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## Community Medicine in turmoil 1974 -1989

*There is a certain relief in change, even though it be from bad to worse; as I have found in travelling in a stage-coach, that it is a comfort to shift one's position and be bruised in a new place.*

Washington Irving - *Tales of a Traveller*

*The age-old function of the medical officer of health has been criticised... and community physicians everywhere have been displaced under Griffiths. The zenith of epidemiological reductionism in the academic field has coincided with the nadir of fortunes of service community physicians in the NHS and local government. Yet the greatest paradox is that from this lowest point may arise the opportunity to rebuild the 'bare ruin'd choirs' of the public health tradition.*

Huw Francis 1987

### THE REORGANISED NATIONAL HEALTH SERVICE

During the 1960s, as we have seen, it became clear that some fairly fundamental reorganisation of the National Health Service was essential.

#### ENGLAND AND WALES

The Labour Government published a Green Paper in 1968 putting forward for consultation a proposal for the health services in England and Wales to be administered by between 40 and 50 health authorities - a suggestion originally recommended in the Porritt Report.<sup>1,2</sup> One suggestion was that local government, itself undergoing reorganisation at the time, should be the unit of administration.

A second Green Paper, published in 1970 suggested 90 area health authorities as the main units of local health services administration, regional health councils to deal with planning and around 200 district committees to promote local

participation.

The Conservative Government's consultative document of 1971 strengthened the regional planning tier and proposed the establishment of local community health councils and the subsequent White Paper stressed the importance of improving the efficiency of management. The resulting National Health Service Act came into force on 1 April 1974 and the new structure is shown in Figure 1.<sup>2</sup>

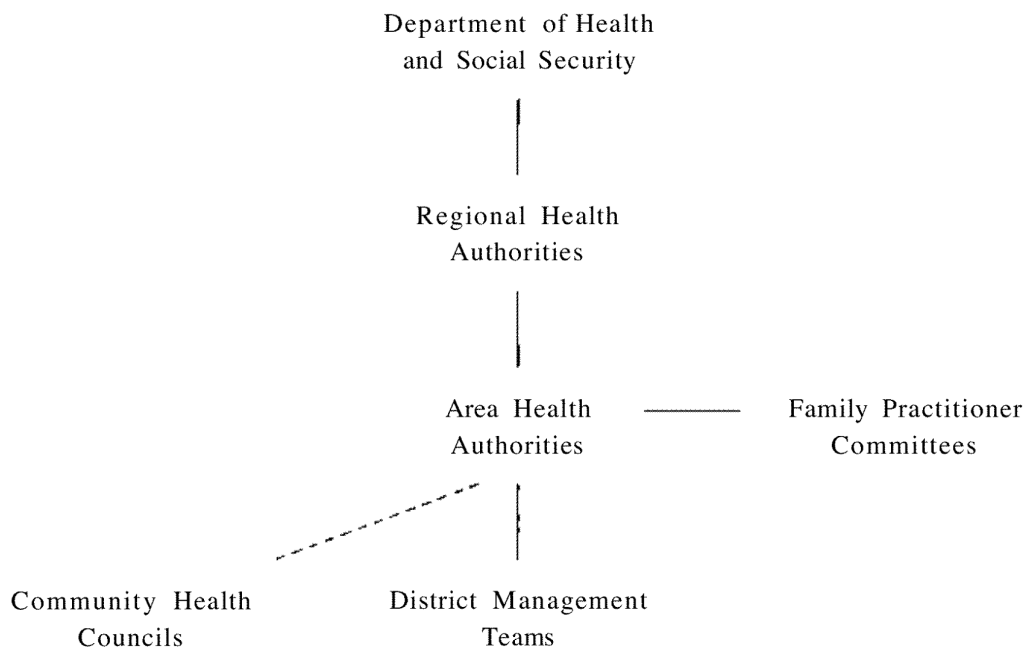
The reorganisation had three main objectives.

The first was to unify health services under one authority instead of the three separate entities for different parts of the service. As Ham points out, this aim was not achieved in full. In practice, general practitioners retained their independence with family practitioner committees taking over the functions previously carried out by executive councils, although theoretically they were subcommittees of the area health authorities. In addition, a small number of postgraduate teaching hospitals retained separate boards of governors.<sup>2</sup>

The second objective was improved co-ordination between health authorities and related local government services. The boundaries of the new Area Health Authorities were mainly made to match those of one or more of the local authorities providing personal social services — the county councils and the metropolitan district councils or London Boroughs. The two types of authority were also required to establish joint consultative committees to enhance collaboration in development of services. As a deliberate policy decision from the centre, however, coterminosity was not achieved for all areas. This was to prevent or at least complicate any future plan to move the National Health Service to local authority control.

The third main objective of reorganisation was to improve the management of services. Ham<sup>2</sup> deals with the background to this and the detailed functions of each of the three tiers and job descriptions for health authority officers were published by the government.

Central ideas included working in multidisciplinary teams and consensus management. A key principle was to be 'maximum delegation downwards, matched by accountability



**Figure 1.** Structure of the NHS in England 1974-1982.  
 (Reproduced from Ham" by kind permission of the author and Macmillan Press Ltd.)

upwards' with government looking to the private sector and management consultants for ideas about how to run the National Health Service more efficiently. There was also a concern to locate national priorities more appropriately in local settings and to shift resources to more disadvantaged groups both in terms of socio-economic status and disease and disability.

There was undoubtedly a need for improvement in how the National Health Service was run, both in 1974 and later in 1982, and much of what has been achieved was both essential and laudable.

The fundamental flaw on both occasions has been a failure to acknowledge three truths — the importance of personalities, at all levels, in making any organisation move smoothly, the untidiness of reality however many flawless diagrams and flow

charts there are to illustrate how things should work, and the fact that health or its absence is such an important commodity to everyone that it cannot be run absolutely on cost-effective or management efficiency grounds without the intrusion of flexibility and humanity.

*SCOTLAND, WALES AND NORTHERN IRELAND*

There were slightly different arrangements for other parts of the United Kingdom after reorganisation.

The National Health Service (Scotland) Act<sup>3</sup> did not allow for a regional tier of administration but established fifteen health boards dealing directly with the Scottish Office. There was no separate system of administration for family practitioner services and the Scottish equivalent of community health councils were called local health councils.

The Welsh reorganisation was the most similar to England but the Welsh Office combined the functions of a central government department and a regional health authority. In Northern Ireland, four health and social services boards were established, in direct contact with the Department of Health and Social Security (Northern Ireland). Each of these boards was divided into a number of districts and dealt with personal social services as well as health. There was no separate administrative mechanism for family practitioner services and district committees fulfilled the functions of community health councils.<sup>2</sup>

### EFFECTS OF REORGANISATION

From the start there were problems with the reorganised health service from various points of view — delays in decision-making, top-heavy administration with too many tiers, high cost of the whole process both financially and in terms of staff morale.

The Morrison Royal Commission was set up in 1976 with the following remit:

To consider 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 national health service.



The report — the first comprehensive review of the service for nearly a quarter of a century — was published in 1979 and made various recommendations.<sup>4</sup> It found that the 1974 reorganisation had had the worthy objective of trying to integrate all health services for patients in hospital and community into one administration. Sir Keith Joseph, Secretary of State at that time, had planned a unified structure in which the area health authority would provide comprehensive health care for the population of a defined geographical location, and where in theory coterminosity of health and local authority boundaries would facilitate collaboration in planning the delivery and continuity of health care.

