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THESIS

THE CONSERVATIVE PARTY AND THE FORM OF THE  
NATIONAL HEALTH SERVICE, 1964 – 1979

A thesis submitted for the degree of  
Doctor of Philosophy

by

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April 2002

## ABSTRACT

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The Conservative Party policy on the form of the National Health Service, 1964-1979

2002

PhD

This thesis focuses on the development of the Conservative Party's policy in respect of the form of the National Health Service in England between the general elections of 1964 and 1979. By form is meant the basic principles of the Service and the organisational arrangements (structure, management processes and financing) made to give effect to those principles.

After an account of the form of the NHS in 1964, the thesis documents the development of Conservative Party policy on those aspects of form to which attention was given between 1964 and 1979. In doing so, it draws extensively on primary material, much of which (especially that relating to the Party's periods in Opposition) has not, as far as the author can discover, been brought together previously in an historical study. By examining this material in its appropriate context, it is hoped that the thesis makes intelligible a passage of history quite tightly circumscribed both in terms of subject and period.

Insofar as an overall theme might be said to emerge, it is of a Party committed to the idea of a comprehensive health service, uncomfortable with the consequences of aspects of the form enacted in 1946 but, conscious of the popularity of the NHS, cautious about making radical changes.

DEDICATION

In remembrance of:

Archibald Allan Bacon, 1912–1981,  
Irene Louise Bacon, 1913–2001

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## ABBREVIATIONS AND CONVENTIONS

ACP	-	Conservative Party Advisory Committee on Policy
AHA	-	area health authority
AHC	-	area health council
ARM	-	British Medical Association Annual Representative Meeting
AST	-	Acton Society Trust
BG	-	board of governors
BIOSS	-	Brunel Institute of Organization and Social Studies
BMA	-	British Medical Association
BMAA	-	British Medical Association Archive
BMJ	-	British Medical Journal
BUPA	-	British United Provident Association
CMS	-	Conservative Medical Society
CPA	-	Conservative Party Archive
CPS	-	Centre for Policy Studies
CRD	-	Conservative Research Department
CSD	-	Civil Service Department
DHSS	-	Department of Health and Social Security
EC	-	executive council
EPG	-	Economic Policy Group
ERPG	-	Economic Reconstruction Policy Group
FPS	-	family practitioner services
GDP	-	gross domestic product
GP	-	general medical practitioner
HAS	-	Hospital (later Health) Advisory Service
HCSA	-	Hospital Consultants and Specialists Association
HI	-	Hoover Institution on War, Revolution and Peace
HMC	-	hospital management committee
HPG	-	Health Policy Group
HSORU	-	Hospital Organization Research Unit, BIOS
IEA	-	Institute of Economic Affairs
LJA	-	Lord Joseph Archive, CPA
LCC	-	Leader's Consultative Committee
LSE	-	Leader's Steering Committee

NHS	-	National Health Service
NHSPG	-	NHS Policy Group
NUCUA	-	National Union of Conservative and Unionist Associations
OG	-	Official Group
PCFSS	-	Policy Committee on the Future of the Social Services
PHSS	-	[Conservative] Parliamentary Health and Social Security Committee
PRO	-	Public Records Office
PSBR	-	public sector borrowing requirement
PSPG	-	Public Sector Policy Group
PSRU	-	Public Sector Research Unit
PSS	-	personal social services
RCNHS	-	Royal Commission on the NHS
RHA	-	regional health authority
RHB	-	regional hospital board
RHC	-	regional health council
SRM	-	British Medical Association Special Representative Meeting
SSPG	-	Social Services Policy Group
WGSP	-	Working Group on Social Priorities
WPNHSF	-	Working Party on NHS Finance

### Conventions used

1. Abbreviations: the full title or phrase is used the first time it appears in the text and in a footnote if it has not already appeared in the text, thereafter the appropriate abbreviation is used.
2. Individuals: the first time reference is made to a named individual, his or her usual first name (or initial) and surname are used, thereafter in general only the surname is used unless this could cause confusion, ie Arthur Jones is usually referred to in full, to avoid possible confusion with other MPs with that surname.

## ACKNOWLEDGEMENTS AND SOURCES

I am indebted to my supervisor, Dr Charles Webster of All Souls College Oxford, whose knowledge of the history of the National Health Service is matchless, for his generous help over several years. I would also like to thank Professor Maurice Kogan, my second supervisor, for his help and encouragement.

Much of this thesis is based on archival research at the Conservative Party and Lord Joseph Archives at the Bodleian Library, Oxford; the British Medical Association's Archive in London, and the Public Record Office at Kew. In addition I have consulted relevant Institute of Economic Affairs papers archived at the Hoover Institution for War, Revolution and Peace at Stanford University, California.

I am grateful to the Conservative Party (and especially to Michael Simmonds and James Walsh) for permission to examine and quote from papers in the Party Archive that are normally closed; to Lady Joseph for permission to examine and quote from papers in the Lord Joseph Archive; to the British Medical Association, for access to their Archive, and to the Department of Health which, on request, "opened" numerous files hitherto "closed" under the thirty year rule. I would particularly like to thank Jill Davidson, archivist at the Conservative Party Archive, and Emily Naish and Mandy Mordue, archivists at the British Medical Association, for all their patient help in finding relevant papers.

In addition to the Department of Health (Pauline Connor), several other government departments were generous in providing information and in some cases letting me see material that had yet to be passed to the Public Record Office. The Treasury (Terry Herd) were particularly helpful, and I am also grateful to the Cabinet Office (Richard Ponman), the Department of the Environment Transport and Regions (Ian Smart) and the Foreign and Commonwealth Office (Paddy Maudsley).

Several individuals kindly gave me access to their private papers, and I should like to thank Stephen Cang, Sir Arnold Elton, Lord Howe of Aberavon (whose papers are now in the Bodleian Library), Professor Elliott Jaques, Robert Nicholls, Anne Noble (custodian of material from the now defunct Health Services Organization Research Unit, Brunel University), Dr David Tod, and Nigel Weaver (who holds the "Weaver Group" papers). Sadly Clifford Graham, who knew of my research interest long before I formally embarked on study for a PhD and kindly allowed me to copy several papers in his personal collection, died before this work was completed.

Finally I would like to thank those who involved in the issues covered by this thesis who gave up time to talk to me, or write, helping fill gaps in the archive material. They include Michael Alison, Sir John Banham, Michael Barsby, Roy Cunningham, David de Peyer, Professor Roger Dyson, Professor Brian Edwards, Professor Hugh Freeman, Lord Howe of Aberavon, Geoffrey Hulme, Lord Jenkin of Roding, Tony Kember, David Knowles, Professor Maurice Kogan, Dr Robert Maxwell, Christopher Mockler, Robert Nicholls, Lady Ridley, Arthur Seldon, Dr Peter Simpson, Brendon Sewill, Dr David Tod, Sir Gerard Vaughan and Nigel Weaver.

## INTRODUCTION

This Introduction has two broad aims. First, to set out the scope of the study and the approach used in its preparation (sections 1 and 2). Second, to provide a point of historical departure for the substantive chapters (sections 3 and 4).

### 1. THE SCOPE OF THE STUDY

This study is an historical account of policy consideration by the Conservative Party on the *form* of the National Health Service (NHS) in England (described in section 3 below), between the general elections of 1964 and 1979.

#### 1.1. The Conservative Party

By 1964, the Conservative Party had been in office (on its own or in coalition) for nearly two thirds of the previous hundred years. Over that period the Party had developed into a complex organisation, with a formal structure of roles and committees (1).

Much of the organisation was concerned with matters such as raising resources to fund Party activities, the recruitment of members, and the selection and support of candidates for parliamentary elections, which are outside the scope of this study. However, the development of policy had long been a major aspect of Party activity and is the focus of this study.

(1) Seldon A and Ball S (eds.), *Conservative Century*, 1994, Oxford, Oxford University Press, pp. 69/311.

In respect of policy development, whether the Party is in government or opposition, the role of the Leader is central. The Leader has the responsibility of appointing the Party's spokesmen on the various policy areas and a significant, probably often decisive, influence in what becomes Party policy as expressed, for example, in policy statements such as general election manifestos.

The formally appointed frontbench spokesmen (whether ministers or Opposition spokesmen) also have key roles in policy consideration, individually in respect of their areas of responsibility, and collectively as the cabinet or shadow cabinet (or the Leader's Consultative Committee (LCC) as the latter is formally titled). They in turn may be assisted in their policy considerations by parliamentary colleagues (some formally appointed as junior ministers or Opposition spokesmen); officials (Party officers or civil servants in opposition and government respectively) and various standing or specially convened committees.

Further, the Party has a mass membership who may also from time to time contribute to the formation of policy, particularly perhaps at the annual Party Conference.

The aim in this study has been to research how policies on the *form* of the NHS were considered within this set of potential contributors. In addition, the research has sought to identify individuals and organisations not part of the Party structure who may nevertheless have had a significant impact on policy consideration.

## 1.2. The policy focus

The policy area focused upon in this study is the NHS, established following the NHS Act 1946, covering England and Wales, and the NHS (Scotland) Act 1947. Despite much similarity, there are differences between the services in the three countries, for example in their structures. This study is solely concerned with the NHS in England.

By *form* (henceforth without italics) the author means the basic principles of the NHS (its scope, who has the right to use it, and on what terms) and the organisational arrangements (structure, management processes, practical matters and financing) made to give effect to those principles, an account of which is given in section 3.

## 1.3. The period covered by the study

The NHS was enacted and implemented under the Labour Government elected in 1945, but from 1951 to 1964 successive Conservative Governments had been responsible for the Service and (it will argued in section 4) had made no significant change to its form. Following loss of office at the 1964 general election, however, the Party leadership instituted the first major review of policies since that after the election defeat in 1945, with "modernisation" (discussed in Chapter 2) as a major objective. A further, equally wide-ranging review was instituted after Mrs Margaret Thatcher became Party Leader and largely completed by the end of 1978. The Party's policies on the NHS were explicitly included in both reviews.

Given that it included these two wide-ranging policy reviews, the period 1964 to 1979 seemed to the author to be likely to be one rich in reflection about the form of the NHS, and as such well worth researching.

## 2. THE HISTORICAL APPROACH TAKEN

In addition to their differences in subject, historical studies differ due to what might be called the personal (and particularly the political) values of their authors, and the methodologies adopted. In this section these aspects of approach are discussed.

### 2.1 Personal values

It is probable that few historians would totally dissent from Hobsbawm's proposition that "purely objective and value-free" social science (including history) is not possible (2), though there are exceptions (3).

In the case of some historians, part at least of their personal values is, explicitly, public knowledge (4). For others, this is not the case and, while their personal values may perhaps in part be deduced from their work, in a formal sense they are unknown. The author does not regard himself as having any personal values likely to result in bias in the way he has approached his subject. He is therefore content to adopt the position of the second category of historians referred to above.

- (2) Hobsbawm E, *On History*, 1998, London, Abacus, p. 164.
- (3) for example Hillgruber, quoted in Kershaw I, *The Nazi Dictatorship - Problems and Perspectives of Interpretation*, 2nd ed., 1989, London, Edward Arnold, p. 9.
- (4) for example, because of their public roles (such as Lord Jenkins of Hillhead and the late Alan Clark, both at one time government ministers).

## 2.2 Methodology

This section sets out the approach taken in this study by reference to different levels of discussion about methodological issues.

At the highest, or at least most general level, there is considerable debate as to whether the contemporary era is appropriately thought of as "modern" or "postmodern", in the sense in which those terms have been employed by, for example, Lyotard (5), and about the implications of this for the study of history (6).

Jenkins has defined postmodernists as "people who recognise that we are finite creatures in an unintelligible, existential condition" (7), and thus usefully distinguishes them from those who take the view that both the past and present are potentially intelligible in terms other than those of the individual's own subjective consciousness. The author takes the latter view, and has thus undertaken this study as an essay in what Himmelfarb has referred to as "'modernist' history, familiarly known as 'traditional' history" (8), in the belief that Evans is broadly correct when writing that history "really happened, and we really can, if we are very scrupulous and careful and self-critical, find out how it happened" (9).

- (5) Lyotard J, *The Postmodern Condition*, 1984, Manchester, Manchester University Press.
- (6) as explored by, for example, Jenkins K, in *Re-Thinking History*, 1991, London, Routledge, and Evans R, *In Defence of History*, 1997, London, Granta.
- (7) Jenkins K, *Why History*, 1999, London, Routledge, p. 204.
- (8) Himmelfarb G, "Telling it as you like it: Postmodern History and the Flight from Fact", in Jenkins K (ed.) *The Postmodern History Reader*, 1997, London, Routledge.
- (9) Evans, 1997, p. 253.

Within the "modern" frame of reference, there is a further level of discussion about the conceptual framework within which it is appropriate to try to understand change. In his study of the NHS, for example, Mohan distinguished three broad frameworks which, respectively, emphasised "developmentalism and determinism", "political theory" and "political economy". In the first, change is explained predominantly in terms of such forces as international trends or technical progress. In the second, change is explained from assumptions about the nature of the political context, encapsulated in such terms as "pluralism", "Marxism" and "the New Right". In the third, change is explained through ideas drawn from the field of political economy, as such as the shift from "Fordism" to "post-Fordism" (10).

Mohan's categorisation was, like others, neither definitive nor unproblematic (for example the term Marxism is commonly used to connote something much wider than an interpretation of the political context). However, in the author's view it offers a reasonable taxonomy of a wide range of differing frameworks, one within which this study can be located.

The author's approach is primarily rooted in what Mohan referred to as the "political theory" conceptual framework, and more particularly in that of "pluralism": the belief that "political power is widely distributed and that no one group is dominant; consequently each can exercise some influence" (11)

(10) Mohan J, *A National Health Service?*, 1995, London, Macmillan, pp. 25/6.

(11) *ibid.*, p. 29. Mohan's use of the term is similar to others', eg Ham C and Hill M, *The Policy Process in the Modern Capitalist Society*, 2nd ed., 1993, Hemel Hempstead, Harvester, pp. 26/31 and Vincent A, *Theories of the State*, 1987, Oxford, Blackwell, p. 183.

In his taxonomy, Mohan employed the notion of pluralism in what Vincent has described as its "descriptive" rather than "normative" sense (12). In identifying his approach as pluralistic, therefore, the author is not expressing a moral preference: simply his belief that changes in policy can best be understood as the outcome of considerations in which there are potentially many contributors.

How is this belief to be justified? Mohan gave two examples of studies of the NHS that he regarded as written from a pluralist approach, by Pater and Rivett (13), both of whom had been senior civil servants within the Ministry of Health and its successors, and much involved in the formulation of policies for the NHS (14). It is perhaps reasonable to infer that the pluralist approach taken in their historical studies reflected their sense that its core notion - many potential contributors to policy making - accurately reflected their practical experience, even if the occasion for policy re-consideration arose from, for example, technical progress or changing economic circumstances.

Like Pater and Rivett, the author was for many years a civil servant within the Health Department, and a contributor to numerous policy considerations (15). Whether or not the inference made above is correct as regards Pater and Rivett, a pluralist frame of reference for understanding policy change in the context of the NHS accords with his practical experience.

(12) Vincent, 1987, p. 183.

(13) Mohan, 1995, p. 29. (Pater J, *The Making of the NHS*, 1981, and Rivett G, *The Development of the London Hospital System*, 1986, both London, Kings Fund.)

(14) Pater from 1933 to 1973, retiring as an Under Secretary; Rivett from 1972 to 1992, retiring as a Senior Principal Medical Officer.

(15) from 1970 to 1999, retiring at grade 4. For example, the policy flowing from the consultation paper *Patients First*, 1979, London, HMSO, announced in July 1980.

Within the context of modernist or "traditional" history, and a primarily pluralist conceptual framework, there is a further level of methodological issue - the use, if any, to be made of theory.

Some historians' work is based on their personal, and often unarticulated, assumptions about the meaning of the events of which they are offering accounts; others seek to explain the meaning of such events by drawing upon theories of various kinds. In relation to the NHS, these two broad approaches are exemplified in recent studies by Webster, and by Harrison.

The two volumes of Webster's *The Health Services Since the War* (16) were the product of a publicly-funded commission "to write an account of the British health service from the inception of planning for a comprehensive health service to 1979" (17). They were based on extensive study of official documents, and concentrated on what the author regarded as "central issues of policy" (18).

Nowhere in the nearly 1,200 pages of text in the two volumes is there reference to, or evidence of, the use of theories or theoretical models drawn from other disciplines (19). Rather, the volumes contain what is, in essence, the author's interpretation of (mainly written) evidence relating to the genesis, enactment, implementation and first thirty years of a public service, understood on his own assumptions about meaning and presented in his own terms.

(16) Webster C, *The Health Services Since the War*, Vols. I, 1988, London, HMSO; and II, 1996, London, The Stationery Office.

(17) *ibid.*, 1996, p. xi.

(18) *ibid.*, p. xii.

(19) specifically confirmed by Webster in personal communication to the author, 17/12/01.

By contrast, in *National Health Service Management in the 1980s*, "a study of the political history of ... NHS management ... 1979 to 1992" (20), Harrison sought to "describe and *explain* what happened" (21), both by offering a chronological and evidence-based account of events and by considering "several *plausible accounts*" (22) cast in terms of theories, consciously on the lines of Allison's work in relation to the Cuban missile crisis of 1962 (23). The theories Harrison drew upon included "rational/ideological", "individual personality", and several about "what determines government policy agendas" (24).

Allison believed that his "several plausible accounts" approach had enabled him to "probe more deeply into the event, uncovering additional insights" and to "demonstrate how alternative conceptual lenses lead one to see, emphasize, and worry about quite different aspects of events like the missile crisis" (25). It can reasonably be inferred that Harrison took the view that the theoretical approaches he used might illuminate the events with which he was concerned more fully than had he relied solely upon his own, perhaps less fully articulated, personal assumptions.

While studies of the kinds exemplified by Webster and Harrison's are both within the broad church of historical scholarship, is there any sense in which one approach is intrinsically better than the other?

(20) Harrison S, *National Health Service Management in the 1980s*, 1994, Aldershot, Avebury.

(21) *ibid.*, p. 2. Emphasis in original.

(22) *ibid.*, pp. 4/5. Emphasis in original.

(23) *ibid.*, p. 4.

(24) *ibid.*, pp. 128/133.

(25) Allison G, *Essence of Decision*, 1971, Boston USA, Little, Brown and Company, p. v.

Both depend on the assumptions (and imagination) of the individual in deciding the research programme, carrying it through and bringing what is judged to be the appropriate evidence together into a coherent account.

The approach exemplified by Webster's work is the historian's personal, critical interpretation of relevant evidence, and subject to personal bias, whether disclosed or not.

However, it is not self-evident that the use of one or more of what Harrison has referred to as "a near infinity of theoretical approaches" (26) makes an historical study any less idiosyncratic or free from personal bias. The choice, from this "near infinity", is necessarily the personal one of the historian concerned. And there is an additional consideration. While the use of theories may lead the historian to insights he or she would otherwise not have found, it is also possible that they may serve as limits on the historian's imagination.

Perhaps recognising that neither broad approach was intrinsically superior, Marwick has suggested that differences among historians on this matter are primarily explicable in terms of "individual predilection" (27).

The author's predilection is the approach exemplified by Webster, on the ground that, while any historical study is inevitably personal, those undertaken without the constraint imposed by the use of theories are likely to be more open to the creative individuality of the historian, and may therefore be ultimately richer. Accordingly, within the "modern", pluralistic frame of reference discussed above, that is the approach adopted for this study.

(26) Harrison, 1994, p. 127.

(27) Marwick A, *The Nature of History*, 3rd ed. 1989, London, Macmillan, p. 142.

### 2.3. The evidence

Apart from the examination of appropriate political memoirs and academic publications, this study is based on the results of extensive archival research, the object of which has been to discover primary evidence relevant to its focus.

The research programme flowed from the nature of the Conservative Party's formal arrangements for policy review summarised in section 1.1 above. The formally-appointed Party spokesmen on the NHS were identified and efforts made to research how they approached the issue of policy consideration, what seemed to be the influences on them, and the results in terms of policy change. This necessitated exploration of the contributions of all those elements of the Party referred to section 1.1; the government departments who advised Conservative ministers (during the period 1970 to 1974); and individuals and organisations outside the Party (and government departments) who seemed to have been influential.

This last point needs particular mention. There was during the period under study (as there remains) a wide range of individuals, professional bodies, policy-based pressure groups and commercial organisations actively concerned with the NHS, any of whom, in principle, might have contributed to Conservative Party policy thinking, even if just by publishing something which a minister or shadow minister regarded as illuminating an issue under consideration. Where any evidence has been identified in Party or public records suggesting such a contribution, efforts were made to examine the records of the individual or organisation concerned. It was not, however, practicable systematically to seek to examine the records of all those who might in principle have contributed in this way, but for which no reference was found in Party or public records.

As with any historical study, there is an element of the fortuitous about the evidence that survives, and there were some notable gaps (referred to in the following chapters). Nevertheless, the author believes he has been able to identify sufficient evidence to create a reasonably coherent account of the main areas of policy consideration, and policy change, within his chosen remit.

As regards the criteria for selecting material as evidence for inclusion as part of the overall account, the author has had two criteria in mind - authenticity and relevance.

Most of the primary evidence referred to in this study is in written form and "official" in character, forming part of formal Party or public archives. Whilst the interpretation is to be placed on any particular document is a matter of judgement, the authenticity of the material was rarely in doubt. However, in some cases the author sought to supplement archival evidence by interviewing those who had been involved in the policy deliberations under study. Here it quickly became apparent that memories (of events typically twenty five years earlier) were patchy, and at times quite inaccurate. The use made of such evidence is discussed in the concluding chapter.

As regards the second criterion, relevance, the questions constantly in the author's mind have been whether the material under study was itself evidence of the development of Party policy (for example the statements of ministers and shadow ministers, and published policy documents such as general election manifestos), or whether it could be viewed as contributing to the thinking of those who played a part in Party policy consideration. Inevitably, the judgement in particular cases is a subjective one, in that other historians may disagree - either regarding evidence deployed in the study as irrelevant, or noting the omission of evidence they regard as relevant.

### 3. THE FORM OF THE NHS

As noted in section 1.2 above, by form is meant the basic principles of the NHS (its scope, who has the right to use it, and on what terms) and the organisational arrangements (structure, management processes, practical matters and financing) made to give effect to those principles

#### 3.1 Basic principles

The 1946 Act placed a duty on the Minister of Health to promote the establishment of a "comprehensive health service" (28). This comprised three main types of health service: the general medical, dental, pharmaceutical and ophthalmic services (hereafter referred to collectively as the family practitioner services (FPS)); the local authority health services (such as midwifery, health visiting and ambulances); and the hospital and specialist services.

In terms of current expenditure, in 1949/50 the hospital service was the largest element, accounting for approximately 51% of the total. The FPS accounted for about 36%, and the local authority health services 7% (29). (The remaining 6% was in respect of the school health services and central government expenditure.)

(28) NHS Act 1946, s. 1(1).

(29) *Royal Commission on the National Health Service, Report*, Cmnd 7615, 1979, London, HMSO, p. 434. (Percentages calculated from the NHS data, ie excluding the personal social services (PSS) data.)

The Act imposed no limitations on availability: everyone resident in Britain had the right to use all three types of service. At the same time, individuals were free to make private arrangements for part or all of their health care needs (with doctors who worked in private practice, or partly for the NHS and partly privately).

Services provided under the Act were free to the individual at the time of use, except for charges for certain local health authority services and appliances supplied by the FPS (30), the revenue from which initially amounted to less than 1% of annual NHS expenditure (31). Subsequent legislation enabled additional charges to be made for prescriptions, spectacles, dentures and dental treatment (32), increasing the revenue from charges to just over 5% of annual NHS expenditure by 1964 (33). The Service remained, however, largely free to the individual at the time of use.

(30) NHS Act 1946, ss. 1(2), 22(2), 28(2), 29(2) and 44.

(31) Cmnd 7615, 1979, p. 436.

(32) under the NHS (Amendment) Act 1949 (prescription charges); the NHS Act 1951 (charges for spectacles and dentures) and the NHS Act 1952 (charges for dental treatment).

(33) Cmnd 7615, 1979, p. 436.

The basis on which individuals could seek medical advice and treatment under the NHS had two characteristics. First, patients were to have free choice of senior doctors (general medical practitioners (GPs), specialists and consultants) employed by or contracted to the Service, though qualified by the equally free choice of doctors as to whether to accept an individual as a patient. Second, when offering advice or treatment, the doctor did so as a principal, in the sense that he or she had the right to exercise his or her personal clinical judgement and not be subject to instructions from other doctors or administrators (34). This organisational form of medical practice, characterised by the mutual choice of patient and clinically autonomous doctor, has been termed "personal doctoring" (35).

In summary, the basic principles of the NHS, both at its inception and by the time of the 1964 general election, can be said to have been its comprehensive nature; its availability to all those resident in Britain (individuals also retaining the right to make private arrangements); the provision of services largely free of charge at the time of use; and the provision of medical advice and treatment by doctors able also to practice privately, on the basis of "personal doctoring".

(34) with regard to free choice, in respect of GPs this was included in statute (NHS Act 1946, s. 33(2)(b)). In respect of consultants it was not so included. Rather, it was assumed as practice, eg the *Handbook for General Practitioners*, 1955, London, HMSO, p. 32. With regard to doctors' clinical autonomy, this too was not included in legislation, but was stated as the intended practice by the then Minister of Health, Aneurin Bevan, eg during the Third Reading of the NHS Bill (Commons Hansard, 26/7/46, vol. 426, col. 474) and, in more detail, in his reply to "The [British Medical Association's] Negotiating Committee's Case", published in the supplement to the *British Medical Journal* (BMJ), 20/12/47, p. 155.

(35) Bacon A, *Doctors, Patients and the NHS*, 1996, SSP Books, pp. 3/7.

### 3.2 Organisational arrangements

As noted above, the NHS as enacted in 1946 comprised three main services - the FPS, the local authority health services (or personal health services as they were sometimes called), and the hospital and specialist services.

In respect of the FPS, new public bodies, executive councils (ECs), were created under the Act and were fully accountable to the Minister of Health. The ECs were responsible for making arrangements for the provision of services with those GPs in their areas who wished to work full or part-time within the NHS, on terms negotiated nationally, and then for administering those arrangements. The ECs had broadly similar responsibilities in respect of dental, ophthalmic and pharmaceutical services.

The hospital and specialist services were created by the nationalisation of hospitals previously managed by local authorities and voluntary bodies, and placing them under the management of new public bodies. These were hospital management committees (HMCs) and, for teaching hospitals, boards of governors (BGs), both fully accountable to the Minister, in the case of HMC hospitals through regional hospital boards (RHBs).

The BGs and RHBs were responsible for employing specialists and consultants, who had the right to undertake private practice if they wished. The 1946 Act enabled provision to be made for hospital doctors to see their private patients in what became commonly referred to as "pay beds" within NHS hospitals (36). This arrangement was enacted because the Labour Government saw it as necessary in order to attract doctors to the Service (37).

(36) NHS Act 1946, s. 5(2).

(37) Commons Hansard, 30/4/46, vol. 422, col. 57.

The local health authority services were provided by the county and county borough councils. Unlike the executive councils and the public bodies responsible for hospitals, the local authorities were not the Minister of Health's agents, and were accountable to the Minister only in respect of those matters specified in the 1946 Act, principally the approval of their plans for services.

Arrangements for financing the Service were consistent with decisions about basic principles and structure. The services that were the direct and full responsibility of the Minister of Health, the FPS and hospital service, were funded "by moneys provided by Parliament" (38), in practice principally from general taxation, with a contribution from the national insurance fund (often referred to as the NHS Contribution). The services provided by local authorities were funded from local taxes (rates) and central government grant.

No significant changes were made in the main organisational arrangements of the Service between 1946 and 1964, except for the enactment of additional powers to extend the range of charges that could be imposed, referred to above.

In summary, the main organisational arrangements enacted in 1946, and extant in 1964 consisted of separate administrative arrangements for each of the three main categories of health service (collectively often referred to as the tripartite structure), two within central government and fully accountable to the Minister of Health, the third part of local government and accountable to the Minister only so far as provided by statute. The Service was funded largely through taxation, both national and local.

(38) NHS Act 1946, s. 52(1).

#### 4. CONSERVATIVE POLICY ON THE FORM OF THE NHS TO 1964

##### 4.1 The Party in Opposition, 1945-1951

The basic principles of the NHS proposed by the Labour Government in 1946 were essentially those set out in the wartime coalition Government's 1944 White Paper (39), and carried forward by the 1945 caretaker Conservative Government into its own unpublished White Paper (40). Conservative frontbench spokesmen were thus able to support the basic purpose of the NHS Bill 1946 (41).

On organisational arrangements, however, there were "two fundamental principles" (42) which led the Conservatives to vote against the Bill on Second and Third Readings (43).

The first such principle was concern that the Labour Government's proposals for remunerating GPs would introduce a salaried GP service, which the Conservatives believed would undermine the traditional doctor/patient relationship. The second was in respect of the organisational arrangements proposed for the hospital and specialist services, namely the nationalisation of the local authority and voluntary hospitals and their incorporation under public bodies fully accountable to the Minister of Health. The reasons for opposition were what was seen as the adverse impact on "voluntary effort and association" and local government, and the extent of authority and patronage (through appointments to the new public bodies) given to the Minister (44).

(39) *A National Health Service*, Cmd. 6502, 1944, London, HMSO, p. 47.

(40) *Progress with the Proposals for a National Health Service*, Public Records Office (PRO) CAB 66/66.

(41) for example, Second Reading speeches by Richard Law, Henry Willink and JSC Reid, all in Commons Hansard vol. 422, cols. 66/7, 224 and 385 respectively.

(42) Commons Hansard, vol. 422, col. 69.

(43) *ibid.*, vol. 422, col. 408, and vol. 426, col. 476.

(44) Commons Hansard, vol. 426, col. 400.

Despite sustained Conservative opposition, the size of Labour's parliamentary majority meant that the Bill could be enacted and the controversial arrangements for the hospital service implemented.

During the period from the enactment of the Bill to the 1950 general election, however, the Conservatives came to accept not just the basic principles of the NHS, but the organisational arrangements as enacted in 1946.

This was partly because concern about the first "fundamental principle" was largely met by the NHS (Amendment) Act 1949, which provided that a salaried GP service could not be introduced by regulation, but only through new primary legislation (45).

There was, however, no parallel amending legislation addressing the Party's concerns on the second "fundamental principle", the organisation of the hospital and specialist services. Here, the Party had to decide whether to accept the position enacted in 1946 or commit itself to change.

A Conservative Research Department (CRD) memorandum prepared in March 1949 by Iain Macleod (46) and drawn upon in the preparation of the Party's statement of overall policy, *The Right Road for Britain*, issued in July 1949, referred to the need to "decide whether we intend to return any, and if so which, hospitals to voluntary effort". The memorandum contained no reference to the possibility of returning to local authorities responsibility for the hospitals they had managed (47).

(45) NHS (Amendment) Act, s. 10.

(46) Macleod went on to become a Conservative MP and hold a range of ministerial appointments, including that of Minister of Health from May 1952 to December 1955 (Webster, 1996, p. 778).

(47) *Statement of Social Services Policy*, Conservative Party Archive (CPA) CRD 2/29/2.

As Harriet Jones has evidenced, there were those on what she has referred to as "the liberal wing" of the Conservative Party who favoured denationalisation (48). However, *The Right Road for Britain* included a commitment only to reconsider the cases of voluntary hospitals nationalised against their wishes. Like the CRD memorandum, *The Right Road for Britain* made no reference to denationalising the former local authority hospitals (49). The commitment in respect of the voluntary hospitals was not, however, carried into the 1950 general election manifesto (50).

Early in 1951 an enquiry into the NHS was undertaken for the Party's parliamentary Health Policy Committee. The majority view was that "a further major reorganisation could not be justified now", and that only when local government was reorganised would there be "a suitable opportunity to review the present administrative structure of the Hospital Service" (51).

- (48) Jones H, *The Conservative Party and the Welfare State*, PhD thesis, 1992, London University, pp. 159/60, especially footnote 274.
- (49) reprinted in *Conservatism 1945-50*, 1950, London, Conservative Political Centre, p. 209.
- (50) Craig F, *British General Election Manifestos 1900-1974*, 1975, London, Macmillan, p. 148.
- (51) paper ACP/51/10, CPA CRD 4/7/19.

The majority view commended itself to the ACP (52) which, at its meeting on 18 April 1951, agreed that "the whole re-organisation of the Hospital Service was dependent on its being incorporated into the local government structure, but this in turn was dependent on the long-overdue reform of local government boundaries and functions" (53). Not surprisingly, therefore, the 1951 general election manifesto, like that for 1950, implicitly accepted the form of the NHS enacted in 1946.

How is this acceptance to be understood? One possibility would be to see it as part of an overall shift resulting from the Party's policy reviews of the period 1947-50, particularly associated with RA Butler in his capacity as Chairman both of the CRD and the ACP.

(52) The ACP had been established in 1950, and included the Chairman and Deputy Chairman of the Party, representatives of the Lords, Commons and Executive Committee of the National Union, the Director of the CRD, and co-opted members. As its name implies, the ACP was "not a policy-making body", but rather a high level forum where the leadership could explore issues with people from all the key elements of the Party, Barnes J and Cockett R, "The Making of Party Policy", in Seldon A and Ball S, 1994, p. 366.

(53) ACP(51)7th meeting minutes, CPA ACP 2/1.

Some have seen these reviews (especially that resulting in the *Industrial Charter* (54)), as having led to substantial change from the Party's policy stance in 1945. This change is said, for example, to have "placed the Conservative Party back on the middle course in politics, away from the political fringe where it had seemed to be since Beveridge" (55) and provided the basis for "modern "One Nation" Conservatism" (56). More specifically, Butler in leading the reviews and securing the Party's acceptance of their products is said to have "cut the Party afloat from its 1930s unemployment moorings ... [and] had brought it to accept the concept of the Welfare State" (57).

From this perspective the virtual acceptance of the NHS as enacted in 1946 in *The Right Road for Britain*; the not carrying through to the 1950 general election manifesto of the possibility of denationalising some of the former voluntary hospitals; the view of the ACP on the 1951 enquiry report; and the lack of any reference to changing the NHS's structure or financial arrangements in the 1951 general election manifesto, could all be seen as of a piece, reflecting a new, middle ground Conservative Party.

However, this interpretation turns on whether there was indeed a significant shift in overall policy stance as a result of the policy reviews, marked by the publication of documents such as the *Industrial Charter* and *The Right Road for Britain*.

(54) 1947, London, Conservative Central Office.

(55) Ramsden J, *The Making of Conservative Party Policy*, 1980, London, Longman, p. 111.

(56) Heath E, *The Course of My Life*, 1998, London, Hodder and Stoughton, p. 128.

(57) Howard A, *RAB*, 1987, London, Cape, p. 176.

While regarding the new policy documents as significant ("comparable politically to the Crystal Palace and Manchester speeches of Disraeli in 1872" (58)), Blake and others have taken the view that the major shift in the Party's policy orientation came during the Second World War, expressed formally in, for example, the 1944 coalition White Papers on *Employment Policy*, *Social Insurance* and *A National Health Service* (59).

For these White Papers seemingly committed the major political parties to a substantial extension of the role of government after the war. And an examination of the Conservative manifesto for the 1945 general election, with its word-for-word inclusion of the wartime coalition Government's commitment to accept, after the war, as one of its "primary aims and responsibilities the maintenance of a high and stable level of employment" (60); its undertaking "... to pass into law and bring into action as soon as we can a nation-wide and compulsory scheme of National Insurance based on the plan announced ... in 1944" (61); and its commitment to the creation of a "comprehensive health service" (62), suggests that the Party leadership indeed intended to accept a substantial increase in the role of government.

(58) Blake R, *The Conservative Party from Peel to Thatcher*, 1985, London, Fontana, p. 259

(59) *Employment Policy*, Cmd. 6527, 1944; *Social Insurance*, Parts I and II, Cmds. 6550 and 6551; and Cmd. 6502, all 1944, London, HMSO.

(60) Cmd. 6527, p. 3 cf. the manifesto, Craig, 1975, p. 115.

(61) the manifesto, Craig, 1975, p. 117.

(62) *ibid.*, p. 118.

Blake has suggested that the Party's defeat in the 1945 general election was due not to its policies but to lack of credibility: "people did not believe that the Conservatives meant what they said" (63), and indeed there have been suggestions of ambivalence among Conservatives (64). If, in the aftermath of electoral defeat, the Party leadership had itself reached the view Blake was later to express, the policy reviews could be seen more as attempts to build credibility rather than develop new policies, which in turn could make understandable the continuities that, for example, Lindsay and Harrington and Ramsden have noted between the 1944 White Papers and the 1945 manifesto, and subsequent policy documents (65).

Within the CRD there was certainly concern, as late as 1949, that the Party was not yet credible on the NHS. In his March 1949 memorandum referred to above, Macleod commented that "no single accusation is doing us more harm at the moment than that we are against the health service", presumably in part because of the votes against the Second and Third Readings of the NHS Bill more than two and a half years earlier. He repeated this view in a memorandum to the Director of the CRD, David Clarke, in the Autumn (66).

(63) Blake, 1985, p. 254.

(64) for example, Lowe has noted that during the general election the Party "temporarily played down" their commitment to the maintenance of full employment, perhaps because of "an undercurrent of feeling within the Party that the threat, or even the reality, of unemployment was necessary to ensure industrial discipline and wage restraint". Lowe R, *The Welfare State in Britain since 1945*, 2nd ed., 1999, London, Macmillan, p. 109.

(65) Lindsay T and Harrington M, *The Conservative Party 1918-1970*, 1974, London, Macmillan, pp. 154 and 156; Ramsden J, *The Age of Churchill and Eden, 1940-1957*, 1995, London, Longman, p. 152.

(66) CPA CRD 2/29/2, p. 11 (the March memorandum); Shepherd R, *Iain Macleod*, 1995, London, Pimlico, p. 51 (the Autumn memorandum).

If Macleod's judgement was right, in a context where the Party was seeking to establish credibility in respect of its commitment to the policies it had included in its 1945 general election manifesto, placing before the electorate proposals that could have been construed as dismantling aspects of the now established NHS could well have seemed potentially counter-productive.

Probably, therefore, within the broad context of trying to secure credibility for what has been referred to as "the postwar settlement" (67), and in part because of the reassurance it found in the passage of the NHS Amendment Act 1949, "the two fundamental principles which ... divide us" seemed of markedly less concern within the Party in 1950 than they had in 1946. To avoid providing any further basis for public belief that the Conservatives were "against the health service", the Party leadership decided to accept the structure and financing arrangements enacted in 1946.

(67) for example by Shepherd, 1995, p. 79.

## 4.2. The Party in Government, 1951 to 1964

As noted above, in the 1944 White Papers and its 1945 general election manifesto, the Conservative Party committed itself to significant extensions of the role of government. These commitments were carried through into the 1950 general election manifesto, in which the Party stated that it regarded "the maintenance of full employment as the first aim of a Conservative Government", and undertook to "give a solid base of social security below which none shall fall ... [and] to maintain and improve the Health Service" (68). The commitments seem to have been carried through from the 1950 manifesto to the much shorter one for the 1951 general election, though the references there were very brief (69).

