in the way nurses work." "The theme of introducing flexibility into the administration of the NHS" underlies the thinking in the chapter on management. This is most welcome—large organisations rapidly become inflexible. Encouragement of this attitude could improve the "low morale" complained of to the commission and might also permit devolution of decision making—also advocated by the commission, who worked from the refreshing premise "that large organisations are most efficient when problems are solved and decisions taken at the lowest effective point."³

This attitude will raise cheers from the profession but the commission will not let our enthusiasm carry over into the popular sport of administrator bashing. I could hardly believe one finding emphasised in the report that, since Salmon, the number of nurse administrators has fallen. Perhaps this shows the importance of the commission's overall perspective; administrators are judged in the balance and not found wanting: "we would reject criticism of them as a group." The report is essentially eirenic.

Research, information, and debate

One reason given for flexibility of approach is the uncertainty of the future. There is a feeling almost of memento mori underlying the report: timely warnings that resources are finite; that medicine is only one factor in a nation's health—"improved nutrition, hygiene, and drainage have had greater effects than many dramatic cures for specific ills"; and that future needs, life styles, and advances are not all predictable.

"With flexibility should go more experiment." The need for research and informed public debate is another constant theme. "Good information is of prime importance for planning purposes" but "the information available to assist decision makers in the NHS leaves much to be desired." Current priorities, for example, are determined not as a "result of objective analysis but of subjective judgment." The commission urges the health departments "to stimulate and support research into the effectiveness of alternative patterns of health care delivery, and to propagate the findings." It is concerned that information should then be made public, that discussion "should be conducted in public and illuminated by fact," and that "more of the professional advice on which policies and priorities are based

should be made public." On the question of how the DHSS currently establishes priorities the commission confesses itself "mystified."

The concepts of "flexibility" and "research" are not proposed as panaceas—the paragraphs are hedged about with caution. The commission's attitudes and ideas raise many questions, provoke thought, and often leave the questions open. How do you assess the health of a nation? For all its emphasis on research, the commission is well aware of the limitations of statistical measures. While few would disagree that "total tooth loss is a good measure of the ultimate breakdown of dental health," the extracted teeth reflect the diet of our children more than the skill of our dentists; and measuring our health does not necessarily mean measuring the efficiency of our health services. How is quality of care to be assessed? Can "need" be measured? Difficult as these questions are, and imperfect as methods may be, the commission thinks "it is nevertheless important to use what tools may be available," and recommends cost effectiveness studies, randomised controlled trials, and "peer review."

This last brings us to the commission's attitude to doctors, which seems sometimes to be less than sympathetic. One paragraph, discussing the "elaborate financial inducements" of hospital medicine, struck me as naïve: a graduated system of carrots—consultancy, distinction award, and higher level award—is seen as dangling in front of the hospital medicine trainee. That must have raised a cynical chuckle from peripheral hospital consultants, newly promoted from senior registrar. The advantages of schedule D tax assessment are seen as a reason for GPs wishing to retain contractor status. The commission is antipathetic to the new contracts for hospital doctors—"we do not like" them... they are "inappropriate to a leading profession and ultimately contrary to the interests of patients." In an appendix they propose a new hospital career structure, but for all their old-fashioned, dignified ring, new assistant physician, physician, and consultant physician are but old registrar, senior registrar, and consultant writ large. Few doctors will accept that the Ombudsman "be allowed to accept cases involving clinical matters" and the recommendation of the MRCGP as "the norm for appointment as a principal in general practice" will ruffle some medical feathers.

Positive particulars

There is much in the report, however, that is realistic, practical, and sensible. The commission seemed to be getting and giving a rounded view of the difficult brief, unimpaired by special pleading, and attempting fairly to do justice to what must have been a welter of confusing and conflicting evidence. Out of context my examples may seem banal but they illustrate important attitudes. The commissioners are essentially pragmatic: "the way health care should be brought to the people of Wester Ross and to the people of Tower Hamlets will be entirely different." Nor, despite accusations of bias, do they seem doctrinaire: they recognise that private practice shows up defects in the NHS, argue for amenity beds, and talk of the foolishness and unprofitability of trying "to force general practice into one particular mould." In politically sensitive areas they try to avoid "emotive issues" and "striking moral postures." They seem sensitive to the tensions between clinicians dealing with the daily needs of individuals and others concerned with the long-term health of communities.

The report recognises that "in developed countries we now pay more attention to the diseases of affluence than we do those of deprivation." While emphasising the importance of health education the commissioners have realistically limited expectations of its usefulness, but recommend using television as a medium. A considered paragraph looks at mass screening and ends by recommending the expansion of proven screening programmes. The onus of the elderly is to be borne by us all—"the care of the old is inescapably part of the mainstream of medicine," but here they recognise the importance of nurses as

"the only category of caring staff essential when active treatment is no longer possible."

