structure. Several objections to transfer are set out but the most important is omitted—that is, the generally poor quality of local authority membership and officers and the likelihood that administration would be inefficient and improperly responsive to locally organised party political pressures.

Postscript

The report is a rather sad document. The commission, with a distinguished, intelligent, and perceptive membership, was

established in May 1976 but the changes in thinking since then, and particularly the deterioration in the economic climate, have made much of what it says difficult to implement. If a commission were to be established today its main task would be to suggest how to maintain a skeleton service with diminishing real resources. Much of what the report recommends is sensible and constructive but the conclusions do not take sufficient account of the distinctive long-term needs of the teaching hospitals, the universities, and research; nor do they place sufficient emphasis on the maintenance of personal freedom in the provision of health care.

Living with its disabilities

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After reading the report of the Royal Commission on the National Health Service,¹ the medical profession now knows what patients feel like when their doctors tell them that they have got to learn to live with their disabilities. There is no heroic surgery which can cure their ailments, but only ways of relieving some of the stresses and helping them to cope. Inevitably, the result is a feeling of disappointment and anticlimax. The royal commission has sat for more than three years and spent nearly £1m. The commissioners received evidence from 2400 organisations and individuals, talked to nearly 3000 others, and toured extensively in this country and abroad. Yet, in the words of the report, there is no "blinding revelation which would transform the NHS." Instead the commissioners reassure the patient by telling him that his condition is not nearly as critical as he imagines and prescribing a mixed bag of 117 recommendations designed to make life more comfortable.

Was the whole exercise a waste of time? In trying to answer that question it is important to be clear about the job of royal commissions and their limitations. Royal commissions are not in the "revelation" business. It is not their function to come up with new, ground-breaking discoveries, which might or might not be acceptable. The point may be simply illustrated. If the Royal Commission on the NHS had decided that the only way to increase expenditure on health care in Britain was to scrap the existing structure and adopt an insurance-based system—a perfectly respectable intellectual position in the abstract—its report would have gone straight into the ministerial wastepaper basket. Even given that a Conservative Secretary of State might have been sympathetic to such a radical change, and had carried it out, the next Labour Government would, of course, have immediately reversed the decision. In other words, the job of a royal commission is consensus engineering: to recommend changes which do not stretch the limits of the generally acceptable too far: to create support for incremental adaptation of existing institutions, rather than to stir up controversy and create instability.

Strategy of adaptive change

In this respect, the royal commission's report can be rated a considerable success. Its proposed strategy of adaptive

organisational change may seem timidly unadventurous. It is, however, preferable to recommending yet another wholesale reorganisation with all its consequent uncertainty and demoralisation. Again, it is by no means unimportant that the report—signed by a member of the TUC's staff and a former leading official of NALGO—accepts private practice as a fact of life and recognises the irrelevance of the whole pay-bed issue. This is precisely the kind of educational function which royal commissions are designed to perform. It is unfortunate that—as a kind of ideological quid pro quo—the commission recommends the abolition of all charges. But then it has to be accepted that such reports, if they are not to splinter into a series of minority, dissenting notes, must inevitably represent compromises among the views of the members.

To make this point is also to underline a specific weakness of the Royal Commission on the NHS. Its appointment was, quite clearly, a political expedient. It was set up to defuse an explosive political problem and not—as its general terms of reference, which only just stop short of reforming the universe, indicate—to address itself to a set of discrete, clearly defined issues. Moreover, its membership reflected the circumstances of its birth. Royal commissions have, in the past, tended to fall into three categories.^{2,3} There have been representative commissions—that is, those whose membership reflects the various interest groups concerned. There have been expert commissions—that is, those whose membership is based on demonstrated skill in the particular subject. Lastly, there have been impartial commissions—that is, those whose membership was picked on the jury principle of selecting dispassionate laymen. The Royal Commission on the NHS does not fall neatly into any of these categories. Not surprisingly, its heterogeneous membership—reflecting some idiosyncratic choices by Mrs Barbara Castle and Mr Harold Wilson—has produced a rather heterogeneous set of recommendations. And the stature of its membership—the chairman, Sir Alec Merrison, apart—is not such as to ensure automatic respect for its proposals. Unfortunately for the commission, and perhaps unfairly, it cannot claim the authority of representativeness, skill, or impartiality.