The enthusiasm with which individual Conservatives embraced these commitments varied, and some within the Party opposed the extension of the role of government that they implied (70). It remained to be seen how strongly, and for how long, future Conservative Governments would remain attached to the commitments. The Labour Party regarded it as worth raising doubts about these matters at the 1950 and 1951 general elections (71).

(68) Craig, 1975, pp. 142, 146 and 148.

(69) *ibid.*, p. 170.

(70) for example, Richard Law, whose *Return from Utopia*, published in 1950 (London, Faber and Faber), has been described as "the gospel of post-war liberal [ie anti-interventionist] Conservatism" (Cockett R, *Thinking the Unthinkable*, 1994, London, HarperCollins, p. 98).

(71) Craig, 1975, pp. 154 and 158 (1950 general election manifesto) and pp. 174 and 176 (1951 manifesto).

In the event, it is clear that the commitment to the maintenance of full employment was, in broad terms, sustained by successive Conservative Governments over thirteen years from 1951 (72). Similarly, although "major changes to social security" were made, "their net result was to extend rather than contract the role of government" (73). The Conservative leadership regarded such changes as "important improvements in the ... social security system ... framed twenty years ago" (74).

As regards the NHS, Jones has commented that "it would be misleading to speak of a Conservative "consensus" in favour of the NHS" between 1951 and 1954 (75), reflecting the range of views among Conservative MPs noted above. However, this lack of consensus was not much in evidence in the actions of the Conservative Government. According to Seldon, in 1951 "senior officials at the ... Ministry of Health did not as a whole feel that the incoming ... [Conservative] Government would make major changes" (76). If this was the official view, it proved to be correct, not just in the lifetime of the Government elected in 1951, but throughout the period to 1964.

(72) full employment as a policy objective featured in the Party's 1955, 1959 and 1964 general election manifestos (Craig, 1975, pp. 191 (1955), 215 (1959) and 242 (1964)). As to successive Governments' willingness to intervene to prevent unemployment rising see, for example, Brittan S, *Steering the Economy*, 1971, London, Penguin, pp. 187/290, where several interventions are noted.

(73) Lowe R, "The Replanning of the Welfare State, 1957-1964", in Francis M and Zweiniger-Bargielowska I (eds.), *The Conservatives and British Society 1880-1990*, 1996, Cardiff, University of Wales Press, p. 259.

(74) Craig, 1975, p. 250.

(75) Jones, 1992, p. 331.

(76) Seldon A, *Churchill's Indian Summer*, 1981, London, Hodder and Stoughton, p. 262.

After the 1951 general election Henry Crookshank was appointed Minister of Health, but was replaced by Macleod in a ministerial reshuffle after barely six months in the post. In Shepherd's view, Macleod "concentrated on the overriding political objective ... [of] enlightened Toryism - namely ensuring that the Conservative Party continued to be committed to the postwar settlement" (77). Specifically, this meant "trying to consolidate the NHS", rather than modify it in any substantial way (78). Macleod's five Conservative successors to 1964 (79) in practice adopted much the same approach.

From 1952 to 1964 expenditure on the NHS increased in real terms every year (80). Several initiatives to improve aspects of the Service were announced, which received broad support both politically and among NHS staff (81). It is evident from successive general election manifestos that the Conservative leadership saw advantage in highlighting growth within the NHS (particularly new hospital building), and plans for further improvements (82).

(77) Shepherd, 1995, p. 79.

(78) *ibid.*, p. 80.

(79) Robert Turton, Dennis Vosper, Derek Walker-Smith, Enoch Powell and Anthony Barber (Webster, 1996, p. 778)

(80) Cmnd 7615, 1979, pp. 432/3.

(81) for example, the policy of a shift to community-based care for the mentally ill announced in 1959 (*Mental Health Services*, HM(59)46, London, Ministry of Health); and the hospital building programme announced in 1962 (*The Hospital Plan for England and Wales*, Cmnd. 1604, London, HMSO).

(82) Craig, 1975, pp. 198 (1955 manifesto); 219 (1959); and 252 (1964).

In terms of the form of the NHS, while proposals were considered that would have modified two of the basic principles of the Service (83), they were not implemented. Nor were any significant changes made in organisational arrangements, despite the fact that some within the Party continued to take the view that the hospitals should be placed under local government (84).

Overall, despite regular examinations of the Service, including one as part of what has been described as "a comprehensive reappraisal of welfare policy" undertaken in the early 1960s (85), and ample opportunity to seek to make changes, Conservative Governments sustained the NHS essentially in the same form as it had been enacted. The manifesto for the 1964 general election referred to "continuously expanding health services", indicated how further improvements would be achieved, and made no reference to changing the form of the Service (86).

(83) the abolition of the dental service (Webster, 1996, p. 48), and the right of overseas visitors to free use (Webster, 1988, pp. 189 and 213). The former, if enacted, would have reduced the NHS's comprehensiveness, while the latter would have modified the principle that the Service was available to all British residents.

(84) for example, discussion at the ACP meeting on 12/2/54 (ACP(54)17th, CPA ACP 2/1) and at the Party Chairman's Policy Study Group on 24/6/58 (minutes of eighteenth meeting, CPA CRD 2/53/28).

(85) Lowe R, in Francis and Zweiniger-Bargielowska, 1996, p. 264.

(86) Craig, 1975, p. 252.

Quite apart from any general wish to demonstrate continuing commitment to the postwar settlement, two particular factors seem likely to be relevant to understanding this lack of change in the form of the Service to 1964, or proposals for change in the 1964 general election manifesto.

First, from the outset some Conservatives suspected that the NHS was inefficient. For example, enquiries set up by the Party's parliamentary Health Policy Committee in 1950 and 1952 both had as part of their terms of reference to "consider what changes ... should be made with a view to increasing the efficiency of the Service" (87). In both cases, however, little potential for real improvement in efficiency was identified (89).

These backbench enquiries were followed by one established by the Conservative Government in 1953 to examine the cost and efficiency of the NHS. This enquiry, by a Committee chaired by Claude Guillebaud, an economist, reported in January 1956 that in its view, "the Service's record of performance since [1948] has been one of real achievement" and that "any charge that there has been widespread extravagance ... is not borne out by our evidence" (89).

(87) *The National Health Service*, ACP/51/10 and *National Health Service*, PMC(53)8, reports of enquiries established in 1950 and 1952, both CPA, CRD 4/7/19.

(88) the 1950 enquiry identified a possible £0.75m saving by placing the ambulance service under the hospital service (ACP/51/10, 1951, para. 89 ("Plan 1")). The 1952 report included additional recommendations, such as that hospital authorities should to invite competitive tenders for the supply of goods, without quantifying the savings expected as a result (PMC(53)8, 1953. The reference to competitive tendering is in para. 26.)

(89) *Report of the Committee of Enquiry into the Cost of the National Health Service*, [the Guillebaud Committee], Cmd. 9663, 1956, London, HMSO, p. 269.

Although the report came in for some criticism within Conservative and official circles (90), its verdict on the NHS, following the two Health Policy Committee enquiries, provided no obvious basis for making any significant change in its organisational arrangements.

Second, Conservative politicians were clear that the NHS was popular. As early as December 1948 within the CRD Macleod was advising that "there can be little doubt that the [NHS] scheme on the whole is immensely popular with the majority of patients" (91). This belief in the Service's popularity was sustained. Shortly after the Party lost office in 1964 this popularity was judged by Enoch Powell (92) to be such that "the very contemplation of denationalising it [in his view the only change worth making] is enough to daunt the stoutest political heart" (93). Any proposal to make significant change to the NHS was thus regarded as having potential electoral risk.

#### 4.3 The position in 1964

The starting position for this thesis is thus that throughout the period in office 1951 to 1964, the Conservative Party remained committed to the main objectives of the 1944 White Papers. With regard to the NHS specifically, the Party's position remained what it had been from 1950 - acceptance both of the basic principles and organisational arrangements enacted in 1946.

(90) for some contemporary reactions, see Webster, 1988, pp. 210/1, and Jones, 1992, pp. 328/9. The CRD regarded the report as having "some serious gaps", *The Guillebaud Report on the National Health Service*, 14/2/56, PMC(56)1, CPA CRD 4/7/19.

(91) 13/12/48, CPA CRD 2/27/10.

(92) Powell was Minister of Health from July 1960 to October 1963 (Webster, 1996, p. 778), and in 1966 published *A New Look at Medicine and Politics* (London, Pitman Medical).

(93) Powell, 1966, p. 67.

1. THE 1964 GENERAL ELECTION AND ITS AFTERMATH

At the general election on 15 October 1964 the Conservatives won 304 seats in the new House of Commons, compared with Labour's 317 and overall majority of four (1). Thus, five years after achieving an overall majority of one hundred, the Party had lost office.

This reversal of political fortune had not been a surprise to the Conservative leadership, some of whom drew consolation from the narrow margin of defeat (2), but it was naturally followed by reflection and, in time, some expression of dissatisfaction (3).

Some leading Conservatives took the view that the fact that the Party had been in office for thirteen years was itself an explanation of the defeat. For example, Douglas-Home apparently believed that "thirteen years were too much of a drag" (4), while Edward Heath, the newly appointed Chairman of the ACP, told members that "after 13 years in office time is not on your side (5).

(1) Butler D and King A, *The British General Election of 1964*, 1965, London, Macmillan, p. 289.

(2) for example, Douglas-Home/Dame Barbara Brooke, quoted in Ramsden J, *The Winds of Change*, 1996, London, Longman, p. 230, and Edward Heath at ACP meeting 2/12/64, ACP(64)61st, CPA ACP 2/2.

(3) for examples of the "broad dissatisfaction" at constituency level see Ramsden, 1996, p. 231.

(4) quoted *ibid.*, p. 230.

(5) ACP(64)61st, CPA ACP 2/2.

Within these rather imprecise views seems to have been the a sense that, despite what Heath was later to refer to as "the few modernising reforms ... carried through in recent years" (6), insufficient attention had been given to bringing other aspects of Party policy up to date.

To address this concern, a fortnight after losing office Douglas-Home announced that Heath would take charge of reviewing policy (7). Heath had been the Secretary of State for Industry, Trade and Regional Development prior to the general election, and responsible for initiating the legislation which abolished resale price maintenance, one of the "few modernising reforms" that had been implemented (8).

### 1.1 The review of Party policy

On 2 December 1964, at the ACP's first meeting since the general election and his first as its Chairman, Heath spoke of the need to "tackle the problems of policy which had emerged", and he identified five as requiring "urgent attention". These were "our future economic policy in the broadest sense", "the place of Britain in the world", "the future of the National Insurance Scheme", "the availability and price of land" and "the place of the trade unions in our economy and society" (9). Heath proposed that "some 20 policy groups" be established to carry out the policy reviews (10).

(6) Heath, 1998, p. 267.

(7) *Times*, 29/10/64, p. 12, col. f.

(8) on the abolition of resale price maintenance see, for example, Heath, 1998, pp. 258/264.

(9) ACP(64)61st, CPA ACP 2/2.

(10) *ibid.*

With Labour's small parliamentary majority, Heath emphasised the urgency of the policy review work at the next ACP meeting on 3 February 1965. It was hoped that the various groups would produce interim conclusions by the end of June, so they would be available for an Autumn general election (11).

At this stage the NHS was not seen as requiring policy attention. This may have been because, as noted in the Introduction, in government the Conservatives had seen no need for changes in its form, re-enforced by the fact that the NHS seems not to have been a significant issue during the election campaign (12).

At its meeting on 4 March, however, the ACP discussed a paper by Lord Chelmer, Chairman of the Party's National Executive Committee, which (among many other issues) questioned whether the NHS should remain a scheme available without regard to the individual's ability to pay for the services received. Responding to discussion, Heath said that, although it had not originally been intended to have a group on the NHS, he had arranged for a sub-group of the National Insurance Policy Group to be established, to "look at the whole of the health service" (13). Thus the NHS became part of the programme of policy reviews.

(11) ACP(65)62nd, CPA ACP 2/2.

(12) an analysis of the "issues" of the 1964 election campaign has noted some discussion over Labour's proposal to abolish prescription charges, without suggesting it was a significant issue. Butler and King, 1965, pp. 128/145.

(13) ACP(65)62nd, CPA ACP 2/2.

## 1.2 The Health Policy Group

After the general election Sir Keith Joseph, who had been Minister of Housing and Local Government from 1962, was appointed to the Leader's Consultative Committee (LCC), often referred to as the Shadow Cabinet, with responsibility for policy on labour and social services matters, assisted on health matters by Richard Wood (14). In this capacity, Joseph was appointed to chair the National Insurance Policy Group, and later its Health Policy Sub-group (generally referred to as the Health Policy Group (HPG).)

Heath personally oversaw the composition of policy groups, and in April Joseph secured his agreement to the HPG's membership (15).

In addition to Joseph and Wood, the HPG initially included nine MPs, including two former Ministers of Health (Anthony Barber, 1963/4 and Robert Turton, 1955/7), and two junior health ministers (Bernard Braine, 1962/4 and Sir John Vaughan-Morgan, 1957). The others were Lord Balniel, Paul Dean, Geoffrey Howe, David Mitchell, and Margaret Thatcher (16). The HPG also included four non-parliamentarians: two academics, Professor Jack Wiseman and Mrs Barbara Shenfield; GAC Hamilton, a management consultant, and Dr Lawrence Payne, a specialist in applying automation to medicine (17). Initially, therefore, the HPG did not include a member of any of the health professions.

(14) *Times*, 29/10/64, p. 12, col. f.

(15) Joseph/Heath 13/4/65, Heath/Joseph 26/4/65, CPA CRD 4/7/16.

(16) Balniel and Howe subsequently became LCC spokesmen on social services. All five achieved ministerial, and in Thatcher's case prime ministerial, status subsequently.

(17) CPA CRD 4/7/16.

As noted in the Introduction, financing the Service had been a regular concern to successive Conservative Governments from 1951, though no major changes were made to the arrangements established by the 1946 Act. Given the continuing nature of the concern, however, it was understandable that financing, and the related issue of the balance between public and private provision, were key elements in both the papers considered at the first meeting of the HPG on 1 June 1965. The first, a position paper by the CRD, also focused on the structure of the NHS (18). The second, by Wiseman, an economist, suggested how some NHS services might be provided on an insurance basis (19).

After a "wide ranging discussion" it was agreed that sub-committees should be set up to examine the relationship between public and private provision, and the Service's structure, to be chaired by Joseph and Wood respectively (20).

As noted earlier, Heath was looking for material from the policy groups for inclusion in the manifesto for a possible Autumn election. Despite the HPG's late start compared with other policy groups, draft manifesto items on NHS finance and structure had been prepared by the first week of July (21). Their intended purpose was, however, overtaken in the short term by broader political events.

(18) *The National Health Service*, PG/13a/65/1, CPA CRD 4/7/15.

(19) PG/13a/65/4, CPA CRD 4/7/15. The paper was given originally to an Acton Society Trust (AST) colloquium and published in *Buying Better Health*, 1962, AST, London. (The AST was an independent body concerned with "social research ... [with] one unifying theme - the relationship of *the individual* to the impersonal forces of modern society, *The Acton Society Trust*, 1965, London, AST, p. 1.)

(20) minutes, PG/13a/65/5, CPA CRD 4/7/15.

(21) papers *Health Service Finance*, PG/13a/65/8, and *Organisation and Structure of the Health Service*, PG/13a/65/7, both CPA, CRD 4/7/15.

### 1.3 The change of Party leadership

Douglas-Home's appointment to succeed Harold Macmillan as Prime Minister in October 1963 had been controversial within the Party (22), and shortly after the 1964 general election Douglas-Home had announced a review of the arrangements by which future Party leaders would be selected (23). This resulted in the adoption of a scheme of election by Conservative MPs (24).

Given the Labour Government's small overall majority in the Commons, an Autumn 1965 general election had been thought possible. The likelihood was, however, greatly diminished by Prime Minister Harold Wilson's "categorical assurance" on 26 June that he did not intend to seek a dissolution in 1965 (25).

Since the general election there had been some discontent among Conservative MPs with Douglas-Home's performance as Leader. Wilson's announcement made it possible for those who were discontented to consider challenging Douglas-Home's position, relatively safe from concern that a general election might be called while the Party was in the midst of a leadership election. In the light of continuing discontent and speculation about the leadership, on 22 July Douglas-Home announced that he was resigning (26) and so triggered the first election under the new procedure.

(22) see, for example, the account in Ramsden, 1996, pp. 196/214.

(23) *Times*, 7/11/64, p. 6., col. a.

(24) *Times*, 26/2/65, p. 12., col. a.

(25) *Times*, 28/6/65, p. 6, col. f.

(26) *Times*, 23/7/65, p. 12, col. a.

There were two main candidates: Heath who had been appointed shadow Chancellor in a re-shuffle in February (27), in addition to his role in respect of future policy, and Reginald Maudling, the shadow Foreign Secretary. Enoch Powell also stood.

Heath secured an overall majority of the votes cast in the first ballot on 27 July, though not the 15% lead required by the new procedure. However, Maudling withdrew rather than exercise his right to contest a second ballot, later writing that "the Party had spoken" (28).

Commentators have suggested that Heath's success against a man of wider ministerial experience may have been due to admiration among backbenchers at the way he led the opposition to the Government's Finance Bill, and to a perception that he was the more wholly-heartedly committed to politics. (After the 1964 election Maudling had taken on a number of directorships of private sector companies, which may have caused some to question the extent of his continuing commitment to politics (29).)

As far as future Party policy was concerned, the effect of the leadership change, and Heath's retention of the chairmanship of the ACP, was to strengthen the drive for new policies through the approach he had initiated in the previous December. And there was no diminution in the urgency of the work for, despite the fact that there seemed no longer to be a need to prepare a manifesto for an Autumn election, Heath made it clear that he intended to publish a substantial policy statement before the next Party conference in October.

(27) *Times*, 17/2/65, p. 12, col, e.

(28) Maudling R, *Memoirs*, 1978, London, Sidgwick & Jackson, p. 136.

(29) Ramsden, 1996, p. 237; Blake, 1985, p. 298.

## 2. HEALTH POLICY DEVELOPMENT PRIOR TO THE 1966 GENERAL ELECTION

Discussion within the HPG during 1965 covered a wide range of issues outside the scope of this thesis, including health screening, the handling of complaints against hospitals, waiting lists, rehabilitation and the future of general practice, some of which were included in a draft *Health Working Paper* by Joseph, dated 19 November (30).

The matters given most attention (as judged from the meeting minutes) were, however, financing and structure, (31), both central to the form of the NHS as discussed in the Introduction. The following sections trace policy discussions of these issues through to the 1966 general election.

### 2.1 Financing the NHS

As noted in the Introduction, the financing of the NHS was a continual source of concern to Conservative Governments from 1951. During thirteen years in office, however, despite having considered more radical options, the Party had only widened the range of charges, the path for which had been paved politically by the previous Labour Governments' acceptance of legislation permitting prescription charges and introduction of charges for dentures and spectacles.

(30) PG/13a/65/10, CPA CRD 4/7/15.

(31) PG/13a/65/12, CPA CRD 4/7/15.

The CRD position paper considered at the HPG's first meeting on 1 June 1965 posed three questions. Should the Party adopt a policy of re-instating prescription charges, abolished by the Labour Government with effect from 1 February 1965? Should the NHS Contribution be increased? And, the most radical, should the family doctor service "be taken right out of the NHS altogether and placed on an insurance basis"? (32), an issue that had been considered by a high level officer committee, the Policy Committee on the Future of the Social Services (PCFSS), in its interim report in April 1961, without any major proposal for change resulting (33).

Also available was the paper by Wiseman referred to above, which suggested how aspects of the NHS could be moved to an insurance basis, with compulsory minimum provision arranged either through an actuarially sound government scheme or private insurers, at the individual's preference (34).

The minutes of the HPG meeting indicate that there was some support for a strategy to expand the private sector from 5% to 15% of total health provision, and for considering putting the family doctor service on an insurance basis. Concerns were, however, expressed about the development of two standards of service, with better services available to those able to pay more. A sub-committee under Joseph was charged with considering the relationship between public and private provision (35).

(32) PG/13a/65/1, CPA CRD 4/7/15, pp. 6/9.

(33) The PCFSS was chaired by Sir Michael Fraser, then CRD Director, and included two future Directors (Brendon Sewill and James Douglas). It met 65 times over three years. A copy of its interim report, PCFSS/61/86, is in the CPA, ACP 3/8.

(34) PG/13a/65/4, CPA CRD 4/7/15.

(35) PG/13a/65/5, CPA CRD 4/7/15.

It proved impracticable for Joseph's sub-committee to meet. Instead, he circulated a paper on finance solely in his name that he described as "deliberately provocative". In it he was sceptical about radical change (36).

In respect of the hospital service, Joseph regarded a charge on in-patients for board, considered but rejected by the Party when in office, as likely to be "bitterly unpopular" and "net relatively little". Voluntary insurance, as a way of establishing a substantial private hospital sector, "hasn't a chance", even if government offered a tax concession on premiums. If, however, the Party "move[d] back ... slightly" from the plan for general hospitals announced by Powell as Minister of Health in 1962 (37), and retained local hospitals, Joseph thought that both capital and revenue for them could be raised locally, including by insurance, leaving the taxpayer to finance a somewhat reduced general hospital programme.

Joseph regarded "a free GP service [as] so hallowed that we cannot move", though he did see "a full-bloodied insurance scheme" as a possible answer if the GPs resigned from the NHS over their remuneration. He favoured the re-introduction of prescription charges, though with new exemptions ("pensioners, children, pregnant mothers and chronic sick") in addition to those than had applied until the charges had been abolished (war pensioners and those in need, defined operationally as receiving National Assistance). He did not support a long standing policy aspiration of many within the Party, that drugs should be made available to private patients on the same basis as NHS patients, because this carried "the serious risk of a net loss of doctors' time for the public service."

(36) PG/13a/65/8, 5/7/65, CPA CRD 4/7/15.

(37) Cmnd. 1604.

Joseph's proposal to restore prescription charges with wider exemptions was not included in the policy document *Putting Britain Right Ahead* published in October (38), though briefing produced for its launch suggested that it had been accepted. (This referred to the £30m a year foregone by the abolition of charges, and the plans being developed by the last Conservative Government to reduce the burden on those who were not in receipt of National Assistance but nevertheless found charges a strain on their resources (39).)

Although Joseph had described his July paper on NHS finance as "deliberately provocative", as noted above it proposed little change, and his caution was evident in correspondence with Arthur Seldon, Editorial Director of the IEA.

The IEA had been established in 1955 as a non-party political research and educational trust "to propagate sound economic thought" (40). Its basic premise was that most matters should be left to the free play of market forces, a view often referred to as economic liberalism. Joseph made contact with the Institute after the 1964 election and "leaned heavily on it for intellectual support and economic data as he developed his own philosophy of economic liberalism during the 1960s" (41).

(38) 1965, London, Conservative Party.

(39) briefing dated 4/10/65, CPA CRD 3/24/2.

(40) Cockett, 1994, pp. 131/2.

(41) *ibid.*, pp. 167/8.

In a letter to Seldon in November 1965, Joseph expressed interest in opening up health care provision to the market "to a limited extent", but saw substantial impediments. Increasing private sector demand would, in the short term "be bound ... to reduce the amount of medical attention to the public" and thus be open to the charge of "robbing the large pre-dominantly less well-off public clientele of irreplaceable doctor and medical man hours in favour of private and generally better-off clientele". The implication was clear. Unless a way could be found of avoiding "political difficulty", Joseph saw it as unrealistic to pursue such a policy (42)

Joseph carried forward his thinking about NHS financing into the draft working paper of 19 November, which served as the agenda for a HPG meeting on 24 November. He suggested that "there may be a case for tempting more people to cover themselves by insurance for private hospital treatment", without setting out the pros and cons. He repeated his view that prescription charges should be re-introduced, with the wider exemptions referred to above, but posed the questions "Is this practicable? Will the doctors co-operate?" (43).

The HPG's membership had been augmented in the Autumn by the inclusion of three recently appointed junior Opposition spokesmen (Charles Longbottom, Arthur Tiley and William van Straubenzee) and Dr Hugh Freeman, a consultant psychiatrist. Despite having its first medical member, the HPG still lacked the expertise to address Joseph's questions about the practicability of the exemptions he proposed, and this seems to have been left over for discussion at a meeting planned with a number of GPs.

(42) Joseph/Seldon, 6/11/65, Hoover Institution (HI), IEA papers, box 333, folder 5.

(43) PG/13a/65/10, CPA CRD 4/7/15.

The HPG did, however, address other issues relating to finance. It judged that expenditure on health should have a higher priority than it had been accorded in the Government's recently published *National Plan* (44), and commissioned work on ways in which the expenditure necessary for this priority might be found. Specifically, enquiries were instigated into "hotel" charges for hospital patients; the potential receipts from state lotteries; and schemes under which patients paid doctors for their treatment but were re-imbursed in whole or part by the government, of the kind the HPG believed to be in operation in New Zealand (45).

The practicality of the prescription charge exemptions proposed by Joseph was discussed at the first of two meetings with the GPs referred to above (46). The GPs seem to have been approached individually because they were known to members of the HPG and regarded as "good opinions". They were generally "sympathetic to the idea of some sort of fee payable by the patient" and saw "no particular difficulties" with the type of exemption proposed (47).

(44) *The National Plan*, Cmnd. 2764, 1965, London, HMSO, p. 179. The Government's proposals provided for an increase of 23.5% in the five year period 1965/6 to 1969/70, a rate of growth slightly below the 25% growth target for national output (Cmnd. 2764, 1965, pp. 1 and 179).

(45) PG/13a/65/12, CPA CRD 4/7/15.

(46) Drs DL Crombie, J Hunt, GS Little, A MacAuslan, A Smith and G Swift. They were not all Conservative supporters. Dr MacAuslan, for example, was Joseph's GP, and remembers being invited despite the fact that Joseph knew that they disagreed on NHS matters (personal communication, 5 May 2000).

(47) note of meeting 19/1/66, Howe papers, white box 24, file 3.

In addition to the meetings with the GPs, there was extensive action to follow up the HPG meeting on 24 November. Papers were circulated on "hotel" charges, the French National Lottery, the situation in New Zealand, and the British United Provident Association (BUPA), a major provider of health insurance and private health care facilities (48).

There seems no evidence that these papers were discussed within the HPG prior to the March general election. It is therefore impossible to assess the Group's reactions to them. However, Wood raised one of the ideas in them, reimbursement of fees (examined in relation to health care arrangements in New Zealand) in a Commons debate. Specifically, he proposed that some family doctors should be "allowed to charge a fee for service, which subsequently could be wholly or partly reclaimed" (49). Kenneth Robinson, the Minister of Health, responded that this was "wholly alien to the whole concept of the National Health Service as we see it" (50).

If the papers circulated following the meeting on 24 November were discussed before the general election, they did not lead to any positive conclusions reflected in the manifesto. The only reference it contained to matters of NHS finance was in respect of prescription charges (51).

(48) PG/13a/65/13 (hotel charges), PG/13a/66/16 (French lottery), PG/13a/66/14, 18 and 19 (New Zealand) and PG/13a/66/15 (BUPA), all CPA CRD 4/7/15.

(49) 3/2/66, Commons Hansard, vol. 723, col. 1387.

(50) *ibid.*, col. 1426.

(51) Craig, 1975, p. 287.

On prescription charges, the response of the GPs consulted on 22 December could only have partially re-assured Joseph that his proposal for wider exemptions was practicable. For during a debate in the Commons on 9 February 1966, he anticipated a future Conservative Government seeing whether it could "evolve practicable methods of exempting all those who could be hurt or deterred" by a re-introduced charge (52).

Joseph noted that removing charges from those able to pay meant less finance for the NHS, and therefore less services, a point to which Heath returned during a debate on social policy a fortnight later. In Heath's view, when faced with a choice between free prescriptions for all, or better services and special arrangements for those who could not afford charges, people would choose the latter (53).

In the event, Joseph quickly put aside his caution about the practicability of introducing wider exemptions. When proposing items for the election manifesto, he wrote that "those who cannot afford [charges] - pensioners, children, expectant and nursing mothers, the disabled, the chronic sick, the low wage earner and his wife - will be exempt", with no caveat about practicability (54). The essence of this definite statement, without qualification about the practicability of the exemptions, was included in the manifesto (55).

(52) Commons Hansard, vol. 724, cols. 470/2.

(53) Commons Hansard, vol. 725, col. 439.

(54) CPA CRD 3/9/33.

(55) Craig, 1975, p. 287.

## 2.2 The structure of the NHS

As noted in the Introduction, the NHS had three main elements - family practitioner, local authority and hospital services - each with its own structure. The Conservatives had opposed aspects of this at the outset but, despite pressure from some within the Party to transfer the hospital service to local government, and increasing concerns about the effectiveness of the tripartite structure, had made no changes during thirteen years in office.

The tripartite structure meant that, at local level, the effective delivery of services to patients often required co-operation and co-ordination by professionals working in each of the three elements. For example, follow-up treatment of an elderly person discharged from hospital (managed by an HMC or BG) often required co-ordination with the family doctor (an independent practitioner in contract with an EC) and the after-care and domestic help services (the responsibility of the local health authority).

The difficulty of achieving effective co-ordination at local level within the tripartite structure had been regularly noted, not least by Conservatives (56). It was again drawn to attention in the report of a Committee established by the British Medical Association (BMA), the Royal Colleges and other medical organisations to inquire into public medical services in the light of ten years' experience of the NHS (57).

(56) for examples, see Webster, 1996, pp. 322/3 and 330/1. Conservative concerns about co-ordination included the 1954 report of the Parliamentary Health sub-committee, CPA CRD 2/30/10, and Joseph K, *The Health Services - The Second Decade*, 1958, London, Conservative Political Centre, pp. 8/9.

(57) *A Review of the Medical Services in Great Britain*, 1962, London, Social Assay, p. 1.

The Committee was chaired by Sir Arthur Porritt, who had been a founding member of the Fellowship for Freedom in Medicine, set up in 1948 to campaign against State control of the medical profession following the establishment the NHS. As a senior member of the profession (58) with this background, he could be expected to lead an inquiry that would be questioning, and command respect among doctors.

The Committee concluded that "basically, the concept of a comprehensive national health service is sound" (59), though the tripartite structure was one of "the major stumbling blocks to a properly co-ordinated service" and could lead to "a loss of economy and efficiency" (60). It recommended the establishment of new statutory bodies, area health boards, to take responsibility for administering all health services in a given area, including the personal health services currently the responsibility of local authorities, but saw "no reason" to transfer to it the local authority welfare services (61).

Powell, Minister of Health when the report was published, wrote to congratulate Porritt, and subsequently met him (62). The evidence suggests, however, that at least as regards the establishment of area health boards, Powell did not find the Committee's recommendations persuasive. For in March 1963, one of his Parliamentary Secretaries, Lord Newton, responding to a House of Lords debate on the Porritt report, and raised a series of questions about the Committee's "central recommendation" for structural change that suggested the Government remained far from convinced that such change was necessary (63).

(58) Porritt was, simultaneously, President of the BMA and the Royal College of Surgeons in the early 1960s.

(59) *A Review of the Medical Services in Great Britain*, 1962, p. 14.

(60) *ibid.*, pp. 18/9.

(61) *ibid.*, pp. 22/4.

(62) Webster, 1996, p. 326.

(63) Lords Hansard, 7/3/63, vol. 247, cols. 606/7.

When Anthony Barber succeeded Powell in October 1963 he seemed no more sympathetic to the Porritt recommendations (64). It was therefore not surprising that the Party's 1964 general election manifesto contained no reference to change in the structure of the NHS. Nor indeed did the Labour Party's manifesto (65).

However, within the Conservative Party not everyone shared the views of Powell and Barber. In 1958 the CRD had referred to the main problems of the NHS in the future being "not its structure but first its priorities and second its financing" (66). By 1963, however, the Director of the CRD and his senior colleagues (meeting as the PCFSS) had concluded that the existing structure had given rise to difficulties, though only "poor communication between the arms of the Service" was specified. To put these right, the PCFSS favoured the alignment of HMC, EC and local health authority boundaries, with a view first to increasing the opportunities for liaison and then to "a gradual unification of the ... structure over the years". The Porritt Committee recommendations were noted as an "imprecise" alternative (67).

Given the high level nature of the PCFSS, it is not surprising that its conclusion that some change was needed to deal with the problem of co-ordination created by the tripartite structure was drawn upon by Charles Bellairs, the CRD officer charged with the task of preparing a position paper for the meeting of the HPG on 1 June 1965.

(64) Barber wrote to Butler as chairman of the CRD criticising the Porritt recommendations. The letter is missing from the CPA file, though there is a summary of its content, CPA CRD 2/29/10.

(65) Craig, 1975, pp. 251/2 (Conservative), p. 266 (Labour).

(66) *Health*, 22/1/58, CPA CRD 2/53/27.

(67) Report of the PCFSS, August 1963, CPA CRD 2/29/10, pp. 37/8 and 51/2.

Bellairs' paper took the Porritt report as its starting point (and the meeting itself followed one earlier in the day that some HPG members had had with Porritt (68)). The paper included variations on the Porritt proposals, for example giving the proposed area health councils (AHCs), (Porritt had called them boards), responsibility for the local authority welfare services (such as home helps and meals on wheels) as well as the personal health services. It also included an alternative approach: the transfer of smaller hospitals to the management of those local authorities with personal health responsibilities, and the alignment of their boundaries with those of the ECs (69).

As noted above, a sub-committee chaired by Wood had been established on issues of structure, which reported on 2 July. In its judgement, the NHS had become "increasingly top heavy and over-centralised", with consequent frustration to doctors and patients and waste of time and money. The sub-committee was clear that reorganisation was necessary. Following examination of the possibilities identified in the CRD paper, members agreed that there should be pilot schemes on Porritt lines, but "failed to agree on the scope and functions of the AHCs" and suggested there might be experiments with different variations within the pilot schemes (70).

(68) manuscript note of meeting in CPA CRD 4/7/19.

(69) *The National Health Service*, paper PG/13a/65/1, CPA CRD 4/7/15.

(70) PG/13a/65/7, CPA CRD 4/7/15.

These ideas - a top heavy and over centralised administrative structure, the consequent need for reorganisation, and the proposal for pilot studies to find a way forward - were largely incorporated into the fourth draft of Heath's proposed statement of Party policy on 21 September (71), and were carried through to the published version, *Putting Britain Right Ahead* (72). However, briefing prepared for use on publication made it clear that the pilots would only include the family practitioner and hospital services. Consideration of merging these with the local authority health (and possibly welfare) services was to await the report of the inquiry into the welfare services, which the Government was known to be planning (73).

Within the HPG, there remained doubts about a policy of reorganisation on Porritt lines. In the draft working paper Joseph prepared for discussion at the third meeting of the Group on 24 November, he posed the question "Porritt Worth Pursuing?", without offering an answer (74).

- (71) *Policy Document 1965 - Putting Britain Right*, LCC(65)44, CPA CRD 3/24/3.  
(72) 1965, pp. 14/5.  
(73) brief dated 4/10/65, CPA CRD 3/24/2. In the event, the inquiry, chaired by Frederic Seebohm, was announced on 20/12/65, Commons Hansard, vol. 722, col. 373.  
(74) PG/13a/65/10, CPA CRD 4/7/15.

HPG members' responses were equally inconclusive. "The majority of members felt that we should go some way towards the Porritt model", and professional opinion was reported to be favourable, but members had concerns about the feasibility of experimentation, the difficulties such an approach would cause local government, and the upheaval that would result from such a reorganisation. It was agreed that the matter would be considered further, after consultation with "medical opinion" (75), in practice this probably meant the group of six GPs referred to above.

In general, the GPs thought that the Porritt approach was the right one and "should be the long-term aim with the way paved by pilot schemes" (76). Following a second meeting with them on 19 January 1966, Joseph prepared a paper on structure for discussion by the HPG, in which he proposed a two stage strategy (77). First, the ECs and bodies responsible for hospitals should be merged into new boards. A requirement would be placed on these new boards to work closely with the local authority health services to "produce and administer a community health plan". Second, as effective co-operation between the new boards and the local health authorities developed, and reform of local government boundaries allowed, the boards and the local health authorities would be amalgamated into new local health boards. (It was not clear whether the local health boards would be bodies like the ECs and HMCs, appointed under the NHS Act and agents of the Minister of Health, or part of local government.)

(75) PG/13a/65/12, CPA CRD 4/7/15.

(76) note of meeting, 22/12/65, Howe papers, white box 24, file 3.

(77) *Health Service*, 26/1/66, Howe papers, white box 24, file 3.

There is no evidence that any further meetings of the HPG were held, and therefore it is likely that Joseph's proposed strategy was not discussed by the Group, though he may have received comments on it from members individually.

Whether or not as a result of colleagues' comments on his proposed strategy, in response to a request for a manifesto contribution Joseph offered a two page note which, on structure, was less specific than his January paper. It proposed bringing the different sectors of the health service "more closely together" and the decentralisation of management within the hospital service, without offering any details as to means (78).

Those within the CRD seem to have had experience of Joseph's contributions. A note by the recently appointed Director, Brendon Sewill, early in February had recorded that Joseph had promised a draft "but no doubt will want to revise it at least a dozen times" (79). Perhaps in the expectation of further versions, or because there was insufficient time to edit Joseph's contribution to the length needed, the first draft of the manifesto circulated after his note included only one short point on the NHS. This was a commitment to improve the Health Service by giving family doctors "closer contact with hospitals and local health and welfare services" (80).

Joseph sought to remedy this on 22 February, by sending Sewill six additional points in brief, "bullet" style, for inclusion with the existing item referred to above. These included the decentralisation of hospital management (81).

(78) draft dated 12/2/66, CPA CRD 3/9/33.

(79) 4/2/66, CPA CRD 3/9/32.

(80) 3rd draft, 18/2/66, CPA CRD 3/9/34.

(81) CPA CRD 3/9/34.

Possibly to support Joseph in securing a place in the manifesto for these points, on the same day Wood sent Sewill what was essentially a shortened version of Joseph's note of 12 February, stating that it had been "discussed and agreed by the "Health and Social Security" frontbenchers and represents what we should like to see in the Manifesto" (82).

The fourth draft of the manifesto, circulated on 23 February, included all six of Joseph's "bullet" points, and was sent for comment to him and Macleod, a former Minister of Health. Macleod thought the reference to giving family doctors closer contact with the other elements of the Service was "meaningless" (83), but at the galley stage of the production of the manifesto that point was retained while all Joseph's "bullet" points were removed. The only other reference to the NHS in the manifesto, published on 6 March (84) was in respect of prescription charges (discussed above).

It is uncertain why Joseph's "bullet" points, including decentralisation of hospital management, were dropped at galley stage. It is known that, while Heath wanted to show that the Conservatives had lots of ideas and were not open to the charge of "running out of steam" after the thirteen years in office, some of his senior colleagues were concerned that there were far too many commitments in the draft manifesto (85). Probably Joseph's points were lost in an effort to balance these two views rather than because of any very considered judgement as to their merits.

(82) CPA CRD 3/9/34.

(83) CPA CRD 3/9/36.

(84) *ibid.* (copy embargoed until 00.01 on 6/3/66).

(85) note of meeting with Heath on 25/2/66 to discuss draft manifesto, CPA CRD 3/9/35.