As Kember and Macpherson point out,<sup>5</sup> the Royal Commission found that serious flaws had hindered the implementation of this worthy concept. There had also been industrial action during the 'winter of discontent' in various groups of health workers and staff morale was low. The Commission summed up its criticisms thus:

Too many tiers, too many administrators in all disciplines, failure to take quick decisions, money wasted.

On the election of the Conservative Government in May 1979, public expenditure was immediately targeted to try to reduce the inflation rate and the national debt. With regard to the National Health Service, the aim was to limit the rising costs, increase efficiency, introduce management and structural reforms, and encourage other means of providing health care such as the private and voluntary sectors.<sup>5</sup>

In December 1979, the government published a consultative paper in response to the Merrison Commission's Report<sup>6</sup>. It accepted the basic criticisms and most of the recommendations and stated its intention to simplify the services in such a way as to 'avoid wholesale upheaval' and 'minimise turbulence'.

### RE-REORGANISATION

The final decision on the main aspects of amendments to reorganisation were published in July 1980. The main measures applying to England are summarised from the Royal Commission Report by Kember<sup>7</sup> and shown in Table 1.

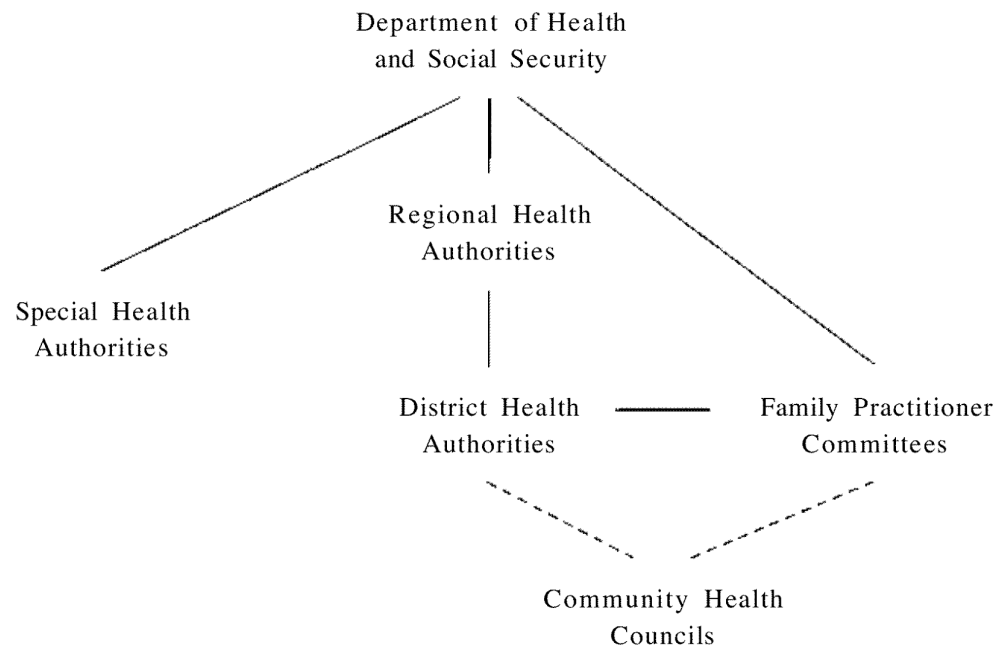
**Table 1.**

Main recommendations of the Royal Commission's Report on the National Health Service.

- 1) Strengthen management arrangements at local level with greater delegation of responsibility to those in hospital and community services.
- 2) Simplify the structure of the service in England by removing the area tier in most of the country and establishing district health authorities.
- 3) Simplify the professional advisory machinery so that the views of clinical doctors, nurses and other professions would be heard by the health authorities.
- 3) Simplify the planning system to ensure that regional plans are fully sensitive to district needs.

One hundred and ninety-two District Health Authorities were created and came into existence on 1 April 1982 with an emphasis on delegation of power to units of management. Detailed management arrangements varied greatly with some units covering a single large hospital and some covering specific services — such as psychiatry — throughout a district as a whole. Administrative costs were certainly reduced by the changes — Ham<sup>2</sup> quotes an estimate that the amount spent on management fell from 5.12 per cent of total budget in 1979-80 to 4.44 per cent in 1982-83, a saving of £364 million. But the principle of coterminosity between health authorities and local authorities was lost by the changes.

In November 1981, it was announced that Family Practitioner Committees were to be given the status of employing authorities in their own right. This measure was incorporated in the Health and Social Security Act 1984 and came into effect on 1 April 1985. At the same time a number of Special Health Authorities were established with the responsibility of running the postgraduate teaching hospitals in London. The structure of the National Health Service in



**Figure 2.** Structure of the NHS in England 1982-1990.  
(Reproduced from Ham<sup>2</sup> by kind permission of the author and Macmillan Press Ltd.)

England after 1982 is illustrated in Figure 2. In Wales the main change was the abolition of the district level of management and its replacement by a system of unit management similar to that in England. In Scotland there was initial variation with some health boards abolishing and some retaining the district tier — all districts in Scotland were, however, replaced by a system of unit management from 1 April 1984. The existing arrangements applied in Northern Ireland where the basic structure of health and social services boards was retained.<sup>2</sup>

The mission of the 1982 and 1984 changes was to try to achieve 'greater devolution and clearer personal accountability' in an attempt to get the best value for money in a situation where an ever increasing share of public money was being spent on health.<sup>7</sup> The main emphasis was on simplification of the management and structure, planning and collaboration. The 1974 reorganisation had been very radical and the service was

understandably reluctant to undergo a second major upheaval in such a short space of time. The second aim was therefore to achieve the changes with the minimum of disruption to those involved and because of this an opportunity may have been missed to create a 'genuinely new pattern of local health authorities, with new roles, new levels of delegated authority, and with new and close relationships with clearly defined communities'.<sup>7</sup>

### COMMUNITY MEDICINE AFTER TWO REORGANISATIONS

This was then a period of general upheaval and unrest in the National Health Service and for the medical profession and public health under its new name of community medicine in particular. So many changes in such a short period of time created a feeling of instability and job insecurity. There was also the problem of falling recruitment into community medicine - in terms both of numbers and quality — mentioned in the previous chapter.

There was tremendous general confusion about the role of the community physician within the local structure, and the actual meaning of the title in practice. There were constraints of limited staff, budgets and power and a general feeling of inferiority and loss of status. Once again community medicine displayed its inability to master the power play used so skilfully by general practitioners and hospital clinicians since 1948 in protecting their interests.

The change of name from public health to community medicine and the abolition of the post of Medical Officer of Health had added to the confusion and lack of confidence in the specialty. Sir John Brotherston expressed the view of many when he stated that community medicine was merely 'the latest name for that ancient, honourable and essential responsibility which is concerned with the medicine and health of the group. This is public health with a new name and new responsibilities.'<sup>8</sup>

In 1975, a former MOH of Kilmarnock with over 30 years experience published an account of the changes in the health of

that community during his years in office and the improvements in conditions that had taken place.<sup>9</sup>

He quoted the original advertisement which had appeared in the British Medical Journal for the post:

The Town Council invite applications from duly qualified and registered Medical Practitioners holding the Diploma in Public Health or an equivalent qualification for the appointment of Medical Officer of Health for the Burgh. Candidates must not exceed 45 years of age.