There is a further limitation on the royal commission's report, which, it might be argued, is self-imposed. This is its reliance on what might be called sturdy commonsense rather than research-based analysis. The royal commission did commission several research papers. But none of these begins to measure up to the quality of analytic work carried out for the Guillebaud inquiry into the NHS 23 years ago by Abel-Smith and Titmuss.⁴ Indeed, implicit in the royal commission's whole approach is a decision that the big questions about the NHS are not likely to be solved in the near future by more research. There are two

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reasons for endorsing the commission's view, which does not appear to have been shared by Professor Alan Williams, the distinguished economist, who resigned his membership. The first is that the research problems are so intractable that they are not likely to be much advanced in the lifespan of a royal commission; I hope, however, that the recommendation for the creation of an Institute of Health Service Research will be quickly implemented. The second is that most of the central issues cannot, by their nature, be resolved by analysis, research, or information but only by judgments about the balance between different desirable aims of policy.

There is, for example, the crucial issue of whether or not the NHS is underfinanced and, if so, how this state of affairs can best be remedied. In a sense, the royal commission's report can be criticised for its seeming acceptance of financial famine as an irremediable fact of life. Of course, the royal commission recognises that it would be desirable to have more money and indeed some of its proposals would call for extra resources. But the report makes no attempt to assess whether or not Britain is spending an adequate proportion of its national income on health care: "There is no objective or universally acceptable method of establishing what the 'right' level of expenditure on the NHS should be" is the conclusion reached. Indeed, the report's demonstration of a high degree of consumer contentment and its dismissal of the claims that the service is on the point of collapse are, if anything, calculated to reduce the pressure for more money.

Lack of close analysis

Some of these conclusions can be criticised. If consumers are happy, this may merely be because their expectations are too low—deference and gratitude to the service providers swamp any discontent. And, while the commission was surely right to dismiss the rhetoric of collapse, it might usefully have analysed more closely the reasons for the feelings which lie behind such statements: the frustrations which are created by the gap between the available resources and what is perceived to be socially desirable and technically possible. Any system of health care, such as the NHS, where the service providers have to ration scarce resources is bound to create tension and, in periods of financial stringency, to threaten morale. If the royal commission's report had recognised this more brutally—if it had shown a clearer recognition of the built-in deficiencies of a centrally financed, tax-based system like the NHS—its report might have carried more conviction.

For the case of maintaining the present NHS system of finance has nothing to do with arguments about the adequacy or otherwise of resources. It rests on a value judgment that a system which aims at distributing access according to need—which is seen to be socially fair—is preferable to one which, while it might generate more resources, might also use them less efficiently and distribute them less equitably. It may, of course, be argued that equity can be bought at too high a price if it means that governments can turn off the financial tap at will. But this is an argument less about facts than about social values.

Facts, however, are not irrelevant for they are bound to illuminate choices about values. For example, clearly governments are concerned about financial control even in insurance-based, fee-for-service systems. Shortly after the royal commission's report came out the French Minister of Health announced that in future spending on medical services and the earnings of doctors would be indexed to the growth in national income.⁵ Again, the commission's extraordinarily inadequate discussion of charges would have been more convincing if it had been based on analysis rather than assertion. On the one hand, the commission might well have considered the evidence that the present system of automatic exemptions for prescription charges seems to work remarkably well. On the other hand, the commission might well have asked itself whether the Treasury would find the extra money which would be needed if charges

were abolished. The fact that governments do not like putting up taxes (central to the financial problems of the NHS) seems not to have been considered in this context. The commission was quite right to point out that introducing more charges is not a certain way of increasing the NHS's budget, since (quite apart from the administrative costs) this might tempt the Treasury into making an equivalent cut in the existing allocation. It seems strange, however, to assume the converse as axiomatic: that the vacuum of resources created by the abolition of existing charges would automatically be filled. Lastly, the commissioners might usefully have considered whether consumers, whose interest they rightly emphasise throughout, prefer to pay charges or the higher time and queueing costs which might result from abandoning this source of revenue.