### 3. THE SITUATION BY THE 1966 GENERAL ELECTION

#### 3.1 Policy development

Apart from the abolition of prescription charges, the Labour Government from October 1964 had proposed no change to the form of the NHS to which the Conservatives had to respond. However, as noted above, the NHS came explicitly into the Party's formal policy review programme.

In terms of policy consideration, there had been some interest in actively encouraging the private sector, and in the possibility of putting the family doctor service on an insurance basis, either of which could have led to a major change in the form of the NHS. There had, however, been insufficient time to develop these ideas before the 1966 general election was called, and in any case Joseph, the key frontbench spokesman, was clearly sceptical about the political viability of such change. The only manifesto commitment on finance, the re-imposition of prescription charges with wider exemptions, was essentially a return to the Party's position when in office.

On the structure of the Service, there was some support for change within the HPG, and in particular interest in the Porritt Committee's proposals. This interest seemed to mark something of a shift in the Party's stance from when it had been in government. In part this may have been attributable to the shift in thinking within the CRD, almost certainly more influential when the Party was in Opposition and shadow ministers lacked advice from civil servants. In part it probably also reflected sensitivity to what seems to have been a growing sense in what might be described as the wider Health Service world that the tripartite structure needed to be unified (86).

(86) Webster, 1996, p. 330.

Whether the commitment to give family doctors closer contact with the hospital and local authority health services was a marker to provide a manifesto basis for a possible policy of structural change, or simply an aspirational statement without any substance (as it seemed to have been regarded by Macleod), is uncertain.

### 3.2 The arrangements for policy review

Up to the 1966 general election, the evidence suggests that the review was concentrated within the HPG. Members drew on a range of written material (including the Porritt report and descriptions of aspects of arrangements in France and New Zealand), but had little direct contact with individuals and organisations knowledgeable about the NHS. Porritt himself, the group of six GPs and Seldon of the IEA were the exceptions. There is no evidence of substantive contact with professional bodies such as the BMA or Royal College of Nursing.

There is little evidence that the HPG's emerging thinking was shared more widely within the Party. Some HPG members were also members of the Party's Parliamentary Health and Social Security Committee (PHSSC), and might be assumed to have kept the Committee informed. Beyond that, there is no clear evidence that the issues the HPG were discussing were put in any way formally to the wider Party - in Parliament or outside. For example, the NHS was barely touched upon at the Party's 1965 Annual Conference.

Overall, therefore, policy review prior to the 1966 general election seems essentially to have involved relatively few within the Party and even fewer "outsiders". In part, at least, this may have been because of the relatively short timescale available due to the parliamentary situation after the 1964 general election.

1. THE 1966 GENERAL ELECTION

The Labour Government elected in 1964 had only a small overall majority, widely expected to prove insufficient for a full parliament. From September 1965, Labour had a 5% or more lead over the Conservatives in public opinion polls, and this seemed to be supported by the result of a by-election in Hull North (1). Against this background Harold Wilson successfully sought a dissolution for a general election to be held on 31 March 1966.

The campaign, in which the NHS does not appear to have featured, seems to have made little difference to the parties' levels of support. Labour secured the support of 5.8% more of the electorate than the Conservatives and increased its overall majority to 96 (2). Commentators seem to agree that Labour's success was due to a widely held sense that it had inherited difficulties, especially in respect of the deficit on the balance of payments, and had had insufficient opportunity to prove its worth in addressing them (3).

(1) Butler D and King A, *The British General Election of 1966*, 1966, London, Macmillan, pp. 3 and 22.

(2) *ibid.*, p. 260.

(3) for example, Ramsden, 1996, pp. 263/4; Blake, 1985, p. 306; Campbell J, *Edward Heath*, 1993, London, Cape, p. 208; Fisher N, *Iain Macleod*, 1973, London, Deutsch, p. 282.

## 1.1 Heath's position

Labour's majority meant that the new Government could expect a full term, which in turn meant that, if it had so chosen, the Conservative Party could have elected a new leader with time to establish his or her position. However, although never very popular among his parliamentary colleagues or the electorate prior to the 1970 election (4), Heath's position was not formally challenged, and he thus had a whole parliament to lead the Party in the direction he favoured.

What was that direction? Shortly after Britain's first application to join the European Economic Community (EEC) had been vetoed in January 1963, Heath made a speech which, in the view of his biographer, Campbell, might have "served as his personal manifesto for the next seven years" (5). The theme was the need for Britain to change if it was to prosper, and among the examples Heath gave were for industry to adopt more efficient practices, and for better industrial relations.

This theme – the need for modernisation – was reflected in further speeches and articles (6). Indeed, Campbell has suggested that, by October 1964, for Heath "'modernisation" had become the supreme goal of politics" (7).

(4) Ramsden, 1996, pp. 245/6; Campbell, 1993, pp. 189, 199/200 and 216 (parliamentary colleagues); Butler D and Pinto-Duschinsky M, *The British General Election of 1970*, 1971, London, Macmillan, p. 64 (electorate).

(5) Campbell, 1993, p. 134.

(6) for example, in his first Commons speech as President of the Board of Trade (14/11/63), during the Second Reading debate on the bill to end resale price maintenance (10/2/64) and in a *Daily Mirror* article (9/10/64), all quoted in Campbell, 1993, pp. 150, 152 and 162.

(7) Campbell, 1993, p. 163.

Heath's advocacy of modernisation may well have been the key consideration in Home's decision to appoint him to oversee the review of policy after the election, an appointment that provided an opportunity to develop a "modernisation" agenda.

When briefing the chairmen of the various policy groups, Heath said that the need was to find "new Conservative solutions to the problems that the electorate are worried about" (8). This emphasis on the new seems to have been reflected in the policy groups' reports. Sewill noted in March 1966 that "efficiency and competition" was one of two themes emerging, and in April he identified several areas where "we could also break our links with the past and build a new framework of policies" (9).

Heath's emphasis on modernisation had been reflected in the 1966 general election manifesto, with its action-oriented style and frequent usage of words such as "reform", "remodel", "new", and "change" (10). It remained a key theme, both in the years in opposition to 1970, and in government.

## 2. POLICY DEVELOPMENT

While Heath regarded much of the modernisation agenda as having been completed by the time of the 1966 general election, there remained important policy gaps. All the pre-election policy groups were wound up, but some were reconstituted - "starting afresh" in Heath's words (11) - to fill those gaps.

(8) Ramsden, 1980, p. 241.

(9) Ramsden J, 1996, p. 257.

(10) Craig, 1975, pp. 282/91.

(11) Heath/Miss Mervyn Pike, 13/5/66, CPA CRD 4/7/16.

Economic policy was seen as the major gap, and Heath reported to the first ACP meeting after the election that he would be chairing "a high level Economic Policy Group" (12). Health policy was another gap. It was palpable that the HPG, established later than most policy groups, had not had time to complete its deliberations, and there was some post-election concern about the adequacy of social services policy as a whole and aspects of health policy in particular. (At the ACP meeting referred to above, for example, the view was expressed that "there was still a great deal more work to be done on the whole of our social service policy, and on prescription charges in particular" (13).)

## 2.1 Responsibilities for reviewing health policy

Prior to the election Joseph had been the principal frontbench spokesman on labour and social services. Afterwards the two portfolios were separated. Joseph was given responsibility for labour, Miss Mervyn Pike for social services (14). This probably reflected the importance of policies in both areas to Heath's strategy - reforming the trade unions and remodelling the welfare state had been two of the five manifesto objectives.

(12) ACP(66)74th, CPA ACP 2/2.

(13) *ibid.*

(14) *Times*, 20/4/66, p. 12, col. b. Pike had been a MP since 1956 and a Home Office minister prior to the 1964 election.

Pike remained social services spokesman for eighteen months, until she "asked to be relieved of her duties for personal and health reasons", and was succeeded by Lord Balniel in October 1967 (15). Later that month Maurice Macmillan was appointed to assist Balniel as spokesman on health matters (16). Both retained their responsibilities until the 1970 general election.

Heath wrote to Pike on 13 May 1966 to invite her to chair a reconstituted HPG. She was requested to discuss the Group's membership with Sir Edward Boyle, vice Chairman of the ACP, whom Heath had asked to appoint policy group members on his behalf and "generally to co-ordinate and supervise the central administration of all policy groups" (17).

Heath made it clear that Pike was not limited to the membership of the pre-election HPG, though he did advise that Joseph wished to remain a member. He also emphasised the importance he attached to policy groups including officers of relevant Party committees, to ensure proper co-ordination between the committees and the groups (18).

On 25 July Boyle invited prospective members to join the reconstituted HPG, stating that the remit was "to consider the National Health Service in all its aspects and to make recommendations as to the lines of its future development" (19).

(15) *Times*, 11/10/67, p. 2, col. c. Balniel had been a MP since 1955 and had an interest in mental health services, being Chairman of the National Association for Mental Health.

(16) *Times*, 31/10/67, p. 4, col. b.

(17) Heath/Pike, 13/5/66, CPA CRD 4/7/16.

(18) *ibid.*

(19) Boyle/prospective members, 25/7/66, CPA CRD 4/7/16.

By mid August the Group had been established. In addition to Pike, the HPG included ten politicians, six of whom (Dean, Howe, Joseph, Longbottom, Thatcher and Turton) had been members of the pre-election HPG. To these were added Miss Harvie Anderson, Macmillan, Lord Windlesham and Marcus Worsley. Two of the five expert advisers continued - Freeman and Shenfield. They were joined by John Cambrook, a lecturer in dental surgery, and Alderman Mrs Wood who had many years experience as an EC and HMC member, and later still, by David Skidmore, a surgeon (20)

The HPG met periodically while Pike was its Chairman, though Barney Hayhoe, a CRD officer (and later a MP and minister) regarded it as one of the more disappointing groups, due to "the recurrent illness of the Chairman ... which has meant that the impetus of the Group has been lost" (21). Thereafter, although nominally extant, the HPG seems never to have met again. According to Hayhoe, Balniel "was reluctant to hold formal meetings of the Group, and in fact it has never met since he became Chairman". However, the HPG's members "are consulted from time to time as appropriate both by the Front Bench spokesmen and by the Research Department" (22).

In practice, therefore, policy thinking on health was carried forward through the reconstituted HPG for the first year or so after the 1966 election, but was then taken forward by Balniel and Macmillan, the frontbench spokesmen, without formal reference to the HPG.

(20) CRD memorandum 24/10/66, CPA CRD 4/7/15 - initial appointments; membership as at 1/12/67, attached to Hayhoe's memorandum to Fraser, 11/3/69, CPA CRD 4/7/16 - Skidmore. (There seems to be no extant written evidence as to why two of the expert advisers continued while three (including Wiseman) did not.)

(21) Hayhoe/Fraser, 11/3/69, CPA CRD 4/7/16.

(22) *ibid.*

## 2.2 The context for the development of health policy

Part of the context for reviewing Party policy on health matters was Heath's modernisation theme, and one of the issues examined during the first year was efficiency, on which the HPG sought advice from Ernest Marples, a former minister invited by Heath to consider ways of modernising the public services (23).

Arguably, however, policies in two other areas contributed more to the context, namely those on public expenditure, being developed by the Economic Policy Group (EPG), and on what was often referred to as selectivity in the social services, a set of issues reviewed by the Working Group on Social Priorities (WGSP). Before describing the development of Party thinking on those aspects of health policy relevant to the form of the NHS, therefore, emerging policies in these two context-setting areas will be considered.

## 2.3 Policy on public expenditure

As part of its consideration of economic policy the EPG examined public expenditure, which a CRD paper suggested was "already too large relative to private spending with the result that taxation is excessively onerous and demand management is extremely difficult" (24).

(23) *Times*, 17/3/67, p. 1, col. b. Marples established a small unit, the Public Sector Research Unit (PSRU), "separate from the Conservative Research Department and report[ing] direct. to Mr Heath and members of the Shadow Cabinet" (ACP(69)58, CPA ACP 3/18), which co-ordinated a range of research projects into ways of improving the performance of the public services, and was instrumental in forging relationships with a number of senior businessmen, several of whom acted as advisers in the first two years of the Heath Government (see chapter 3).

(24) EPG/67/27, p. 2, CPA CRD 3/7/6/2.

This conclusion led to the proposition that overall public expenditure needed to be reduced by "the order of £1,000 million" (25), included in a discussion paper the EPG prepared for a weekend meeting of senior Conservatives at Swinton in September 1967, attended by two members of the HPG, Joseph and Macmillan (26).

The paper suggested that new policies for agriculture and the nationalised industries could be expected to make a substantial contribution to such a reduction. To achieve the rest there needed to be "a major elimination of waste in the public services", and an examination of expenditure asking "whether the service is one which the State alone ... [or] can best provide and whether [it] needs to be provided for all or only for the exceptional cases of need" (27). Effectively, therefore, the EPG was inviting all those responsible for policy areas to consider the government's role in the provision of services, and ways in which services were managed. Both featured in policy thinking on the NHS.

#### **2.4 Selectivity in the social services**

As noted above, one of the five main objectives set out in the 1966 manifesto was to remodel the welfare state. More specifically, remodelling meant "recognising the overriding claims of those most in need" (28), that is, by adopting a more selective approach. The WGSP was established "to clarify the arguments [for selectivity] and to see if we could find a theme valid for all the social services" (29).

(25) Discussion Document by the Economic Policy Group, August 1967, CPA CRD 3/32/1, p. 18.

(26) attendance list on CPA CRD 3/32/1.

(27) *ibid.*, pp. 18/9.

(28) Craig, 1975, p. 282.

(29) *Social Priorities*, ACP(67)38, CPA ACP 3/14, p. 2.

The WGSP was chaired by Sewill, and comprised Pike, Dean and Macmillan (all members of the HPG) and Bellairs and Norman Lamont from the CRD. Boyle, Joseph and Thatcher sometimes attended, and commented on the draft report (30).

The Group examined the arguments on selectivity and the related issue of private provision, and concluded that a selective approach was the appropriate policy for the Party. It was "in keeping with our basic philosophy of limiting the role of the State" and essential if "any improvements are to be made in the social field without imposing an insufferable burden of taxation". The Party should facilitate private provision, by tax relief on contractual savings that would include savings towards insurance for private health, education and pensions (31).

The WGSP distinguished between "the allocation of future resources and changes in existing services". Selectivity should apply to the former, but "there is a grave danger that we may lose many votes" if present benefits were reduced. The Party should be very careful before committing itself to imposing new charges for existing services (32).

On the NHS, the WGSP envisaged the restoration of prescription charges, as proposed in the 1966 manifesto, though pointed out that giving exemptions to groups such as expectant mothers was selective only up to a point, because such a policy had no regard to the individual's means. There was a case for the introduction of charges for visits to GPs, as they could act as a deterrent against abuse, but less of a case for charges for hospital treatment, where there was little abuse (33).

(30) *ibid.*, preface.

(31) *ibid.*, pp. 30/1.

(32) *ibid.*, p. 30.

(33) *ibid.*, pp. 15/7.

As regards private health provision, the WGSP's preference was to facilitate it through the general tax relief on contractual savings referred to above, which would include payments for health insurance. If such a general tax relief was implemented, there would be no case for letting private patients have prescribed medicines free (a proposition often made by Conservatives and others, including the BMA) or for subsidising private beds in NHS hospitals (33).

The WGSP's report was discussed by the ACP on 27 July 1967. The principle of selectivity and the encouragement of private provision were supported, though the political difficulties were noted. Heath's summing up suggested that he was particularly concerned about the political difficulties. While intimating that the various arguments for selectivity and private provision might usefully be deployed by frontbench speakers at the next Party conference, he thought that at this stage it would be better not to be "too specific" about policy (34).

In parallel with helping prepare the WGSP's report, Lamont had collaborated with Howe (an HPG member despite losing his parliamentary seat at the 1966 election) in producing a Bow Group paper published in August 1967 (35). This translated aspects of the WGSP's report into two "golden rules" that it was argued should govern policy in the social field, namely that future improvements in benefits should be granted on a selective basis and that people able to pay towards the cost of welfare services should be charged for the services they received.

(33) *ibid.*, pp. 18/9.

(34) ACP(67)83rd, CPA ACP 2/2.

(35) Howe G and Lamont N, *Policies for Poverty*, 1967, London, Bow Group, p. 2. The Bow Group had been founded in 1950 by former university students as a group concerned with "constructive thought and research", a Conservative equivalent of the Fabian Society (Ramsden, 1996, p. 53).

The issues of selectivity and private provision were discussed at the same Swinton conference as the EPG's discussion paper on economic policy. The CRD's report on the conference noted that those present "in effect started from the principle of selectivity as opposed to universality" and its author, James Douglas, was encouraged that "tax and social policy, contributions and benefits, [were] beginning to coalesce into a whole system whose impact could be assessed and rationalised instead of, as in the past, a motley collection of disparate policies each considered on its own merits and in relative isolation" (37). Boyle reported to the ACP on 1 November that at the conference "selectivity in the social services was widely accepted", but added that the scope for its application "emerged as narrower than many had appreciated" (38).

Following the discussion at the ACP in July and such reports as he received of the Swinton conference, Heath felt able to refer to seeing "future resources in the social services used for those who have the greatest need" in his speech to the Party Conference in October (39). Nevertheless, it is clear that both the political and practical problems of selectivity remained of concern.

Early in 1968 a Steering Committee, chaired by Heath and comprising Maudling, Macleod, Barber, Boyle, William Whitelaw, Lord Carrington and Fraser, was established against the contingency of an early general election (40).

(37) *Swinton Policy Weekend 1967 Report*, 26/9/67, CPA CRD 3/21/1.

(38) ACP(67)th, CPA ACP 2/2.

(39) *Conservative Conference Report*, 1967, London, National Union of Conservative and Unionist Associations, (NUCUA), p. 134.

(40) SC/68/1, CPA SC 5.

At its second meeting on 18 March, (which Joseph and Balniel attended by invitation), the Committee considered a CRD paper setting out several key issues on which policy decisions would be required. One was social policy, and the Committee was invited to consider whether, given the political and practical difficulties, to continue to emphasise selectivity and private provision. The alternative was to "shift the emphasis and concentrate on policies designed to improve the existing services". The paper noted that the electorate seemed generally satisfied with the education and health services, and would be "suspicious, perhaps hostile" to policies which seemed to threaten their existence (41).

Without abandoning the ideas that help should be concentrated on those who most needed it, and that there should be selective rather than universal increases in benefits, it was clear that the Steering Committee, and Balniel, regarded the word "selectivity" as unhelpful and had considerable doubts about setting out too much detail in advance of gaining office. As to encouraging private provision, although Macleod was in favour of tax relief for contractual savings, Maudling, a former Chancellor, was concerned that it could be used as a means of evading tax (42).

The Steering Committee's caution was reflected three months later in an ACP discussion. Heath commented that many of the means of achieving selectivity, such as charges, means tests and income related family allowances, "all tended to penalize the middle income groups who were largely our own supporters" (43).

(41) SC/68/3, CPA SC 5.

(42) SC/68/4, CPA SC 5.

(43) ACP(68)90th, CPA ACP 2/2.

As a result of these deliberations, the policy document *Make Life Better* published just before the 1968 Party Conference contained only a brief reference to selectivity, promising that a future Conservative Government "will concentrate additional available resources on those who need them most" (44). The 1970 election manifesto had a similarly brief reference to giving "priority to those most in need", though it did identify particular categories ("the over-80s without pensions, the elderly, the disabled, the chronic sick, the children in families below the poverty line"), and some policies to implement this aim (45).

For those concerned with the NHS, policy on selectivity provided an ambiguous context. It would be safe to assume that proposals for new charges would be carefully scrutinised for their political impact (though the WGSP's report specifically recommended that charges for visiting GPs should be examined by the HPG). It was more difficult to know how policy to encourage private provision would develop, and in particular whether tax relief on contractual savings would be offered. For any policy depending on an increase in the number of people insuring themselves for private medical care, this was potentially a very material consideration. Uncertainty here seems to have remained up to, and arguably beyond, the publication of the 1970 election manifesto. For while this included a commitment to introduce a "more imaginative contractual savings scheme", there was little detail and no assurance that it would cover savings in the form of contributions to health insurance schemes (46).

(44) 1968, London, Conservative Central Office, p. 22.

(45) Craig, 1975, p. 328 (the policy aim) and, pp. 337/8 (policies such as pensions for the over-80s and "a scheme based on negative income tax" to give effect to the aim).

(46) *ibid.*, pp. 330 (contractual savings) and 339 (private provision in health).

### 3. THE DEVELOPMENT OF HEALTH POLICY UNDER PIKE

Pike was the LCC spokesman on social services until October 1967, and responsible for leading the development of health policy during this period.

The principal vehicle for reviewing policy was the HPG, which first met in its reconstituted form on 25 October 1966, with both sub-committee and Group meetings until August 1967 (47). The author has found no evidence that the HPG met after August and, as noted above, it seems clear that the Group did not meet after Balniel had succeeded Pike as its Chairman.

It was noted in Chapter 1 that a number of papers had been prepared by members of the original HPG late in 1965 and early in 1966, but the timing of the general election seems to have precluded their discussion at a Group meeting. Despite the continuity of membership, and agreement at the first meeting that the previous papers would be available to members, they do appear not to have been explicitly considered. Rather, the reconstituted HPG seems to have begun work afresh.

Discussion at the first meeting led to agreement that the HPG would "consider the problems of the financing of the health services", for which a paper was commissioned (48).

(47) the CPA contains the minutes of the first meeting, and a *Progress Report* dated 24/8/67 which implies that the HPG had recently met to discuss papers circulated in July. On files CRD 4/7/15 and 16 respectively.

(48) a note of the meeting, PG13a/66/21, is on CPA CRD 4/7/15.

Following that meeting, some members had discussions with Marples and Powell (49). In the case of Marples, the discussion was about cost effectiveness in the NHS, from his perspective of having a general advisory role on efficiency. In the case of Powell, the meeting was to discuss the ideas in his recently published book (50). The latter meeting warrants particular attention, because Powell's views and the response to them, especially by Howe, represented two distinct approaches which, among others, are discernible in subsequent policy deliberations.

### 3.1 Powell's views on the NHS, and Howe's alternative

In the early 1960s Powell had been Minister of Health for three years, until in 1963 he declined to continue after the appointment of Home as Prime Minister. He had been a member of the LCC since the 1964 election and by 1966 had become a controversial public figure, frequently speaking on matters outside his LCC brief, sometimes seemingly at odds with his LCC colleagues. In particular, Powell had become identified with the kind of economic liberalism associated with the IEA (51). His views on the NHS were thus likely to attract interest both within the Party and outside.

(49) on 7/2/67 (Powell) and 23/3/67 (Marples). Notes of both (PG/13a/66/23 and 26) are on CPA CRD 4/7/15.

(50) *A New Look at Medicine and Politics*, 1966.

(51) Heffer S, *Like the Roman*, 1998, London, Weidenfeld & Nicolson, p. 367. In a letter to Howe on 2/8/66 Seldon, Editorial Director of the Institute, had described Powell as "our best political hope". Howe papers, white box 25, file 10.

Those who shared Powell's economic liberalism, and hoped to find him proposing a market alternative to the NHS, were disappointed by the conclusions he reached. Indeed Ralph Harris, General Director of the IEA, and Howe, then closely associated with the Institute, had both seen the book in draft and written to Powell trying, seemingly without success, to persuade him to modify his conclusions (52).

In Powell's view, the central issue with regard to the NHS arose from its form: "the nationalisation of medical care and its provision gratis at the point of consumption" (53). This necessarily produced a highly centralised service in which demands could never be satisfied and, rationally, the members and staff of health bodies such as HMCs and ECs had a "vested interest in denigration" to try to pressure government to allocate more money (54).

Powell judged that any reform that did not address the central issue would change little. Yet, as noted in the Introduction, in his view the Service was so popular with the public that there was no realistic prospect of addressing the central issue: "the very contemplation of denationalising it is enough to daunt the stoutest political heart" (55). Powell was reported as saying, at the launch of his book, that "I am not denying that one day [fundamental change] might be possible, but I do not think it is on the horizon" (56).

- (52) 12/9/66 (Howe), 13/9/66 (Harris), Howe papers, white box 25, file 10.  
(53) Powell, 1966, p. 67.  
(54) *ibid.*, p. 16.  
(55) *ibid.*, p. 67.  
(56) *Times*, 24/11/66, p. 12, col. g.

This was the message Powell gave to the HPG members on 7 February 1967. The note of the meeting records that he was "generally pessimistic about the possibilities of making any major fundamental changes ... He also felt that any changes other than major ones were pointless". He doubted whether private provision would ever grow sufficiently to enable the NHS to be reduced in size; questioned the point of making "marginal adjustments to the balance between private and public provision" and saw "little opportunity for the reform of the structure of the NHS" (57).

Others were more optimistic about the prospect for radical change. A week before Powell's book had been published, another Conservative, Dr Wyndham Davies, had published his assessment, a development of a paper he had produced following meetings organised by the Monday Club (58).

Davies, MP for Perry Barr from 1964 to 1966, regarded the NHS as unsatisfactory, but he felt that the situation could be changed by the encouragement of private provision and, for those who could afford it, the introduction of charges for medical consultations and drugs which, overall, would result in more resources being spent on health care (59).

This notion that more resources needed to be spent on health care, by the encouragement of private provision alongside the NHS, was the essence of perhaps the most considered alternative to Powell's view, that of Howe.

(57) PG/13a/67/24, CPA CRD 4/7/15.

(58) Davies W, *Reforming the National Health Service*, 1966, London, Conservative Political Centre, and *Collectivism or Individualism in Medicine*, 1965, London, Monday Club. The Monday Club had been formed in 1961 by those opposed to the government's policy of decolonisation, and was generally regarded as "right-wing" (Ramsden, 1996, pp. 148/9).

(59) Davies, 1966, p. 29.

Howe was an admirer of Powell and was concerned that *A New Look at Medicine and Politics* could lead Conservatives to draw wrong conclusions. He used a speaking engagement the day after publication to say that "the prophet Enoch has by no means pronounced the last word on the future of the NHS", and to suggest a way to achieve over a ten to fifteen year timescale the kind of substantial change assumed to be favoured by Powell (60).

Howe proposed an approach which brought together two major aspects of the form of the NHS. In respect of financing, his view was that the aim should be an expansion of the private sector, and while this was being achieved Conservatives should be "willing to look favourably on almost any intermediate device that will boost health expenditure without higher taxes". In parallel, the NHS's structure should be reconstructed and decentralised, so that new "Area Health Executives" managed by "Beeching-type executive directors", with "genuine freedom to plan and organise services" could develop additional sources of revenue (such as local lotteries and contracts with health insurance organisations) and increase efficiency (61). (Howe's reference to "executive directors" may have been inspired by a CRD paper circulated a fortnight earlier (62), noting a recommendation that health boards in Scotland should appoint chief executives, rather than continue having the leadership responsibility at officer level split among three posts (63).)

(60) speech to Hemel Hempstead Conservatives, 24/11/66, Howe papers, white box 24, file 3.

(61) *ibid.* (Beeching was a senior executive brought in by the 1959 Conservative Government to prepare a plan to modernise the railways.)

(62) PG/13a/66/22, CPA CRD 4/7/15.

(63) the committee, appointed by the Health Services Council, was chaired by William Farquharson-Lang, a Scottish RHB chairman. Its report was published as *Administrative Practice of Hospital Boards in Scotland*, 1966, Edinburgh, HMSO (see pp. 64 and 97 for the recommendation for chief executives).

Thus while sharing Powell's sense of the political difficulty, Howe took the view that it was possible, over time, actively to seek to create the conditions for major change.

### 3.2 The substantive Health Policy Group discussions

It seems almost certain that the full HPG did not meet for a second time until 6 April 1967, and it may have only met once more after that, in August 1967 (64). Following the meetings, a progress report was prepared, setting out conclusions on key aspects of the form of the NHS.

On 6 April, members had available to them the notes of the meetings with Marples and Powell, the paper on finance commissioned at the first meeting (it also covered structure); the paper on the Farquharson-Lang report referred to above; and papers on *Social Work in the Community* and *International Comparisons in Voluntary Health Insurance Schemes* prepared by the CRD.

Only a very brief note of the meeting was prepared, which did not even record the names of the HPG members attending (65). From that note it would seem that the paper on finance and structure (prepared by Lamont) provided the agenda.

(64) notes of HPG meetings and HPG papers were numbered consecutively in the PG/13a/66 series. The note of the first meeting of the reconstituted HPG was number 21 in that series, the note of the meeting on 6 April was number 28. The intervening numbers were all used for papers.

(65) PG/13a/67/28, CPA CRD 4/7/15.

The paper included a description of the existing structure and referred to criticisms of it, including Powell's concern about excessive centralism and the view that the tripartite structure led to a lack of co-ordination between the various branches of the Service. The Porritt proposal for area health boards as a means of unifying the Service at local level was described (66).

In identifying possible ways forward, the paper took the Porritt recommendation as the point of departure. The principal difficulty was seen to be "the relationship of the Area Health Boards to local government". The medical profession would be wary of local authority control of the Boards, while local government was unlikely to be prepared to surrender health functions to Boards "in which they would have no say".

As an alternative, the paper identified what at the time was the core of the Labour Government's position, examining the means by which integration was in practice being achieved within the existing structure, and encouraging successful practice. (Despite agreeing to explore the legislative change that would be needed to enable experiments with new forms of NHS administration to be undertaken (67), Robinson was sceptical as to whether the Porritt recommendation would promote integration at the level of provision of services for the individual patient, and emphasised the Ministry's efforts to achieve this within the existing structure. A written parliamentary answer in May 1967 suggested that this remained the Government's position (68).)

(66) PG/13a/67/27, CPA CRD 4/7/15.

(67) Webster, 1996, p. 328.

(68) Commons Hansards for 8/8/66 and 2/5/67 (written answer), vols. 733, col. 1170 and 746, col. 50.

At its April meeting, the HPG favoured the more radical of the two CRD options, administrative integration of the hospital and general practitioner services under one authority which, in the "general" view, would also become responsible for the local authority personal health services. Given the continuity of membership with the pre 1966 election HPG, which was moving toward a similar position, this was unsurprising. Some HPG members were, however, reluctant to see the local authority health services divided from the welfare services, and it was agreed that a firm conclusion could not be reached until the Seebohm Committee review of the organisation of local authority personal social services had been completed (69).

The meeting noted that there was also the forthcoming report of the Royal Commission on Local Government to consider. Depending on its conclusions, it might be feasible to bring all three branches of the Service within local government which would achieve administrative integration; avoid the problem of separating the local health and welfare services; and (because of local government's revenue raising powers) potentially shift an element of health service financing from central to local government, thus in part addressing Powell's concerns about central control (70).

(69) PG/13a/67/28, CPA CRD 4/7/15.

(70) *ibid.*

The Seebohm Committee had been given an indication of the Party's emerging policy early in 1967 when Joseph gave evidence. The Committee's note records that "Sir Keith Joseph's main concern was to make sure that the Committee had regard to the possibility of area health boards, very broadly on the lines suggested by the Porritt Committee" (71).

The emerging policy was expressed more firmly, authoritatively and publicly by Pike during a debate in the Commons on 11 July 1967 when she argued that "we should move towards a Porritt solution, by which all the major branches of the services are brought together under one authority on an area basis" (72).

As regards NHS finance, the CRD paper suggested that "the main problem for a Conservative Government ... is how to secure rising standards and wider choice without also increasing taxation". Five possibilities were identified: savings in administration, charges, increased private provision, the use of lotteries and encouraging charitable bequests and voluntary effort (73).

(71) note of meeting on 9/3/67, PRO HLG 120/1103. In referring to area health boards, the note includes the phrase "he [Joseph] mentioned that he had put the same suggestion to the Royal Commission on Local Government in England" (reflected in Webster, 1996, p. 451). In fact, the note of Joseph's evidence to the Royal Commission, on 4/11/66, does not support his recollection four months later (PRO HLG 69/901).

(72) Commons Hansard, vol. 750, col. 541.

(73) PG/13a/67/27, CPA CRD 4/7/15.

Of the five, "extra private provision [was] probably the most important". Without offering any recommendations, the paper outlined a range of possibilities for encouraging private provision, including making drugs available to private patients on NHS, or at least subsidised, terms; the payment of subsidies to reduce the cost of private beds in NHS hospitals; subsidising private health insurance schemes by enabling the insurance company to claim from the Exchequer up to 40% of the average insurance prescription (thus allowing companies to provide insurance markedly cheaper than at present); and allowing contracting out of the NHS Contribution for those with health insurance (74).

The HPG agreed that private provision should be encouraged, and saw the two most feasible means as allowing private patients to have drugs on the same basis as NHS patients and allowing tax relief on private health insurance premiums (the note of the meeting does not indicate whether the Group favoured the CRD option of subsidising the companies or preferred to grant the tax relief to the individual subscriber). Additional revenue could be generated by "a campaign against waste" and the introduction of an earnings-related social security tax, a proportion of which would be borne by employers though relieved by reductions in the general tax burden and the abolition of selective employment tax" (75).

At the April meeting, or shortly after, sub-groups were established on the family doctor and hospital services.

(74) *ibid.*

(75) PG/13a/67/28, CPA CRD 4/7/15.

The family doctor service sub-group reported in favour of a charge for NHS drugs, with exemptions for pensioners and the chronic sick, but were divided on whether the charge should be a flat rate one (as with prescription charges prior to their abolition) or be proportionate to the actual cost of the drug in question (the patient paying the full cost and then reclaiming "say 70%-80%". The sub-group also considered whether charges for medical attention and advice should be introduced, and concluded that a charge when a GP made home visits at night "merited particular study", probably more with a view to "preventing the doctors' time being wasted" than for its revenue raising potential" (76).

The hospital service sub-group seems to have concerned itself principally with issues arising from the discussion with Marples. The theme of its report was using resources more effectively, by a change in the pattern of hospitals (to ensure that there were suitable hospitals for patients not needing high intensity, high cost care of the kind provided in district general hospitals), and by the greater use of industrialised building and computers (77).

It seems almost certain that what was the final meeting of the HPG took place in August 1967, following which Bellairs produced a *Progress Report* which incorporated the views of the Group on the sub-groups' reports, together with the conclusions reached at the meeting on 6 April. The report records that the HPG were as divided as the family doctor sub-group on the form charges for drugs should take and about charges for medical attention and advice, but otherwise agreed with the views of both sub-groups.

(76) *Interim Report on Family Doctor Service*, 18/7/67, CPA CRD 4/7/15.

(77) as recorded in *Progress Report*, 24/8/67, CPA CRD 4/7/16.

Pike suffered recurrent illness which led to her standing down from the LCC in October 1967. It seems probable that production of the August *Progress Report* effectively marked the end of the work of the HPG as a group. There are no notes in the Conservative Party Archive (CPA) of HPG meetings after August 1967, nor evidence that the *Progress Report* was discussed beyond the HPG, for example by the ACP or the LCC.

The result of the HPG's deliberations by August 1967 was, on structure, that consideration of change had gone as far as members felt realistic in advance of the recommendations of the Seebohm Committee and the Royal Commission on Local Government, and the direction of the Group's thinking had been made public by Pike during the Commons debate in July, noted above. On the inter-related issues of the financing of the Service and the balance between public and private provision, some agreement had been reached on preferred options but a practical policy to give them effect had yet to be drawn together, and Pike had said nothing substantive publicly.

Shortly after he succeeded Pike, Balniel responded briefly to Robinson's announcement that he had set in train studies of the administrative structure of the NHS (78), but until the resulting consultative document, and the Seebohm recommendations, were available, he had no need to take matters further. Initially, he seems to have focused mainly on the issues of financing and public/private balance.

Policy development on financing and public/private balance to the publication of the 1970 general election manifesto will therefore be examined first, and then policy development on the structure of the NHS.

(78) Commons Hansard, 6/11/67, vol. 753, cols. 644/5.

#### 4. NHS FINANCING

Financing was not just the first matter relating to the form of the NHS to which Balniel and Macmillan gave substantive attention, but in the latter's view also "the main issue" (79). Its importance was recognised by Heath who, prior to the 1970 election, saw it as "one of the biggest problems we [will] have to face as a Government from the financial point of view" (80).

This concern with finance was by no means confined to Conservatives. Within the Labour Party, with its history of favouring resourcing the Service from taxation, some were beginning to express the view that additional funding needed to be raised through charges or putting the NHS Contribution on an earnings-related basis (81). The BMA was concerned enough to establish and resource an advisory panel whose main focus was financing health services, the origin and findings of which are summarised below.

Why did the issue of NHS finance become of concern in the mid to late 1960s? Essentially because to some it seemed that it would be difficult to maintain, let alone improve, services when the annual increase in resources was determined by considerations of economic management. While the NHS's resources had been increased in real terms in every year from 1952, and from 1954 to 1968 NHS expenditure as a percentage of the gross domestic product (GDP) had increased annually (82), to many within the Service the rate of increase was insufficient to match growing needs.

(79) recorded in note of meeting with Heath, 17/7/68, CPA CRD 4/7/16.

(80) 31/1/70, transcript of Selsdon Conference discussion on health, p. 12, CRD 3/9/93.

(81) eg Douglas Houghton, *Paying for Social Services*, 1967, London, IEA, p. 18 (charges); Dr David Owen, *Times* 4/7/68, p. 9, col. e (graduated contributions).

(82) Cmnd 7615, 1979, pp. 431/3.

Changes in the age structure of the population meant that the size of groups which made most call on health services - under 5s and the elderly - were increasing relative to the population as a whole (83). Advances in medical and surgical techniques and the range of drugs being developed (84), meant that the potential scope of the NHS was constantly expanding. The need to modernise the pattern of hospitals, identified in Powell's *Hospital Plan for England and Wales*, generated pressure for increased capital expenditure (85). Judging by resolutions at the BMA Annual Representative Meetings (ARMs), many doctors felt that the Service was inadequately resourced (86). The number of British born doctors emigrating (87) was cited as evidence of dissatisfaction with working conditions and remuneration.

This, then, was the background against which, from their appointments in October 1967, Balniel and Macmillan began thinking about the Party's policy on NHS funding.

- (83) between the 1961 and 1971 censuses the population of England and Wales increased by 5.7%. The increases in the under 5s and 65s and over were 8.6% and 18.2% respectively. Census data summarised in Mitchell B, *British Historical Statistics*, 1988, Cambridge, Cambridge University Press, p. 15.
- (84) a range of examples is given in Rivett G, *From Cradle to Grave*, 1998, London, King's Fund, pp. 134/62.
- (85) Cmnd. 1604, 1962. £93m had been spent on hospital building in the five years 1956/7 to 1960/1 (p. 2). The Plan envisaged £200m being spent in the quinquennium beginning 1961/2 and £300m in that beginning in 1966/7 (p. 13). In the revised Plan, published in May 1966 as *The Hospital Building Programme*, Cmnd 3000., London, HMSO, the expected level of expenditure was increased to "roughly £1,000 million ... over the next ten years" (p. 5).
- (86) for example, resolutions 208 and 31 at the 1966 and 1967 ARMs, minutes, British Medical Association Archive (BMAA), p. 28 and p. 5 respectively.
- (87) a written parliamentary answer contained the estimate that there was a net loss of such doctors of 250 a year in 1962/3 and 1963/4, 500 in 1964/5 and 300 in 1965/6. Commons Hansard, 25/3/69, vol. 780, col. 284.