The person appointed will be required to carry out all the duties pertaining to the position of Medical Officer of Health under the Scottish Burgh Police, Infectious Diseases, Notification of Births, Public Health, Housing, Milk and Dairies, Food and Drugs, Blind Persons and Local Government Acts and all other relative Statutes and Orders. The appointment will include the duties of Medical Officer of Kirklandside Infectious Diseases Hospital, Kaimshill Tuberculosis Sanatorium, the Maternity Home and Child Welfare Centre, and the Clinic for the Treatment of Venereal Diseases; the duties of Tuberculosis Officer, Police Surgeon and Medical Officer of the Model Lodging House; and from 15 May 1930, the duties of Medical Officer under the Scottish Poor Law, Lunacy and Mental Deficiency and Vaccination Acts; and all other relative Statutes and Orders. The appointment will also include generally any other responsibilities or works (including work in connection with medical inspection and treatment of schoolchildren and hospital facilities for the sick poor that may be assigned to the Medical Officer of Health by the Town Council either by themselves or in conjunction with any other Public Authority or Body).

The author commented that — 'it will be seen that no-one undertaking these duties was likely to be idle!'. He had also pointed out that the Medical Officer of Health of a Burgh at that time was a well-known figure locally, in touch with the community, easy to approach and ready to address relevant problems. The duties were very clearly defined. He expressed confidence that under the new arrangements this close contact would be maintained — since 'each district will be provided with a community physician whose job it will be to maintain the local contact and be easily available to the public'. His confidence was to be disappointed.

Two issues were important in this context. Firstly, the community physician became an independent consultant



without a team — a major loss for those used to having a department. Secondly, the major concern of the administrative bodies was with hospital services, except in a few places, and the idea for hospital and public health to work closely together did not become a reality for various reasons, including financial difficulties caused by the world-wide increase in oil prices. Pressures of acute illness were as always a priority and, on committees at local level, community physicians without clear authority were outnumbered by around five to one by hospital physicians.

The new emphasis on management was fine rhetoric but there was no clearly defined management function within the National Health Service to support it. Shortly after the 1982 reorganisation, Roy Griffiths, the Deputy Chairman and Managing Director of Sainsburys was appointed chairman of a small team to give the government advice on the effective use of management and manpower and related resources in the National Health Service.<sup>2</sup>

The Griffiths Report was published in 1983<sup>10</sup> and recommended that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach. Doctors should also:

accept the management responsibility that goes with clinical freedom

and become more involved in management. The report also proposed that a Health Services Supervisory Board and an NHS Management Board be established within the Department of Health and Social Security and that the Chairman of the Management Board should be appointed from outside the health service and the civil service. It concluded:

Action is now badly needed and the Health Service can ill afford to indulge in any lengthy self-imposed Hamlet-like soliloquy as a precursor or alternative to the required action.

After debate and discussion, the government asked health authorities to appoint general managers at all levels by the end of 1985<sup>11</sup> and, although the report did not cover Scotland, Wales



or Northern Ireland, similar changes were introduced there although not quite so quickly.

### RESOURCE ALLOCATION

Another issue that came to the forefront during this period was allocation of resources for health services. Until the 1960s, the resource allocation policy tended to be based on the somewhat brutal description by Maynard and Ludbrook<sup>12</sup> — 'What you got last year, plus an allowance for growth, plus an allowance for scandals'.

There then followed various initiatives to put allocation of resources on a more professional footing which culminated in the Crossman formula of 1971-72 where each Regional Hospital Board's target allocation was derived from three elements.<sup>13</sup>

- 1) Population — weighted by the national bed occupancy for different age and sex groups and adjusted for net patient flows.
- 2) Beds — in each specialty weighted by the national average cost per bed per year.
- 3) Cases — inpatient, outpatient and day cases weighted by the national average cost per case.

The formula failed in implementation mainly because of the second element on number of beds.<sup>14</sup> This element meant that Regions with adequate resources in terms of beds were rewarded while those with fewer beds who needed support were penalised. Another factor was the component to cover the cost of capital schemes (RCCS — Resource Consequences of Capital Schemes) which covered the total cost of the new revenue required to meet the costs of new hospitals — always greater than the old. Since the new hospitals were mainly in the south of England, the inequalities increased.

The Resource Allocation Working Party (RAWP) was appointed in May 1975 with the following remit:

To review the arrangements for distributing NHS capital and revenue to RHAs, AHAs and Districts respectively with a view to establishing a

method of securing, as soon as practicable, a pattern of distribution responsive objectively, equitably and efficiently to relative need and to make recommendations.

An interim report was published in August 1976 and this interpreted the underlying objective of the terms of reference as being:

to secure, through resource allocation, that there would eventually be equal opportunity of access to health care for people at equal risk.

This was a Herculean, some might say impossible, task.

The final RAWP Report appeared in September 1976<sup>15</sup> and acknowledged that demand for health care world-wide:

is rising inexorably... And because it can also be shown that supply of health care actually fuels further demand, it is inevitable that the supply of health care services can never keep pace with the rising demands placed upon them. Demand will always be one jump ahead.

The Working Group also acknowledged that supply of health facilities everywhere was variable and very much influenced by history. They, therefore, sought criteria broadly responsive to relative need rather than supply or demand to try to establish and quantify the differentials of need between different geographical locations. The criteria selected were size of population, population make-up, morbidity, cost, health care across administrative boundaries, medical and dental education and capital investment.

The general recommendations of the final summary chapter were four-fold.

- 1) New arrangements for flexibility between capital and revenue should be introduced in addition to the retention of the existing arrangements.
- 2) A review of the interaction between expenditure of family practitioner services and all other health expenditure should be undertaken.
- 3) Data requirements should be kept under review.
- 4) Research requirements should be considered by a group of Departmental officials and expert advisers from outside the Department and should command reasonable priority.

The RAWP Report attracted a great deal of comment and criticism. As Paton<sup>16</sup> has stated, the whole area of resource allocation is:

a minefield of conflicting ideologies, proposals and alternatives: made more complex frequently by conflicting methodologies and general principles, which require to be brought into the general perspective.

Paton saw RAWP as a central mechanism of allocation, based on criteria of need which could be more or less effectively translated into health services and facilities at a pace dependent on how quickly targets had to be met. But local authority expenditure runs on a different system and there is local definition of need, subject to national constraints. Systems for matching local and national revenue are as imperfect as those for reconciling local and national objectives for housing, education and social welfare.

The NHS itself lives with an uneasy but probably creative tension between centralism and localism, professionalism and politics. Yet the consequences for a resource allocation or reallocation policy are that even more when one looks at the 'big picture' of overall public policy, pragmatism is called for.

One of the major problems in this area has always been this tension between local and central control — a political though not necessarily party political tension. As with so many other aspects of health service management, a rigid formula for resource allocation, while looking good in theory and matching up to the increasing emphasis on better management, is unlikely to work well in practice. As ever a certain untidiness — more respectably described as flexibility and pragmatism — is the reality. As conventional wisdom puts it 'When confronted with an elephant to eat, all you can do is walk up to it and take the first bite'.