However eirenic, the commissioners are not afraid to speak their minds. On fluoridation they are "certain that it is entirely wrong to deprive the most vulnerable section of the population of such an important public health measure for the sake of the views of a small minority of adults for whom its benefits come too late." They do not mince matters concerning the quality of, for example, recruitment into psychiatry, services for the mentally handicapped, and some urban primary care, where "the National Health Service is failing dismally." They recognise the less than altruistic pressure of pharmaceutical companies on GPs and make no bones about drawing up a limited list of drugs, eliminating "ineffective and unnecessarily expensive drugs."

Depending on your point of view, you will accept or reject the report in part or in whole. Of course, it will be a disappointment to those whose favourite remedies have not been exhibited or who, unrealistically, expected the heavens to open and the NHS to be transformed by "some blinding revelation." The commission is well aware that "there are no magic wands to be

waved." If accused of some complacency in their verdict that "we need not feel ashamed of our health service," which "is not suffering from a mortal disease," they could argue that their lofty view enables them to see the wood unimpeded by trees. Those of us working down among the roots may not be quite so sanguine. For me, however, the importance of the report lies in its perspective "overview," presumably free from sectional interest and given in good faith. Its overall attitudes seem healthy and should stimulate ideas and action. They are right that "our work can therefore be regarded only as a beginning." I hope, at a cost of £918 000, that the exercise will prove to have been cost-effective.

References

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- ² Owen, D, *In Sickness and in Health*. London, Quartet Books, 1976.
- ³ Royal Commission on the National Health Service, *The Task of the Commission*. London, HMSO, 1976.

A rather sad document

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I have picked on several sections of the report that seem to me, as a provincial professor of medicine and consultant physician, to be on the one hand particularly encouraging, imaginative, constructive, or intriguing or on the other, unhelpful, ill-informed, or potentially destructive.

In health, prevention is better than cure and there can be few areas of public health in which there would be a greater reward for a change in public habits than a reduction in cigarette smoking. The commission states its belief that the NHS should "encourage and assist individuals to remain healthy." Despite the massive evidence of the adverse effects of cigarette smoking, the commission's recommendations are largely confined to the statement: "There are major areas in which government action could produce rapid and certain results: a much tougher attitude to cigarette smoking. . . ." This bald comment is little better than the general statement of a proposition to be for virtue and against sin and will certainly do little to influence government policy in an important area. I have perhaps capriciously selected this item as a general indicator of the pious but evasive nature of many of the recommendations in the report.

NHS, the universities, and research

I was pleased with the general sentiments in this chapter but disappointed with the recommendations. The report acknowledges the major contribution made by the universities and medical schools to the Health Service and records the view that the universities' interests tend to be submerged in the struggle to deal with the daily problems of the NHS. When much of the

service has suffered from financial restraint, the teaching hospitals have felt particularly hard-pressed. The report emphasises that the health authorities have the responsibility of seeing that the joint NHS/university liaison committees work well and that the medical schools and their teachers participate in all planning which affects their interests and to which they can usefully contribute. In many regions the planning role of the universities is less direct and I hope that this recommendation can be fully implemented.

Somewhat platitudinously, the report points out that the important national and regional function of the teaching hospitals must not be allowed to suffer and that this places an important responsibility on the health authorities concerned. A firmer recommendation on the need to meet the special interests of the teaching hospitals would have been welcome and at least a partial return to the old board of governors formula would be desirable. The comment from the Welsh National School of Medicine that "Some way must be found to insulate the teaching hospital from the conflict between short-term patient care and longer-term needs of medical education" is germane and I think that the distinctive functions of the teaching hospitals are in danger of suffering unduly from the present financial constraints, with major longer-term harm to British medicine and the nation's health.

Medical education, according to the commission, should be "relevant to the major health problems of the day, and amongst these are geriatric illness, mental illness, disability and handicap, and the potentially preventable diseases and injuries which result from unhealthy life styles. There should be more emphasis on community care and the importance of continuity of care. There has been some change in these directions in the curricula of the medical schools since the Royal Commission on Medical Education reported in 1968, but not enough." But there is no evidence of inadequate change. Surely the objective of undergraduate medical education is to impart to the student the knowledge, skills, and attitudes that will enable him to be safe in and to benefit from the year of preregistration training and then to equip him to embark on a more formal vocational and specialist training, followed by a lifetime of continuing self-education.