A week after he succeeded Pike, Balniel used the opportunity of responding to a debate at the Party Conference to say that he was "deeply interested ... [in] arranging for contractual savings for medical insurance, for private medical treatment, for nursing homes, all to be freed from tax", and that Paul Dean, an HPG member, was overseas, studying other countries' schemes (88).

Dean's studies included three weeks looking at the Australian health services, which he contrasted favourably with the NHS. One of three areas where, in his view, the Australian system was superior was in the plural nature of its funding, with "about half the money [coming] from various private sources - voluntary health insurance, third-party motor insurance, charges of various kinds, charitable contributions, and lotteries". The result was that Australians were spending proportionately more of their gross national product on health. In Dean's view, the encouragement of such means in Britain would provide the extra money needed to improve services (89).

Of the various sources of funds from private sources referred to by Dean, action on one had, in the form of prescription charges, been Party policy at the 1966 election. This policy had been reviewed and supported by the reconstituted HPG, albeit with differences of view about the form of the charge (flat rate or proportionate to the cost of the drug concerned). However, as noted above, after the 1966 election there had been some concern about the electoral impact of the policy.

(88) *Conservative Conference Report*, 1967, p. 24.

(89) Commons Hansard, 7/12/67, vol. 755, cols. 1792/3.

In the event, the state of the economy by late 1967 led the Government to devalue the pound and to follow this up with reductions in public expenditure announced on 16 January 1968 (90). These reductions included the re-imposition of prescription charges just over three years after they had been abolished, though with exemptions for those under fifteen or over sixty five, expectant and nursing mothers and the chronic sick. The Conservatives supported the re-imposition of charges, and were saved the need to decide whether to propose re-imposition in the next general election manifesto (91).

During 1968, both Balniel and Macmillan gave thought to more fundamental changes to the financing of the NHS than the re-imposition of prescription charges. As noted above, it seems clear that they did not use the HPG, as a group, to assist them (92).

What is less clear is what sources of information and advice Balniel and Macmillan did draw upon. In addition to the results of Dean's studies, research by the CRD and, almost certainly, discussions with BUPA (93), a probable source of information was the BMA Advisory Panel referred to above, of which Howe was a member.

(90) Commons Hansard, vol. 756, cols. 1577/1618.

(91) Commons Hansard, 30/5/68, vol. 765, cols. 2269/73.

(92) "... the Group ... has never met since [Balniel] became Chairman", Hayhoe/Fraser, 11/3/69, CPA CRD 4/7/16.

(93) in LCC(68)202, 10/9/68, Balniel included "in strict confidence" information about BUPA's future plans which he was most likely to have learnt from discussions with BUPA. CPA LCC(68)255-269.

#### 4.1 The British Medical Association Advisory Panel

Following a resolution of its ARM in July 1966 (94), the BMA established a Forward Planning Unit, one of whose first initiatives was to invite Dr Ivor Jones, assisted by an Advisory Panel, to "review the history of the Health Services in this country and to indicate future trends" (95).

The Advisory Panel consisted of "a small number of knowledgeable and forward thinking doctors ... and ... laymen with particular experience in socio-medical problems and the economics of medical care" (96). The laymen were Howe, and Seldon of the IEA.

The Advisory Panel began its meetings early in 1967, but its position and remit changed somewhat in the Summer. First, it ceased to be linked to the BMA's Forward Planning Unit (97). Second, an ARM resolution in July 1967, concerned about the "inadequate finance" available to the NHS, instructed the BMA Council to "prepare an alternative Health Service" (98). The Council discharged this instruction by submitting the resolution to the Advisory Panel and asking that an interim report be prepared on matters relating to the 1967 resolution (99).

(94) Council minutes, 8/7/66, BMAA, doc. C5, minute 44.

(95) Council minutes, 1/2/67, BMAA, doc. C30, minute 306.

(96) Jones' letter of invitation to prospective Advisory Panel members, 9/2/67, Howe papers, white box 16, file 5.

(97) note of 7th meeting of Advisory Panel, 1/6/67, BMAA, Planning Unit papers, P/1/19.

(98) minutes of ARM, 6/7/67, BMAA, p. 5, resolution 31.

(99) *Interim Report of Advisory Planning Panel*, para. 278(2), reprinted in the supplement to the *BMJ*, 20/4/68, pp. 95/8.

The Advisory Panel saw its initial task as reporting on methods of financing medical care, and with this in view set up a number of research projects to inform its thinking, including studies of health financing in Europe, Australasia and the USA, mostly by commissioning university economic departments. The Panel thus had available to it very much more substantial sources of information and advice than the HPG, whose research had been largely undertaken by its members personally.

The Panel produced an interim report early in 1968. In its view, the "present system of financing health services in Britain must be reconsidered", and the Panel sought to contribute to a reconsideration by examining six main sources of finance - direct payment, voluntary insurance, compulsory insurance (State or private), general taxation, special taxes and charitable funds and lotteries. The Panel's conclusion was that, while taxation must inevitably be the principal means of finance of certain sectors of medical care, raising a greater proportion of finance by insurance would enhance choice and could result in higher minimum standards for everyone (100).

Through Howe, and the interim (and, later, final) reports of the Panel, Balniel and Macmillan thus potentially had available to them a great deal of material about ways in which health services could be funded. There is clear evidence that they knew of the Panel's work; it was, for example, referred to in a CRD paper prepared for Macmillan and copied to Balniel (101). The extent to which they drew on it is unclear.

(100) *ibid.*

(101) *Health Services Finance*, 31/7/68, CPA CRD 4/7/84.

## 4.2 The Balniel and Macmillan approaches

While the means by which they reached them are uncertain, it seems that Balniel and Macmillan formed different conclusions on the best way of funding the NHS. A CRD memorandum in July 1968 records that "Balniel favours the idea of the graduated health service contribution, whereas Maurice Macmillan strongly favours the proposal for a genuine health insurance" (102).

When he had invited Pike to chair a reconstituted HPG, Heath had said that he was asking for all working groups to report by Summer 1968, as the basis for a policy document later in the year (103). In July 1968, having received no report from the HPG (except possibly the rather provisional *Progress Report* of August 1967 referred to above), he met Macmillan to discuss progress. (It is unclear why Heath did not seek to meet with Balniel, who was in overall charge of the development of health policy.)

The meeting gave Macmillan, who referred to finance as the main issue, the chance to explain his thinking, as well as to mention that Balniel "and others" were working on different lines (unspecified in the note of the meeting). He favoured a two part system. Hospitals would be funded by "a graduated contribution preferably on an unsubsidized basis, and weighted to the employer rather than the employee". For other services - including GPs, dentists and outpatients - there would be charges, "so that in effect people were providing for themselves". The charges would be financed by insurance schemes. There would be a State scheme but, possibly aided by tax concessions, individuals could contract out to approved private schemes (104).

(102) Bellairs/Sewill, 30/7/68, CPA CRD 4/7/84.

(103) Heath/Pike, 13/5/66, CPA CRD 4/7/16.

(104) note of meeting 17/7/67, CPA CRD 4/7/16.

Macmillan judged that with the kind of approach he outlined, "it might be possible to push a wide range of the health services, except hospitals, back into the private sector over a period of 15 to 20 years" (105).

Heath seems to have been interested in Macmillan's approach, suggesting Dr Elston Grey-Turner, then Assistant Secretary at the BMA, as someone "he knew would be willing to help", and offering computer time for "problems ... [that] could usefully be dealt with that way" (106).

Balniel's approach was different. According to the Bellairs' memorandum of 30 July 1968 referred to above, he favoured the idea, being considered by the EPG, of a graduated NHS Contribution. In addition, in a paper to the LCC in September 1968 (107), Balniel developed the idea of tax relief in respect of contractual savings he had raised at the 1967 Party Conference, referred to above.

In Balniel's view, the Party should move from a "neutral" attitude to private health provision, to one of "positive encouragement". Specifically, he proposed that tax relief should be given in respect of contributions to BUPA and similar health insurance schemes, preferably as part of broader policy of giving tax reliefs on contractual savings. In addition, consideration should be given to allowing those with adequate health insurance cover, whether privately arranged or occupational, to contract out of the "health stamp" (the NHS Contribution) to some extent.

(105) *ibid.*

(106) *ibid.*

(107) *Private Health Provision*, LCC(68)202, CPA LCC(68)255-269.

Such a policy would, in Balniel's view, bring more money into health services, in the long run reduce the pressure on the State funded service, provide more choice in health services and perhaps reduce the emigration of doctors and nurses.

To illustrate the potential additional resource, Balniel calculated that if, as a result of the availability of tax relief, the number covered by private health insurance quadrupled from the present two million, total contributions would be £80m a year. Tax relief at 40% would mean £32m tax revenue was foregone, leaving what Balniel described as "a net gain" (his underlining), that is, additional expenditure on health services, of £48m a year. The total expenditure on the NHS in the UK in 1967 had been £1,558m (108), so Balniel was hoping to see "a net gain" of about 3% of expenditure through his tax relief proposal, though this would be reduced if a degree of contracting out of the "health stamp" was agreed.

Quite apart from the assumption that the number of people taking out private health insurance could quadruple, and the issue of the revenue foregone by allowing contracting out, Balniel's calculation of the "net gain" was flawed. On his estimate, private health insurance was already contributing £20m a year to total expenditure on health. If the numbers insured quadrupled, the comparable sum, after taking account of revenue foregone though tax relief, would be £48m per year. The real "net gain" in total health spending, compared to the situation then obtaining, would be £28m a year, not £48m (that is, the putative £48m less the current £20m).

(108) Cmnd 7615, 1979, p. 431.

The paper was intended for discussion at an LCC meeting on 13 September 1968, but it was not reached and at Heath's request Fraser, who served as Secretary to the LCC, wrote asking members for their comments.

Six LCC members responded. Maudling and Lord Hailsham replied briefly and supportively, though Hailsham pointed out that the line of argument applied to areas other than health and suggested that the principle should be examined by a policy group (109). Joseph Godber, Robert Carr, Joseph and Macleod replied at greater length.

Godber (brother of the Ministry of Health's Chief Medical Officer), and Carr both supported the proposal to offer tax relief on contributions to health insurance schemes, but opposed the idea that those with insurance might, in part at least, be exempt from the NHS Contribution. Godber could see that allowing at least partial exemption might be logical, but thought it would be "bad politics". Carr thought it worth preserving the "principle of universality in contributions to the National Insurance Scheme", though noted it had been breached with the Conservative Government's graduated pensions scheme (110).

Macleod expressed broad sympathy with Balniel's aims, but clearly regarded the likelihood of extra money flowing into health care as somewhat speculative. On Balniel's figures, whatever the "gain", for Macleod there was "a clear loss to the Exchequer of £32m", the tax relief given on contributions (111).

(109) 23/9/68 (Maudling), 25/9/68 (Hailsham), CPA CRD 4/7/1.

(110) 20/9/68 (Godber), 30/9/68 (Carr), *ibid.*

(111) 3/10/68, *ibid.*

Joseph agreed with the objective of getting more private money into health, and favoured, in the longer term, changing the form of the NHS into an Australian type of health service "based on private practice with costs covered by insurance", with the State meeting a share of the individual's premiums, which would be higher for those with lower incomes.

While Joseph supported Balniel's proposals he did not see that, in isolation, they met Powell's objection to such schemes that, even if they led to growth in the private sector, that growth would be insufficient to allow a reduction in NHS expenditure (112). Unless NHS expenditure could be reduced, the taxpayer would in effect be faced with additional costs, in the form of the reduction in tax receipts through the relief granted on contributions.

Joseph therefore suggested that Balniel's proposals be part of an overall plan to "bring more resources into medicine, public and private", of which the key additional step would be to introduce a "substantial bed-charge for hospital patients other than children, elderly and mental and chronic cases", against which individuals would be compulsorily required to take out private insurance, the burden of which would be mitigated for low earners through higher family allowances. The State would regulate the insurance companies, and "offer ... a partnership to help them cover the less good risks".

(112) Powell, 1966, p. 70.

The resources raised through the bed-charge, which Joseph estimated at £150m a year, would be used to improve the pay and conditions of staff and offer bounties for British-trained doctors who had emigrated to return, thus hopefully offsetting any reduction in NHS staff that growth in the private sector would cause in the short term (113).

Fraser sent copies of the six replies to Heath and Balniel, but there was no immediate follow up. There was no mention of changing NHS funding arrangements or encouraging the private sector in the October 1968 policy document *Make Life Better*, though there was reference to giving "real encouragement to new savings" and "tax relief to those who want to save regularly over a period of years" (114), which would have provided a basis for giving tax relief on private health insurance premiums. Similarly, in his speech at the Party Conference, Balniel made no reference to either, despite being presented with the opportunity when one of the speaker (Dr Anthony Trafford, a future Conservative MP) referring to the possible encouragement of private medical insurance schemes, saying that it "would be illusory to think that they can make any real impact on the problem of health costs" (115).

(113) 25/9/68, *ibid.* Joseph's letter was referred to misleadingly by Heath in his autobiography. Without any reference to Balniel's paper, he says that "Joseph circulated a paper to the Shadow Cabinet ...", which suggests that Joseph was taking the initiative in this matter. Rather, Joseph (who had no responsibility for health policy at this time) was responding to Balniel's initiative, alongside five other LCC members, not by "circulating a paper to the Shadow Cabinet" but by writing a letter to Fraser, copied to Balniel, which Fraser then passed on to Heath. (Heath, 1998, pp. 451/2.)

(114) 1968, p. 10.

(115) *Conservative Conference Report, 1968*, London, NUCUA, pp. 87 (Trafford) and 90 (Balniel).

By Autumn 1968, therefore, Balniel and Macmillan had proposed different ways of increasing expenditure on health, and presented their ideas to Heath, who had also seen the reservations of some of his LCC colleagues. Nothing had yet been decided as regards Party policy, however, and it was unsurprising that, when relinquishing chairmanship of the ACP in mid November and commenting that "the broad pattern of policy is now complete", Heath excepted health (together with transport) (116).

#### 4.3 Discussions leading to the 1970 general election manifesto

During the period between the 1968 Party Conference and the drafting of the 1970 election manifesto, both Macmillan and Balniel made what appear to have been rather spasmodic attempts to take their proposals forward.

In December 1968 Bellairs prepared a paper taking forward the ideas that Macmillan had put to Heath at their July meeting. In so doing, Bellairs suggested that part, at least, of hospital treatment should be brought within the scope of the minimum level of health care for which people would be required to take out insurance, and spelt out some of the practical issues, such as insuring the "bad risks", which would have to be resolved. He thought that such a scheme would fit well alongside the Party's policy for pensions, and "give us a consistent social service policy, putting emphasis on encouraging people to help themselves and concentrating State subsidies on people rather than things" (117).

(116) *Times*, 15/11/68, p. 1, col. d.

(117) *The Finance of the National Health Service*, 19/12/68, CPA CRD 4/7/77.

Bellairs' Director, Sewill, was critical of this approach. While "in favour of making the health service into a self-financing insurance system", Sewill thought that the way to achieve this was that being examined by the EPG, namely by increasing, possibly on an income related basis, employers' contributions under the national insurance scheme, which could relieve the taxpayer of the need to finance health care except for "chronic cases and bad risks". His objection to the Macmillan scheme, as developed by Bellairs, was that it would make little practical difference: "contributions would still be compulsory and the health services would still in effect be free at the time of use". For Sewill, to effect such a change would "involve a major political upheaval for no real benefit" (118).

There is no evidence that the issue of NHS financing was considered either by the ACP or the LCC until June 1969, by when the work of the BMA Advisory Panel was in its last stages. The Panel was moving towards a policy on the same lines as Macmillan's, involving compulsory insurance, though Howe, like Sewill, drew attention to the "enormous upheaval the introduction of such a scheme would involve" and that the notion of compulsory insurance would be "difficult to accept politically". At this stage Howe clearly regarded the expansion of voluntary insurance, "with large encouragements ... such as tax reliefs" as more realistic (119).

(118) Sewill/Bellairs 2/1/69, CPA CRD 4/7/77.

(119) minutes of Advisory Panel meeting 30/4/69 - 1/5/69, BMAA, P/1/109.

By June 1969, the Balniel and Macmillan approaches seem to have been brought together as potentially consecutive elements in an overall strategy on NHS financing. In a CRD paper put to the ACP, various "comparatively minor" ways of raising additional revenue for health services, including lotteries, a more flexible system of hospital finance and charging for the treatment of casualties of road accidents were described but, in the CRD's view "the most important source of new money is through the encouragement of private provision" (120).

In a possible strategy to encourage private provision, the Balniel scheme was suggested as the immediate step - giving tax relief on the premiums of private health insurance schemes, preferably as part of general tax relief for contractual savings. The paper included, without comment, the same estimate of an addition of £48 million a year as Balniel's paper to the LCC.

If further steps were judged to be necessary, there were three options - higher charges with wider exemptions, as advocated by Houghton; meeting a larger part of the cost of health care by earnings-related social security contributions; or, "the most radical alternative", Macmillan's proposal for charges met through compulsory insurance. The paper suggested that it would be useful to have a feasibility study of the Macmillan option.

The ACP offered no specific advice, though in summing up the discussion Maudling, Chairman since December, agreed that a feasibility study of Macmillan's proposal would be useful (121).

(120) *The National Health Service - Administration and Finance*, 3/6/69, CPA, paper ACP/59, CRD 4/7/16.

(121) ACP(69)100th meeting, 11/6/69, CPA CRD 2/3.

Three weeks after the ACP meeting, on 1 July 1969, the Conservatives used one of their Supply Day opportunities to raise NHS financing in the Commons. Macmillan argued that it was unrealistic to expect the adequate financing of the NHS to be achieved on its present basis. To meet the cost pressures generated by demographic change and medical innovation, more resources were needed than could be raised by taxation, even at times of economic growth. While aspects of the Service, such as provision for the chronically ill, would always need to be funded from taxation, in Macmillan's view perhaps a quarter of NHS expenditure could be raised by other means which, in turn, could lead to even more resources overall being spent on health care. He listed most of the options set out in the CRD paper and invited the Government's response (122).

Richard Crossman, the Secretary of State for Social Services, accepted much of Macmillan's argument about the need for additional resources, but regarded encouragement of the private sector as unacceptable, as "there may well be a considerable number of leading consultants who treated only private patients ... We could no longer claim that all citizens, whatever their means, were able to obtain the same standard of medical care". He regarded charges as something which "should not be made more than a small factor - a useful adjunct, but only an adjunct, to the main source of finance" (123).

(122) Commons Hansard, vol. 786, cols. 242/53.

(123) *ibid.*, cols. 253/66.

In Crossman's view, the most realistic way of raising money over and above taxation was through higher NHS contributions, which the Government had recently proposed should cease to be paid on a flat-rate basis and (like contributions for national insurance) be earnings-related (124). This represented a considerable shift in the Labour leadership's thinking, as statements made whilst in Opposition "implied that the NHS Contribution was not a favoured source for health service funding" (125).

Bal Niel did not take part in the Supply Day debate, but he opened a debate a few days later about what the Conservatives saw as the muddle in respect of the introduction of higher charges for dentures and spectacles. While agreeing with Crossman that the scope for increasing revenue through charges was limited, he regretted that the Government were not exploring other possibilities, including encouraging private insurance (126).

Later in July Bal Niel sought to persuade his LCC colleagues to take a positive step in respect of encouraging the take up of private insurance, by asking for agreement that he could announce at the next Party Conference that tax relief would be offered in respect of private health insurance premiums, within a framework of encouraging savings through tax relief. Heath asked that, before the Conference, the matter should be discussed by the LCC on the basis of a paper Bal Niel should prepare in consultation with Macleod, Boyle and Barber (127).

(124) *ibid.* (The Government's White Paper, *National Superannuation and National Insurance*, Cmnd. 6883, 1969, London, HMSO, published in January, had proposed putting social security contributions, including the contribution towards the NHS, on an earnings-related basis.)

(125) Webster, 1996, p. 190.

(126) Commons Hansard, vol. 786, cols. 1031/2.

(127) LCC(69)319th, 23/7/69, CPA LCC(69)312-319.

The LCC's remit to Balniel seems not to have been discharged directly. Rather, in the light of the motion on social security and health proposed for the Party Conference, a paper was prepared within CRD on private provision in the social services generally, which included a section on tax relief on health insurance.

This paper made it clear that details of the framework for tax reliefs for contractual savings generally had yet to be worked out, and therefore any announcement in respect of relief on private health insurance could not be made in that context. A form of words was suggested for an announcement on tax relief for private health insurance - "I am authorised to give the assurance that when we return to office we will see that tax relief is available for health insurance on a no less favourable basis than exists for life assurance" (128).

The paper was not put to the LCC, and it is not clear from the CPA in what forum it was discussed. In the event, at the Party Conference Balniel did not use the form of words proposed, instead simply referring to tax relief on health insurance as "a proper objective for the Conservative Party, but ... subordinate to our wider aim of an overall reduction in direct personal taxation" (129).

(128) *Private Provision*, 26/9/69, CPA CRD 4/7/16.

(129) *Conservative Conference Report*, 1969, London, NUCUA, pp. 57/8.

By December 1969, preparation of the manifesto for the next general election began in earnest. As the policy on health financing had still to be agreed, the first draft was able only to contrast the Conservative attitude - welcoming the growth in private provision and asserting the Party's belief that it was right that individuals should be free to make provision for themselves - with the "danger" that Labour saw in such freedom (130). The word "danger" in this context referred to a phrase in a recently published Labour Party publication which referred to the need to be "alive to the danger of a growth in private health and welfare provision which is now gathering momentum" (131).

The Conservatives used another Supply Day to emphasise the different attitudes of the two major parties, by debating a motion welcoming the development of private health insurance schemes. The two themes of Balniel's speech were the potential contribution of the private sector, and a warning to the Government to "keep their hands off the freedom of choice which men and women want and ... off private health insurance" (132).

The second draft of the manifesto was prepared in time for discussion at a meeting of the LCC over the last weekend of January 1970, at the Selsdon Park Hotel. The meeting also considered a number of other papers, including one by the CRD specifically on health.

(130) draft dated 8/12/69, CPA SC/69/3.

(131) quoted by Balniel, Commons Hansard vol. 793, col. 492.

(132) Commons Hansard 10/12/69, vol. 793, cols. 491/6.

This paper, prepared by Sewill and Bellairs, dealt solely with the inter-related issues of finance and private provision. It rehearsed the minor possibilities for raising additional revenue, such as lotteries; took the Balniel view that additional charges could only raise relatively small additional sums; welcomed Crossman's plans to put health contributions on an earnings related basis - "revenue would be much more buoyant", and effectively added Balniel's proposal for tax relief on private health insurance premiums to the list of measures of marginal effect. In Sewill and Bellairs' view, the major decision was whether to continue with the present system, or to transfer the bulk of the FPS to a charging basis. If the latter option was preferred, there was then the choice of instituting compulsory insurance arrangements to cover the charges, as proposed by Macmillan, or to introduce a reimbursement scheme of the kind examined by the HPG (133).

To reflect the need for decision, the health section of the second draft of the manifesto contained an additional, provisional, paragraph committing the Party to "consider the financing of the National Health Service with a view to finding ways of devoting more resources to the health of the nation without increasing the burden on the taxpayer" (134).

At the Selsdon meeting, health was discussed on 31 January. According to a verbatim transcript, although a variety of issues were touched upon, most of the discussion focused on financing and proposed changes in the structure of the NHS (the latter is considered below).

(133) *Health*, 22/1/70, SP/70/7, CPA CRD 3/9/92.

(134) SP/70/1, CPA LCC(70)340-357.

Macmillan explained the issues as he saw them, essentially as he had in the Supply Day debate on 1 July 1969. He seems to have received little support for the idea of putting the FPS on a charging basis with the charges being covered by compulsory insurance. In particular, Macleod, the Shadow Chancellor, came down "flatly in favour of continuing broadly with the present system", and regarded an estimate that the compulsory insurance would cost 15/- (75p) per week per insured worker as "quite unacceptable". Balniel agreed with Macleod that "it was not on for [the] Manifesto" (135).

Despite the fact that the radical alternative deployed in the CRD paper and, in particular, Macmillan's option within that alternative, seems to have found no support within the LCC, the possibility of including in the manifesto a reference to alternative means of funding the NHS was left open.

The provisional paragraph referred to above was carried unchanged into the third draft. At that stage Heath criticised it as "weak", and "was now becoming convinced that it would eventually be necessary to charge a fee for every visit to the doctor, which would both relieve the general practitioner ... and in time ... the hospital service". Fraser argued that it would be "unwise to say this in the Manifesto". Maudling, however, thought that there should be a sentence, to justify a Conservative Government if it decided to act (136).

(135) transcript, CPA CRD 3/9/93, pp. 12/9.

(136) Steering Committee minutes, 12/3/70, CPA SC/70/10.

No change resulted from the discussion on the third draft, the provisional paragraph was carried forward, without amendment, into the fourth, fifth and sixth drafts. It was only in the week prior to publication that it was omitted, following consideration of a "new draft section on health" circulated by Sewill (137). The notes of the Steering Committee meetings on 18 and 19 May at which the manifesto was finalised do not include the reason. Years later, Sewill, who had been present at both meetings, expressed the view that it was to avoid giving an unnecessary point of possible attack, at a time when it looked as though Labour might be recovering electoral support (138).

The result was that, in respect of what both Heath and his frontbench spokesmen on health regarded as a major issue, the manifesto included only a shortened version of reference in the first draft, some six months earlier. The final, published wording contrasted the Party's belief that it was "right and proper" that people should have the freedom to provide for themselves with Labour's view that there was "danger" in the growth of private provision (139).

## 5. THE ADMINISTRATIVE STRUCTURE OF THE NHS

As noted above, by August 1967 the HPG had taken its thinking as far as was regarded realistic in advance of the Seebohm and Royal Commission on Local Government recommendations.

(137) CPA SC/70/10.

(138) discussion with author, 21/9/99.

(139) Craig, 1975, p. 339.

In November 1967 Robinson announced that he had begun "full and careful examination of the administrative structure" of the Service, with a view to setting out his views "as a basis for public discussion and wide consultation" (140). This decision opened up the possibility of structural change of the kind advocated by some of his parliamentary colleagues (141). His principal official advisers, too, had for some months been of the view that the tripartite structure "was not satisfactory ... [it] creates difficulties of co-ordination and must waste manpower" (142).

Bal Niel responded briefly to Robinson's statement, welcoming the studies (143).

The report of the Seebohm Committee and the Government's consultative document (or Green Paper, as it was commonly called) were both published on 23 July 1968 (144), by when the mid-term Conservative policy document for the Party Conference in October was in an advanced stage of preparation.

(140) Commons Hansard, vol. 753, cols. 643/6.

(141) for example, Laurie Pavitt who favoured structural change in his pamphlet *The Health of the Nation*, 1965, London, Fabian Society, and Dr David Owen who criticised the tripartite system in a Commons debate on 8/6/66, Hansard vol. 733, cols. 1153/5.

(142) informal evidence by the Ministry of Health's Permanent Secretary and Chief Medical Officer to the Royal Commission on Local Government, 7/7/67, PRO HLG 69/902, RC(67)24th meeting.

(143) Commons Hansard, vol. 753, cols. 644/5.

(144) *Report of the Committee on Local Authority and Allied Personal Social Services*, Cmnd. 3703, 1968, London, HMSO, and *The Administrative Structure of the Medical and Related Services in England and Wales*, 1968.

In the seventh draft, which was considered by the LCC on 27 August, it had not been felt necessary to say anything about the structure of the NHS beyond a re-ordering of the brief reference in the 1966 general election manifesto (145). The wording of the seventh draft was carried unchanged into the final version published as *Make Life Better* on 7 October, though by then a commitment to take "immediate action to implement the recommendations of the Seebohm report" had been added (146).

### 5.1 The Seebohm Committee's conclusions and the first Green Paper on the administrative structure of the NHS

As noted in Chapter 1, the Seebohm inquiry had been announced in December 1965, with a remit to review the organisation and responsibilities of the local authority personal social services (PSS).

The Committee regarded the term PSS as including some or all of the services then being provided by a range of local authority departments. It concluded that the local authorities concerned should create new social services departments, into which would be incorporated the existing children's department, most of the functions of the welfare department and some of the responsibilities of the education, health and housing departments.

(145) "Hospitals, family doctors and the local health services should be brought closer together", paper LCC(68)201, p. 15, CPA LCC(68)225-269.

(146) "*Make Life Better*", 1968, p. 23.

The potential impact on the local authority health departments was considerable. The Committee estimated that its recommendations "would remove half their staff and a substantial part of their budgets, contracts and interests" (147). This would call into question whether the residual health departments would be "viable working unit[(s)]". The Committee had noted the Government's November 1967 announcement that it was to review the structure of the NHS, and emphasised the importance of the review paying "particular attention to the need for a coherent organisation of local medical services and to the [local authority] medical officer of health ... and his team" (148).

The Government's proposals in respect of the structure of the NHS did indeed address the question of the local authority health services generally, and the role of the medical officer of health in particular.

In its Green Paper the Government noted both the "increasing efforts devoted to trying to secure proper collaboration [among the elements of the tripartite structure], and the obstacles to their success" (149). It noted, too, the "great challenges" of the next two decades: and particularly the need to use staff effectively - "without duplication of tasks and without confusion of function" (150).

(147) Cmnd. 3703, 1968, p. 120.

(148) *ibid.*, p. 122.

(149) *The Administrative Structure of the Medical and Related Services in England and Wales*, 1968, p. 9.

(150) *ibid.*, p. 10.

The Government's conclusions were that the existing arrangements inhibited both "more integrated services and patterns of care" and the effective use of resources, and that "a new administrative structure is required" (151). That structure, it proposed, should be new area boards for medical and related services in each area, appointed by and directly responsible to the Minister of Health, which would take over the functions of the RHBs, BGs, HMCs, ECs and "all the health functions of the present local health authorities". The medical officers of health would become officers of the area boards, of which the Green Paper suggested there might be "about forty" in England and Wales (152).

Although the paper included some detail about the proposal for area boards, it was made clear that other options were not ruled out, including the integration of health services under "a suitably constituted committee of the new type of local authority that may be established when the recommendations of the Royal Commission on Local Government have been received and considered" (153).

## 5.2 Policy development from July 1968 to June 1969

The publication of the Seebohm report and the Green Paper in late July gave those within the Conservative Party concerned with policy on the NHS issues of substance to address.

Publication of the documents was not accompanied by a statement in the Commons and, with the Summer recess imminent, there was no parliamentary opportunity for discussion of them until the Autumn.

(151) *ibid.*

(152) *ibid.*, pp. 12 and 14.

(153) *ibid.*, p. 19.

The first substantive opportunity came on 24 October during a debate on the Order that gave statutory force to the merger of the Ministries of Health and Social Security into the Department of Health and Social Security (DHSS). As merger had been in the Conservative general election manifesto in 1966, it was unsurprising that, in responding to Crossman, Balniel welcomed it, though he urged him to take two further steps. First, to establish within the new Department a "substantially stronger" research intelligence unit than currently existed. Second, to announce the Government's acceptance of the principles of the Seebohm report (154), something that, as noted above, the Conservatives had already done in the policy document *Make Life Better*.

As Webster has documented, the Government was at that time, and for several more months, in something of a quandary over Seebohm. Quite apart from the question of which department should become responsible for the social services, there was the question of whether it was reasonable to take action on the Committee's recommendations in advance of knowledge of the conclusions of the Royal Commission on Local Government (155). Crossman was therefore unable to respond substantively.

The Debate on the Address provided Balniel with a further opportunity to press the Government to accept the principle of the Seebohm report, as well as to offer an initial Conservative response to the Green Paper. While noting the "fairly general agreement" within the Commons that the three branches of the NHS should be "brought together on an area basis", he suggested that the Conservatives would prefer to see the necessary unification within local government (156).

(154) Commons Hansard, vol. 770, col. 1619/20.

(155) Webster, 1996, pp. 305/9.

(156) Commons Hansard, 1/11/68, vol. 772, col. 370.

Such a solution would offer the best means of achieving "a massive administrative devolution", to redress what Balniel saw as the undue centralisation of the existing structure. In his view, "it is easier and more acceptable to delegate authority to bodies which are answerable to local electors than to a ministerially appointed board" (157).

Balniel seems to have been expressing a personal preference rather than Party policy, for in January 1969 the CRD prepared a paper for Macmillan, copied to Balniel and Dean, which set out the history of the proposal for area [health] boards and the issues which needed resolution if such boards were to be established. First among these issues was whether boards should be "entirely professional in composition", as proposed by the Porritt Committee, or "fitted into the local government structure" (158).

The CRD conclusion was that "it would be much more in line with current Conservative thinking if any new area health service council could be fitted into the structure of local government". Noting the concerns of the medical profession about being "controlled by local authorities", however, the CRD suggested there should be a large professional element in the new arrangement (159).

(157) *ibid.*

(158) *Administration of the National Health Service*, 3/1/69, CPA CRD folder Health Service Finance 1968/9. The paper was misleading when it asserted that the Porritt Committee favoured "an entirely professional administrative body". Rather, the Committee had recommended that on the area health boards "all professions involved in the Service should be represented" (*A Review of the Medical Services in Great Britain*, 1962, p. 25).

(159) *ibid.*

As to devolution, the CRD linked administrative restructuring with the parallel discussions within the Party on NHS finance. Adoption of the Macmillan proposal that part of the Service should be funded from contributions to health insurance would reduce the extent to which NHS resources came from the Exchequer, and would make devolution easier, especially to a local government based structure. In the CRD's view, consideration should also be given to the establishment of a NHS Corporation, with "a large professional element in its membership", to be responsible to Parliament for running the Service. Such a Corporation could help diminish "excessive central government control" (160).

Whatever approach was adopted, the CRD suggested that it should first be tested through pilot schemes, as suggested by Porritt, and indeed in the Party's policy document *Putting Britain Right Ahead* (161).

During the period when Balniel and the CRD were indicating a preference for placing the administration of the NHS within local government, Crossman had been advised in an "off the record" conversation Dr Derek Stevenson, Secretary of the BMA, that a Special Representative Meeting (SRM) of the Association called to discuss the Government's Green Paper was likely to resolve that this should not happen (162).

(160) *ibid.* The notion of an NHS Corporation or Board had a long history. In the 1960s, on the Conservative side, "non-ministerial management" of the NHS, had been rejected by Powell as "a chimera" (Powell, 1966, pp. 12/3). Considerations by the Labour Government are summarised in Webster, 1996, pp. 334/6.

(161) *ibid.*

(162) note of meeting, 18/11/68, on PRO MH 166/7.

Stevenson's expectation was confirmed at the SRM in January, which approved a recommendation from the BMA Council that "the profession is opposed to the transfer of the administration or financing of the health service to local authorities, either in their present form or [anticipating the Royal Commission] in any modified form" (163). Council representatives put this formally to Crossman at a meeting at the Department of Health and Social Security (DHSS) on 5 March (164).

Possibly because of the BMA's opposition, the preference for a local government solution expressed by Balniel, and in the CRD paper, seems to have become less marked during the early months of 1969. In a paper the CRD prepared for an ACP meeting in June, under the heading "Administration" several "things which should be done" were itemised - the appointment of an Ombudsman and a Health Inspectorate, the promotion of group practices and health centres, the provision of "cottage type" hospitals, and the expansion of voluntary effort. Reform of the administrative structure was "not a first priority". No mention was made that a local government solution was the preferred option (165). The minutes of the ACP meeting contain no reference to discussion on the administrative structure of the Service (166).

(163) resolution C, SRM minutes, 30/1/69, BMAA, pp. 5/6.

(164) para. 11 of DHSS note of meeting, included with papers for Council meeting on 16/4/69, BMAA, C31, 1968/69, pp. 4/10.

(165) ACP/59, 3/6/69, CPA CRD 4/7/69.

(166) ACP(69)100th meeting, 11/6/69, CPA ACP 2/3.

### 5.3 The Report of the Royal Commission on Local Government in England

The Commission's report was published on 11 June 1969. For most of England (except the Greater London area, specifically excluded from its remit), the establishment of fifty eight unitary authorities was recommended, to undertake all local government functions for their areas. Three exceptions were Merseyside, the West Midlands and SELNEC (the South East Lancashire. North East Cheshire area), where a two tier structure was recommended, metropolitan areas, principally responsible for planning and co-ordination, and metropolitan districts, responsible for delivering most services (167).

The Commission made no formal recommendation about whether the NHS should be incorporated within the new structure of local government it favoured, because to have done so "would exceed our competence". However, the Commission expressed the view that incorporation "offers as good a chance of ending the present divided administration of the national health service as do nominated boards - and a better chance of establishing close relationships between the national health service and the personal social services" (168).

The Government's considered response to the Commission's report was not given until February 1970, when its main recommendations were broadly accepted, though not its "steer" on incorporating the NHS in local government (169).

(167) *Report of the Royal Commission on Local Government*, 1969, Cmnd. 4040, London, HMSO.

(168) *ibid.*, p. 92.

(169) in *Reform of Local Government in England*, Cmnd. 4276, 1970, London, HMSO, and *The Future Structure of the National Health Service*", 1970, London, HMSO.

#### 5.4 Policy development to the 1970 general election

While interest in placing the NHS within local government may have diminished among those responsible for health policy within the Conservative Party, it had not gone completely. A fortnight after the June ACP meeting and the publication of the Royal Commission on Local Government's report, Bellairs wrote to Macmillan, noting that the "professions are pretty solidly against local government control" but suggesting that the Party should "keep the options open". Discussions with interested bodies "would probably result in a compromise whereby the membership of the AHC [area health council] is shared between the professions and local authority representatives (rather on the analogy of the Police Authorities ...) and there is a right to pre-empt rates within certain defined limits" (170).

While the Conservative preference for the nature of any new structure was still for decision, there seemed to be substantial agreement on the desirable attributes of such a structure. There should be "proper representation ... at a genuinely local level" and devolution to avoid "too much control from the centre" (171). Both attributes were emphasised in the July 1969 *Quick Brief on Health* sent to constituency parties (172).

(170) Bellairs/Macmillan, 25/6/69, CPA CRD 4/7/16.

(171) *ibid.*

(172) 1969, London, Conservative Central Office, p. 5.

In an August *Daily Telegraph* article, Howe linked the idea of devolution through structural change to increasing overall spending on health. New area health boards should be "truly independent agencies. They should control their own budgets - with freedom to sell and develop land, to promote lotteries, to receive charitable gifts, and to raise money as they please". In his view, administrative change was "as important as extra cash" (173).

With the Government clearly rethinking its approach, Balniel and Macmillan had no need to identify, let alone announce, a definitive policy position, but could explore possibilities.

At the Party Conference in October, Balniel referred to the need to bring together the "two main branches of the Health Service and the welfare service ... under one administrative roof" (without reference to whether this would be within or outside local government). He added the idea that these might also amalgamate at local level with the social security organisation of the DHSS (174). It was, however, unclear whether by "welfare service" Balniel was referring just to the local authority personal health services, or also to the welfare services provided, largely, under the National Assistance Act.

(173) 12/8/69, p. 12.

(174) *Conservative Conference Report*, 1969, pp. 58/9.

Following the announcement in the Queen's Speech that the Government would be bringing forward "fresh proposals" for the future administration of the NHS (175), Balniel used the opportunity of the Debate on the Address to go beyond what he had said at the Conference.