Mays and Bevan, in their review of the RAWP methods and report,<sup>13</sup> concluded that RAWP stands out as a 'signal success' in public policy initiatives, particularly when compared with other failed attempts to apply rational approaches in public policy. They identified four particular areas for further research in the resource allocation area. The first was to develop a constructive

approach to measuring and coping with social deprivation. The second was to refine RAWP's remarkably durable working hypothesis that standard mortality ratios are adequate proxies for morbidity. The third was to develop skills in regional strategic management. And the fourth concerned the financing of teaching hospitals which was important in terms of the conflict between bed requirements for teaching and the equitable distribution of resources but not always perceived by most health authorities as a priority.<sup>1718</sup>

Mays and Bevan conclude that the RAWP Report fundamentally altered resource allocation to health authorities. 'Its underlying objective and chosen methods of measuring an appropriate distribution of resources are likely to be profoundly influential for the foreseeable future.'

It is important, however, to note also that while health service resource allocation between Regions has been largely equalised as a result of RAWP, differences between districts within a Region have persisted.

RAWP noted that it was essential to include general practitioner and other resources in the equation as well as hospital resources. Twenty years later this has yet to happen. The Working Party also emphasised the resource implications for the health service of environmental, economic and social factors and this is another issue that remains to be addressed.

#### WHAT'S IN A NAME ?

One of the calamities for public health, which had had its origins much earlier, was the change of name to social and preventive medicine and then officially to community medicine. It was in Britain in the 1940s that a distinction started to be drawn between public health and social medicine.<sup>19</sup> In 1948, FAE Crew, the Professor of Public Health (later social medicine) in Edinburgh said that 'it should be acknowledged frankly that public health, the forerunner of social medicine, has steadily lost status during the last twenty years or so...'.<sup>20</sup> John Ryle, the first professor of social medicine in the United Kingdom, writing in 1948, drew a clear distinction between social medicine and

public health.<sup>21-22</sup>

Public health, although in its modern practice attaching an ever-increasing importance to the personal services, for a long time and at first for very sufficient reasons, placed the emphasis on the environment. Social medicine, deriving its inspiration more from the field of clinical experience and seeking always to assist the discovery of a common purpose for the remedial and preventive services, places the emphasis on man and endeavours to study him in and in relation to his environment.

Although Ryle himself seemed to see his notion of social medicine as a broad concept of the extension into the community of the holistic attitude he had applied to individual disease, others had a more narrow concept of social medicine as applying essentially to the methods of epidemiology.

McKeown and Lowe, for example, used the term to describe 'a body of knowledge and methods of obtaining knowledge appropriate to a discipline. This discipline may be said to comprise a) epidemiology and b) the study of medical needs of society.

Alwyn Smith took the exclusion of public health from the field of social medicine further, arguing that 'all medicine is now generally accepted as being involved with the public health, and provision of all kinds of health and medical care is accepted in most communities as a general social concern.'<sup>24</sup> In 1985 he expressed the opinion that medical officers of health had been wrong to forsake 'since the early years of the century... their consultative roles as community physicians in order to assume the responsibility for the day-to-day direction of extensive personal services'.<sup>25</sup>

Whatever the truth about definitions, there is no doubt that the multiplicity of names in use and the lack of uniformity, indeed ambiguity, in how they were used, added to the general confusion and demoralisation of the specialty. Other medical specialties, such as paediatrics, cardiology, psychiatry, have not been subject to such difficulties and while their responsibilities may change slightly according to scientific development and political whim, the substance and focus of their work as doctors remains clearly on a particular age, body system or patient group. No other specialty has been subjected to the same



changes in status and responsibility as public health.

Francis<sup>26</sup> saw the reorganisation of local government and the health service in 1974 as hugely significant and far-reaching in its effects. 'The future of the Medical Officer of Health and of the public health service, however important in itself, was not central to the restructuring of local administration, but was a problem that resulted from it. The effects on the public health services have been severe and can be traced in the change from the Medical Officer of Health to the community physician, the break-up of the public health team and the downgrading of the public health tradition... all in all, 1974 was a crisis for the Medical Officer of Health in 'which almost all elements of the structure which supported his unique role disappeared.'

What was seen by many at the time as a crisis of confidence in community medicine contained within it the seeds of recovery. The Medical Officers of Health who were involved with senior academics in the foundation of the Faculty of Community Medicine were people of outstanding stature and the syllabus for membership of the faculty included much that was relevant to the public health function.

### THE ACHESON REPORT

Towards the mid to late 1980s, the term 'public health' began once again to be used in thinking about future directions. In 1986, the Secretary of State set up an inquiry team under the chairmanship of Sir Donald Acheson, the Chief Medical Officer at that time "to consider the future development of the public health function, including the control of communicable disease and the speciality of community medicine, following the introduction of general management into the Hospital and Community Health Services...".

In announcing the establishment of the Committee in Parliament, the Secretary of State said 'The Inquiry will be a broad and fundamental examination of the role of public health doctors including how such a role could best be fulfilled'. It was the first general review of the public health function in England since the Report of the Royal Sanitary Commission in 1871.



The Committee adopted a broad definition of public health as 'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society'.

The Committee took evidence from a wide variety of individuals and organisations with an interest in public health and its report was published in 1988.<sup>27</sup> It identified five main problems.

The first was a lack of co-ordinated information on which to base policy decisions about the health of the population at national and local levels. The second was a lack of emphasis on the promotion of health and healthy living and the prevention of disease. Thirdly, there was widespread confusion about the role and responsibilities of public health doctors — both within the health service and in the public perception. Fourthly, there was confusion about responsibility for the control of communicable disease and poor communication between the various agencies involved. Finally, there was weakness in the capacity of health authorities to evaluate the outcome of their activities and therefore to make informed choices between competing priorities.

The Committee recognised the overwhelming support for the need for a well-trained, medically qualified public health specialist as a key figure in the health service working with a wide range of non-medically qualified practitioners in the field. They made 39 recommendations of which 31 could be implemented without delay, 29 of them at very low or minimal cost.

Their first recommendation was crucial to ending the prevailing confusion on names and roles of which the Committee had considerable evidence from a wide range of opinion.

We recommend that the specialty of community medicine should in future be referred to as the specialty of public health medicine and its qualified members as public health physicians. Those appointed to consultant career posts in the NHS should be known as consultants in public health medicine.

The final paragraph of the report expresses the belief that the recommendations as a whole represent a significant package of

proposals which will clarify and strengthen the discharge of the public health function.

### CONCLUSION

The period under consideration in this chapter was one of almost constant turmoil and uncertainty for all involved in the National Health Service and perhaps in particular for community medicine. But as we have said, the period ended with some glimmers of hope for the re-creation of a revitalised and modern public health service.

One of the major public health issues during the 1980s was that of inequalities in health and the beginning of the decade saw the publication of the Report on *Inequalities in Health* (the Black Report) which was presented to the Secretary of State in April 1980.<sup>28</sup>

This was followed in 1987 by publication by the Health Education Council of a review of studies on the same subject under the title *The Health Divide: Inequalities in Health in the 1980s*.<sup>29</sup>

This politically sensitive and absolutely central health issue was thus thrust once again to the forefront of the public health agenda for the present decade and presented opportunities to be grasped by the public health physicians of today.

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## 6

## The Health of the Nation 1989 -1997

*The relation of poverty to disease is so great and inseparable  
that it is astonishing legislators should not ere now have  
acknowledged it.*

*The Lancet* 1 April 1843

*There are rich and poor and if diseases are to be combated,  
these inequalities must be made good.*

Bernet 1935

*The crude differences in mortality rates between the various  
social classes are worrying... it is a major challenge for the  
next ten or more years to try to narrow the gap in health  
standards between different social classes.*

David Ennals 27 March 1977

*If (any) government is to give itself a chance of making an  
appreciable impact on inequalities in health or any associated  
social problems, it must overcome its fear and encourage more  
imaginative intersectoral approaches to policymaking.*

*BMJ* 4 November 1995

### HEALTH SERVICE FUNDING

During the 1980s, health pohcy was dominated by questions of finance.<sup>1</sup> As the decade wore on, the gap between the money provided by the government for the National Health Service and the funding required to meet ever-increasing demand grew wider.