Government's function

The price of trying to achieve social justice by a centrally financed health service is not measured just in terms of the NHS budget. It also carries organisational costs. If there is to be a truly "national" health service—with national standards and national criteria of equity—then it follows that central government is going to play a dominant part. If the service is further tax-financed, and the Secretary of State is accountable to Parliament for all the money spent, then it also follows that the central department will keep a close eye on local spending. Not surprisingly, therefore, the post-1974 NHS has been more notable for upward accountability than downward delegation. And one of the major themes in the royal commission's report is precisely how best to achieve a more flexible, less centralised, and more locally responsive system. But, once again, the report's weakness stems from its reluctance to be more explicit—and brutal—about the trade-offs: about the fact that the problem of bureaucratic centralisation is not a circle to be squared but an issue which demands choices between competing policy aims.

If the success of the NHS continues to be judged by its achievement of national norms and standards, then clearly the job of central government is unlikely to diminish. If, in contrast, there were to be a greater tolerance of diversity, then there would clearly be more scope for decentralisation. It is a pity, therefore, that the royal commission did not face this issue head on. It might, for example, usefully have defined the limits of acceptable diversity within a national system. As it is, a tantalisingly brief paragraph raises the possibility—likely to have special resonance with the present Conservative administration—of local authorities "being able to contribute to NHS funds." This seems to imply that local authorities might be free to finance local hospitals which would otherwise close. In turn, to push this argument one step further, such an approach might eventually lead to a state of affairs where the National Health Service provides a basic package of health care, while leaving it to local authorities to decide whether or not to top it up. At present, given the restrictions on local government finance, this may seem a remote possibility. But the royal commission could surely have explored this policy option more fully.

Again, there is a strong case for arguing that the Department of Health's detailed administrative interference in the workings of the NHS reflects the lack of management information: that civil servants interfere in detail because there is no way of measuring the output or efficiency of the service using the kind of routine indicators which managers in industry can draw on. Unfortunately, the royal commission rejected one possible solution to this problem: a strengthened inspectorial system—which would provide information to the centre without requiring central intervention in detail. Instead, the royal commission recommends a much greater degree of devolution of responsibility to the regional health authorities. RHAs, it is proposed, should be directly accountable to a special parliamentary committee. The DHSS would be limited to a more general, strategic

role. Community health councils would be strengthened in order to deal with more of the personal cases which now are often raised by MPs, and the latter would be asked to exercise self-restraint in using their right to put questions to the Secretary of State.

This attempt to square the circle of decentralisation and accountability in a tax-financed service, though excellent in intention and attractive in many respects, is unlikely to appeal to any government. Indeed, it is odd that the royal commission should have put it forward. Its report rejects the case for a health commission to run the NHS, mainly on the grounds that the Secretary of State would have to continue to be accountable to Parliament. It is difficult to see how setting up what would in effect be 14 regional health commissions would make this problem any more tractable. The best that can be hoped for is that the royal commission report will persuade the Secretary of State to allow more discretion to the regions and create greater acceptance of diversity, since discretion and diversity are the two sides of the same coin.

Two main contributions

This somewhat critical discussion might suggest that the answer to the question put at the beginning—Was the whole exercise a waste of time?—is “yes.” Some of the royal commission’s main recommendations will be rejected by the Secretary of State. Some of the main issues facing the NHS have been inadequately analysed in the report. But this is to ignore the two main, if least spectacular, contributions of the royal commission’s work.