He re-iterated his support for the Seebohm Committee's recommendation in favour of a unified social services department, but would be "very reluctant ... to see any break between this new department and any of the health and welfare services for the elderly, the handicapped, the disturbed, the unfortunate and the homeless" (176).

This implied that Balniel favoured retaining the personal health services within local government, alongside the proposed new local authority social services departments. However, when referring explicitly to the future structure of the Health Service, his position was not wholly clear.

Balniel favoured a "two-tiered reconstruction of the NHS, the upper of which would be "an authority covering a large area, because overall health planning must be on a regional basis", and "perhaps [its] chairman should be appointed by the Minister, but there should be firm local authority representation ... and ... equally firm professional representation". The day-to-day running of the "hospitals and the health and welfare services" would be the responsibility of the lower tier, covering areas providing the appropriate population for a 600 to 800 bedded district general hospital" (177). This suggested an organisation for the NHS separate from local government.

(175) Commons Hansard, 31/10/69, vol. 790, cols. 6/7.

(176) *ibid.*, cols. 529/30.

(177) *ibid.*

The "health" section of the first draft of the Party's manifesto for the next general election, produced in early December, did not provide a definitive answer. In respect of the structure of the NHS, the draft was limited to an undertaking to bring the hospitals, GPs and local health services together "under a unified administration on an area basis with genuine local participation" (178).

The possible need to go beyond this was identified by the CRD in a paper on a wide range of outstanding policy issues prepared for the LCC meeting at Selsdon Park. While noting the commitment to reorganise the NHS so that its three branches were under the same administrative responsibility in each area, the CRD pointed out that "the nature of the new administrative authority implied has not been decided, nor the extent of its responsibilities. For example, should it be a local authority, a professional body, or a combination of both; how far should it take over local authority welfare services like meals-on-wheels" (179).

The Selsdon discussion on the future structure of the NHS was inconclusive. Macmillan explained his difficulty in thinking about solutions in advance of a firm Party view on the Royal Commission on Local Government's recommendations. His suggestion was a three stage approach which would conclude with regional boards responsible for all three major elements of the Service, constituted solely of "representatives of local authorities and of professions". This new arrangement could then be "adopted in [the] two-tier local government structure", but still receiving the majority of funding from the Exchequer (180).

(178) draft dated 8/12/69, CPA SC/69/3.

(179) *Other Issues Requiring Policy Decisions*, 21/1/70, CPA CRD 3/9/92.

(180) Selsdon transcript, CPA CRD 3/9/93, p.17.

There was little discussion of Macmillan's suggestion, though Heath made it clear that he was sceptical of structural change. While in certain circumstances "changing structure is useful", it was important not to "fall into [the] error that by changing system it will make life of [the] citizen better". In his view, "the more that local councils have to do with [the NHS] the better" (181).

As noted above, in February 1970, shortly after the inconclusive Selsdon discussion, the Government announced its broad acceptance of the main recommendations of the Royal Commission on Local Government and issued revised proposals for the structure of the NHS. The latter document, although widely referred to as the second Green Paper, announced "three firm decisions" and sought comments on what were, arguably, second order issues (182).

The "three firm decisions" were, first, that the NHS was not to be administered by local authorities but by area health authorities (AHAs) directly accountable to the Secretary of State for Social Services. Second, that the reorganised NHS would include many of the personal health functions of the local authorities. Third, that in general the new AHAs would match the boundaries of the unitary authorities and metropolitan districts proposed by the Royal Commission, which were to be the social services authorities but not, in the case of the metropolitan districts, the education authorities (183).

(181) *ibid.*, p. 18.

(182) *The Future Structure of the National Health Service*, 1970, p. v.

(183) *ibid.* The Government's decision that the metropolitan authorities, rather than metropolitan districts, should be the education authorities was one of the issues on which it rejected the Royal Commission's view.

While Balniel and the CRD's preference for the transfer of the NHS to local government may have been modified somewhat during 1969, the tenor of the admittedly brief and (from the transcript) somewhat disjointed Selsdon discussion seemed favourable to it, particularly perhaps Heath's comment. The Government's decision to restructure the NHS outside local government thus created the possibility of a clear policy difference between the two major parties.

No indication of whether the Conservatives did intend to press for transfer of the NHS to local government was given in the brief responses of Macmillan and Balniel to Crossman's statement announcing publication of the second Green Paper (184).

The first substantial parliamentary opportunity for the Conservatives to comment came on the Second Reading of the Bill to implement the Seebohm recommendations. In fact, Balniel, essentially reserved his position. In welcoming the main purpose of the Bill, he said that he accepted "for the purpose ... of discussing this Bill ... the Government's assumption that the National Health Service will be administered ... outside local government" (author's underlining) (185).

The following month, however, the Party could no longer realistically reserve its position, as debates on the second Green Paper were held in the Commons and the Lords.

(184) Commons Hansard, 11/2/70, vol. 795, cols. 1255/61.

(185) Commons Hansard vol. 796, cols. 1406/1520.

In the Lords, Baroness Brooke of Ystradfellte spoke for the Conservatives. She was clear that "the medical world has won the battle of administration" and that transferring the NHS to local government "in 1970 ... is obviously not going to be "on"". Noting the intention that the new area health authorities were to have boundaries coterminous with the local authorities responsible for social services, however, Brooke thought that part of the reason was to facilitate transfer if the medical opposition diminished. That this might be the Conservative preference was suggested by her comment that "perhaps after another decade such a transfer would be in the best interests of everyone" (186)

Before the Commons' debate nearly a fortnight later, the second Green Paper was discussed by the LCC. Balniel suggested that the Party's line should be that the Government's proposals were excessively centralist ... "every decision would have to be approved by the Minister". He would also like to see stronger local government representation on the new health bodies (187)

There seems to have been no objection to the line Balniel proposed though Heath, consistent with his comments at the Selsdon meeting, was clearly sceptical about the proposed new structure, which he saw "as the beginnings of bureaucracy". He acknowledged, however, that there might be a case for it "in exceptional circumstances" (188)

(186) Lords Hansard, 10/3/70, vol. 308, cols. 710/1.

(187) LCC(70)356th, 18/3/70, CPA LCC(70)340-357.

(188) *ibid.*

Both Balniel and Macmillan spoke in the Commons' debate on the Green Paper on 23 March. On the issue of transferring the NHS to local government, Balniel took exactly the same line as had Brooke in the Lords debate. He accepted, "sadly", that "old fears" required "a line ... to be drawn for the moment between local government and central administration", but hoped that "good leadership of the medical profession and good leadership in local and national public life will one day overcome this fear". He also welcomed the principle that the boundaries of the proposed new AHAs and local government bodies should be coterminous, though not the Government's broad acceptance of the Royal Commission's recommendations for the new structure of local government (189).

Balniel's principal criticism of the Government's proposals was that they were too centralist, that by having the proposed AHAs directly accountable to him, the Secretary of State "will become involved in detailed control which will not only be inefficient, but positively harmful to the interests of the medical profession" (190). In particular, Balniel drew attention to the proposal that the chairmen and one third of the membership of the AHAs should be appointed by the Secretary of State, the other two thirds being appointed half by the health professions and half by the relevant local authorities. He would prefer to see a reduction, perhaps elimination, of the ministerially appointed element (191).

- (189) Commons Hansard, 23/3/70, vol. 798, cols. 1015/6.  
(190) *ibid.*, col. 1012.  
(191) *ibid.*, col. 1017.

During the debate, one Conservative MP, Arthur Jones, a vice Chairman of the Association of Municipal Corporations, questioned the reasons advanced for rejecting the transfer of the NHS to local government (192) but, in closing the debate for the Conservatives, Macmillan made it clear that he did not "quarrel" with the Government's decision to reject that option. He, like Balniel, emphasised the Party's concern over undue central control (193).

By the end of March 1970, therefore, the Conservative Party's policy on the future structure of the NHS had become more definite. While seeming in principle to favour transfer to local government, the leadership had accepted that the opposition of the medical profession precluded this for the foreseeable future. Given the reluctant acceptance of a structure for the NHS outside local government, the principle of coterminosity of health and local authority boundaries was seen as offering the best opportunity of ensuring effective collaboration between health and the proposed new social services departments.

On these issues of principle, both major parties had effectively reached the same conclusions. Significant differences remained, however, over implementation. The Conservatives opposed the local government structure the Government was proposing and, given the commitment to coterminosity of health and local authority boundaries, this had implications for the number of health authorities and the size of population they served. The Party also opposed what it saw as the excessive centralism of the Government's proposals, and had given some indication as to how it would seek to eliminate this, for example having greater local authority and health professional membership of the AHAS, rather than the third of centrally appointed members proposed in the second Green Paper.

(192) *ibid.*, col. 1076.

(193) *ibid.*, cols. 1090 and 1097.

None of this was inconsistent with the brief undertaking to "reorganise the National Health Service so that its three main branches - hospitals, general practitioners, and local health services - are brought together under a unified administration on an area basis with genuine local participation" included in the first draft of the manifesto for the next election that had been circulated in December 1969. No changes in this form of words were made in successive drafts circulated after the debate on the second Green Paper, as late as 15 May (194).

In the ten days before the manifesto was published on 26 May under the title *A Better Tomorrow* (195), however, a potentially significant change was made. For the commitment to "reorganise the National Health Service so that its three main branches ... are brought together under a unified administration on an area basis" was substituted one to "improve the administration ... so that its three main branches ... are better co-ordinated" (196)

The CPA contains no material to indicate whether this late change was a considered shift in policy, or simply some late "polishing" by someone who did not recognise its potential significance.

The effect of the manifesto wording was to leave open the Party's options if elected. For the commitment neither promised nor precluded any change to the structure of the Service. It was, for example, entirely compatible with the type of approach favoured by Robinson before he became convinced of the need for structural change, noted above, namely of trying to find means of ensuring that the separate administrative elements worked together to deliver co-ordinated services to the individual patient.

(194) 6th draft, 15/5/70, CPA SC/70/17.

(195) *Times*, 27/5/70, p. 1, col. c.

(196) Craig, 1975, p. 339.

## 6. THE SITUATION IN 1970

### 6.1 Policy development

As described above, between 1966 and 1970, despite the evident interest of Pike, Balniel and Macmillan in alternative financing arrangements, and the indications that new structural arrangements, possibly on Porritt lines, were favoured by successive LCC spokesmen, no substantive proposals for change in the form of the Service were included in the 1970 election manifesto. In that sense, the Party's policy on the form of the NHS was conservative (with a small "c"). The question arises as to how characteristic this was of the Party's overall policy stance?

For some commentators, the Conservative Party had changed its overall policy stance dramatically between 1964 and 1970. Thus, in Blake's view, the 1966 election manifesto marked "a clear departure from the paternalistic progressivism of 1959-63" (197), while for Norman Tebbit, the programme adopted at the LCC weekend at Selsdon Park was "the Tory Party's first repudiation of the post-war Butskellite consensus ... [a commitment] to the new liberal economics" (198). The Labour Prime Minister, Harold Wilson, sought to create an image of change by coining the phrase "Selsdon Man", personifying for him "an atavistic desire to reverse the course of 25 years of social revolution" and the rejection of "a civilised society in which the community, working through Government and Parliament, provides for the needs of the community" (199).

(197) Blake, 1985, p. 300.

(198) Tebbit N, *Upwardly Mobile*, 1988, London, Weidenfeld and Nicolson, p. 94.

(199) speeches given on 6 and 21 February 1970, quoted in Wilson H, *The Labour Government 1964-1970*, 1971, London, Weidenfeld & Nicolson, pp. 758/9.

Others have disagreed. For Anthony Seldon, for example, "Heath's aim was to make the post-war settlement work better, not to destroy it" (200), while for Norton to regard Heath as "neo-liberal" was to "misdiagnose" - he was "a corporate Whig [whose] emphasis was on achieving efficiency" (201).

The Conservative election manifesto in 1970 undoubtedly included new emphases and policies, for example the emphasis on incentives such as lower taxation and the proposal to introduce legislation to provide a framework of law for the conduct of industrial relations.

On the other hand, there was much in the manifesto that suggested continuity with the policies of the 1950s and 1960s, for example regional policy where the commitment was to "stimulate long-term growth by increasing the basic economic attraction of [areas of high unemployment]" (202). On social policy as a whole, including the NHS, Raison has suggested that "nobody could say [the manifesto policies] represented a radical change of direction" (203).

Overall, on its face, it is difficult to see the Conservative manifesto in 1970 as marking as major a shift away from the policies of the post-war years as Tebbit had hoped and Wilson had sought to suggest. At that stage it was simply too early to judge whether Heath intended "to break the postwar social settlement accepted by Churchill, Eden, Macmillan and Home" (204).

(200) Seldon A, "Conservative Century", in Seldon A and Ball S (eds.), *Conservative Century*, 1994, Oxford, Oxford University Press, p. 56.

(201) Norton P, "History of the Party III", in Norton P (ed.), *The Conservative Party*, 1996, Hemel Hempstead, Prentice Hall, p. 54.

(202) Craig, 1975, p. 333.

(203) Raison T, *Tories and the Welfare State*, 1990, London, Macmillan, p. 69.

(204) Campbell, 1993, p. 267.

Within this overall context, the conservatism of the Party's policies on the NHS was by no means exceptional. Equally, it was by no means the rule, and therefore invites specific understanding.

Among relevant considerations was the popularity of the NHS and the consequent difficulty perceived in making substantial change. Conservatives drawn towards economic liberalism, who might in principle have favoured radical change, acknowledged this. Thus, for example, Joseph regarded "a free GP service [as] so hallowed that we cannot move"; for Powell, "the very contemplation" of radical change was "enough to daunt the stoutest political heart", and Howe saw it as an "immutable rule ... that [quoting Powell] in a democracy "social benefits once conferred cannot be withdrawn"" (205)

A further consideration was the difficulty in finding practical solutions to the perceived problems of the Service. Agreement seems often to have been reached on objectives expressed at a relatively high level of abstraction, such as "encouraging the private sector" and "unifying the tripartite structure". Agreement on practical steps to achieving such objectives, without creating what were seen as additional problems, such as increasing public expenditure (in the case of encouraging the private sector) or distancing the personal health services from the welfare services (in the case of unifying the tripartite structure) proved less easy to reach.

(205) PG/13a/65/8, 5/7/65, CPA CRD 4/7/15 (Joseph); Powell, 1966, p. 16; Howe's speech to the Fellowship for Freedom in Medicine, 9/5/70, copy in Treasury, 2SS 21/338/02.

Overall, the impression the material studied gives of those thinking about Party policy in respect of the NHS from 1966 to 1970 is not that they displayed an "atavistic desire to reverse the course of the last 25 years", but rather were searching for ways to address what they perceived to be real but complex problems, with caution flowing, in part at least, from a clear sense of the popularity of the Service with the electorate.

## 6.2 Arrangements for policy review

Following the 1966 general election, the formal policy review arrangements continued essentially as they had been since the establishment of the HPG though, as noted above, after Balniel succeeded Pike in practice the Group seems not to have met. At that point Balniel and Macmillan were, in effect, the Party's policy reviewers, in discussion with LCC colleagues as appropriate.

That Pike and the HPG, and later Balniel and Macmillan, drew on expert sources outside the Party is clear. Under Pike, the Porritt recommendations continued to be the starting point for consideration of the issue of the structure of the NHS, and there can be little doubt that, later, Balniel and Macmillan drew on the work of the BMA Advisory Panel on issues of financing. Further, leading Conservatives would have been aware of relevant public statements, such as the resolution of the BMA's SRM in January 1969.

However, the evidence is that the Party drew on written sources rather than having substantial relationships with any of the many bodies representing health service professionals, or other organisations knowledgeable about the NHS. Overall, the evidence gives the impression that policy consideration was a very close-knit activity, to which only a very small number of people contributed directly.

Similarly, as with the period prior to the 1966 general election, the author has found little evidence of discussions between Pike and the HPG (and, later, Balniel and Macmillan), and the wider parliamentary Party, though this may reflect the lack of surviving evidence, such as notes of PHSSC meetings, rather than the absence of such discussions. However, parliamentary colleagues interested in NHS matters had opportunities both to set out their views, and hear those of the frontbench spokesmen, in the several Commons debates, both on organisational and financial issues, referred to above

As to the wider Party, the NHS was discussed, relatively briefly, at the 1966, 1967, 1968 and 1969 Annual Conferences where, as noted above, LCC spokesmen disclosed a continuing interest in encouraging private provision, and (at the 1969 Conference) Balniel set out his views, not without ambiguity, on the Service's structure. In addition, an initiative was taken to secure constituency-level feedback, by including questions on the financing and organisation of the NHS in one of the Party's regular consultative processes (206).

(206) through the leaflet *Three Way Contact Brief 28: Health and Family*, November 1969, London, CRD. The author has not yet been able to trace what feedback resulted.

## CHAPTER 3 – THE CONSERVATIVE PARTY IN GOVERNMENT, 1970–74

### 1. THE 1970 GENERAL ELECTION

As noted in Chapter 2, following the 1966 election Labour Party had an overall Commons majority of 96, sufficient for a full term.

Opinion poll evidence suggests that support for the Government fell markedly after the devaluation of the pound in November 1967, with a Conservative lead of over 10% until Autumn 1969. Then support for the Government seems to have recovered, until by Spring 1970 on some polls Labour was ahead (1). Following favourable local election results in May 1970, and a poll showing a Labour lead of 7% (2), Wilson successfully sought a dissolution for a general election on 18 June.

Four opinion polls just prior to election day forecast a Labour lead averaging over 5%. In the event, however, the Conservatives won 330 seats and an overall majority of 30 in the new House of Commons (3).

Explanations of this outcome vary, but tend to focus on aspects of economic management. Among leading Labour politicians, for example, in Wilson's view "the improvement in our economic position ... had not erased all the scars from the tough things we had to do" to achieve it. Barbara Castle, a cabinet member prior to the election, seems to have shared the view of "a lot of people in the Labour movement" that the Government failed to budget "more generously for growth – and for the Election" (4).

(1) Butler D and Pinto-Duschinsky M, 1971, p. 24.

(2) *ibid.*, pp. 134/5.

(3) *ibid.*, p. 354.

(4) Wilson, 1971, p. 790; Castle B, *The Castle Diaries 1964–70*, 1984, London, Weidenfeld & Nicolson, p. 805.

The view that economic management was the main factor is shared by academic commentators, who have drawn attention to the possible influence of short term matters such as the large trade deficit for May announced three days before polling, as well as to longer term disillusion with the competence of the Wilson Government (5). There seems to be no evidence that perceived differences in the parties' policies on the NHS were factors.

## 2. THE "NEW STYLE OF GOVERNMENT"

A party's manifesto provides some evidence of its leadership's intentions and, if the party goes on to form the government, a frame of reference that can help to make subsequent actions understandable. The Conservative manifesto for the 1970 election is thus of particular interest in considering the actions of the Heath Government.

As noted in Chapter 2, the Party's manifesto, *A Better Tomorrow*, was a meld of new emphases and proposals arising from the policy work initiated by Heath, with much that suggested continuity with the 1950s and 1960s. To the extent that the manifesto had a theme, it was the commitment to introduce what, in his Foreword, Heath referred to as "a new style of government" (6).

(5) see, for example, Ramsden, 1996, pp. 314/8; Blake, 1985, pp. 307/9, and Butler and Pinto-Duschinsky, 1971, pp. 343/51.

(6) Craig, 1975, p. 325.

Shortly before the election David Howell, who from 1967 had worked with Marples at the PSRU and become its head, had published a booklet entitled *A New Style of Government*. This offered "a Conservative view of the tasks of administrative, financial and parliamentary reform facing an incoming government" (7), and the title phrase has sometimes been used to describe the programme of changes to central government introduced by the Heath Government. Indeed, it was used specifically in that sense in the 1970 election manifesto, which included commitments to "systematically rationalise" the "functions and responsibilities of all departments and public agencies", and introduce "the most modern management, budgeting and cost-effectiveness techniques" (8).

As used by Heath in his Foreword, however, the phrase "new style" meant more than changes in the structures and management processes of central government. It had what could properly be termed a moral aspect, as well as one in respect of the nature of future policies.

As to the moral aspect, Heath regarded Wilson as leading "a cheap and trivial style of government", where "decisions lightly entered into [had] been as lightly abandoned". As a result, in Heath's view, the country had not just suffered from "bad policies". Politics itself was falling into disrepute, with young people becoming "suspicious and cynical" about it. Heath promised a different political morality. If elected, his Government would "sweep away the trivialities and gimmicks" and "re-establish our sound and honest British traditions" (9).

(7) Howell D, *A New Style of Government*, 1970, London, Conservative Political Centre.

(8) Craig, 1975, p. 330.

(9) Craig, 1975, p. 325.

Beyond that, "a new style" promised substantively better government. In contrast with what Heath saw as the "lightly entered into" short-termism of the Wilson Government, if elected Conservative policy making would be "deliberate and thorough", based on "up to date techniques for assessing the situation", and for "the long term". In particular, when a policy was established, the Government would "have the courage to stick to it, for in Heath's view, nothing had "done Britain more harm in recent years than the endless backing and filling which we have seen" (10).

With regard to the NHS, as noted in Chapter 2, no substantive proposals for changes in its basic principles or organisational arrangements were included in the manifesto.

On financing, there was an acknowledgement that the NHS was short of resources, with the implication that this would be addressed as Conservative government led to higher economic growth. As noted above in Chapter 2, however, a commitment to "consider the financing of the National Health Service with a view to finding ways of devoting more resources to the health of the nation without increasing the burden on the taxpayer" had been excised shortly before the manifesto was published. There was no mention of tax relief on health insurance premiums, though there was a commitment to "introduce a more imaginative contractual savings scheme" which in principle could have included such relief (11).

On the structure and management of the NHS, a commitment to unify the three main branches of the Service had been replaced at the final stage before publication by one to improve its administration through better co-ordination.

(10) *ibid.*

(11) *ibid.*, pp. 339 (the NHS) and 330 (contractual savings).

Overall, therefore, the impression conveyed by the election manifesto was that, if elected, an incoming Conservative Government would pursue organisational change in the public sector (including local government), but as regards the NHS this might be limited to improving co-ordination, with basic principles and organisational arrangements left very much as they were.

### 3. MINISTERIAL RESPONSIBILITY FOR THE NHS

From October 1967, Balniel had been the LCC member responsible for social services policy including the NHS. Heath did not, however, appoint him as Secretary of State for Social Services (or indeed to any Cabinet position) in the new Government. Instead Joseph, who had shadowed trade and technology immediately prior to the election, was appointed, with, as his junior ministers on Health Service matters, Lord Aberdare and Michael Alison (12).

As noted in Chapter 1, in the 1960s Joseph had been associated with the economic liberalism of the IEA. One commentator, writing just before the 1970 election, summed up the essence of Joseph's view as being that "the struggle for profit in a competitive situation is the best engine of material progress that we have" (13). Joseph's biographer has noted that, through a series of speeches "about the invigorating effect on industry of the free-market economy", he had been referred to as "Selsdon Man incarnate" and as such had become a target of Labour criticism (14).

(12) *Times*, 22/6/70, p. 2, col. f. (Joseph), 23/6/70, p. 1, col. b (Aberdare) and 24/6/70, p. 2, col. c (Alison).

(13) Harrington M, in Stacey T and St Oswald R, *Here Come the Tories*, 1970, London, Tom Stacey Ltd., p. 81.

(14) Halcrow M, *Keith Joseph*, 1989, London, Macmillan, p. 43.

In Campbell's view, Joseph's appointment "was a surprise", but there "was probably no significance in Heath's deciding to switch him" to social services (15). There was, however, some press speculation that it was Joseph's free-market views that led Heath to decide to appoint Geoffrey Rippon as Trade Secretary (16). Nearly thirty years later, Heath wrote that he appointed Rippon because of his "more reliable judgement" (17). Given Joseph's role in Heath's demise in 1975, however, (see Chapter 4), this comment needs to be treated with caution.

There can be no doubt of Joseph's personal interest in social services matters, and in particular the NHS. As noted in Chapters 1 and 2, Joseph had been the LCC spokesman on social services from 1964 to 1966 and had chaired the HPG from its inception to the 1966 election. Although responsible for shadowing labour issues after that election he had, at his own request, remained a HPG member, and had contributed to the WGSP.

In Opposition, Joseph had shown himself to be open to change in the organisational arrangements of the NHS. On NHS financing and the private sector, as noted in Chapter 2, Joseph seemed in principle to favour opening up health care provision to the market "to a limited extent", though saw formidable political difficulties. In supporting Balniel's proposals for tax relief on insurance premiums, he had suggested "the minimum adequate accompaniment" that would render them effective. On structure, Joseph had, after some doubts, expressed himself cautiously in favour of change on Porritt lines, the policy favoured by Pike, his immediate successor as LCC spokesman on social services.

(15) Campbell, 1993, p. 381.

(16) *Times*, 22/6/70, p. 2. col. b.

(17) Heath, 1998, pp. 310/1.

During his years in office Joseph did not seek to change the basic principles of the NHS as described in the Introduction. He did, however, examine the organisational arrangements of the Service, and initiated substantial change. In this chapter, Joseph's approach will be examined under the two headings of Financing, and Structure and Management, and some conclusions reached as to Conservative policy in respect of the form of the NHS by the February 1974 general election.

#### 4. NHS FINANCING

In the 1970 election manifesto, while committing itself to "cutting out unnecessary state spending" to help provide the basis for reductions in taxation, the Conservative Party had also noted areas of public provision, including the social services, where the fundamental problem was "the shortage of resources" (18).

The NHS was specifically included as a service viewed as inadequately resourced. Due to what the Conservatives saw as "the slow rate of economic growth under Labour", the "resources going into the Health Service are inadequate" (19). (1969 was the first year expenditure on the NHS fell in volume terms, and as a percentage of the GDP, since the early 1950s (20).) In the Conservative view, there were "too many outdated hospitals, too many old people not getting the care they need in their own homes, too many mentally ill people either in overcrowded hospital wards or getting insufficient care through local community services" (21).

(18) Craig, 1975, pp. 328 and 336.

(19) *ibid.*, p. 339.

(20) Cmnd 7615, 1979, pp. 433/4.

(21) Craig, 1975, p. 339.

However, apart from a general commitment that "more sensible priorities" within the social services would be established; the implication that the NHS could expect additional funding if and when a faster rate of economic growth was achieved; and a promise of "better value for money" through improved co-ordination of its three branches, the manifesto gave no indication of how inadequate resourcing of the Service would be addressed (22).

#### 4.1 The Government's overall approach to public expenditure

Shortly after taking office, the Government set in hand what Macleod, Heath's first Chancellor of the Exchequer (and a former Minister of Health), referred to as a "radical and searching review of public expenditure" (23). Its first products were a statement and White Paper in October 1970 (24).

In this statement, Barber, another former Minister of Health, who had succeeded Macleod after the latter's unexpected death in July, emphasised that in respect of the social services, the Government intended to adopt "a more selective approach". There would be increased public expenditure "on the basic structure - schools, hospitals, payments to those in need", but with "the scope of free or subsidised provision more closely [confined] to what is necessary on social grounds" (25), because "many services are subsidised to an extent which is unnecessary and out of date in our present society" (26).

(22) *ibid.*, p. 336 (priorities) and p. 339 (economic growth and better value for money).

(23) Commons Hansard, 7/7/70, vol. 803, col. 510.

(24) Commons Hansard, vol. 805, cols. 37/51; *New Policies for Public Spending*, Cmnd. 4515, 1970, London, HMSO.

(25) Commons Hansard, vol. 805, col. 37.

(26) *ibid.*, col. 42.

Henceforth, it was the Government's view that where the user of a social service could afford to do so, "he should bear more of the cost and the taxpayer less", this shift to be achieved "partly by the abolition of subsidies and partly by new or increased charges, but with exemptions and better remission arrangements for those who are poor or who have special needs" (27).

Barber also announced the first application of these new public expenditure principles to the health and welfare services. A subsidised service - cheap welfare milk - was to be withdrawn, and various NHS charges increased for those the Government judged able to pay them (28). Taken together, it was estimated that, across the UK, these measures would result in a net reduction in planned public expenditure of about £64m in 1971/2, rising to £81m in 1974/5 (29).

However, part of the potential net reduction in planned public expenditure was foregone, as Barber also announced increases in the resources to be made available to "those parts of the [health and welfare] services which are in greatest need", particularly services for the elderly and mentally handicapped (30).

Thus in its first statement of public expenditure plans, the 1970 Conservative Government announced an overall reduction in public expenditure on health and welfare, while increasing expenditure in areas it regarded as in greatest need, by withdrawing a subsidy it regarded as no longer necessary and requiring those it judged able to do so to pay more in dental, ophthalmic and prescription charges.

(27) *ibid.*

(28) *ibid.*, cols. 42/3.

(29) Cmnd. 4515, 1970, para. 26.

(30) Commons Hansard, vol. 805, col. 45.

Allowing for a small increase in expenditure on social security that the Government estimated would flow from its decisions on health and welfare (31), the overall reduction in planned public expenditure in 1971/2, on a UK basis, was estimated to be £45m, or about 2.1%, on a programme hitherto expected to be £2,108m (32).

Within the Government's broad approach to public expenditure described above, in order to address deficiencies in the NHS of the kind set out in the 1970 general election manifesto Joseph pursued what could be viewed as a fourfold approach, the elements of which are described in the following sections.

(31) Cmnd. 4515, 1970, para. 26.

(32) *ibid.*, table 1, p. 4. (Calculated on the basis that the net reduction of £49m in health and welfare expenditure shown in line 15 of the table was offset by the £4m increase in social security expenditure referred to in para. 26 and incorporated in line 16 of the table.)

## 4.2 Asserting the needs of the NHS

Throughout his period as Secretary of State, Joseph sought to persuade colleagues of what he saw as the needs of the NHS. For example, in September 1970 he wrote that "what we said in our Manifesto was not an exaggeration ... [for example] standards in psychiatric and geriatric hospitals are scandalously low" (33). In May 1972, the draft White Paper on NHS reorganisation included the statement that "there is no question about the need for continued increase in [NHS] resources", until it was vetoed by the Treasury (34). In February 1973 Joseph wrote to Barber that "conditions in many of our long-stay hospitals ... are still deplorable and are likely to remain so until [substantial] additional funds can be injected" (35). In July 1973, responding to a request from Heath for items for the next manifesto, Joseph noted that, despite devoting "a slightly higher proportion of the GNP ... than ever before" to the NHS, "the expectations ... of the disabled, the mentally ill and the mentally handicapped AND their families have rocketted: the impatience to rebuild our obsolete hospitals has intensified: the acute services are all asking to expand or improve: waiting times are awful: and the working and living conditions for doctors, nurses and other groups of workers are often intolerable" (36).

Supported, as they were, by evidence of shortcomings such as the reports on specific long-stay hospitals prepared by the Hospital Advisory Service (HAS) (37), Joseph's assertions seem to have borne some fruit.

(33) quoted in Webster, 1996, p. 392.

(34) Treasury/DHSS, 18/5/72, PRO MH 166/31.

(35) quoted in Webster, 1996, p. 397.

(36) Joseph/Heath, 26/7/73, CPA Official Group box 28-44.

(37) an inspectorate established in 1969 by the Labour Government. For the origins of the HAS, and an example of the evidences of shortcomings detailed in HAS reports, see Webster, 1996, pp. 231/6.

In the 1971 review of public expenditure, an additional £100m was allocated to the health and personal social services in England, while in the 1972 and 1973 reviews, despite the deteriorating economic situation, the services largely escaped reductions in the growth planned for future years (38).

Even in December 1973 when a curtailment in oil supply and industrial action in the coal and electricity industries faced Britain with what Barber agreed was "the gravest [situation] since the end of the war" (39), the planned spending on the NHS was reduced by less than some other programmes (40).

#### 4.3 Increasing revenue through charges

As noted above, the Government explicitly adopted a policy of seeking to transfer the costs of public services from the taxpayer to those who used them and were judged to be able to afford to pay. With respect to the NHS this meant examining the scope for introducing new charges and increasing existing ones.

Within a month of taking office, Joseph had asked officials to examine the scope for two new direct charges on those using services - a boarding charge for hospital patients (which, as noted in earlier chapters, had frequently been considered) and a charge for visiting GPs (41).

(38) Commons Hansard, vol. 826, cols. 957/8; Webster, 1996, pp. 396/8.

(39) Commons Hansard, vol. 866, col. 952.

(40) the NHS gained substantial exemptions from the general 10% reduction in public expenditure on supplies. The exemptions were in respect of "food, drugs and related supplies" (Commons Hansards vol. 866, col. 964 (the general policy) and vol. 868, col. 117 (the NHS's exemptions)).

(41) note of Joseph's meeting with officials, 21/7/70, no. 70/200, PRO BN 13/156.

By August 1970, however, Joseph seemed to have been largely convinced that the boarding charge "was not ... worth pursuing, in view of the substantial administrative burden and litigation that would be involved", and Macmillan, the Chief Secretary to the Treasury, agreed that "this proposal should not now be pursued" (42).

Joseph referred to the limitations on charging within the NHS at the Party Conference in October. While stating that the Government had "no ideological objection as such to charges", he noted the "real, not ideological limitations" which included the need for widespread exemptions, the costs of collection, and the danger that some would be deterred from seeking medical attention (43).

Despite these doubts, the possibility of introducing the boarding charge, perhaps if recommended by the Working Party on NHS Finance (see below), was still in Joseph's mind as late as January 1971 (44).

However, the Working Party reached essentially the same conclusions as had Joseph the previous August - "the administrative costs ... would far outweigh any possible advantages". On charges for visits to the GP, in the Working Party's view there were "strong medical arguments against" and in any case it was "doubtful whether the medical profession would be willing to operate" them without a "change in their method of remuneration", which would be "undesirable" (45).

(42) note of Joseph's meeting with the Macmillan, 19/8/70, Treasury file 2SS 21/338/01A.

(43) *Conservative Conference Report*, 1970, London, NUCUA, p. 53.

(44) Joseph/Sir Philip Rogers, 1/1/71, PRO BN 13/163. (Rogers was Permanent Secretary of the DHSS.)

(45) the Working Party's report, sent to Joseph under a covering letter from JJB Hunt dated 4/6/71, Treasury file 2SS 21/338/01E. Copy of report also in PRO BN 13/219.

On 3 June 1971, the day before the Working Party's report was sent to him, Joseph decided not to pursue either possible new charge, and asked that the Treasury should be advised that "once the pledge of proportionate prescription charges is fulfilled [see below] ... it is not proposed to impose any more new charges (46).) At a meeting of the ACP a few days later Joseph was frank about what he saw as the disadvantages of such charges. In addition to the "administrative and legal complications of charging", there would be "political odium" (47).

On the face of it, the timing of Joseph's decision was strange, as he had not received the Working Party's report. There is, however, clear evidence that he had seen it in draft, and his senior official on the Working Party, CL [Dick] Bourton, was present at the meeting on 3 June, so Joseph could have been in no doubt as to the Working Party's conclusions (48).

In parallel with the initial consideration of the two new charges, the scope for increasing revenue by raising or extending existing ones was examined. In the discussion with Macmillan in August 1970, Joseph agreed to the introduction of higher charges for dental and ophthalmic services (49), which were announced by Barber in October 1970 (50).

(46) note of Joseph's meeting with officials, 3/6/71, no. 140/71, PRO BN 13/157.

(47) ACP(71)112th meeting, CPA ACP 2/3.

(48) that Joseph had seen a copy of the report in draft is stated in a Treasury note, 10/6/71, of a conversation with Bourton, Treasury file 2SS 21/338/01E.

(49) Webster, 1996, p. 391.

(50) Commons Hansard, vol. 805, col. 43.

It was also agreed, and announced by Barber, that the prescription charge would be increased from 2/6 (12.5p) to 4/- (20p) per item, with the existing exemptions from payment continuing, and in due course be converted into a charge proportionate to the cost of what was prescribed (51).

Webster records that in July 1971 it was reported to the Cabinet that discussions with doctors, dentists and pharmacists on the possible form of what was referred to as the graduated prescription charge had failed to reach a workable solution, but that health ministers were asked to continue to seek one (52). By October, however, Joseph was clear that no solution could be found (53), and the decision not to proceed with graduated charges was publicly announced on 15 November 1971 (54).

Another area of possible charges was in respect of aids and appliances. In September 1970 Joseph held a meeting with officials on the scope for charging for numerous categories of aids and appliances hitherto provided free. He decided not to pursue charges in respect of eleven categories (including wheelchairs), but commissioning further work on others, such as the possibility of a 10/- (50p) or 15/- (75p) charge on elastic hosiery and charges for wigs (55).

The possibility of raising additional revenue through restructuring the charges for the use of beds in NHS hospitals by private patients - pay beds - was also considered. The idea was that higher charges should be made for pay beds with in more modern rooms, or with better associated facilities such as adjacent sitting rooms or bathrooms, than for more basic accommodation.

(51) *ibid.*

(52) Webster, 1996, p. 394.

(53) meeting with officials, 7/10/71, PRO BN 13/158.

(54) Commons Hansard, vol. 826, col. 72 (written answers).

(55) 22/9/70, meeting note 232/70, PRO BN 13/156.

Officials reported that the scope for differential charges was so narrow under existing legislation, but that the idea might be reconsidered "at the next suitable legislative opportunity" (56). Aberdare was reported as wanting to increase hospitals' discretion in relation to such charges (57), but the author has found no evidence that any further action was taken.

Overall, after considerable reflection no new charges were introduced by the Government. The effect of the increase in prescription charges and restructuring of dental and ophthalmic charges was to raise the proportion of NHS finance raised through charges from 3.2% in 1970/71 to 3.5% in 1973/74 (58), a very small step towards the Government's objective of transferring costs from the taxpayer to the service user.

#### 4.3 Using resources more efficiently

In parallel with seeking to persuade ministerial colleagues that the NHS needed additional resources, and searching for ways of increasing revenue through charges, Joseph sought to remedy some of what he regarded as the deficiencies of the Service by increasing the efficiency with which existing resources were deployed.

(56) paper prepared for Aberdare by officials dated 1/3/72, PRO MH 166/45.

(57) note dated 13/3/72, PRO MH 166/45.

(58) Cmnd 7615, 1979, p. 436.

As noted in the Introduction, in the early years of the NHS some Conservatives suspected that it was inefficient. However, two Party parliamentary Health Policy Committee enquiries and the Guillebaud Committee failed to identify any major inefficiencies.

The view that there was little significant scope for improvements in efficiency continued into the 1960s. Powell, for example, when interviewed by members of the HPG following the publication of *A New Look at Medicine and Politics*, was reported as saying that he "did not think that there was scope for dramatic savings in the NHS by reducing cost differences between different hospitals", though "savings could be made ... by a careful examination of staffing policies" (59).

Joseph took a different view. In 1958, two years after the Guillebaud Committee had reported, he gave a paper on prospects for the second decade of the NHS. Although he did not expect improvements in efficiency to enable future demands on the NHS to be met without additional Exchequer funding, he regarded there as being scope for greater management efficiency, more effective co-ordination between the elements of the tripartite structure and savings in the management of the hospital building programme and in the cost of drugs (60).

(59) note PG/13a/67/24, 7/2/67, CP CRD 4/7/15.

(60) Joseph, 1958.