The cash crisis came to a head in 1987 when the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists took the unprecedented step of issuing a

joint statement claiming that the NHS was almost at the point of breakdown and that additional or alternative sources of funding would have to be found.

The government response had two strands. First, ministers announced in December 1987 that an extra £101 million was to be made available in the United Kingdom to help tackle immediate problems. Secondly, in January 1988 the Prime Minister announced a far-reaching review of the future of the National Health Service, the results of which would be published within a year.

When the Prime Ministerial Review was announced, it was widely suggested that the government would use the opportunity of the crisis in health service funding to put forward radical alternatives to the NHS.<sup>1</sup>

In reality, a working party had been set up in the early years of the Conservative Government to examine alternative ways of financing health services. Its report, which was never published, had been submitted to ministers early in 1982 and in July of that year Norman Fowler, then Secretary of State for Health and Social Security, had announced that the government had no plans to change the system of financing the NHS largely from direct taxation.

Ham<sup>1</sup> quotes the conclusion of the working party that:

every country in Europe was facing an explosion in demand for health care; every country in Europe was spending substantial public resources upon health, and in many ways our centrally run, centrally funded system was the most effective in controlling costs. There was no inherent cost advantage in moving over to an entirely new financing system and it was also clear that whatever system was chosen, taxation would still have to finance a giant share of the service.

### PRIME MINISTERIAL REVIEW OF THE NHS

At the beginning of the review process, the main emphasis was quite naturally on the financing of health services. It became clear, however, that there was little support for a major change in this area and the focus moved quite quickly towards how to achieve more efficient use of resources through changes in



health care delivery.

The idea that hospitals should compete for resources in an internal market gained credence and there were also proposals that doctors should be made more accountable for their performance and become more involved in management. Proposals were put forward on how to strengthen the overall management of health services with the introduction of general management.

In 1988, the Department of Health and Social Security was divided into two separate departments. In 1989, a government White Paper, entitled *Working for Patients*, confirmed that the founding principles of the National Health Service would be preserved and funding would continue to be provided mainly out of taxation.<sup>2</sup> Similar White Papers applied to other parts of the United Kingdom.

The main changes related to the delivery of health services and were designed to create competition between hospitals and other service providers with the separation of responsibility for purchasing and providing health services. Thus, health authorities would purchase services on behalf of their local populations from a range of public, private and voluntary providers. Large general practices would also be able to purchase some hospital services for their patients.

By introducing market principles, the government hoped not only to make services more responsive to patients, but also to stimulate greater efficiency in the use of resources. Ministers argued that competition would be carefully managed or regulated to ensure that appropriate services continued to be available in each locality.

The White Paper also tried to strengthen management arrangements. Centrally the Department of Health would have a Policy Board and a Management Executive instead of a Supervisory Board and Management Board. Locally, the composition of health authorities, or health boards in Scotland, would be revised along business lines.

There were also various ideas aimed at encouraging doctors to become more accountable for their performance and more involved in management.

As Ham<sup>1</sup> has pointed out, *Working for Patients*, while it did



include important recommendations affecting primary care, was concerned mainly with hospital services, particularly acute services. But the government also developed radical proposals for primary care and community care.

The White Paper, *Promoting Better Health*,<sup>3</sup> proposed changes to raise standards of health and health care, to place greater emphasis on health promotion and disease prevention, and to offer wider choice and information to patients with new contracts for general practitioners and dentists introduced in April and October 1990 respectively. The new GP contract included provision for new patient health checks, annual checks for patients aged 75 years or over, targets for vaccination, immunisation and cervical screening, encouragement for the development of health promotion clinics, pre-five child health surveillance and the provision of minor surgery. Another important feature was extra payment for GPs practising in areas of deprivation.

In responding to the proposed new contract, a senior general practitioner summarised the duties of general practice.<sup>4</sup> These include:

- i) responding to new requests for care from patients by identifying their problems and taking action;
- ii) providing continuing care for those with chronic conditions, the elderly, the terminally ill and the bereaved;
- iii) undertaking appropriate screening and health education;
- iv) primary, secondary and tertiary prevention.

Morrell<sup>4</sup> also lists five requirements for good quality primary care:

- i) provision of adequate premises and appropriate equipment;
- ii) maintenance of good records of care provided;
- iii) accurate age and sex registers of the practice population;
- iv) provision of services for patients with particular needs;
- v) development of a team approach to primary care to make the best use of non-medical health professionals.

The general practitioner should not be expected to be responsible for controlling people's health-damaging behaviour — described by Ivan Illich<sup>5</sup> as the medicalisation of social

behaviour — or with the provision of routine medical examinations for healthy adults. Morrell's reservations about some aspects of the proposed contract and in particular about unrealistic targets were widely shared in the profession. 'Certain standards of performance have been determined that are concerned almost entirely with preventive care — some of which is of questionable benefit. Some of these standards seem to ignore the rights of patients to accept or reject care.' The emphasis on income derived from capitation fees would, he felt, encourage the development of practices with large lists of patients to the detriment of sometimes time-consuming consultations with individual patients.

Morrell<sup>4</sup> suggested ways in which general practitioners could be encouraged to provide care sensitive to quality of services with basic clinical care monitored through audit of records and prescribing.

The overemphasis on prevention in the new contract, which is just a part of the general practitioner's normal services, could largely be delegated to nurses and would be balanced by good general care and not constrained by unrealistic targets related to unreliable denominators.

In December 1986, Sir Roy Griffiths had been asked to suggest a solution to the problems of community care. He presented this in the form of a report entitled *Community Care: An Agenda for Action* in March 1988.<sup>6</sup> In it, he assigned to local authorities a pivotal co-ordinating role for community care services with a Minister of State in the Department of Health to have responsibility for community care. His report did not examine funding in detail but he proposed that central government should arrange 'for the necessary transfer of resources between central and local government to match the defined responsibilities' and emphasised that the review was about 'cost improvements not cost cutting'.

The report did not meet with the approval of a government which was critical of what it saw as the wastefulness and inefficiency of local government. As *The Lancet* reported, Sir Roy's pedigree was 'not sufficient to win support for an idea which is heresy to the present administration'. The Royal College of Nursing argued that nursing provided a much better

base from which to recruit and train the right staff.

Others were more positive. Local government organisations were, not unnaturally, enthusiastic about the core role proposed for social service departments and the National Association of Health Authorities and Trusts (NAHAT) also welcomed the proposals. There were fears that without political commitment to the reforms they would fail and there was also criticism of the proposal to use means testing.

The BMA broadly supported the proposals and emphasised the importance of adequate and properly directed funding and the perils of over hasty implementation. An editorial in the British Medical Journal expressed concern as to:

whether local authorities have the ability or the will to implement the recommendation... an appreciable minority have elected members whose priorities are concerned largely with the advancement of an ideology.

Sir Roy himself summed up the response to his proposals as 'two cheers for Griffiths'.

The government finally responded to the report in July 1989. They had failed to provide a sensible alternative to making local authorities and social service departments the central players but rejected the idea for a minister of state for community care and the proposal to ring-fence funds for this specific purpose within the annual grants to local authorities, with the inevitable consequences, although the latter proposal was implemented in 1992.