Firstly, the royal commission’s emphasis on adaptive change is right. Its report shows that the lesson to be drawn from the 1974 reorganisation is not so much that any particular aspect of that was wrong but that playing around with the administrative structure of the NHS cannot produce miracles. Slimming down the administrative hierarchy by progressively eliminating one

tier, putting more responsibility on to administrators at hospital level, and eliminating some of the existing cat’s cradle of consultative committees—as recommended by the royal commission—should all help to produce a less cumbersome structure but should not be seen as providing automatic entry tickets into the promised land.

Secondly, the royal commission’s insistence that there are no magic cures may seem somewhat negative but is perhaps its most important positive contribution to the debate about the NHS. It is no accident that most of the issues it discusses—from overcentralisation to underspending on capital—all featured in the 1956 Guillebaud report.⁶ The problems faced by the NHS are peculiarly intractable; its complexity defies instant solutions. And while it can perfectly respectably be argued that the NHS should be scrapped—since certain problems seem to be endemic in its nature—it is unrealistic to think that these problems can be wished away while rejecting the alternative of abandoning the NHS and replacing it with a totally different system with its own set of built-in advantages and disadvantages. If the first reaction of the medical profession to the royal commission’s elegantly written report is to conclude that they consulted the wrong doctor, second thoughts might perhaps persuade them to think that it is not the doctor’s advice but the patient’s unrealistic expectations which need revising.

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A woman of 76 is being treated with steroids for polymyalgia rheumatica. She wants to travel to Australasia: is it wise to vaccinate her against smallpox?

Steroid treatment is a well-established contraindication to smallpox vaccination. As there have been no cases of smallpox transmission anywhere in the world for nearly two years, there is no reason whatsoever for vaccination.

Is there a minimum age for the use of bronchodilators?

Bronchodilators in appropriate doses have been used at all ages including the neonatal period. Theophylline derivatives successfully reduce apnoeic attacks in preterm infants, though there is some concern about the possible long-term adverse effects on brain development which have not been studied.¹ For airways obstruction, there is considerable evidence that sympathomimetic drugs are unlikely to be effective in children under 18 months, though theophyllines may produce some improvement from as young as 12 months. Despite the association of bronchiolitis and so-called wheezy bronchitis of infancy, with the subsequent diagnosis of asthma, many studies have shown that the bronchodilators isoprenaline, orciprenaline, and salbutamol, administered by nebuliser, are ineffective in wheezing infants. Corticosteroids are the only drugs of proved value in severe acute asthma in infants under 12 months, but their effect is often not dramatic. Thankfully, most infant wheezers are not severely compromised by their symptoms and therefore do not need specific treatment.² While there is relatively less smooth muscle in the small airways of infants compared with adults, this is unlikely to account for the poor bronchodilator response. The conventional explanation is that airways obstruction in infant wheezers is due to mucosal oedema, excessive secretions, and mucus plugging; factors not influenced by broncho-

dilators. Even phenylephrine, known to reduce mucosal oedema at least in the nose, does not influence wheezing.³ It remains to be seen whether parasympatholytic drugs, such as ipratropium bromide, have any place in the treatment of this problem.

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Two to three years after post-tubal ligation some women develop severe menorrhagia, the uncontrollable flooding being of such an extent as to require hysterectomy. What is the explanation for this?

There is certainly no simple explanation. In a Dundee series hysterectomy was performed in almost 19% of patients after sterilisation, and 13% of the 374 cases had the operation for menorrhagia.¹ The most common belief is that the cause of the symptom is psychological, but that may be because of lack of evidence of anything else. There are complex hypotheses of endocrine upsets affecting the ovaries² and of vascular disorders virtually incapable of proof or disproof. There is obviously room for a prospective research project with modern methods of hormone assay coupled with coagulation studies and psychological analysis. There may be a case for hysterectomy as a method of sterilisation to prevent menorrhagia.³ The arguments for and against such a procedure are not yet fully resolved. A clear-cut instance where primary hysterectomy might be best would be in a woman with menorrhagia at the time sterilisation was thought advisable.

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