As Chairman of the HPG after the 1964 election, Joseph demonstrated continuing interest in ways of improving the efficiency of the NHS, initially by having a management consultant (Hamilton) and a specialist in the application of automation (Payne) appointed to the Group. Following discussions within the HPG, in his draft working paper of November 1965 Joseph included the application of operational research and automation, and improvements in arrangements for hospital building, as avenues to be pursued in the interests of efficiency (61).

As Secretary of State, Joseph immediately took the opportunity to set in hand work to pursue improvements in efficiency.

Early in July 1970, officials were commissioned to explore a number of options to improve efficiency in the hospital service, including widening the responsibility of the HAS to include the acute hospital service and extending its remit to cover "the efficient use of resources"; developing "comparative statistics, one HMC with another, of indices of effective resource utilisation"; and holding "a conference of RHB Chairmen to discuss ways of increasing performance, of persuading staff to adopt them, and of following-up progress" (62).

(61) *Draft Health Working Paper*, PG/13a/65/10, CPA CRD 4/7/15.

(62) 6/7/70, draft meeting note 182/70, PRO BN 13/156.

In the same month Joseph held discussions with officials on hospital building and the capital investment programme, and commissioned a detailed analysis of the use of space within hospitals (63), and papers on "the possibility of financing hospital building by private capital" (64) and "ways of breaking down consultants' autonomy in resource allocation and utilisation (65). In addition, he had carried forward his interest in operational research by proposing its use "to construct mathematical models to optimise resource allocation both between and within the hospital and community health services" (66), an initiative that led to an extensive examination of "the balance of care".

The issue of efficiency was not a transitory interest: during his first year in office Joseph held numerous meetings on different issues bearing on it. In the early Autumn of 1970, for example, he asked that financial incentives and "Queens Awards" to encourage better management be considered, together with the establishment of a "Hospital Corporation" which would take over the management of some hospitals to provide exemplars of efficient management (67). Later in the year he requested an operational research study "to evaluate the case for day treatment rather than in-patient care", instigated an enquiry into hospital building procedures, and discussed the establishment "as soon as possible" of an inspectorate which would "supervise the total performance of both hospital and local authority services" (68).

(63) 9/7/70, meeting note 70/188, PRO BN 13/156.

(64) 21/7/70, meeting note 70/200, PRO BN 13/156.

(65) 27/7/70, meeting note 203/70, PRO BN 13/156.

(66) *ibid.*

(67) "*Setting standards in the NHS*", 10/9/70 (financial incentives) and "*Stimuli to good management in the NHS*", 24/9/70 (Queens Awards and the Hospital Corporation), both PRO BN 13/156.

(68) notes 70/277, 18/11/70 (OR study) and 70/300, 9/12/70, (procedures enquiry), both PRO BN 13/156; and 70/306, 17/12/70, (inspectorate), PRO BN 13/157.

As Joseph's interest in the administrative reorganisation of the NHS developed, however, initiatives in respect of efficiency seem increasingly to have become aspects of that policy. This was foreshadowed in September 1970 when, in taking the decision to recommend to ministerial colleagues that the Government ought to go ahead with the administrative reorganisation of the NHS, Joseph told his officials that he was "particularly keen to discuss management, competition, standards and inspectorate" (69), with the implication that these would be issues within the reorganisation policy. Over the subsequent two years until the publication of the White Paper on NHS reorganisation, Joseph sought repeatedly to see that these issues were indeed part of the reorganisation discussions.

Although Joseph came to see NHS reorganisation as central to using existing resources more efficiently, that policy was much more than an efficiency initiative. It will therefore be considered separately, below.

#### **4.5 Alternative means of financing the NHS**

The three elements of Joseph's approach to increasing the resources available for the NHS described above were essentially working within the financing arrangements established at the inception of the Service, as only slightly modified (in respect of charges) since. Potentially the most radical element was a fourth - examination of alternative means of financing the NHS.

(69) Joseph's manuscript note, 16/9/70, PRO MH 166/97.

Joseph's position on alternative financing in the 1960s has been summarised above. Although, as noted in Chapter 1, his correspondence with the IEA in 1965 had evidenced caution, by 1970 Harris and Seldon are said to have come "to regard Joseph as their principal political hope" (70).

Seldon wrote to Joseph shortly before the 1970 general election, enclosing a copy of the report of the BMA's Advisory Panel (which he regarded himself as having greatly influenced (71)). He expressed the hope that an incoming Conservative Government would "come out more clearly in favour of a growing private sector of medicine, and with proposals to help everyone - including the "poor" to pay for it" (72). Perhaps mindful of the apparent lack of response to the suggestions he had made on Balniel's paper in September 1968, and the reaction to Macmillan's proposals at the Seldon meeting, Joseph responded that "the first thing is to get the policies that some of us can put forward enthusiastically among our colleagues" (73).

(70) Cockett, 1994, p. 169.

(71) in a letter to Joseph dated 7/8/70, Seldon described the report as "about 70% "pure" Seldon (and Howe?), and the rest was sordid expediency in the hope of pushing the report through the BMA". HI, IEA papers, box 333, folder 5.

(72) Seldon/Joseph, 10/6/70, *ibid.*

(73) Joseph/Seldon, 12/6/70, *ibid.*

Soon after taking office, and despite stating in the Debate on the Address that he could "confidently assert" that the NHS would continue "to be paid for very largely out of taxes and contributions" (74), Joseph took a step towards exploring alternative financing arrangements. He convened a meeting with Macmillan and Howe (who had returned to the Commons at the 1970 election and been appointed Solicitor General), to discuss possibilities "from the background they had collected in previous thinking about financing health services by insurance rather than from the point of view of their Ministerial Offices" (75).

Macmillan, when an Opposition frontbench spokesman, had favoured putting the FPS on an insurance basis, a proposal which, as noted in Chapter 2, seems to have received no support at the Selston meeting. Howe, at the time of the publication of Powell's *A New Look at Medicine and Politics*, had expressed the hope that radically different arrangements for the organisation and funding of health care could be achieved over a ten to fifteen year timescale, and later became a member of the BMA Advisory Panel examining methods of financing health care.

The Advisory Panel's report had been published prior to the general election (76). It had recommended that a range of NHS services should continue to be funded from taxation, including the services then provided by local health authorities and hospital in-patient care for geriatric patients, the chronic sick, and patients suffering from mental subnormality or long term mental illness. In its view, however, the remainder of medical services, comprising "the bulk of medical care given to those who are normally well", should be "financed by insurance" (77).

(74) Commons Hansard, 13/7/70, vol. 803, col. 1176.

(75) DHSS note of meeting on 28/7/70, Treasury file 2SS 21/338/01A.

(76) a summary was published in the *BMJ*, 25/4/70.

(77) *ibid.*, p. 90 (paras. 22/5).

The Panel proposed that "the act of insurance should be compulsory", though individuals would have the opportunity of contracting out of the "compulsory health insurance" scheme into alternative schemes offering increased benefits in return for higher premiums (78).

Although only able to attend about a quarter of its meetings, Howe was present at the one at which the Advisory Panel discussed its emerging conclusions. The note of that meeting recorded that, while warning of the political difficulties of the proposal for compulsory insurance, "G Howe accepted the general outline of the insurance proposals" (79). Some months later, when commenting on the final draft of the Panel's report, Howe wrote that "I see no point on which I feel disposed to dissent with any violence ... the entire tenor of the report ... is most attractive to me" (80).

Shortly after the Panel's report was published, Howe gave a speech to a Fellowship for Freedom in Medicine conference. The starting point of his analysis was the "need for more money to be brought into health", something he did not think "anyone challenges". Howe thought it "almost impossible to see how we can hope to raise the additional expenditure necessary from general taxation". More realistically, it could be secured by giving individuals opportunities to choose to divert to spending on health part of the "£25,000 million a year" spent in aggregate on consumption (81). In Howe's view, the BMA Advisory Panel's recommendations offered a way of creating the opportunity for increased personal expenditure on health care.

(78) *ibid.*, (para. 26).

(79) Panel meeting 30/4/69 and 1/5/69, note on BMAA, P/1/109.

(80) Howe/Macpherson (BMA), 8/12/69, Howe papers, white box 16, file 5.

(81) 9/5/70, copy on Treasury file 2SS 21/338/02.

At the meeting Joseph had convened, both Macmillan and Howe explained the thinking that had led them to make their respective proposals. Macmillan said his proposal had been designed so that "patients themselves would assume an interest in the costs and standards of the services they used" (82). Howe who, without disclosing the reason for his request, had asked Seldon for urgent briefing on twelve questions about the BMA Advisory Panel's report prior to the meeting (83), emphasised the potential of Panel's scheme to tap into the £25,000 million a year consumer expenditure (84).

Joseph's position was unclear. On the one hand, he thought the compulsory insurance premium under the Panel's scheme might be £15 a year per person, and thus "very high", and "doubted whether Government had a mandate to switch the NHS fully to an insurance-based system". On the other, he clearly did not want to leave matters as they stood, and concluded that further studies should be made of schemes in other countries and consideration given to the possibility of experimentation (85).

In parallel with considering Macmillan and Howe's ideas, Joseph had been thinking about a different option, shifting part of the cost of the NHS "from the taxpayer to industry over a period of years" (86).

(82) DHSS note of meeting on 28/7/70, Treasury file 2SS 21/338/01A.

(83) Howe/Seldon, 23/7/70 and Seldon/Howe, 24/7/70, both HI IEA papers, box 332, folder 3.

(84) DHSS note of meeting on 28/7/70, Treasury file 2SS 21/338/01A.

(85) *ibid.*

(86) 29/7/70, meeting note 70/211, PRO BN 13/156.

Joseph had read the BMA Advisory Panel's report "three times" (87) and, despite concerns over what would be "politically possible (or administratively practicable?)" (88), he decided to explore alternative funding possibilities. On 15 August he wrote to Seldon: "Despair not. I hope you won't be too dissatisfied even if my methods and aims are not exactly as you would wish" (89). Four days later he had a further meeting with Macmillan, this time with the latter firmly in his role as Chief Secretary, on public expenditure. This resulted in the decision that an official working party should be established to study alternative methods of funding (90). A note to a colleague by one of the Treasury officials present stated that this proposal was Joseph's (91).

At the beginning of September Joseph wrote to Barber to advise him that he intended putting to the Working Party his proposal to shift "most" of the cost of the NHS from the taxpayer to industry. The shift would take place over "5 or 6 years", and its impact "could be divided as seemed best between employer and employee" (92). Joseph envisaged that "in due course" contracting out of part of the "industrial cost" might be permitted, rather as the BMA Advisory Panel had envisaged contracting out of the "compulsory health insurance" it favoured.

(87) according to Seldon, letter to Joseph, 7/8/70. HI, IEA papers, box 333, folder 5.

(88) Seldon, summarising Joseph's view that he, Seldon, did not allow sufficiently for these considerations, *ibid.*

(89) Joseph/Seldon, 15/8/70, *ibid.*

(90) note on Treasury file 2SS 21/338/01A.

(91) M Widdup/J Patterson, 20/8/70, *ibid.*

(92) Joseph/Barber, 1/9/70, *ibid.*

Joseph's letter led to discussion within the Treasury on whether what was proposed represented a move away from financing the NHS by taxation, or merely a shift in the incidence from one tax to another, and on the acceptability of hypothecating the proceeds of a particular tax to the NHS (93). The result was that Barber sent Joseph an acknowledgement in which he commented that "it seems possible that it will be difficult to distinguish employers' and employees' contributions from other forms of taxation" (94).

The Working Party on NHS Finance (WPNHSF) met for the first time on 13 October. Its terms of reference were "To examine possible alternative methods of financing health and welfare services in the public and private sectors, having regard, particularly, to the probable continuing increase in demand for the services, the inevitable continuing constraint on resources, the planned re-organisation of the structure of the National Health Service and of local government, and the government's general taxation policy" (95).

The WPNHSF consisted solely of civil servants (96), and seems not to have been overseen by a Cabinet committee, unlike a similarly titled group established in 1960 under the auspices of the Social Services Committee (97).

(93) minutes by Patterson, 10/9/70, Patrick Jenkin (Financial Secretary), 14/9/70, and Macmillan, 15/9/70, *ibid.*

(94) Barber/Joseph, 16/9/70, *ibid.*

(95) Treasury file 2SS 21/338/02.

(96) from Treasury, Inland Revenue, Cabinet Office, Department of Health and Social Security (DHSS), Welsh Office and Scottish Home and Health Department.

(97) personal communication, R Ponman, Cabinet Office, 4/10/00 (Working Party); Webster, 1996, p. 77 (1960 group).

At its first meeting the WPNHSF was advised that Joseph "felt strongly that additional national resources should be applied to health and welfare services ... [and] wanted to find ways in which the pressures on public expenditure could be relieved to allow further growth in the services" (98). In identifying possibilities, however, "there should be no distinction in medical treatment and no one should enjoy worse conditions than now" (99).

A copy of Howe's speech to the Fellowship for Freedom in Medicine was circulated, with a covering note from the DHSS to the effect that Joseph was understood to agree with some of the views expressed in the paper (100).

A positive decision was taken that the formation of the WPNHSF should not be announced, as it "would inevitably lead to pressure from the BMA and others to be afforded an opportunity to put forward their own partisan views, and the character of the exercise would change" (101). This decision was adhered to even after the *Times* carried a well informed report of the initiative (102). For example, in briefing Aberdare for an appearance before the Party's parliamentary Health and Social Services Committee in January 1970, the secretary to the WPNHSF advised that its existence "has somehow become known to the Press but it would be embarrassing if this were confirmed by the Government and any question on it could best be answered evasively ..." (103).

- (98) minutes, Treasury file 2SS 21/338/02.
- (99) *ibid.*
- (100) *ibid.*
- (101) Rogers/Joseph, 30/10/70, PRO BN 13/163.
- (102) *Times*, 21/12/70, p. 1, col. g.
- (103) H Salter/Aberdare, 25/1/71, PRO BN 13/219.

Despite the existence of the WPNHSF, it seems that Joseph did not expect to be proposing any radical change in NHS financing arrangements. In January 1971 he attended a BMA dinner, at which he was reported as having given his pledge that the NHS would remain "overwhelmingly financed by taxation and contributions" (104), much what he had said in the Debate on the Address the previous July. In March, in answer to a parliamentary question Joseph stated that "alternative sources of revenue are constantly under consideration", but qualified this by repeating the phrase he reportedly used at the BMA dinner, that as far as he could see the NHS would remain "overwhelmingly financed by taxation and contributions" (105).

Possibly in Joseph's mind the issue was in part one of timescale. Certainly this was the position of some of his parliamentary colleagues. A sub-committee of the Party's parliamentary Health and Social Security Committee completed a report on the organisation of the NHS in April 1971. While accepting "that for the time being the major sources of finance ... must be taxation and/or national insurance", most members favoured more radical change in the longer term. Specifically, the sub-committee believed that "the basis of finance should be compulsory health insurance (normally non-state) which would allow patients to buy either NHS or private services as they preferred". As a "step towards" change, relief on private health insurance "would be a valuable way of testing whether the demand for choice and an enhanced private sector [was] strong enough to justify a radical shift in policy designed to restore the market element to health provision" (106).

(104) *Guardian*, 15/1/71, p. 13,, col. b.

(105) Commons Hansard, 16/3/71, vol. 813, cols. 1177/8.

(106) copy of report, under cover of letter from Raison to Macmillan, 20/5/71, Treasury file 2SS 21/338/01E.

This potential "step towards" a more radical policy was essentially what Balniel had proposed in Opposition. It had been put to Joseph by BUPA during a meeting in August 1970, but his reply had been that "it would be very difficult for the Government to give tax relief on subscriptions to BUPA and similar organisations", though the nature of the difficulty was not specified (107).

Shortly before receiving the sub-committee's report, Macmillan had been approached on the same issue by the BMA. His response was that he did "not think that the granting of tax relief would give sufficient extra encouragement to [private health insurance] to justify creating the very considerable difficulties involved". These he specified as, first, explaining why similar relief could not be given in respect of "many forms of expenditure which are considered to be especially worthy" and, second, the increased number of civil servants that would be needed to run the consequently more complex tax system (108).

The WPNHSF report was submitted to Joseph on 4 June. In the members' view, "any change ... which carried with it a substantial switch from State to private provision outside the National Health Service could increase the cost and reduce the effect of the co-ordinated Service" (109).

- (107) note 216/70, 19/8/70, PRO BN 13/156.
- (108) Macmillan/BMA, 7/5/71, on PRO BN 13/200.
- (109) report, p. 37 (para. 91), PRO BN 13/219.

On the sort of arrangement favoured by Macmillan in Opposition, and by the BMA Advisory Panel and Conservative Party Health and Social Security sub-committee, members judged that the administrative costs "would far outweigh any possible advantages" and "be far greater than any likely diversion of extra resources to the health services which contracting out might bring". On ideas for what would in effect be a "health tax", with the yield allocated to the NHS, members saw objections on the ground of hypothecation (which would reduce "the Government's freedom of action in controlling expenditure or taxation"). A health tax of the kind favoured by Joseph, paid by employers and employees, was open to the additional objection of making the proposed reconstruction of the National Insurance scheme more difficult (110).

The "step towards" a more radical solution proposed by the Party sub-committee, giving tax relief on private health insurance premiums, would, in the Working Party's view, "have a very small effect on the problems of financing the NHS", "complicate the income tax" and carry the implication that taxpayers "should get relief from general taxes if they choose not to contribute to the cost of public expenditure programmes of which they do not make direct use". If relief was given the cost of the NHS "might actually increase" (111).

(110) *ibid.*, pp. 38/9.

(111) *ibid.*, p. 40 (paras. 105/7).

Three days after the WPNHSF's report was sent to ministers, M Widdup, a Treasury Assistant Secretary, asked Bourton what view Joseph had taken of it. According to Widdup's note, Joseph had seen a draft of the report, which had been returned "with the sole comment "Read" ... Bourton has presumed from this that [Joseph] accepts the main conclusions ... there was no likelihood ... at present ... of [Joseph] ... wishing the Working Party to pursue particular lines of further enquiry" (112).

Within the Treasury, officials reported this assessment of Joseph's position to Macmillan when discussing the WPNHSF's report with him. Macmillan "accepted the main findings ... viz, that, short of a major revolution in the whole NHS system, there is very limited scope for any changes whose benefits would outweigh the practical difficulties to which they would give rise" (113). Subsequently Bourton was advised that "he might inform his Secretary of State that the Chief Secretary is not proposing that any further action should be taken on the Working Party's report" (114).

A few days later, a paper on NHS reorganisation drafted for Joseph was circulated for comment within the DHSS. It contained a reference to possible consideration by ministers of the WPNHSF's report (115). This elicited an immediate and successful request from Bourton that the reference be deleted, as "both [Macmillan] and [Joseph] have now, separately, studied the Report ... and neither seems disposed to take any action on it. I should not like us to lead [Joseph] to think that we are expecting him to take some kind of initiative" (116).

(112) note by Widdup, dated 10/6/70, Treasury file 2SS 21/338/01E.

(113) note of meeting 8/6/70, Treasury file 2SS 21/338/01F.

(114) manuscript note by Widdup, 9/6/70, *ibid.*

(115) paper by T Nodder, 15/6/71, PRO MH 166/45.

(116) Bourton/Nodder, 16/6/71, *ibid.*

As far as the DHSS papers currently publicly available show, no further action was taken in respect of the WPNHSF's report. Joseph certainly made no reference to it, or to the issue of alternative financing for the NHS, in a six page report on the areas within his responsibility made to Heath in October 1971 (117), or in his speeches to the 1971, 1972 and 1973 Party conferences.

#### 4.6 The effects of Joseph's approach

As noted above, Joseph had some success in increasing Exchequer funding of the NHS resources. Between 1971 and 1974 expenditure increased by 10% in volume terms, and rose from 4.67% of GDP to 5.34% (118). Joseph secured this increase by successfully arguing for a degree of priority for the service in question, and by increasing and restructuring existing charges. He was assisted initially by the acknowledgement in the manifesto that the resources of the NHS were "inadequate", and later by Barber's policies to seek to reduce unemployment.

In parallel, Joseph took a sustained interest in improving the efficiency of the Service, both at the micro level, through individual initiatives such as improved hospital building procedures, and at the macro level, through the emphasis on better management in the policy of reorganising the NHS. It is impracticable to estimate what effect his efforts had in this regard.

In addition, Joseph explored the scope for new charges, and set in hand a review of alternative funding arrangements, the latter of which, in particular, could have resulted in a major change in the form of the NHS.

(117) Joseph/Heath, 5/10/71, CPA, Strategy Committee papers, 1970/4 box.

(118) Cmnd 7615, 1979, p. 434 (volume increase) and calculated from p. 433 (GDP).

Joseph seemed to have been persuaded against the possible new charges on the merits of each case. What is less clear is why he seemed to take no follow up action in respect of the report of the WPNHSF. How is this to be understood?

It was characteristic of Joseph to study reports he received in detail, making numerous comments and posing officials many further questions. For example, when sent the first draft of a "full summary of what the White Paper [on NHS Reorganisation] might say", Joseph responded with three typed pages of general comments and 17 manuscript pages of comments on the text (119). He studied HAS reports in detail: "I would get say three reports, one 90 pages, one 40, one 70. After reading them I would have put a cross against say 170 different items" (120).

It would, therefore, have been uncharacteristic of Joseph to have received both a draft of the WPNHSF's report, and the report itself, and to have contented himself with responding simply "Read" to the former.

The DHSS files currently available seem not to include the copy of the WPNHSF report sent to Joseph, and there is no evidence that the Official Historian of the NHS had access to it (121). Aberdare's copy is publicly available, but not accompanied by any evidence of a detailed response or follow up action (122).

(119) draft dated 29/7/71, Joseph's response dated 12/8/71, both PRO MH 166/130.

(120) quoted in Halcrow, 1989, p. 50.

(121) the section in the Official History is based on Treasury, not DHSS, papers - Webster, 1996, pp. 385/390.

(122) on PRO BN 13/219.

One possible explanation is that Joseph did not have time to deal with the report immediately, that officials (as noted above) did not prompt him for a response, and that the whole matter vanished from view under the weight of the business that was occupying Joseph.

However, the notion that, unprompted by officials who might well have preferred no further action to be taken on the report, Joseph simply overlooked it, is as inconsistent with his character as the idea that he would have returned it simply marked "Read". There is clear evidence on other issues that Joseph kept in view matters which officials seemed reluctant to action. For example, he noted as an omission from both the draft consultative document on NHS reorganisation, and the draft White Paper, one of his ideas (that health authority senior officers should not have tenured posts), despite the fact that he was presented with the second document well over a year after the first (123).

It seems unlikely, therefore, that Joseph simply overlooked the WPNHSF's report, even if his officials did not seek actively to encourage a response. Rather, it seems more likely that, despite some evidence of support within the Party for change over the longer term, as evidenced by the report of the sub-committee of the PHSSC referred to above, Joseph consciously decided to take no further action. He possibly agreed with the PHSSC sub-committee that achieving change would be a long term matter - some years later he was quoted as saying that such change "would take up to four consecutive parliaments" (124) - and, with NHS reorganisation, regarded himself as having enough on hand in this Parliament.

(123) 21/1/71 (comments on the draft consultative document), PRO MH 166/129, and 9/5/72 (comments on the draft White Paper), PRO MH 166/131.

(124) *Times* 17/4/78, p. 2, col. c, reporting Joseph's comments at a Conservative Medical Society (CMS) meeting on 15/4/78.

This possibility may be supported by a comment in a letter to Joseph from Seldon, following up a meeting at the DHSS in April 1972. With regard to alternative financing, Seldon wrote "I will remind you that you said last week you would consider making public the reasons why you rejected the proposals you examined last year" (125). It is not clear to which "proposals" Seldon was referring: possibly the BMA Advisory Panel's, or perhaps the proposals examined (though certainly not proposed) by the WPNHSF. The sentence does, however, suggest that Joseph had reached a positive decision not to pursue alternative funding possibilities.

Overall, the evidence suggests that while Joseph was interested in alternative financing as a theoretical proposition, especially perhaps through his extensive contacts with Seldon (126), he could not see a way of addressing to his satisfaction what he believed to be the political and practical difficulties that radical change would involve. Although in March 1972 Joseph was minded to raise alternative financing in a speech "later in the year" (127), the author has found no evidence that he did so, or reverted to it again while Secretary of State.

- (125) Seldon/Joseph, 1/5/72, HI IEA papers, box 333, folder 5.
- (126) the IEA papers (ibid.) show that Joseph was on close terms with Seldon, with several meetings, including dinner at Joseph's home, in addition to correspondence. Cockett has suggested something of a falling out, quoting a letter from Seldon, incorrectly referenced as dated 7/2/72 (it is dated 3/3/72), as being "his last, exasperated, plea for Joseph "to at least consider the alternatives", and stating that this was Seldon's "last letter of the 1970-4 Government to Joseph" (Cockett, 1994, pp. 206/7). In fact, friendly correspondence on alternative financing continued until at least May 1972, eg Joseph/Seldon of 2, 14 and 24 March 1972 and 2 May; Seldon/Joseph of 17 and 30 March and 1 May (HI IEA papers, box 333, folder 5.)
- (127) Joseph/Seldon, 2/3/72, HI IEA papers, box 333, folder 5. The papers do not include the draft speech, which had been enclosed with the letter.

## 5. NHS STRUCTURE AND MANAGEMENT

The Government took office committed to rationalising the "functions and responsibilities of all departments and government agencies", which could in principle have included the NHS. However, as also noted, a commitment to "reorganise the NHS so that its three main branches ... are brought together under a unified administration" was replaced at draft stage by the less specific undertaking to improve co-ordination.

Work on the "new style" in the sense of improving the machinery and processes of government was set in hand soon after the general election. The first substantive product was a White Paper, published in October 1970.

This dealt with core central government matters rather than with agencies such as the NHS. It announced the amalgamation of existing ministries to create the Departments of the Environment and Trade and Industry; the establishment of the Central Policy Review Staff to help produce "a strategic definition of objectives"; and a new management process (which became known as Programme Analysis and Review), to facilitate regular reviews of existing programmes (128).

(128) *The Reorganisation of Central Government*, Cmd. 4506., 1970, London, HMSO.

In parallel with the review of central government functions and organisation, Peter Walker, appointed Minister for Housing and Local Government after the election (and made Secretary of State for the Environment in October 1970), began preparing proposals for the reorganisation of local government, in accordance with a manifesto commitment (129). These were published in February 1971, and proposed the establishment of a two tier structure of local government (130), in contrast to the unitary structure recommended by the Royal Commission on Local Government and favoured by the Labour Opposition. Like the proposals for central government, the White Paper on local government envisaged improvements in management arrangements as well as structural change (131).

Early work by the new Government to carry forward manifesto commitments and put in hand reviews of the structure and management processes of central and local government was not matched in relation to the NHS.

As described in Chapters 1 and 2, considerable thought had been given to the administrative structure of the NHS between 1965 and 1970, and by March 1970 the Conservative policy position seemed to have crystallised in favour of unification of the tripartite arrangement outside local government, but with the new health authorities having the same boundaries as the local authorities responsible for social services. However, the manifesto commitment was, as noted above, not nearly that specific.

(129) Craig, 1975, p. 340.

(130) *Local Government in England*, Cmnd. 4584, 1970, London, HMSO.

(131) *ibid.*, p. 12.

Early in July 1970 Joseph discussed the future structure of the NHS with DHSS officials, who favoured administrative unification, without which "the economic and other gains we want could not be secured" (132). Officials argued that, if the health services were not integrated "damaging divisions" would remain between the three branches (133).

The note of the meeting suggests that Joseph was cautious. While he regarded it as "important to have the control of investment in health and welfare services under a single directing authority", he recognised that this was not practicable. For the legislation following the Seebohm report had confirmed the welfare services as a responsibility of local government, while Joseph agreed "that the hospital and Executive Council services could not be put under local government, because of the opposition of the medical profession" (134).

Given that unifying the health and welfare services was not practicable, Joseph questioned the value of unifying the three branches of the NHS, and (in the light of his experience of local government reorganisation in London) was concerned about the upheaval unification would cause (135).

(132) DHSS memorandum, quoted in Webster, 1996, p. 453.

(133) note of meeting on 8/7/70, PRO MH 166/125.

(134) *ibid.*

(135) *ibid.*

No decision on whether to proceed with unification of the Service was reached at that meeting, and Joseph was non-committal in the debate on the NHS and social services in the Commons on 13 July. He emphasised the importance of "linkages" within the NHS and between the NHS, local authority and voluntary services, but made no commitment to structural change as a means of improving them. Noting the [second] Green Paper and the comments on it, Joseph said that "this whole massive reorganisation is something which we shall have to consider closely in conjunction with proposals for local government reform" (136). This strongly suggests that, at this stage, reviewing the organisational arrangements of the NHS was not part of an over-arching policy of introducing the "new style" across the whole public sector, and perhaps supports the idea that the late change made to the draft manifesto in respect of the NHS was a consciously substantive one, rather than "polishing".

### 5.1 The decision to unify the NHS

Joseph asked for consideration to be given to alternative ways of addressing the problems of lack of co-ordination from which it was widely agreed the tripartite arrangement suffered. He wanted to be "sure that there were no simpler and less radical means of achieving the objectives" (137). By 21 July a paper by officials "on ways in which the purpose of the Green Paper might be achieved with less upheaval" was "nearly ready" (138).

- (136) Commons Hansard, vol. 803, cols. 1177/9.
- (137) note of meeting on 8/7/70, PRO MH 166/125.
- (138) meeting note 70/200, PRO BN 13/156.

There is some evidence to suggest that quite soon after the initial meeting on 8 July, and possibly before Joseph considered the "less upheaval" paper referred to above, ministers were becoming persuaded of DHSS officials' view that unification was necessary.

On 4 August Aberdare had a meeting with the leader of the team of businessmen recruited by the Government (see below), and asked for help with "the very difficult problem of working out an administrative structure for the National Health Service", which suggests structural change, rather than different working practices within the existing structure, was in the Minister's mind (139). On 8 August Joseph sent a minute to the DHSS Under Secretary taking forward work on the possibility of unification, and alternatives to it, commenting on Labour's second Green Paper in terms which suggested he was already thinking about the relationship between the Department and new area health boards (140). On 12 August a senior DHSS official minuted a colleague that "the Secretary of State has not yet agreed in principle that the NHS should be unified" (author's underlining), which perhaps suggested a sense among officials that Joseph was moving in that direction (141).

Whether or not ministers were persuaded by or during August that unification was necessary, the evidence is that by early September Joseph had reached that view. According to the note, at a meeting with officials split over two days, he took "unifying the National Health Service" as a given: for him "the main questions on unification were the timetable and the regional tier" (142).

(139) note of meeting on PRO MH 166/97.

(140) Joseph/ J Dodds, PRO MH 166/125.

(141) J Cashman/F Farrant, *ibid.*

(142) note of meeting 8 and 10/9/70, *ibid.*

Given that there was no specific manifesto commitment, and his initial doubts, how is Joseph's decision to propose unification to be understood? It is impossible to be sure, but four considerations in particular may have been relevant.

First, as noted above, work on the reorganisation of central and local government was set in hand early. In this context, perhaps Joseph came to see trying to make the widely criticised tripartite system work more effectively as insufficiently "new style" compared with structural change.

Second, relevant DHSS officials seemed clear and unanimous that unification was desirable (143), and Joseph may well have given considerable weight to their views. His biographer reports unattributed comments to the effect that, as a minister, Joseph had a history of being over-influenced by his officials (144). Alfred Sherman, a journalist who has been described as "Joseph's intellectual mentor", apparently used to refer to him as "a good man fallen among civil servants" (145).

(143) as far as can be judged from the note of the meeting on 8 July (PRO MH 166/125).

(144) Halcrow, 1989, pp. 21/2.

(145) Cockett, 1994, p. 206.

A third possible consideration is that in July 1970 Joseph received the report of a group convened in Opposition by Brooke, with the agreement of Balniel and Macmillan (146). The group consisted of "twelve members ... drawn from all parts of the National Health Service" (147), among whom were Freeman, who had been a member of the HPG with Joseph, and Trafford, who had become a MP at the 1970 general election (148).

The group's report noted the "general agreement that the present three parts of the service should be brought together under one administrative roof", and expressed a preference for a two tier system outside local government (149). This recommendation, matching in kind if not detail the view of his officials, may well have helped persuade Joseph to adopt unification as a policy.

Finally, as noted above, Joseph was enthusiastic about improving the efficiency of the NHS, and began to see reorganisation of its structure and management arrangements as a means of doing so. Webster has suggested that the prospect of using unification as the opportunity to introduce "sound management principles" made it "a more congenial prospect" for Joseph (150).

Given his view about the medical profession's opposition to control of the NHS by local government, Joseph naturally thought in terms of unification outside local government, as proposed in the Labour Government's second Green Paper.

(146) memorandum dated 2/12/69, CPA CRD 4/7/18.

(147) covering note to report by Rosemary Martin of the CRD, dated July 1970, *ibid.*

(148) personal communication from Professor Freeman, 3/8/2000. The report itself (copy *ibid.*) does not include a list of the group members.

(149) Brooke group report, pp. 7/9, *ibid.*

(150) Webster, 1996, p. 453.

The ideas that the NHS should be unified, but outside local government, were set out in a draft cabinet committee paper, together with a timetable for the reorganisation, which Joseph approved on 16 September, and an advance copy was sent to officials in other government departments on 21 September (151).

The draft paper briefly discussed the option of unifying the NHS within local government as advocated by the local authority associations. The principal advantage was seen as having both health and social services administered by the same set of authorities. In the light of "very strong arguments against", including the likely need for the NHS to continue to be funded mainly from the Exchequer, and for decisions on planning and priorities to be taken on a national scale, Joseph concluded, however, "that unification should take place outside local government" (152).

To help secure effective linkage between the proposed new health authorities and local government, Joseph proposed that the two sets of authorities should match "in area and in boundaries" (a feature referred to subsequently as coterminosity), and anticipated an examination of ways of linking the two through, for example, "some common membership, a sharing of staff and ... joint advisory machinery" (153).

(151) under cover of a letter from Nodder (DHSS)/other government departments, copy on Treasury file 2SS 21/04A.

(152) *ibid.*

(153) *ibid.*

Reflecting his judgement that reorganisation of the NHS could be the basis for achieving greater efficiency, Joseph also proposed further reflection on the administrative structure proposed in Labour's second Green Paper, with a view to identifying "stronger devices for ensuring sound and effective management" (154).

Joseph's draft proposals secured broad support from other government departments at official level, and on 29 October were considered by the Cabinet Social Services Committee (along with parallel proposals from the Secretaries of State for Scotland and Wales). Following "a brief discussion", the Committee "agreed with the general approach proposed", and approved an announcement of what had now become Government policy through the medium of a written reply to a parliamentary question (155). The announcement was made on 5 November (156).

Thus by November 1970 the Government had decided to unify the three branches of the NHS, and had accepted, as had the Conservative spokesmen in Opposition, that there were practical reasons against doing so within local government. Effectively, the NHS joined central and local government as the subject of formal organisational review, including the attention of the Government's team of businessmen advisers, and so came, albeit loosely, within the scope of the "new style". It was certainly so linked by one of the architects of the "new style", Howell, in a paper published in November 1971 (157).

(154) *ibid.*

(155) minutes of SL(70)4th, copy on Treasury file 2SS 21/04A.

(156) Commons Hansard, vol. 805, cols. 437/9 (written answer).

(157) *A New Style Emerges*, 1971, London, Conservative Political Centre, p. 10.

## 5.2 The implementation of unification

The decision announced on 5 November of itself signalled a significant change in the form of the Service, as it involved taking responsibility for the personal health services away from local authorities and making the NHS an entirely central government service. Before unification could be implemented, however, a large number of consequential policy decisions had been reached, for example about the nature of the new administrative structure; the necessary legislation had been enacted; and practical issues, such as the appointment of members and senior officers of the new authorities, had been put into effect. These took most of the lifetime of the Government to complete (158).

A substantial account of the development of the Government's detailed proposals, and of the passage of the Reorganisation Bill, is included in the Official History of the NHS (159). The following sections do not seek to duplicate that account, or explore all aspects of the development and implementation of the policy of reorganisation of importance in the history of the NHS. Rather, they seek to examine in some detail those issues arising which seem to throw particular light on Conservative attitudes to, and policy in respect of, the form of the NHS. These issues all related to Joseph's objective of improving the efficiency of the NHS through unification.

(158) the unified Service did not come into effect until after the Heath Government had resigned following the February 1974 general election.

(159) Webster, 1996, pp. 451/579.

### 5.3 Unification and efficiency

Criticisms of the tripartite structure, dating from early in the life of the NHS, including those by Conservatives, were often expressed in terms of the disadvantage in the treatment and care of the individual patient, or to the development of a Service with a proper balance between preventive and curative medicine, and between community based services (the local authority health services and the FPS) and hospital based services (160). However, they also included concern that, in a variety of ways, the tripartite structure was wasteful (161).

This concern about the waste inherent in the tripartite structure was reflected in the 1966 Labour Government's two Green Papers, the second of which concluded that only if there was a single authority responsible for the NHS in each area would "resources be efficiently deployed to meet the needs of each patient" (162)

- (160) for example, Evelyn Emmet's note of dissent to the report of the parliamentary Health Policy Committee report in 1951, para. 4, CPA, ACP/51/10 on CRD 4/7/19 (Conservative); Sir John Maude's reservation to the report of Committee of Enquiry into the Cost of the National Health Service, pp. 279/284, Cmd. 9663, 1956 (a view from a former senior civil servant).
- (161) for example, "a lack of proper co-ordination ... is impairing efficiency", report of the Health Policy Sub-Committee, 1953, para. 62, CPA, PMC(53)8, on CRD 2/30/10 (Conservative); the tripartite structure could lead to "a loss of economy and efficiency", *A Review of the Medical Services in Great Britain*, 1962, pp. 18/9 (the Porritt Committee).
- (162) *The Future Structure of the National Health Service*, 1970, p. 6.

Joseph had long been alive to the possibility of improvement in efficiency through better co-ordination. A conclusion of his 1958 paper was that improved co-ordination was "perhaps the principal way of making more effective use of the resources already employed in the health service" (163). In addition, however, as noted above, Joseph was concerned that the NHS was lacking in what he termed "managerial efficiency" (164).

As Secretary of State, Joseph increasingly saw unification as a major opportunity for taking forward his concern to improve the efficiency of the NHS through better management. His intention in this regard attracted early support from officials within the Treasury and the Civil Service Department (CSD) who were, from differing perspectives, concerned with efficiency in the public services. Carrying through what he saw as its implications, however, led to sustained opposition by Labour, some general criticism from his own backbenchers and a number of specific disagreements which brought out differences of view among Conservatives as to what should be the form of the NHS.

John Silkin, Labour's principal spokesman, seemed to be favouring merging the NHS into local government, and regarded Joseph's overall proposals as having "all the vision and imagination of the cost accountant and all the warmth and compassion of the balance sheet" (165). The Party voted against the enabling legislation on Second and Third Readings.

(163) Joseph, 1958, p. 8.

(164) *ibid.*, p. 6.

(165) Commons Hansard, vol. 853, cols. 946/7.

To some Conservatives, such as Dr Tom Stuttaford, Joseph's whole approach was simply too managerial (166).