Government plans for the future of community care were formalised in a White Paper, *Caring for People*, which was published in November 1989:<sup>7</sup>

Local authorities would be given the lead responsibility in the planning of community care and would be required to prepare community care plans in association with NHS authorities and other agencies. It was expected that local authorities would become enablers and purchasers, co-ordinating the provision of care in different sectors, and providing some services directly themselves.

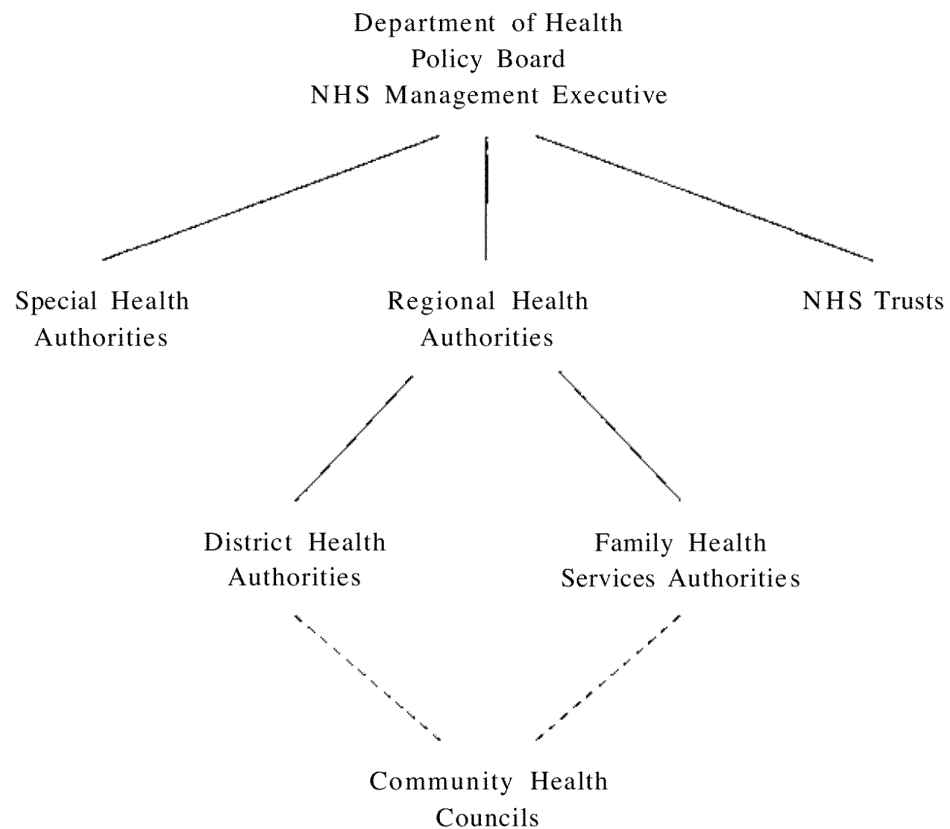
### NHS AND COMMUNITY CARE ACT

The proposals set out in *Working for Patients* and *Caring for People* were included in the NHS and Community Care Act which received the royal assent in June 1990 and came into force in April 1991 in England and Wales. Similar changes with variations in the composition of health authorities were planned for Scotland and Northern Ireland although the timing of the reforms was slower.

Parliamentary debate had focused particularly on the government's proposal to introduce competition into the National Health Service and a fundamental fear of the beginning of an attempt at privatisation. As the debate developed, it was suggested that the reforms should be tested in a series of pilot projects in view of their radical nature. In the event the only concession made by the government during parliamentary discussion was to agree to the establishment of a Clinical Standards Advisory Group to help ensure that the quality of care did not suffer as a result of competition and there was eventual agreement to implement the reforms more slowly than had been intended.

Outside Parliament, there was considerable opposition to the proposals for the health service. This was led by the British Medical Association who took particular exception to the new GP contract. There was greater support for the reforms from managers and health authorities although there was concern about the timetable for implementation. The changes proposed in community care evoked concern both about financial resources and timing, particularly in view of the changes to local government finance with the replacement of domestic rates with the community charge in 1990. The reforms were eventually phased in over a three year period with local authorities finally taking responsibility for the new funding arrangements in 1993.

The structure of the National Health Service from April 1991 is illustrated in Figure 1.



**Figure 1.** Structure of the NHS after 1990.

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## PUBLIC HEALTH IN THE NHS AFTER 1991 - HEALTH OF THE NATION

An unexpected by-product of the radical reforms on the National Health Service at this time was the clear and important role that became available for public health.

In June 1991, the then Secretary of State for Health, William Waldegrave, presented a consultative document entitled *The Health of the Nation* to Parliament and the final report was published in July 1992.<sup>8</sup> The strategy behind the report was to promote health rather than concentrating mainly on clinical



services and had been the subject of much discussion and amendment under successive Secretaries of State for Health.

The final document acknowledged that health authorities had been preoccupied for too long with the — very real — problems of day-to-day management of clinical services to the detriment of their strategic role of maintaining and improving the health of their local populations. A key feature of the health reforms was the creation of a clear strategic role for health authorities. The reforms were also intended to refocus the Department's attention on the broader public health issues which often go beyond the responsibilities of the National Health Service.

In his foreword, the Secretary of State had this to say:

It is often forgotten that the Department of Health's predecessor Ministry was established in 1919, long before the creation of the NHS. Its origins lay in the great public health reforms of the second half of the 19th century. The 1919 Act required my predecessor the Minister of Health to 'take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people'. ...The exercise of these central Government responsibilities has not been in abeyance, but their importance and the attention we pay to them need now to be brought into a better balance with the attention we rightly pay to the National Health Service. ...The strategic role of the Department is clear. Its task is to monitor and assess the health of the nation and take the action necessary, or ensure that the action is taken, whether through the NHS or otherwise, to improve and protect health.

Mr Waldegrave acknowledged the part that a variety of public authorities, such as those concerned with water and sewerage, housing, pollution control and so on, have to play in any national health strategy and urged the development of co-ordination overall.

He emphasised three points in particular. Firstly, the need to find the right balance between what Beveridge identified as the three key areas of prevention, treatment and rehabilitation. Secondly, the need for a proper balance between individual responsibility and government action. Many of the main current causes of premature death and avoidable disease are related to lifestyle but it is not possible to force people into good health.



'Government must ensure that individuals have the necessary information with which they can exercise informed free choice.' Thirdly, setting objectives and targets for health improvements is an essential discipline and these targets must be sufficiently challenging without being unachievable. 'Resources which can be devoted to health care will always be finite in the face of infinite demand.' Setting priorities, however difficult and contentious, is therefore essential.

There was a major difference in approach to the improvement of health between the Department of Health and the Faculty of Public Health Medicine. The Faculty and many others actively concerned with improving health wanted the targets and activities to focus on the factors that led to ill health — smoking, poverty, inadequate housing, for example, rather than on the diseases and conditions that resulted. The Faculty, therefore, identified sixteen priority areas where public health action could have a significant impact on important causes of morbidity and mortality in the United Kingdom.<sup>9</sup>

Within each cause, objectives were further sub-divided into improved health status, risk factor reduction, improved services and protection, surveillance, and data needs.

The objectives were ambitious both in terms of risk factor reduction as well as in the services to be provided or action to be taken — for example, no tobacco product advertising other than small point-of-sale notices, the inclusion in GP health records of a patient's smoking habits in order to identify those at risk, the provision of condoms free of charge on prescription, access to a female doctor or nurse for women when being examined or fitted with a contraceptive device. These proposals identified both the inadequacies of current services and policies, as well as the need to develop appropriate data systems to provide the information necessary to assess both needs and whether objectives were being approached.

The *Health of the Nation* approach was somewhat different. Objectives were limited to five key areas — i) coronary heart disease and stroke; ii) cancer; iii) mental illness; iv) HIV/AIDs and sexual health; v) accidents. The reasoning behind this was two-fold. Firstly, it recognised that the lead role was played by

the Department of Health and secondly that the focus was on disease containment rather than risk/behaviour modification. An inter-departmental committee at Cabinet level, chaired by the Leader of the House of Commons, ensured some co-ordination of policies. But in the crucial area of reduction of harm from tobacco, the Government refused to introduce any measure which would limit tobacco advertising, in spite of the repeated and unanimous advice of all the advisory bodies which had been established to help in designing the *Health of the Nation* policy.

These bodies were partly successful at least in persuading Ministers to include sub-objectives on smoking and alcohol although many of the controversial proposals from the Faculty of Public Health Medicine were omitted.

Although health authorities were required to report progress in achieving the *Health of the Nation* targets, and the prime role of public health in doing this was recognised, both the means of tackling the problems and the methods of surveillance were flawed. The targets, for example, were expressed in national terms — but they obviously required to be translated to local level in view of the wide variation in the United Kingdom of both disease and risk factor incidence. As the targets set were not very challenging, districts often needed to do little to achieve them.

No resources were allocated to this initiative — and since performance of health authorities was judged on process measures, such as waiting lists, or fiscal measures such as savings made, there was little incentive to develop new programmes or change current ones concerned with disease reduction and health promotion. Public health effort was also dissipated by the need to be involved in contracting for services rather than in promoting health.

In 1992, the British Medical Association published a report entitled *Priorities for Community Care* in which it called for community care planning to include input from all relevant branches of the medical and nursing professions. It argued that the public health physician was 'probably the doctor who would have the most continuous input into the needs assessment and

service planning of an area, taking advice from appropriate specialists and liaising with... social service departments and the voluntary sector'.<sup>10</sup>

The failure of the public health speciality to rise to the challenge of linking medical management with planning and developing services for local populations, which could have been such a positive consequence of the 1974 reorganisation, was disappointing and resulted in a crisis of confidence and a drop in recruitment, both in quality and quantity.

The new focus on the central importance of public health offered by the Acheson Report,<sup>11</sup> the NHS and Community Care Act 1990,<sup>12</sup> and *The Health of the Nation*<sup>9</sup> should have begun what Acheson described as a renaissance of the specialty with medically qualified directors of public health being part of the decision-making machinery of health authorities or boards. But once again the specialty failed to grasp this clear opportunity as wholeheartedly and universally as it could and should have done.

#### PUBLIC HEALTH RESEARCH AND TRAINING

In 1987 the House of Lords Select Committee on Science and Technology became concerned with the state of medical research. A sub-committee was set up to determine how priorities were established and research stimulated. Although much of the evidence dealt with whether medical research should be science led or problem led, the committee concluded that there was a need for a balance between the two. The committee was, however, particularly concerned with the difficulties experienced by public health research. They regarded the mechanisms put in place by the Department of Health as inadequate, both in asking those dealing with their research policy to consider what research was required and in applying the research findings. This has been fully described by Kember and Macpherson.<sup>13</sup>

Although the Department of Health responded by creating a Research and Development Directorate which has forged closer links with those responsible for health policy and management,

it has continued to neglect the needs for public health research, concentrating for the most part on the research needs underpinning clinical policies.

This failure to develop a public health research agenda to tackle some of the underlying causes of ill-health and the lack of career development for those required to undertake such research has unfortunate consequences. When longstanding problems, such as inequalities in health, require to be addressed, new research has to be commissioned. This will take some years to yield results and thus policy is made without the benefit of sound research findings or not at all.

One outcome of the Acheson Report was the acceptance of the need for more public health physicians. There was an increase in the number of trainee positions in all Regions with ring-fenced funding available to recruit about 50 more trainees per year for four years.

This had a marked and very welcome effect on recruitment to the specialty. But one fundamental problem was not tackled. No provision was made for the training or career development of non-medical individuals who are essential for the performance of some public health tasks.

With the changes in National Health Service structure, public health physicians in some places began to perform more and more tasks that could be defined as managerial — for example, negotiating clinical contracts. With the inevitable concern with managerial costs once the 1991 changes had been in place for a number of years, public health physicians were regarded as 'grey suit managers' and were subject to managerial 'downsizing'. This has had two effects. Firstly, authorities restricted the expansion of consultant public health posts to take on the new trainees and this caused frustration and disappointment among many who were motivated to become involved in public health. Secondly, the authorities recognised that some of the public health functions could be performed by non-medically qualified individuals such as nurses, statisticians and social scientists who were cheaper to employ. Since no training scheme for such individuals had been established, however, there could be no assurance of the quality of work performed. Many public health

physicians also saw this as a threat and there is, as yet, no resolution of the dilemma.

One result of the concern with managerial costs after the 1991 changes has been a reduction in the number of tiers of management. The regional tier was abolished and incorporated in the NHS Executive in the form of Regional Offices. The Regional Directors of Public Health have thus become employees of the government and are civil servants. In this way, their ability to provide a critical voice on the effects of government policy on regional health needs has been constrained. And their freedom to produce independent annual reports — a crucial public health function — has been compromised.

A very beneficial consequence of Acheson's enquiry on the public health function has been the control of infectious disease. Each district or board has established a mechanism for communicable disease control and has usually appointed a properly trained consultant responsible for this. Close co-ordination has been achieved with the Communicable Disease Surveillance Centre of the Public Health Laboratory Service and with appropriate Public Health Laboratories. Thus, although there have been several major outbreaks of communicable disease in recent times, these have been handled with greater expertise than sometimes in the past. The lack of an adequate legal framework of responsibility for the control of infectious disease remains a major difficulty.

### INEQUALITIES IN HEALTH

One of the most obdurate public health problems which has been reported since social class analysis of mortality was first published by the Registrar General in 1921 has been that of inequalities in health and the link between deprivation and health.

Alwyn Smith and Jacobson, in their report of an independent multidisciplinary committee on *The Nation's Health*,<sup>14</sup> are among many who have drawn attention to the continuing social disparities in death rates at every stage in life.



The Black Report on *Inequalities in Health*, published by the Department of Health and Social Security in 1980, and later updated, concluded that the observed disparities in health were real and had widened continuously among adults since 1951.<sup>15</sup>

This report was the outcome of the work of a Research Working Group which was appointed in 1977 by the Secretary of State for Social Services in the Labour Government to assess national and international evidence on inequalities in health and assess the implications for Britain.

The Group was chaired by Sir Douglas Black, formerly Chief Scientist at the Department of Health and at the time of the inquiry President of the Royal College of Physicians. The other members of the group were Professor Jerry Morris of the London School of Hygiene and Tropical Medicine, Dr Cyril Smith, Secretary of the Social Science Research Council and Professor Peter Townsend, then Professor of Sociology at the University of Essex.