It was, however, discussion on a number of specific issues that brought out different views within the Conservative Party on the form of the NHS. Four of these: the decision to unify the Service outside local government and the related question of the composition of the new health authorities; the need for and role of a regional tier of administration; the form management should take within the unified structure, and arrangements for oversight of the NHS at national level, will be considered below, following descriptions of the positions of the Treasury and CSD.

#### 5.4 The Treasury and CSD

The Treasury had traditionally been concerned with economy within public services, and had criticisms of the adequacy of the DHSS's oversight of the NHS in this respect which predated the formation of the Heath Government.

In July 1969, for example, a minute from a senior Treasury official to a colleague commented that "there is nothing in the way of a comprehensive and deliberate attempt to maintain surveillance over the quality of the managerial decisions taken by the Health Departments' agencies in the field" (167). A month later another official offered the view that "the Health Departments are remarkable in ignoring the material [about comparative costs within the NHS] and the possibilities which it opens up", and commented "we have to press with the utmost energy for an efficient professional managerial system" within the proposed new NHS structure (168).

(166) *ibid.*, col. 981.

(167) Widdup/N Jordan Moss, 28/7/69, Treasury file 2SS 21/786/01E.

(168) F Vinter/Jordan Moss, 22/8/69, *ibid.*

The Treasury found the Labour Government's ideas on reorganising the NHS unsatisfactory from the management perspective. In the brief for Conservative ministers attending the Cabinet Social Services Committee meeting on 29 October 1970, referred to above, for example, it was noted that, under Labour's proposals, "'management" would have been in the hands of a series of totally unwieldy committees, composed to a large extent on syndicalist lines, and with responsibility blurred or divided all down the line" (169).

Given these concerns, it was not surprising that Treasury officials "heartily welcome[d]" Joseph's intention to look again at the administrative structure proposed by Labour (170).

Part of the CSD's remit was to encourage the adoption of efficient management practices in the public service. After the 1970 election it became the base for a number of businessmen recruited by the Conservatives to bring private sector expertise to the management of the public services.

In Opposition, Heath had identified "the machinery of government" as an issue to be examined, and one of the policy groups established had that remit. In parallel, as noted in Chapter 2, Heath had given Marples a brief, initially from the angle of the application of new technology, to make recommendations for improving management in the public sector (171). Marples' activity developed into the PSRU, separate from the CRD and accountable to Heath (172).

(169) brief dated 27/10/70, on Treasury file 2SS 21/04A.

(170) Widdup/Nodder (DHSS), 30/9/70, PRO MH 166/97.

(171) Heath/Marples, 16/3/67, copy at appendix 1 of ACP(69)58, CPA ACP 3/18.

(172) ACP(69)58, *ibid*.

One of the PSRU's initiatives was to recruit business expertise to be "actively involved in preparatory work on the organisational and administrative implications of party policy (173). In office, six of the businessmen so recruited were seconded part-time to the CSD, forming what became known as the Business Team, led by Richard Meyjes of Shell. Others were added later (174).

When consulted at official level on Joseph's proposal that the NHS should be unified outside local government, the CSD expressed itself as "quite content" and suggested that, in thinking about management principles, a member of the Business Team should be involved (175).

There was some confusion among CSD, Treasury and DHSS officials as to whether the Business Team was prepared to be involved. In the event, Meyjes became an adviser to the DHSS and a member of the Steering Committee for the Study Group established to work on new management arrangements for the unified NHS (176). This offered a tangible link to the "new style" approach in central government.

(173) paper by Howell, 22/1/70, ACP/70/70, CPA ACP 3/19.

(174) Commons Hansards, vol. 804, cols. 533/4 (initial appointments); and vol. 814, col. 144, written answer (a later addition). The background to the Business Team, and official advice to the Conservatives in Opposition, are briefly described in Pollitt C, *Manipulating the Machine*, 1984, London, Allen & Unwin, pp. 85/6.

(175) T Caulcott/Nodder, 5/10/70, PRO MH 166/97.

(176) see, for example, DHSS note of meeting between Aberdare and Meyjes, 4/8/70, PRO MH 166/97; notes by Widdup, 18/11/70, D Henley, 19/11/70 and Widdup 23/11/70, all on Treasury file 2SS 21/04.

## 5.5 The new health authorities

From November 1970, the Government viewed the unification of the NHS outside local government as a decision, and not one of the issues open to consultation. And, as noted above, in its second Green Paper the previous Labour Government had reached the same view. Nevertheless, the decision attracted comment.

For the Opposition, John Silkin implied that his Party now felt that a local government solution might be realistic and, during the Bill to give effect to the Government's proposals, said that it would be Labour's "purpose to move the Bill in the direction of democracy" (177).

Among Conservatives, too, there were concerns about the Government's proposal to make the NHS an entirely central government service, organised through local agents of the Secretary of State.

On one hand, Arthur Jones, who had argued the case for unifying the NHS within local government during the debate on Labour's second Green Paper, saw the Government's NHS proposals as "an undesirable erosion of local democratic control over essential services, whereas what is needed in the Health Service is increased sensitivity and responsiveness to local communities" (178).

(177) Commons Hansard, vol. 853, col. 946.

(178) *ibid.*, col. 1019.

Powell took a contrary view to Jones about making local government responsible for the NHS, but shared his regret at the proposed transfer of the local authority health services to central government. Powell saw this as having two consequences. First, it meant the loss of "the only sources of independent policy, initiative and decision which existed outside the central Government in the whole range of health services ... From now on there will only be one sort of policy and initiative in the community health services as in the rest of the National Health Service". Second, and "perhaps [the] most serious" loss, it removed from local government "one of its most valuable and valued functions" (179).

Jones and Powell's concerns, expressed quite late in the process of implementation of the Government's proposals, did not seem to have been shared by ministers at the outset of consideration of the reorganisation policy, or indeed by most Conservative backbenchers subsequently.

Among ministers, in the early stages of development of the Government's policy the contentious issue was the composition of the new health authorities which were to act as the Secretary of State's agents.

Given the desire for effective linkage, Joseph was clear that the new health authorities must have the same boundaries as the local authorities with social services responsibilities. Given the proposals emerging in early 1971 from the Department of the Environment, this meant there would be about ninety health authorities at what was termed area level.

(179) *ibid.*, cols. 1125/7.

This in turn led to consideration of the need for a tier of authorities above these area health authorities, at regional level (discussed below), and of arrangements below area. On this latter issue it was decided that there should be no formal tier of authority below area level, but that some areas should be divided into districts, each with its own team of senior officers. The AHAs were thus to be the basic level of statutory authority responsible for the hospital and specialist services, the FPS, and the personal health services to be transferred from local government.

In the second Green Paper, the Labour Government had proposed that a third of the members of each AHA should be appointed by local authorities, the health professions and the Secretary of State, respectively (180). As noted above, Conservative frontbench spokesmen questioned the need for the Secretary of State's appointees, and seemed to favour AHA members being appointed in equal numbers by the relevant local authority and health professions.

Joseph was concerned that the AHAs should be constructed "on the principle of sound management rather than participation", and when putting proposals to the Cabinet Social Services Committee in March 1971 emphasised that, while some AHA members would be members of local authorities or the health professions, none would be chosen "on a representational footing" (181). Instead, the Secretary of State would appoint the chairmen of the AHAs, and their members would be appointed by the proposed regional health authorities (RHAs), who would in turn have been appointed by the Secretary of State.

(180) *The Future of the National Health Service*, 1970, p. 8.

(181) SL(70)7th, 23/3/71, copy on Treasury file 2SS 21/04C.

To provide a means of expressing community views about local health services, Joseph proposed the establishment of new bodies, outside the management structure of the NHS. These were enacted, as community health councils, despite some departure from the idea that the AHAs would not be representative bodies.

The basis of composition that Joseph proposed for AHAs led to disagreement within the Committee, with some ministers supporting him while others argued that local authorities should have the right to appoint representatives to AHAs. The Chairman, Maudling as Home Secretary, decided to refer the issue to Cabinet (182).

The issue was discussed in Cabinet on 1 April 1971. According to the Conclusions (183), Joseph emphasised the need for efficient management with "a direct and unambiguous chain of accountability". As agents of the Secretary of State, AHAs should be appointed by him and his regional appointees. Local authority appointments to AHAs "militated against the principle of sound management".

Some ministers disagreed, pointing out the position taken in Opposition, noted above. Not to give local authorities appointment rights in regard to AHAs would not only go against what had been said then, but would also be "inconsistent with the Government's professed intention to delegate functions to local authorities as far as possible", and might result in a lack of willingness by local authorities to collaborate with the new AHAs.

(182) *ibid.*

(183) Conclusions of CM(7)19th, *ibid.*

Other ministers supported Joseph, arguing that as local authorities had no financial responsibility for the NHS, they did not have a "presumptive right" to appoint AHA members. If they were given the right, the local authority appointees might find themselves with a conflict of interest, for example favouring uses of AHA resources which relieved the local ratepayer rather than the taxpayer. Further, if the right of appointment was conceded to the local authorities, it would be difficult to deny it to the health professions, which could again detract from the principles of effective management.

The Conclusions do not indicate the positions taken by individual ministers. As Official Historian of the NHS, however, Webster had access to the Cabinet Secretary's notebook, which it may be presumed included a fuller record of the meeting than the Conclusions. Webster records that Barber and Lord Jellicoe supported Joseph which, as Chancellor of the Exchequer and minister in day to day charge of the CSD respectively, was to be expected, together with Gordon Campbell (Secretary of State for Scotland and thus responsible for the Scottish NHS). Those in favour of giving local authorities appointment rights included Peter Walker, the Secretary of State for the Environment, and Peter Thomas, the Secretary of State for Wales (184). Thus on this issue there was a difference of view between Health ministers, as well as between Joseph and Walker, responsible for local government.

(184) Webster, 1996, p. xi (access to Cabinet Secretaries' notebooks) and p. 467 (details of ministers' positions, and of the discussion not incorporated in the Conclusions, not referenced but almost certainly obtained from the relevant notebook).

Heath did not feel able to resolve the issue, and instead invited Joseph to reconsider his proposals "and attempt to reconcile the needs of sound management with the demand for local representative participation" (185).

Given the level of opposition to his initial proposals, Joseph clearly judged it necessary to compromise. At a meeting of the Social Services Committee on 28 April, he conceded the principle that local authorities should have the right of appointment to AHAs, and indeed proposed to give universities providing medical teaching facilities a similar right. Rather than extend the right to the health professions as well, Joseph proposed that at RHAs would appoint at least two doctors and a nurse to each AHA, after consultation with the professions (186).

Within the Committee there was some concern that Joseph's revised proposals did not go far enough, as he sought to limit local authority representation to three out of the proposed fourteen members on each AHA. It was noted that this was less than the one third proposed in Labour's second Green Paper, and much less than the half that had been proposed by the Conservatives in Opposition (187).

In summing up the discussion, Maudling regarded Joseph's proposals as acceptable as a basis for consultation, though he needed to ascertain whether Heath wanted the issue discussed in Cabinet again (188).

(185) Conclusions of CM(71)19th, copy on Treasury file 2SS 21/04C.

(186) SL(71)9th, *ibid.*

(187) *ibid.*

(188) *ibid.* Webster's account, "Once again the Home Secretary was obliged to refer the disagreement to the full Cabinet for further discussion" (1996, p. 468), does not precisely reflect the minutes of the Social Services Committee meeting but, informed by access to the Cabinet Secretary's notebook, is likely to be more accurate than the publicly available record.

Heath presumably judged that the issue should be brought back to Cabinet, as it was discussed there on 6 May. Joseph explained his new proposals, seeing the local authority nominees as having "managerial, as well as representational value", but sought to hold the number of local authority appointees to three per AHA on the ground that that went "as far as was consistent with securing sound management" (189). Other ministers (led, according to Webster, by Walker (190)) argued for a higher level of local authority representation. It was agreed that, in the proposed consultative document, it would be made clear that local authorities would have the right to appoint "some" members, without specifying how many (191).

The view that local authorities should appoint members of AHAs was not limited to members of the Cabinet. As noted above, a sub-committee of the Conservative parliamentary Health and Social Security Committee had been examining NHS issues and had reported in April 1971. It recommended that local authorities should appoint eight of "perhaps 21 members" of AHAs, and indeed favoured giving the health professions the right to make a similar number of appointments (192). Several members of the sub-committee spoke in the Commons debate on the consultative document, which had been published on 17 May, and two (Timothy Raison and Peter Fry) referred to these appointment proposals (193).

(189) Conclusions of CM(71)24th, copy on Treasury file 2SS 21/04C.

(190) Webster, 1996, p. 469.

(191) Conclusions of CM(71)24th, copy on Treasury file 2SS 21/04C.

(192) copy, under cover of letter from Raison to Macmillan, 20/5/71, on Treasury file 2SS 21/338/01E.

(193) *National Health Service Reorganisation*, 1971, London, DHSS; Commons Hansard, vol. 820, cols. 635 (Raison) and 639 (Fry).

Despite arguing in Cabinet on 6 May 1971 that three local authority appointees per AHA was "as far as was consistent with securing sound management", in the light of reflection on comments on the consultative document, Joseph increased this to four when presenting his draft White Paper to the Cabinet Home and Social Affairs Committee on 30 June 1972 (194).

Again some regarded Joseph's proposal as inadequate, on similar grounds as before. However, this time "the majority view [was] ... that the number of local authority members should not exceed four" (195). Maudling reported this to Heath, adding that Walker "felt strongly that the minimum number we could defend was five which would be one third of the membership as proposed by our predecessors" (196).

The draft White Paper, including the issue of local authority appointments to AHAs, was discussed in Cabinet on 20 July. In summing up the discussion Heath said that the draft was approved, and the issue of local authority appointments "could be reconsidered in the light of the representations which were bound to be made" (197).

The White Paper was published on 1 August, proposing that local authorities should appoint four members of each AHA (198).

(194) HS(72)16th meeting, copy on Treasury file 2SS 21/04E.

(195) *ibid.*

(196) minute dated 3/7/72, *ibid.*

(197) Conclusions of CM(72)37th, copy on Treasury file 2SS 21/04C.

(198) Commons Hansard, vol. 842, col. 349; *National Health Service Reorganisation: England*, Cmnd. 5055, 1972, London, HMSO, p. 24.

In the debates on the NHS Reorganisation Bill in both Lords and Commons "relatively little attention [was] given to the question" (199). Webster reports that it had been agreed in the Cabinet Legislation Committee that greater representation than the four local authority appointees per AHA proposed in the White Paper could be offered (200), but in the event no such concession proved necessary. The Bill as enacted provided that the number of local authority appointees should be "not less than four" (201), thus leaving open the possibility of more members if circumstances required.

From the perspective of the form of the NHS, the discussions on Joseph's proposals suggest that there were at least two views about what was desirable.

At the time he became Secretary of State, Joseph shared Brooke and Balniel's sense that it was not practicable to unify the NHS within local government. It is unclear, however, whether he shared their regrets that this was the situation. Regretfully or otherwise, but accepting the impracticability of transfer to local government, Joseph developed a vision of the NHS as a central government service delivered through local agencies organised on "the principle of sound management", which had clear attractions to the Treasury and the CSD. Nothing in his proposals suggested he envisaged the longer term transfer of the NHS to local government.

(199) Webster, 1996, p. 522.

(200) quoted in Webster, *ibid.*

(201) NHS Reorganisation Act 1973, schedule 1, para. 2(1)(d).

Among the backbenchers who, in the parliamentary Health and Social Security Committee, had proposed that local authorities should appoint eight AHA members of "perhaps 21", and possibly among ministers who successfully opposed Joseph's initial proposals in Cabinet, a different view of the form of NHS desirable in the longer term is discernible.

Some ministers may have opposed Joseph's proposals because of what had been said in Opposition, to sustain the "high degree of co-operation among local authority interests [that] had now been created in the context of local government reform" (202), and to help secure what they regarded as appropriate conditions for effective co-operation between local government and the reorganised NHS. However, Walker and ministers who shared his view wanted the Government to "delegate functions to local government so far as possible". Their rejection of what might be termed Joseph's pure central government model, and sustained determination that local authorities should have the right to appoint a significant number of AHA members, suggests that they shared the longer term aim of backbenchers like Raison who, along with Brooke and Balniel in Opposition, explicitly envisaged the NHS becoming part of local government (203).

(202) Conclusions of CM(71)24th, copy on Treasury file 2SS 21/04C.

(203) Raison made his position explicit in the debates on the consultative document and Reorganisation Bill, Commons Hansards vol. 820, col. 635 and vol. 853, col. 1193 respectively.

## 5.6 The NHS regional tier

As noted in the previous section, Joseph saw the composition of the proposed AHAs as material to his vision of the NHS as an efficiently managed central government service, albeit one delivered through local agents of the Secretary of State. Several key ministerial colleagues did not share this view, however, and the outcome was a compromise, in which the AHAs were in part representative bodies.

A second material consideration to Joseph in seeking to create an efficient management structure for the NHS was the role of regional health authorities (RHAs).

The NHS had had a regional element - the regional hospital boards - since its inception. The role of the RHAs, "appointed by and directly responsible to the Secretary of State", was officially described in 1971 as to administer "all NHS hospitals other than designated teaching hospitals", by appointing "Hospital Management Committees to manage groups of hospitals on their behalf and subject to their overall oversight and direction" (204)

(204) *Handbook for Members of Hospital Management Committees*, 1971, London, DHSS, p. 4.

When first considering reorganising the NHS, the 1966 Labour Government had proposed to replace the two tiers of administration of the hospital service below national level (RHBs and HMCs) by one - area authorities - which would also have had responsibility for the FPS and local authority health services (205). However, when reconsidering these proposals that Government decided that AHAs as by then conceived would be "too small for the performance of a number of important functions" including the planning of the hospital services, the organisation of facilities for medical, the deployment of senior medical staff, some staff training activities and the provision of blood transfusion and ambulance services (206).

Accordingly, in the second Green Paper it was proposed to establish regional health councils (RHCs) to carry these responsibilities, but not to "supervise or control the area health authorities" which, like the RHCs, would "have a direct relationship to the central Department" (207).

(205) *The Administrative Structure of the Medical and Related Services in England and Wales*, 1968, p. 12.

(206) *The Future Structure of the National Health Service*, 1970, p. 23.

(207) *ibid.*, p. 24.

By the time he was becoming convinced that unification, rather than finding better ways of achieving coordination within the tripartite structure, was the right policy to pursue, Joseph was also clear that it "would not make sense to have the 90-odd Area Health Boards reporting direct to the Department" (208). Drawing on his business experience, he asserted that having ninety "subsidiaries" accountable to the centre was "totally outside the scope of any chief executive" and that "good business experience limits the number of people reporting to any manager, however senior, to about 8" (209).

Given his view that health authorities in a unified NHS would, in the interests of collaboration, need to match the boundaries of one or more local authorities with social services responsibilities, and the emerging proposals for local government noted in the previous section, Joseph was thus faced with the problem of finding a way of establishing accountable management for some ninety or so AHAs. At his meeting over two days with officials in September 1970, there was brief discussion "on the proposal that a National Corporation might be set up to run the health service". However, there was "no support in the Department for this", and the alternative seemed to Joseph to be a regional tier "with a stronger business element" than proposed in Labour's second Green Paper (210).

(208) Joseph/Dodds (DHSS), 8/8/70, PRO MH 166/125.

(209) *ibid.*

(210) note of meeting 8 and 10/9/70, PRO MH 166/125.

This emerging view was reflected in the draft memorandum circulated to other government departments on 21 September, where Joseph said that one of the points requiring consideration was "the function of any regional health authorities that may be set up. It is in my view of crucial importance to build into the new structure stronger devices for ensuring sound and effective management ...". (211).

A few days later, Joseph re-emphasised to officials his sense that a level of organisation between the Department and the proposed AHAs was necessary - "It would be hubristic madness for the Department to contemplate direct management of 90 Area Health Authorities". He was, however, determined to avoid "4 tiers" (Joseph's underlining), which seemed to preclude having a formal level of organisation below AHA level (212).

By the time the Cabinet considered a draft of the consultative document on NHS reorganisation, having "regional authorities for the co-ordination, supervision and allocation of resources of the area authorities", that is, as "an integral part of the management structure", had become a firm part of Joseph's proposals (213), Unlike the question of local authority appointees to AHAs discussed in the previous section, this aspect of Joseph's proposals seem to have been unopposed in Cabinet. The "creation of a strong regional tier" was included in the consultative document as "one of the main differences between the present proposals and the 1970 Green Paper" (214).

(211) sent under cover of a letter from Nodder to other government departments, copy on Treasury file 2SS 21/04A.

(212) Joseph/Rogers, 28/9/70, PRO BN 13/165.

(213) Conclusions of CM(71)19th, copy on Treasury file 2SS 21/04C.

(214) *National Health Service Reorganisation*, 1971, p. 6.

Although Joseph's proposals as regards RHAs were accepted by Cabinet colleagues, they were not what some Conservative backbenchers favoured.

A majority of the Health and Social Security Committee sub-committee, in their April 1971 report, recommended "that there should be no executive body between the Department and the area boards". Two specific reasons were given. First, having only one tier of organisation below the Department "should accelerate action". Second, whereas the Department would be subject to parliamentary scrutiny, and the proposed AHAs subject to "a considerable degree of local scrutiny", a regional body "would be much less clearly responsible to anyone" (215).

There was, however, a perhaps more significant reason for rejecting "the idea of any formal regional organisation" implicit in the sub-committee's view of the kind of NHS they favoured. Members held the view that, within "clear policies ... the area boards should be given as much power as possible", making "non-medical decision-making less bureaucracy-bound than it is at the moment", To this end it wanted "a reduction of central government interference" (216). In other words, within a service ultimately accountable to ministers and Parliament, the sub-committee wanted to create a situation where AHAs enjoyed in practice a degree of independence broadly analogous to that of local authorities. In this context, a regional tier would be unwelcome because it would have the potential both to reduce the responsibilities delegated to AHAs (some could be assigned to the regional tier), and to be a further source of "interference" in their work.

(215) copy, under cover of letter from Raison to Macmillan, 20/5/71, on Treasury file 2SS 21/338/01E.

(216) *ibid.*

Two members of the sub-committee spoke on the regional issue during the Commons debate on the consultative document on 1 July 1971. While Dr Gerard Vaughan "had hoped that we would be able to do away with the regional boards", but had "reluctantly" (and, it proved, only temporarily) come to the conclusion that Joseph's proposal for RHAs was right, Raison was "still worried about the regional tier" and hoped Joseph would look at the issue again (217).

The detailed working out of the role of the proposed RHAs, together with other detailed management issues, was remitted to a Study Group of officials, supported by management consultants from McKinsey and Co. Inc. and academics from the Health Services Organisation Research Unit (HSORU) at Brunel University, overseen by a thirty strong Management Study Steering Committee (218).

In early 1972 Joseph requested a short statement of the Study Group's emerging work on the role of the RHA. This was furnished by Henry Strage of McKinsey's and endorsed by Sir Philip Rogers, the DHSS Permanent Secretary (219).

The statement, in the form of a two page memorandum, listed eight functions for the proposed RHAs, envisaged them as "firmly in the "chain of command" between the Department of Health and the Area Health Authorities", with the latter corporately accountable to them (220).

(217) Commons Hansard, vol. 820, cols. 618 (Vaughan) and 636 (Raison).

(218) details of the Study Group, and the Management Study Steering Committee, are given in *Management Arrangements for the Reorganised National Health Service*, 1972, London, HMSO, pp. 3/4.

(219) Rogers/Joseph, 13/3/72, covering memorandum from McKinsey's dated 9/3/72, Graham papers.

(220) memorandum, *ibid.*

Joseph declared himself "shocked" - "I could have written this" (Joseph's underlining), and clearly wanted a more substantial analysis as to how the eight functions listed, particularly developing plans, allocating resources and ensuring that AHAs planning and operational activities was co-ordinated with local authorities, would be made to work in practice (221). Having shortly before rejected the advice of Meyjes and Professor Elliott Jaques, the director of the HSORU, that his proposed structure of Department/RHAs/AHAs "simply will not work" (222), it is understandable that Joseph was becoming concerned at what he regarded as lack of progress on a key issue.

The White Paper published on 1 August 1972 referred to the role of the proposed RHAs in similar length and substantive content to the McKinsey memorandum (223), and a month later the report of the Study Group, widely referred to thereafter as the Grey Book, was published (224). The Grey Book built on the account of the regional role given in the McKinsey memorandum and White Paper, giving a very brief account of the means by which functions would be discharged, including the relationships between RHA and AHA senior officers (225).

The policy proposals in the White Paper and the management arrangements in the Grey Book provided the context for the NHS Reorganisation Bill, and the role of the RHAs was one of the issues raised during its passage.

(221) Joseph/Rogers, 13/7/72, *ibid.*

(222) Meyjes R and Jaques E, *A National Organisation Model for a Unified NHS*, undated but undoubtedly February 1972, in the currently closed CAB 157 (Webster, 1996, p. 922). Copy provided to the author by Jaques. This issue is explored in section 5.8 below.

(223) Cmnd. 5055.

(224) *Management Arrangements for the Reorganised National Health Service*, 1972.

(225) *ibid.*, pp. 24/6.

During the Commons Second Reading, both Vaughan and Raison questioned the need for RHAs. Vaughan regarded the need for a regional tier, "except perhaps as a planning and advisory body", as something that would need to be examined closely during the Bill's Committee stage (226). Raison was "still not persuaded that a regional tier is necessary", and thought that the various functions proposed for RHAs could be assigned to the Department and the AHAs (227).

Both Vaughan and Raison were appointed to the Standing Committee to which the Reorganisation Bill was allocated, and Raison tabled an amendment which would have had the effect of removing RHAs from the structure proposed by the Government. In an attempt to resolve differences between the Government and the two backbenchers on the issue, Joseph met them on 30 April 1973, the day before the relevant Committee sitting.

According to Joseph's private secretary's note of the meeting, Vaughan and Raison raised four particular concerns: that the new structure would be less flexible than the existing one, more administrative staff would be needed, members on RHAs would be more usefully deployed at area level, and the new structure would "increase interference between Government and those actually delivering health care". The private secretary's note recorded that these concerns had been put to Vaughan and Raison by some hospital administrators who had impressed them, and that Joseph had offered to meet the administrators concerned, with the two MPs, to hear their views at first hand (228).

(226) Commons Hansard, 27/3/73, vol. 853, col. 1143.

(227) *ibid.*, col. 1194.

(228) note by G Hart, 30/4/73, PRO BN 13/172.

The following day, 1 May 1973, Raison moved his amendment in Committee, "to test and examine the need for a regional tier". In his view, the arguments for RHAs presented by the Government in the White Paper were thin - we are entitled to a much fuller explanation ... than we have had so far". Raison expressed several concerns about the proposed regional tier: its proposed existence called into question whether AHAs were trusted to do their job, offered scope for unnecessary interference with AHAs, helped create a structure with "a pretty lengthy chain of command", would be difficult to hold to account, and would be remote from the patient (229). Vaughan agreed with all Raison's points (230).

Another Conservative on the Committee, David Crouch, a member of a RHB, disagreed with his colleagues, arguing that "it would be fundamentally wrong to remove the regional authority because to do so would produce even greater delay". In his view, AHAs who needed to submit a matter to higher authority would be likely to get a speedier response from a RHA than from the DHSS (231).

Joseph's Parliamentary Secretary, Alison, sought to re-assure the Committee about the need for RHAs, but Joseph felt the need to contribute, too, accepting personal responsibility for "not having explained clearly enough how the Government foresee these tier interacting". He sought to offer re-assurance by described the proposed RHAs as "local sensitive but constructive agents of the Secretary of State, carrying out locally but sensitively national strategy modified to local needs" (232).

(229) Commons Standing Committee G Hansard, 1/5/73, cols. 316/23

(230) *ibid.*, col. 323.

(231) *ibid.*, cols. 329/32.

(232) *ibid.*, cols. 348/54.

Both Vaughan and Raison expressed "lingering doubts" (233), but the amendment to remove RHAs from the Bill was not pressed. Despite, therefore, sustained concern from some Conservative backbenchers, the second element of Joseph's strategy to improve the efficiency of the NHS through better management was enacted as he had proposed.

Like the discussion in Cabinet on the composition of AHAs, the sustained criticism of Vaughan and Raison suggests a preference for a different form of NHS to that the Government was proposing - one with less central control. In Raison's case, it was consistent with his stated view that, in time, the NHS should become a local government service.

#### 5.7 The form of management within the proposed NHS structure

Unlike many other organisations, the statutory bodies responsible for the hospital services created by the NHS Act 1946 had no single executive head, ultimately accountable for the work of all other staff.

HMCs and RHBs were bodies corporate, and comprised of part time members appointed by the Secretary of State (in the case of the RHBs and the chairmen of HMCs) and the RHBs (in the case of HMC members). Accountable to each RHB were three "principal administrative officers" (secretary, senior administrative medical officer and treasurer) and several other "chief officers" (such as the regional architect, engineer and nursing officer). Accountable to each HMC were two principal officers, the group secretary and treasurer, and other "chief officers" (234).

(233) *ibid.*, col. 354.

(234) *Handbook for Members of Hospital Management Committees*, 1971, pp. 11 (RHB officers) and 7/8 (HMC officers).

In the 1960s this form of organisation had been examined by a Committee of the Scottish Health Services Council chaired by Farquharson-Lang which, as noted in Chapter 2, had recommended that, as an alternative, a "chief executive post should be established at each type of [Scottish] board". The CRD had circulated a short paper to the HPG, summarising the Farquharson-Lang report (235), so Joseph, as a member, would have known of the recommendation, which may have resonated with his commercial experience as a manager, director and ultimately chairman of Bovis.

Whatever influenced him, it is clear that as Joseph became persuaded that the NHS should be unified, he favoured the introduction of the chief executive role, in the Department and the new health authorities. From the outset, however, officials sought to dissuade him from the idea.

As early as 26 August 1970, Sir Alan Marre, his Second Permanent Secretary, with many years experience of the NHS, sent Joseph a memorandum noting the difficulty in establishing a chief executive role in an organisation where medical practice was characterised by clinical autonomy, and where many other staff were professionals exercising professional judgement. For Marre, "clearly managers [he had in mind Joseph's putative chief executive] cannot interfere with the exercise by a professional man of his professional judgement". Marre acknowledged that "I think we all see the need for more concentrated authority", and suggested the answer might lie in placing "beyond all doubt the manager's responsibility for effectively co-ordinating the provision of the totality of the services" (236).

(235) *Administrative Practice of Hospital Boards in Scotland*, 1966, p. 64 (Farquharson-Lang report); PG/13a/66/22, CPA CRD 4/7/15 (CRD paper).

(236) Marre/Joseph, extract in note by Cashman (DHSS), 28/9/70, PRO BN 13/165.

Joseph, having decided to pursue a policy of unification, re-read the Labour Government's second Green Paper and minuted Rogers to emphasise his sense that the management proposals needed strengthening. In particular, Joseph envisaged, at area level, "a chief executive with outstanding management ability, drive and sustained determination ... who will accept the obligation to manage by persuasion within the professional areas, but directly elsewhere" (237).

A month later, Joseph and officials discussed a paper on key aspects of a reorganised NHS, including the proposed role of chief executive officer. This noted likely objections to the proposal from the BMA (who would accept it only if the chief executives were medically qualified) and other professional interests; identified the main components of the role (leadership of the authority's team of senior officers, interpretation and implementation of the authority's policies and co-ordination of the authority's activities and of the work of its various departments); and set out the role's limitations (much as in Marre's memorandum). The paper also suggested, as an alternative, leadership by a "triarchy of lay administrator, doctor and nurse, who would carry collective responsibility for administration of the area's health services" (238).

Joseph was not content with the formulation in the paper: for him "it was essential" that the chief executive officer "should not merely co-ordinate but should act as a driving force for the area authority". It was agreed that further thought would be given to the issue (239).

(237) Joseph/Rogers, 21/9/70, PRO BN 13/165.

(238) *NHS Reorganisation: Main Structural Features*, LP(70)1, paras. 31/8, sent under cover of minute from Dodds, 22/10/70, PRO MH 166/126.

(239) note of meeting, 28/10/70, *ibid.*

At this stage Joseph hoped to include the proposal for chief executive officers in "our first published proposals - with appropriate riders about clinical freedom and medical access to the Board [authority]" (240).

In December 1970 a Departmental paper specifically on the issue of a possible chief executive role was produced, covering much the same ground as Marre's August memorandum, and explored the issue of a co-ordinator as an alternative to the kind of chief executive Joseph had envisaged (241).

Joseph discussed the Departmental paper on 19 January 1971 with officials, a number of health service representatives, and Meyjes who was an adviser to DHSS on matters of NHS and Departmental reorganisation from late 1970.

After the meeting Meyjes wrote to say that he was "more convinced than ever of the need for a Chief Executive Officer at each level in the NHS hierarchy", regarded the Department's notion of a co-ordinator as "a wishy-washy and dangerous compromise", and suggested that arguments advanced that the NHS was a special case and different considerations should apply about its management that in other spheres were over-stated (242). Joseph drafted his own reply, expressing his concern about moving "too far or too fast" and harming "the spirit of co-operation we need", but saying that he would go as far as he safely could (243).

(240) Joseph's written comments on paper LP(70)1, 30/10/70, *ibid.*

(241) *Chief Officers of Regional and Area Health Authorities*, LP(70)11, December 1970, PRO MH 159/406.

(242) Meyjes/Joseph, 22/1/71, *ibid.*

(243) Joseph/Meyjes, draft and letter as sent dated 27/1/71, *ibid.*

Sir George Godber, the Department's Chief Medical Officer, and others at the meeting had clearly disagreed with Meyjes. Reflecting on the various arguments, Marre prepared a note suggesting that the differences were "less great than might be inferred from the discussion". Everyone at the meeting had accepted that a chief executive "cannot interfere with clinical freedom". At depth, the key difference seemed to Marre to be whether or not it was accepted that, issues of clinical freedom excepted, there were "some, professional, areas" in respect of which the chief executive could not give orders. Marre also suggested that "general manager" might be a more acceptable term than "chief executive" (244). Rogers and, to an extent, Joseph agreed with Marre's view, but his analysis attracted criticism from Godber who commented "this is all about running an office, not organising a service provided by professionals independent in their own responsibility. It wholly misses the operational requirement" (245).

Joseph held a further meeting on 10 February with Meyjes and senior officials, and questioned whether, "unless there was one person with ultimate responsibility, there was likely to be enough drive and purpose injected into the organisation". There was discussion as to what "ultimate responsibility" was practicable within the NHS with its many professional staff - the authority to decide, or to co-ordinate. In the event, "given the difficulty of reaching agreement", Joseph proposed that the issue should be given more detailed examination, and it was decided that this should be in the context of the "general study on ... management" (the Study Group and Steering Committee referred to above) (246).

(244) Marre/Rogers, 25/1/71, PRO BN 13/157.

(245) Rogers/Joseph, 26/1/71; Joseph/Rogers, 27/1/71; Godber/Henry Yellowlees, 26/1/71, all PRO BN 13/157; Godber/Joseph, 8/2/71, PRO MH 159/406.

(246) note of meeting, 10/2/71, PRO MH 159/406.

Before the issue was remitted to the Study Group, Rogers sought to discover whether differences could be resolved. Following consultations with Godber and Meyjes in particular, he found a measure of agreement on what might be termed a strong co-ordinator post, a "role which did not carry or imply executive authority over other professional officers in the exercise of their professional judgement but should make clear the task of leadership and co-ordinating management" (247). In reply to Rogers, Meyjes expressed minor reservations "which can remain between us", but said that he was content with the proposal which he saw as "a great advance" (248).

Rogers' proposal was considered by Joseph at a meeting on 7 May, where it was agreed, the proposed new role being referred to as "a co-ordinating post". The definition of the functions of the post was remitted to the management Study (249).

It seems possible, however, that the management Study Group was not advised that the strong "co-ordinating" role agreed at the 7 May meeting was a "given" for its purposes. For by January 1972 discussion within the Group had led to the formulation of "five basic alternatives" for the executive function, including "a chief executive officer with subordinate officers" (250).

- (247) Rogers/Joseph, April 1971 (see also Godber/Rogers, 10/3/71 and 7/4/71), all on PRO MH 159/406.
- (248) Meyjes/Rogers, 16/3/71, *ibid*.
- (249) note of meeting 7/5/71, PRO BN 13/166.
- (250) paper dated 14/1/72, PRO BN 13/168.

The issue evidently generated difficulty within the management study Steering Committee, because in March Rogers minuted senior officers to invite them to a meeting to discuss "the problem of "coordination" ... [about which] it is very clear that suspicion and uncertainty ... are poisoning the reaction of a number of members of the ... Committee and ... many members of the NHS, about the whole question of reorganisation". This followed an "off the record and over drinks" meeting that Rogers had had with "the medical members of the Steering Committee" which had led to the thought that, "while the "testing" by the Study Team of the various hypotheses [presumably the five put to Joseph in January] would continue, we might make it clear that the Department does not wish to pursue any proposal for a "Chief Executive" with subordinates" (251).

Rogers' minute made it clear that, if colleagues agreed, the intention was to sound others within the Steering Committee, and if the reaction was favourable the Department would then put a paper to the Committee setting out this "method of approach" (252).

The approach proposed seems to have been agreed, as Rogers wrote to "representative groups of members" of the Steering Committee a week later, suggesting meetings to discuss his proposition. His sense of the potential difficulty was perhaps conveyed by the following sentence from the letter: "I suggest the preliminary of smaller meetings because I feel they might be helpful to all of us before we tackle so delicate an issue in a Committee of such a size" (253).

(251) Rogers/R Gedling and others, 7/3/72, Graham papers.

(252) *ibid.*

(253) Rogers' letter, 14/3/72, *ibid.* Neither the Graham papers nor the DHSS files available in the PRO indicate to which Steering Committee members Rogers sent the letter.

Following these smaller meetings, Rogers put a paper to the Steering Committee on 27 April 1972, but withdrew it in the light of reservations expressed by members (254). He presented a revised version to the Committee meeting on 2 June, with the proposal that co-ordination should be split between two roles. The administrator at each level would have a "general" co-ordinating responsibility, and the chairman of the team of chief officers (who might be elected or appointed by the chairman of the health authority) would have the responsibility of ensuring that the work of the team went ahead effectively. This revised version was accepted (255).

On 3 July a draft chapter of the Study Group's report was sent to Joseph, including the view that "a single hierarchy controlled by a chief executive is not appropriate. The appropriate structure at all levels will be multi-disciplinary teams through which the managers and representatives of the relevant professions can come together to make decisions" (256). A week later, Joseph was advised that the draft chapter had been "substantially approved" by the steering committee (257).

- (254) *One Problem of Management in the National Health Service*, discussed at SCM(72)5th meeting, paper and minutes on PRO MH 159/386.
- (255) revised paper discussed at SCM(72)7th meeting, paper and minutes on PRO MH 159/387.
- (256) under cover of minute from FDK Williams (DHSS Chairman of the management Study Group), 3/7/72, PRO BN 13/169.
- (257) Williams/Joseph, 10/7/72, PRO BN 13/170.