The Working Group completed its review in 1980. It concluded that the poorer health experience of lower occupational groups applied at all stages of life. The class gradient appeared to be greater than in some comparable countries — although data for the United Kingdom were almost invariably fuller — and were becoming more marked. During the twenty years up to the early 1970s, mortality rates for both men and women aged 35 years and over in occupational classes i and ii had steadily decreased while those in classes iv and v had changed very little or deteriorated.

The Working Group felt that much of the problem lay outside the scope of the National Health Service itself. Economic and social factors - such as income, work or unemployment, environment, housing, education, transport, diet — all influence health and are better handled by the more affluent members of society. National health policy did not, but should, involve itself in these factors and different departments of government should work more closely together to influence policy for the benefit of the health of the whole population.

In view of the continuing importance of the issue almost twenty years later, the summary and recommendations of the

Black Report are reproduced as Annexe 2 to this book.

There were two main policy thrusts which are described in the introduction to the 1992 edition of the report.

- 1) A total and not merely a service-oriented approach to the problems of health.
- 2) A radical overhaul of the balance of activity and proportionate distribution of resources within the health and associated services.

In April 1980, the Black Report was submitted to the Secretary of State of the new Conservative administration to what must truthfully be described as a lukewarm reception. It was released to selected journalists on the Friday before the August Bank Holiday of that year. No official press release or press conference was organised and only 260 copies of the duplicated manuscript were made available rather than the usual DHSS or HMSO method of publication and distribution of an official commissioned report.

In his foreword to the document, the Secretary of State for Social Services, Patrick Jenkin, made clear the government's position on the recommendations:

The Working Group on Inequalities in Health was set up in 1977, on the initiative of my predecessor as Secretary of State, under the chairmanship of Sir Douglas Black, to review information about differences in health status between the social classes, to consider possible causes and the implications for policy, and to suggest further research.

The Group was given a formidable task, and Sir Douglas and his colleagues deserve thanks for seeing the work through and for the thoroughness with which they have surveyed the considerable literature on the subject. As they make clear, the influences at work in explaining the relative health experience of different parts of our society are many and interrelated; and while it is disappointing that the Group were unable to make greater progress in disentangling the various causes of inequalities in health, the difficulties they experienced are perhaps no surprise given current measurement techniques.

It will come as a disappointment to many that over long periods since the inception of the NHS there is generally little sign of health inequalities in Britain actually diminishing and, in some cases, they may

be increasing. It will be seen that the Group has reached the view that the causes of health inequalities are so deep-rooted that only a major and wide-ranging programme of public expenditure is capable of altering the pattern. I must make it clear that additional expenditure on the scale which could result from the report's recommendations — the amount involved could be upwards of £2 billion a year — is quite unrealistic in present or any foreseeable economic circumstances, quite apart from any judgement that may be formed of the effectiveness of such expenditure in dealing with the problems identified. I cannot, therefore, endorse the group's recommendations. I am making the report available for discussion but without any commitment by the government to its proposals.

Not surprisingly, this was followed by prolonged and angry correspondence in the medical press and efforts were made by many health related bodies to increase coverage and discussion of the evidence and arguments in the report.

The government, however, continued to defend its reaction to the report on grounds of lack of knowledge of the precise causes of inequalities in health, new evidence claimed (although later discredited) to disprove the thesis that the deprived had poorer access to the health services, and financial constraints.

In 1986, the Health Education Council commissioned an update of evidence on inequalities and health since 1980 and to assess progress made on the Black recommendations (Annexe 2).

This was published as an HEC Occasional Paper, under the title of the *Health Divide*,<sup>16</sup> in March 1987 and confirmed clearly the main conclusions of the Black Report. A press briefing was cancelled by the Chairman of the Council shortly before it was due to begin with a statement to the effect that it was necessary to postpone the briefing until the full Council was able to consider 'this important and possibly controversial document'.

Press interest was naturally heightened by this move and inequalities in health thus became even more of a political issue than it already was in what was also an election year.

In a saner world, this should never have become a political issue. It is a long-standing problem of health and its fair distribution throughout society. It remains very much with us in 1998 and has to be addressed by politicians, health and other relevant professional experts and the public themselves. It will

not be capable of solution easily or quickly but a start must be made.

In 1994, the Government did set up a working group under the Chief Medical Officer's wider Health of the Nation Working Group to 'make the best use of any existing information to tackle ethnic, geographical, socio-economic and gender variations in health status, with particular reference to the strength of skewed relationships and evidence about the effectiveness of interventions'.

Discussion was limited to what the NHS and the Department of Health could do to reduce inequalities in health — or what were somewhat coyly described as 'variations' in health. Other relevant issues, such as poverty, housing and unemployment were not within the remit.

An editorial in the *British Medical Journal* saw the report of the Chief Medical Officer's group, which was published in 1995,<sup>17</sup> as 'a welcome opening of negotiations'. It regarded the report's recommendations as worthwhile.

As well as saying that health authorities should monitor health variations, target resources, ensure equal access, and evaluate interventions, the report also says a little (not enough) about the responsibilities of the NHS as the country's largest employer and - most crucially — emphasises the Department of Health's responsibility for informing the government of the impact of other aspects of policy on health.

But the editorial goes on to say that, as well as influencing the content of the report, political constraints risked starting the discussion off on the wrong foot. It pointed out that there were both expensive and inexpensive ways of tackling inequalities of health, and the former are unlikely to be the best.

What is expensive is to leave the underlying causes intact while establishing new services for those 'at risk' in an attempt to repair continuing damage.

Another commentator lamented yet another missed opportunity.

What is remarkable, in view of the evidence presented of current inequalities - and apparent trends in these - is that the prescription

offered is 'more research'... That the report was commissioned is undoubtedly an advance. It is a pity that such an important intellectual challenge had to succumb to ideology.

Over the past 100 years or more, as we have seen in earlier chapters, there have been challenges of the day to which public health practitioners have sometimes responded magnificently, sometimes adequately and sometimes scarcely at all. It remains to be seen how the specialty of today responds to what is almost certainly today's greatest challenge.

### CONCLUSION

Other medical groupings, such as general practitioners and clinical specialties, have a clear-cut purpose to provide the best forms of diagnosis, treatment and care for individual patients. Public health, as a medical specialty, is in a different and more complex position. It is concerned with populations which can seem rather more remote than individuals. It has the further problem of the heterogeneity of the composition of a population. It has to influence and guide a wide variety of other agencies and establish multidisciplinary networks to achieve its objectives. And as a medical specialty it has to retain credibility with its parent profession.

The establishment of a new post within the Department of Health — Minister for Public Health — is a sign that the Labour Government elected in May 1997 regards public health as one of its priorities. It is an unprecedented position in British central government and one of immense potential influence and importance.

Acheson has given us a perfectly appropriate definition of what the specialty is or should be about. What we need now in the health service of the late twentieth century is to acknowledge the importance of public health at the centre of the National Health Service. There is recent evidence that the Government is preparing to do just this.

In the recent Green Paper *Working Together for a Healthier Scotland*<sup>20</sup> the following quote signals the Government's approach.



True public health policies are embedded in action to improve our quality of life and protect our environment, in improving housing and educational achievement, as well as in addressing poverty and unemployment and in the restructuring of the National Health Service as a public health organisation with health improvement as its main aim.

There is also an imperative for public health to forget its past disappointments and deficiencies and to provide the expertise and strong leadership of some of the previous giants of the specialty. The complexion of some of the public health problems of today may have changed. But 'new plagues' are as important as old and the crucial issue of inequalities and variations in health has been waiting for too long to be addressed.

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