The proposals for management arrangements were trailed in an appendix to the White Paper published on 1 August 1972 as "some ideas being developed in the [management study] (258), and were set out in full in the Grey Book published in September. The latter contained a brief reference to a chief executive role, asserting that the complexity of the NHS made it inappropriate. Instead, "consensus-forming group[s] of equals" at all levels were proposed, with the relevant administrator (regional, area or district administrator) providing "general administrative co-ordination" (259).

The issue had the potential to re-surface in January 1973, when the results of consultation on the Grey Book proposals were reported to Joseph. Several of those who had commented were critical of the idea of management through consensus teams: the BMA, for example, thought that "a medically qualified Chief Executive of each authority" would be preferable (260). Rogers did not refer to this issue in his covering minute to Joseph who, although picking up a large number of issues, made no reference to it himself (261).

(258) Cmnd. 5055, 1972, pp. 57/62.

(259) *Management Arrangements for the Reorganised National Health Service*, 1972, p. 15 (reference to chief executive role; p. 42 ("group[s] of equals")); pp. 35, 39 and 43 (general administrative co-ordination at district, area and regional levels, respectively).

(260) submission sent under cover of Rogers' minute of 2/1/73, PRO BN 13/171.

(261) *ibid.* (Rogers); Joseph's response, 3/1/73, *ibid.*

How is Joseph's acceptance of the co-ordinating role to be understood, given his early enthusiasm for the establishment of the chief executive role, and the support he received in January 1971 from Meyjes?

The evidence suggests that on this specific issue both Joseph and Meyjes were largely, if not wholly, convinced by the analysis offered by Marre and Rogers. Joseph clearly accepted the right of doctors to exercise their personal clinical judgements in advising and treating their patients which, as noted in the Introduction, had been one of the basic principles, and therefore part of the form, of the NHS since its inception (though, as noted above, he wanted to find "ways of breaking down consultants' autonomy in resource allocation and utilisation"). He also accepted, early in the Departmental discussions, that a chief executive could only manage "by persuasion within the professional areas". Given both of these, a chief executive with full authority over all other staff was, by definition, not feasible, and Rogers' strong co-ordinating role seemed a practicable alternative.

The outcome of the discussions over the chief executive role meant that Joseph was unable to see carried through into the reorganised Service two of the three elements of his vision of how to improve the efficiency of the NHS that proved contentious. From Joseph's point of view, on the positive side was the fact that, despite the opposition of some Conservative backbenchers, his proposal in respect of RHAs was enacted. However, he was forced by differences of view in Cabinet to modify his view that AHAs should be constituted on what he regarded as "the principle of sound management rather than participation", and was persuaded from pursuing his proposal for chief executives.

## 5.8 The oversight of the NHS nationally

Joseph's sense of the NHS organised on sound management principles included oversight at national level by the Secretary of State, supported by a re-orientated DHSS. Re-orientation was necessary because Joseph regarded the Department as "not organised to manage" (his underlining). In his view, it was "organised to set policy, but that is not the same thing as active management" (262).

Although Joseph envisaged the RHAs as having a key role, some reorganisation of the Department was required, the better to fit it for its contribution to "active management" of the NHS. Even before detailed work on the proposed new NHS structure was put in hand, McKinsey and Co. was commissioned to review the organisation of the DHSS. As a result, a new division was created within the Department, with (London-based) sections responsible for liaison with each of the proposed fourteen regions.

Joseph's intentions as regards the Department generated little specific parliamentary interest, though the Opposition and some Conservative backbenchers expressed concerns about centralisation (263). They did, however, come under criticism from two of the sources of non-DHSS, non-NHS organisational expertise involved in developing the arrangements for the reorganised NHS - Meyjes and Jaques.

(262) Joseph/Dodds, 8/8/70, PRO MH 166/125.

(263) for example, John Silkin referred to the NHS under the proposed new structure as "firmly under his [the Secretary of State's] control" (Commons Hansard, vol. 853, col. 943; Pavitt (Labour) rejected "the whole managerial hierarchical structure which the Secretary of State makes the basis of his approach and the concentration of absolute power in his own hands" (ibid., col. 952); and in Vaughan's view the proposals offered "a very large dose of line management ... a major tightening of executive authority" (ibid. col. 1142).

In Opposition the Conservatives had enlisted the help of a number of businessmen, and in Government several were seconded to the CSD and deployed on a wide range of projects (264). After some early confusion, referred to above, Meyjes became an adviser on NHS reorganisation and a member of the Steering Committee for the management study.

Jaques was the head of the School of Social Sciences at Brunel University, and Director of both the Brunel Institute of Organization and Social Studies (BIOSS) and the HSORU, a unit almost wholly funded by the DHSS. The HSORU was thus a natural source of advice to which the DHSS could turn.

In April 1971, officials sought Joseph's agreement that McKinsey and Co., already contracted to work on the review of the DHSS, be engaged on the NHS reorganisation management study. In addition, his agreement was sought for Jaques to be appointed to the Steering Committee (265). Joseph agreed to both, the latter after seeing some of Jaques' work (266).

(264) a list for the period July 1970 to May 1972 is attached to a minute from D Hoskin (CSD)/Meyjes, 27/4/72, CSD file MG 425/08.

(265) J Orme (DHSS)/Joseph, 8/4/71, Graham papers.

(266) Joseph, 22/4/71 and 2/5/71, *ibid.*

Before Jaques' appointment was effected, however, a difficulty had to be resolved between his unit, the HSORU, and McKinsey and Co. on how the two would work together. At one stage discussion on this seemed to be reaching "an impasse" (267) and that only one of the organisations would be able to be involved in the management study. At that stage Meyjes (and Rogers) "in the last resort ... prefer[red] to rely on McKinseys alone" (268).

When Meyjes and Jaques found themselves members of the Steering Committee, they had no previous relationship (269) and, although wanting Jaques to be involved, "in the last resort" Meyjes regarded McKinsey's as more important than the HSORU.

From his first contacts with DHSS ministers and officials, Meyjes had criticisms of the way Joseph was approaching the issue of NHS reorganisation, which he regarded as "basically ... an unco-ordinated "in-house" approach", when in his view a small expert team of individuals from inside and outside the DHSS/NHS should be established to make recommendations (270).

During the course of his membership of the Steering Committee, Meyjes' concern about the way matters were being taken forward increased, and he came to the view that the structure Joseph was proposing (and within which the management study was constrained to work) was unsatisfactory. Jaques reached much the same conclusion.

(267) Meyjes/Rogers, 3/6/71, *ibid.*

(268) *ibid.* (Meyjes); Rogers/Meyjes, 7/6/71 (Rogers), *ibid.*

(269) personal communication from Jaques.

(270) Meyjes/Jellicoe, 14/12/70, CSD file MG 281/16/01S.

Early in 1972 Meyjes and Jaques prepared a paper offering an alternative structure above AHA level, as by then their experience of trying to design "a unified NHS organisation" from Joseph's three tier structure had "forced [them] to the conclusion that it simply will not work" (271).

Meyjes and Jaques' main criticism of Joseph's proposed structure was that it lacked "an NHS strategic planning top". As proposed, national level management was provided by a permanent secretary with other duties, assisted by a full time deputy secretary and other, less senior staff: "markedly insufficient strength for managing such a vast organisation. A full time Chief Officer of at least Second Permanent Secretary level is essential" (272).

Instead of the traditional civil service staffing of the DHSS (albeit to be reorganised following the McKinsey and Co. review) and the fourteen RHAs, Meyjes and Jaques proposed a "national statutory health service authority, with the same relationship to the Secretary of State as that envisaged for the RHAs" with, as a Chief Officer at Second Permanent Secretary level as its senior member of staff. The national authority would relate directly to the AHAs which would be "full strength ... not squeezed down by an RHA between [them] and national level (273).

(271) *A National Organisation Model for a Unified NHS*, 1971, p. 1.

(272) *ibid.*, p. 2.

(273) *ibid.*, pp. 3/5.

Meyjes and Jaques had the opportunity of discussing their paper with Joseph, accompanied by Rogers and senior officials, on 1 March 1972. Rogers regarded the proposed national health authority as an attempt "to separate policy and management in organisational terms", which he saw as "highly damaging"; both should be the responsibility of the DHSS. Joseph was unconvinced by the Meyjes/Jaques proposals, and regarded "the inclusion of regional authorities ... [as] a political imperative" (though the evidence suggests that it was he who made it so, and he would have received support from Conservative backbenchers such as Vaughan and Raison, and possibly the Opposition, had he jettisoned them). Nevertheless, Joseph offered a further meeting, for Meyjes and Jaques "to put their case more fully" (274).

The further meeting was held on 6 March. At this, Joseph concluded that the "proposed national NHS authority would not be viable politically or operationally" and could not agree to the issue being discussed by the Steering Committee (275).

It is open to question whether there was any possibility of Joseph being persuaded by Meyjes and Jaques. In reporting on these meetings to Aberdare, who attended neither, his private secretary wrote "I understand that the meetings were in no way consultative. Secretary of State had already decided, on the basis of the papers presented, that the proposals they contained were not acceptable. There were two meetings ... only in order to cushion the blow of what was to be a negative reply" (276).

(274) meeting note 72/35, PRO BN 13/158.

(275) meeting note 72/39, *ibid.*

(276) E Weeple/Aberdare, 7/3/72, PRO BN 13/167.

Why did Joseph reject Meyjes and Jaques' advice? On the basis of the views he expressed at the outset of the development of the NHS reorganisation proposals, they might have been expected to have been well received. For, as noted above, Joseph regarded the DHSS as organised to set policy rather than to manage, and had positively wanted Meyjes' management advice recognising, perhaps, the limitations of his officials in that regard (277).

In understanding Joseph's decision, it is of course quite possible that he was intellectually unconvinced by the Meyjes/Jaques analysis, which is hinted at in his view that the national health authority would not be viable organisationally as well as politically. Other considerations were concern over what by March 1972 was becoming a tight timetable if work was to be completed in time for legislation to be prepared and enacted in the 1970 Parliament and, possibly, the growing influence of Rogers, who disagreed with the Meyjes/Jaques proposal (278).

For Meyjes, Joseph's decision on 6 March marked the end of what he had found to be a generally unsatisfactory involvement with NHS reorganisation. He wrote to Joseph on 9 March, informing him that he was discontinuing his consultancy role to the DHSS and NHS including resigning from the Steering Committee (279).

(277) Joseph/Rogers, 28/9/70 (re Meyjes), PRO BN 13/165; "The Department ... [is] full of talent but not necessarily [management] talent", Joseph/Dodds, 8/8/70, PRO MH 166/125.

(278) Joseph evidently valued Rogers' advice highly. After Rogers retired, Joseph sought it when in Opposition, even to the point where Rogers became a member of the Party's Public Sector Policy Group and its Manpower Sub-group - see chapter 5.

(279) Meyjes/Joseph, in the currently closed PRO CAB 157 (Webster, 1996, p. 922). Author supplied with a copy by Jaques.

In this letter, Meyjes expressed his conviction that the Steering Committees (for the DHSS and NHS studies) were viewed by Rogers and Godber as "little more than elaborate and increasingly tiresome pieces of window dressing to lend credence to a pre-determined solution"; criticised Rogers "desperate attempts not to make constructive criticisms of our proposal ... but to suppress it altogether and thus prevent its wider consideration by the Steering Committees and other interested parties; and commented that he had been "astonished at the superficiality and lack of sophistication in the discussion" of the proposal with Joseph and senior officials. He repeated his view that Joseph's scheme would not work: "I am sure we are moving in the wrong direction towards a bad solution ... thus missing a unique opportunity for positive and much needed reform" (280).

#### **5.9 Conservative views on the NHS's structure and management arrangements**

The Government's decision to unify the NHS provided a focus for reflection on the structure and management arrangements of the Service, and among Conservative responses various views can be discerned.

At what might be regarded as the two poles were Joseph's initial vision of a central government service organised on what he regarded as the "principles of sound management", and Arthur Jones' preference for integrating the NHS into the reformed local government structure.

(280) *ibid.*

Between the poles was a variety of positions. Some Conservatives, such as Raison, shared the views expressed by Brooke and Balniel in Opposition and looked to see the NHS part of local government in the longer term. They clearly favoured organisational arrangements without the degree of central control envisaged in Joseph's proposals, and reflected on specific issues, such as the regional role, from this perspective. It seems likely that Cabinet ministers such as Walker shared this longer term view, which would make understandable their sustained campaign to give local authorities the right of appointment to AHAs.

Other Conservatives who did not look to the NHS becoming part of local government in the longer term, also regretted what they saw as the centralising aspect of Joseph's proposals. In Opposition, Balniel and others had argued against undue centralism (for example, during the debate in March 1970 on then Labour Government's second Green Paper, see chapter 2, section 5.4). This was certainly the case with Powell, for whom the financing arrangements of the Service precluded a local government solution (281), but who regarded the transfer of the local authority health services to central government as creating a monopoly of sources of initiative rather than what he regarded as a more desirable plurality. It was probably also the position of Vaughan and Stuttaford, both of whom criticised Joseph's proposals as unduly "managerial".

(281) Commons Hansard, vol. 853, cols. 1121/2.

Joseph may have felt ambivalent about the outcome of discussions on his reorganisation policy. He started with a clear vision, much of which was widely supported. There was almost universal support for bringing the three branches of the NHS together and, given unification outside local government, for coterminosity of boundaries for health and social services authorities. Within Conservative ranks (Arthur Jones excepted) there was support for the NHS being, for the present at least, a central government service, though some concern about transferring the local government health services to central government.

It was in respect of Joseph's sense of a Service based on the "principles of sound management" that he encountered most opposition and had to modify or abandon aspects of his initial plans. The three elements discussed above proved the most contentious. On one, the appointment basis of the AHAs, Cabinet concerns led to compromise. On a second, the chief executive role, he seems to have been persuaded from his initial plan by the arguments of his civil servants. He succeeded in securing enactment of the third, RHAs in line relationship between the DHSS and the AHAs, but did so in the face of some unease among Conservative backbenchers, and the unambiguous advice from two of his sources of independent management expertise that the RHAs and the Departmental organisation together were a "markedly insufficient" top to such a major organisation which "simply would not work".

As a result, the NHS became a wholly central government based service, consciously managerial in style though less so in substance than Joseph initially proposed. As such, the changes enacted in the NHS Reorganisation Act 1973 marked a significant shift from the arrangements implemented in 1948 and essentially extant until 1974.

## 6. INTERPRETATIONS OF THE CONSERVATIVE GOVERNMENT

In the previous sections an account has been given of Conservative policy thinking on the organisational arrangements of the NHS, within the context of the Government's policies for public expenditure and a "new style of government". In this section interpretations of the Heath Government will be considered, with a view to reaching conclusions as to their relevance to the account given of thinking in respect of the NHS.

Studies of the Heath Government have covered a wide range of facets (282). In the main, however, they have focused on its economic and industrial policies, with much attention to the degree of success enjoyed and, where (usually) the authors' verdict was one of failure, interpretation of that failure (283).

That is understandable as economic and industrial policies were central concerns of the Government, and the subject of "U turns" in policy from the apparently less interventionist approach signalled by the 1970 general election manifesto to a more interventionist one which Thatcher later described as "the most radical form of socialism ever contemplated by an elected British government" (284). And reaction to these policies led Heath to decide to seek a dissolution well before required under the Parliament Act, the consequent general election resulting in the fall of the Government.

(282) for example, those covered in the contributions to Ball S and Seldon A, *The Heath Government 1970-1974*, 1996, London, Longman.

(283) various interpretations are conveniently summarised in Seldon A, "The Heath Government in History", *ibid.*, p. 2.

(284) Thatcher M, *The Downing Street Years*, 1993, London, Harper-Collins, p. 7.

Among the general surveys of the Heath Government, the issues discussed in this Chapter feature, if at all, at the very margin. There are usually (though not invariably) references to the Government's reorganisation of central government (and especially the creation of the CPRS), but rarely more than a sentence or two on either NHS or local government reorganisation (285). Even in works taking an historical view of the NHS, reorganisation tends to be treated briefly, the Official History being by far the most noteworthy exception (286).

In respect of the reorganisation of the NHS, commentators have tended to focus on the basic facts, and to expressions of opinion on its success or otherwise (287). The Official History is, again, the clear exception.

- (285) for example, taking central and local government and NHS reorganisation together, in Blake, 1985 (one sentence in eight pages, p. 315); Butler D and Kavanagh D, *The British General Election of February 1974*, 1974, London, Macmillan (two lines in 17 pages, p. 11); Charmley J, *A History of Conservative Politics 1900-1996*, 1996, London, Macmillan (no reference in 14 pages); Holmes M, *The Failure of the Heath Government*, 2nd ed., 1997, London, Macmillan (no reference in 149 pages); Kavanagh D, "The Heath Government 1970-1974" in Hennessy P and Seldon A (eds.), *Ruling Performance*, Oxford, Blackwell, 1987 (two paras. in 21 pages, pp. 223/4 and 233); Ramsden, 1996, (2.5 pages in 65 pages).
- (286) for example, in Klein R, *The New Politics of the NHS*, 3rd ed., 1995, London, Longman, (five pages, pp. 84/90); Lowe, 1989, (two pages, pp. 189/90); Raison, 1990, (four pages, pp. 79/82). By contrast, Webster, 1996 (128 pages, pp. 451/579).
- (287) for example, Campbell, 1993, p. 384 ("disaster"); Klein, 1995, p. 90 ("satisfied no one"); Lowe, 1989, p. 190 ("a disaster"); Raison, 1990, pp. 81/2 ("over-elaborate" and "flabby").

Some commentators have shared the sense that, though not initially and never formally part of the "new style of government" approach, NHS reorganisation was in keeping with the general approach of the Heath Government, characterised by one as being "optimistic about the benefits of structural and institutional change" (288). The account given in this Chapter supports this view. (It is perhaps worth noting that, while there indeed seems to have been optimism at the outset, despite the scepticism that Heath personally had expressed at the Selsdon Park conference, noted in Chapter 2, there is some evidence that, by 1972, this was diminishing (289).)

Also shared by some commentators is the view that the outcome represented something of a compromise from Joseph's initial sense of what was needed. Thus the development of policy has been described by Klein as "a political exercise in trying to satisfy everyone" (290), while in Lowe's view the outcome - with regional, area and district administration - was "largely a result of lobbying by vested interests" (291).

(288) Kavanagh, in Hennessy P and Seldon A (eds.), 1987, p. 223. Others who have made essentially the same point are Campbell, 1993, p. 384; Raison, 1990, p. 73.

(289) see remark reportedly made by Heath at a dinner with the Business Team cited by Theakston K, "The Heath government, Whitehall and the civil service" in Ball S and Seldon A (eds.), 1996, p. 104. It is the case that Meyjes and some other members of the Team members returned to their private sector employers shortly afterwards (Pollitt, 1984, p. 103).

(290) Klein, 1995, p. 90.

(291) Lowe R, "The social policy of the Heath government" in Ball S and Seldon A (eds.), 1996, p. 206.

As the account given of the discussions between ministers on AHA membership shows, there is no doubt that Joseph compromised on his original proposals on this issue. It is, however, open to question whether, on the main elements of the reorganisation, the end result was quite such a compromise with vested interests as Klein and Lowe imply.

Once unification outside local government had been agreed, the main structural decisions - the basic tier of authority to be at area level with a regional tier between area and the Secretary of State - seem to have been determined, respectively, by what at the time was the shared political view about the need for coterminosity, and by Joseph's sense that it would be "hubristic madness" for the DHSS to try to relate to ninety AHAs. In the latter case, alternatives were available and discussed - Joseph's early idea of a National Corporation and later the not wholly different proposal from Meyjes and Jaques. The choices made in September 1970 (the National Corporation) and March 1972 (the Meyjes/Jaques proposal) not to pursue the alternatives seemed to owe nothing to "lobbying by vested interests" as the discussions never came into the public domain.

Overall, in the author's view the evidence suggests that Joseph personally was absolutely central to the policy to reorganise the NHS. It was Joseph who decided, from a position of initial caution, perhaps even scepticism, to propose the policy to ministerial colleagues (there was no imperative for him to do so, as there was no specific general election manifesto commitment to be discharged). It was Joseph who had a vision of unification with emphasis on better management, flowing from his conviction that improvements in the Service must in part come from the better use of resources: a vision arguably at odds with the emphasis of Balniel and others in the late 1960s on avoiding centralisation. And, apart from the issue of AHA membership, where arguably he had no realistic alternative but to compromise in the face of sustained ministerial disagreement, it was Joseph who, after exposure to the arguments, took the key decisions, for example to accept the Grey Book management arrangements instead of a chief executive model, and to reject the Meyjes/Jaques proposal.

## **7. ARRANGEMENTS FOR POLICY MAKING, 1970-1974**

Once in office, the focus for policy making shifted from Party arrangements such as the HPG to the procedures of cabinet government.

On the both the major issues examined above, the initial consideration was kept within Whitehall: first, discussion between Joseph, ministerial colleagues and DHSS civil servants; then inter-departmental discussions, in the case of aspects of the reorganisation of the NHS, ultimately at cabinet level.

In the case of possible alternative financing arrangements, the issue did not go beyond Whitehall to become a matter of public discussion. In the case of the reorganisation of the NHS, a formal consultation paper was issued, and many NHS and local government interests responded. But the consultation was in practice on very circumscribed matters: on key issues, such as unification outside local government, the possible chief executive role, and the possible "top" level of the NHS, there was no public consultation and little public debate.

The evidence suggests that, on the issues relating to the reorganisation of the NHS examined in this Chapter (apart from that of the membership of AHAs, which became a cabinet decision), Joseph was most influenced by his senior DHSS officials, especially in respect of the need for administrative unification of the NHS and the management arrangements for the new health authorities. However, in both these respects it seems clear that officials were often representing what they knew to be the views of key NHS interests such as the BMA, as they had had the benefit of their views by way of response to the Labour Government's two Green Papers. This is perhaps particularly clear in the case of the discussion on the possible chief executive role, where officials drew attention to the opposition of the medical profession to non-medical chief executives. Although, as noted above, Joseph discussed issues with his expert advisers (Meyjes and Jaques), and with backbench Conservative MPs, he never seemed to accept their views in preference to those of his senior civil servants.

To the extent that DHSS civil servants were often reflecting the views of key NHS interests such as the medical profession, it can be argued that Conservative policy making on issues of the form of the NHS was more pluralistic in nature in government than in opposition, even though in both cases most of the discussions were between the responsible minister or LCC spokesman and a relatively small number of officials and advisers.

## CHAPTER 4 – ELECTION DEFEAT AND OPPOSITION, 1974–75

### 1. PREPARATIONS FOR THE FEBRUARY 1974 GENERAL ELECTION

In September 1971 senior Party officials began discussions about the manifesto for the next election. Fraser, who chaired what was known as the Official Group (OG), suggested that the aim should be to produce a draft for Autumn 1973, as "the possibility of a 1973 Election could clearly not be ruled out" (1).

A draft was prepared by late 1972, and refined in early 1973, in which the section on the NHS referred to the "improved administrative structure" that was being introduced, and committed the next Conservative Government to "vigorously press ahead with the improvement of Britain's health services" (2).

During 1973 ministers became actively involved, and in July, responding to Heath's invitation to suggest suitable items for the manifesto, Joseph identified seventeen possibilities. Consistent with Joseph's position on what he saw as the inadequate resourcing of the NHS, these included "Provide increasing resources of capital and revenue" (3).

In the deteriorating economic circumstances of 1973, however, it is understandable that Joseph's proposal did not find place in successive drafts of the manifesto, though the section on the NHS was expanded to include reference to the additional funding that had been made available since 1970 (4).

(1) OG/71/90, 9/9/71, CPA OG box 28-48.

(2) OG/72/112 and OG/73/114, *ibid.*

(3) Joseph/Heath, 26/7/73, *ibid.*

(4) *Preliminary Draft Manifesto*, OG/73/132, *ibid.*

In the light of the economic and industrial circumstances of Autumn 1973, with increasing oil prices consequent to the war in the Middle East and strains developing in the statutory wages policy the Government had introduced, Fraser judged that the political situation was such that it was necessary to prepare manifestos for an election "fought more or less in the normal way" and against "the possibility of a snap election forced in a particular situation". He had asked Nigel Lawson, the future Conservative minister but then "a friendly journalist" brought in for the purpose, to prepare a draft for the latter (5).

From mid-December 1973, therefore, two draft general election manifestos were under consideration. A lengthy version, covering all the main areas of policy, for a "normal" election, and Lawson's much shorter version for a "snap" election. The shorter version focused solely on the economic and industrial situation and was an appeal for "A MANDATE FOR STAGE THREE" [of the pay policy] (6).

The two versions were discussed by the OG on 12 December and by the Strategy Committee of senior ministers, chaired by Heath, on 20 December. At the latter meeting Heath asked for the Lawson version to be redrafted in the light of the ministerial discussion (where the principal concerns were what was perceived as its confrontational language, and focus on the mechanism (Stage 3) rather than the objective of countering inflation). However, Heath also asked that ministers be consulted on those sections of the "normal" manifesto relating to their responsibilities (7).

(5) OG/73/135, 29/11/78, *ibid.*

(6) OG/73/134 ("normal" manifesto) and OG/73/136 (Lawson's alternative, dated 7/12/73), *ibid.*

(7) Ramsden, 1996, p. 329; SC/73/25, CPA, unnumbered folder.

In the event, despite the fact that Heath secured a dissolution for a "snap" election, it was decided to issue a "normal" type of manifesto.

Heath had asked on 20 December that ministers be given the chance to comment on relevant sections of the "normal" draft manifesto. It is, however, unclear from the CPA papers exactly how much input Joseph had into the NHS section of the published version.

This emphasised what the Party saw as the achievements since 1970 - the increase in resources and the "reform" of the NHS's administration. It promised further improvements in services, as well as "a network of community hospitals" to supplement the general hospitals. It also rejected "Labour's proposal to abolish private practice and private provision in association with the National Health Service" (8).

In terms of the form of the NHS, the manifesto for the February 1974 general election was thus essentially conservative: no further change was proposed.

(8) Craig, 1975, p. 385. The Conservative rejection of Labour's proposal on private practice was not added directly in response to Labour's manifesto (published two days before the Conservatives). It had been anticipated, and included in drafts from mid January (OG/74/139, CPA OG box 28-48).

## 2. THE FEBRUARY 1974 GENERAL ELECTION AND ITS AFTERMATH

The events which led to Heath's decision to seek a dissolution on 7 February 1974 have often been described (9), and their detail is incidental to this thesis. Having failed to reach a settlement with the National Union of Mineworkers on pay, the Government sought "a new mandate and five years of certain authority" in the hope that this would put it in a good position to reach such a settlement" (10). In the event, despite gaining marginally more votes than Labour, the Conservatives won four fewer seats in the Commons (11). An attempt at securing the support of the Liberal Party having failed, on 4 March Heath resigned and a minority Labour Government was formed.

The situation facing the Conservatives was, in electoral terms, not dissimilar to that of October 1964, with a further election likely in the near future.

Following the election Joseph, perhaps disappointed at not being invited to become shadow Chancellor of the Exchequer, asked for, and was given, "a non-specific role in which he could concentrate on studying the reasons for Britain's long-term relative economic decline" (12).

(9) for example, Butler and Kavanagh, 1974, pp. 27/44; Ramsden, 1996, pp. 368/75; Campbell, 1993, pp. 555/97.

(10) Craig, 1975, p. 375.

(11) Butler and Kavanagh, 1974, pp. 275/6.

(12) Heath, 1998, p. 520.

Heath appointed Howe to be the LCC spokesman on social services, including the NHS (13), whether or not realising that in so doing he was appointing the senior Conservative who had most fully articulated the case for change in the form, particularly the financing arrangements, of the Service. For, as noted in previous chapters, Howe was sympathetic to the economic liberalism of the IEA and, unlike Powell, thought that radical change in the NHS was practicable in the longer term. He had been a member of the BMA's Advisory Panel which had proposed alternative financing arrangements for the Service, and shortly before the 1970 election had set out his views in a speech to the Fellowship for Freedom in Medicine which Joseph had commended to officials. Raison was appointed as Howe's junior frontbench spokesman (14).

### 3. POLICY ISSUES MARCH - OCTOBER 1974

With the formation of the new Government, the initiative on NHS matters passed to Labour. The Party's manifesto had included only a brief passage on the NHS, but one that contained several specific commitments. Two of these commitments were in respect of aspects of the form of the Service considered in previous chapters - to abolish prescription charges and "transform the area health authorities into democratic bodies" (15). A third commitment, to phase out "private practice from the hospital service", brought into the political arena the prospect of change in a further aspect of the form of the Service.

(13) *Times*, 12/3/74, p. 1. col. a.

(14) *Times*, 21/3/74, p. 4. col. a.

(15) Craig, 1975, p. 404.

As noted in the Introduction, from the inception of the Service it had been open to senior doctors who wished to work for the NHS to do so full-time, or part-time. Those doctors who chose to work part-time had the right to undertake private practice, and indeed to see their fee paying patients in NHS pay beds. Bevan had accepted this reluctantly, to avoid a situation in which "there will be a rash of [private] nursing homes all over the country ... [and] we will lose many specialists from the public hospitals for they will go to nursing homes" (16).

The ability to see NHS and private patients in the same hospital was often a convenience to the doctor responsible for their care, compared with seeing patients in separate NHS and private hospitals. There were also, arguably, benefits to the NHS both through the income raised in charging for pay beds (17), and in having the doctor on site throughout his or her working day and therefore in principle readily available to deal with NHS emergencies as they arose.

The practice of having private patients within NHS hospitals was, however, opposed within the Labour Party and trade union movement. The principal concern was probably that private patients were perceived as buying earlier admission for treatment, and other advantages such as more of a consultant's personal attention and single rooms. The separation of NHS and private practice by phasing out pay beds from the NHS became a formal part of Party policy by its inclusion in the manifesto for the February 1974 election, thus potentially re-opening a matter many in the medical profession regarded as a founding feature of the Service, long settled.

(16) Commons Hansard, 30/4/46, vol. 422, col. 57.

(17) a private patient treated in NHS pay bed paid a fee to his or her doctor, and a bed charge to the NHS.

### 3.1 The Government's position

Of the NHS issues on which there were manifesto commitments, the Government decided that, in the economic circumstances, it could take only limited immediate action on one, prescription charges. Within the social services the Government's immediate priority was "a big improvement in pensions" (18). While the goal remained "a free health service", to abolish prescription charges outright was estimated to cost £50 million per annum, which was "just ... not within our resources at present" (19). Two minor changes were, however, made in the age limits for exemption, and charges for family planning services were removed (20).

On the second issue, the structure of the Service, in opposition Labour had criticised aspects of the Conservative proposals. Its main concern, as summarised by the new Labour Secretary of State for Social Services, Barbara Castle, was that a system had been created that was "undemocratic and out of tune with the needs of local communities" (21).

(18) Commons Hansard, 15/3/74, vol. 870, col. 530.

(19) Commons Hansard, 28/3/74, vol. 871, col. 650.

(20) *ibid.*, cols. 650/2.

(21) Commons Hansard, 15/3/74, vol. 870, col. 530.

The timing of the election meant that the new Government had in principle the opportunity to seek to postpone or abort implementation of the new NHS structure, due on 1 April. With less than a month to go, however, ministers judged that this was not practicable. In the Queen's Speech it was announced that the Government would "review the working of the reorganised National Health Service" (22), clearly implying that the implementation would continue as scheduled.

In the Debate on the Address Castle confirmed that the Government would not be seeking "to postpone ... or to disrupt" the arrangements by then well advanced. To do so would, in her view, have been "to run very serious risks with the health of individuals and communities" (23). Further, the Government went as far as to rule out "any fundamental changes in the structure of the reorganised service now", instead undertaking to keep matters under review and be ready to propose "in the long term ... whatever changes seem to be desirable in the light of experience". What Castle referred to as "minor alterations" were not, however, ruled out (24).

Howe welcomed Castle's statement in respect of NHS reorganisation and, anticipating one aspect of the "minor alterations" the Government was to propose in May 1974, argued against the idea of adding further local authority representatives to health authorities, on the ground that councillors were "already heavily burdened with the administration of our new large [local] authorities" (25).

(22) *ibid.*, col. 46.

(23) *ibid.*, col. 531.

(24) *ibid.*

(25) *ibid.*, cols. 536/7.

The Government issued proposals for "minor alterations" in a consultative paper published on 30 May 1974, which focused on the membership of AHAs (26). Its objectives were to make the Service "more responsive to the views of the people it serves" and to take "greater account of the contribution which all of those who work in the Service can make to its management" (27).

To achieve these objectives the Government proposed that the membership of each AHA should include four members nominated by community health councils and two members drawn from NHS staff other than doctors and nurses (there were already medical and nursing members on each AHA), and that a third of the members should be "councillors drawn from local authorities matching the AHAs" (28).

In the longer term, the Conservatives criticised these proposals. Prior to the October 1974 general election, however, the proposals were not a matter Howe and his frontbench colleagues sought to place in the front line of issues between the two major parties, and there was no reference to them in the Conservative manifesto for that election (29).

It was in respect of the third of Labour's manifesto commitments - to phase out private practice from the hospital service - that there was political controversy prior to the October election.

(26) *Democracy in the National Health Service*, 1974, London, HMSO.

(27) *ibid.*, p. 5.

(28) *ibid.*, pp. 9/10.

(29) Craig, 1975, p. 440.

In the Debate on the Address, Castle announced that she would be accepting an invitation put by the BMA to Joseph to establish a joint working party to examine the form of contracts of senior hospital medical staff, and that this examination would cover the "place that private practice should have in the National Health Service" (30).

A working party was duly established, under the chairmanship of Castle's Parliamentary Secretary, Dr David Owen. Any political controversy might have been expected to have arisen only when the working party's work had been concluded, which had initially been expected to be late in 1975 (31).

Early in July 1974, however, union activists at the Charing Cross Hospital threatened not to help treat patients in the private wing, and there was similar action elsewhere. The Charing Cross dispute led to a negotiation between ministers, union leaders, the BMA (and the separate Hospital Consultants and Specialists Association (HCSA), the AHA responsible for Charing Cross and local union representatives (32). Central to its resolution was agreement that the work of the Owen working party would be speeded up, with a view to completion by November, a year earlier than originally expected (33).

Thus through the Charing Cross dispute the procedure by which the Government hoped to be able to take forward its policy of phasing out pay beds had become much accelerated, and the issue had become one of significant public profile.

(30) Commons Hansard, vol. 870, col. 532,

(31) Castle B, *The Castle Diaries 1974-76*, 1980, London, Weidenfeld & Nicolson, p. 135.

(32) described, *ibid.*, pp. 131/8.

(33) printed in Commons Hansard, vol. 876. cols. 950/1.

### 3.2 The Conservative response

Within a month of his appointment, Howe told his colleagues on the LCC Steering Committee (LSC), a sub-group of senior LCC members, that he was proposing to set up "three or four small groups" chaired by officers of the parliamentary Health and Social Security Committee (34). A month later he reported to the LCC that six groups had already established, with two more planned. Two of these related directly to aspects of the form of the Service, those on NHS finance and the private sector in health, the latter chaired by Dean (35). The existence of these groups (by then expanded to nine) was made public at a speech to the Conservative Women's Conference on 21 May 1974 (36).

While the groups were announced as in existence by late May, within the CPA there is little evidence of their work. For example, Raison, who chaired one group, wrote to Howe explaining that three proposed meetings had fallen through because of diary problems, and offering a suggestion for the manifesto for the next election arising from the one meeting that had proved practicable (37).

Given the very limited time between the establishment of these groups - April 1974 at the earliest - and the Summer Recess, it is understandable that little of substance should have resulted prior to the October 1974 election.

In advance of any conclusions that the group chaired by Dean might reach, Howe had responded on the issue of pay beds once it had been brought into the public arena by the Charing Cross dispute.

(34) LSC/74/5, 8/4/74, on CPA LCC 1-13.

(35) LCC(74)13th, 13/5/74, *ibid*.

(36) Conservative Party press release 177/74.

(37) Raison/Howe, 26/7/74, CPA CRD 5/27.

He brought the matter to the LSC on the same day that he tabled a Private Notice Question to Castle on the dispute (38). The discussion focused on the financial loss both to the NHS and consultants if pay beds were phased out. Howe advised that the private sector "currently spent £27 million a year of which about £10 million went to consultants" (though not all in respect of pay bed patients), and this accounted for "about half the money they received". Joseph agreed that "there would be very large claims [for extra remuneration] from consultants" if, due to the loss of pay beds, they were in practice unable to have private patients. Heath commented that, in addition to the financial considerations, "freedom of choice was also a powerful general argument and was basic to our thinking in this and other fields such as education" (39).

The Conservative stance on the pay bed issue was thus given specific consideration at the highest level within the Party, and confirmed as the basis for the next election manifesto.

During the Summer Howe also took the opportunity of defending the reorganisation of the NHS against early critics of the disruption some judged it was causing. At a conference in Manchester he acknowledged that reorganisation was disturbing, but was in its essence a consensual policy. He had "little respect for those who now complain" (40).

(38) Commons Hansard, 8/7/74, vol. 876, col. 946.

(39) LSC/74/11, 8/7/74, CPA LCC 1-13.

(40) speech to joint National Association for Mental Health/British Association of Social Workers conference, 18/7/74, Conservative Party press release 318/74.

### 3.3 The Conservative manifesto for the October 1974 general election

Work on the Party's next manifesto began almost immediately after the February election. The first substantial draft was circulated at the end of April. Following revisions, the LCC considered the fourth draft at its meeting on 21 June. At that stage there was only one sentence on the NHS, committing a new Conservative Government to "build on the improvements" made by the last one, with "special emphasis on what had previously been the neglected services for the old, the disabled, the mentally ill and the handicapped" (41).

Howe was unable to attend the LCC meeting on 21 June but wrote to Heath the day before suggesting that there was a number of omissions, including "a promise to review the financing of the Health Service, including the machinery for settling pay. (The Whitley Councils [the machinery used to settle the pay of most NHS employees except doctors] are immensely criticised for delay)" (42).

Howe made further suggestions on 8 July, proposing that the development of community hospitals; the retention of private practice within the NHS; a review of pay machinery, especially the Whitley arrangements; a search for further sources of NHS finance, and a commitment to no further reorganisation until the one implemented on 1 April had settled down, should be included (43).

(41) paper LCC(74)22, 19/6/74, considered at LCC(74)22nd, CPA LCC 14-24.

(42) Howe/Heath, 20/6/74, on CPA LCC 14-24.

(43) Howe, 8/7/74, CPA, CRD 5/27.

The LCC meeting minutes do not indicate whether Howe's proposal for a review of NHS financing was discussed, and the fifth draft, dated 27 July, reflected little of his suggestions. To the sentence on the NHS in the fourth draft was added, in parentheses "and will encourage people to take out insurance for medical treatment. This is one way of channelling additional resources into Britain's health services" (44).

At this stage Howe seems to have taken responsibility for redrafting the NHS section as it eventually appeared in the final version (45), published as *Putting Britain First* on 10 September (46).

The principal theme of the manifesto as a whole was the need for "the Government and the people" to unite on a national policy to defeat what the Party saw as the economic and political dangers facing Britain, "greater than any we have seen since the last war" (47). With this in view, the Party undertook not to re-introduce what had proved to be controversial legislation or "govern in a narrow partisan spirit", and came close to proposing a government of national unity. If elected, the Party would "consult and confer with the leaders of other parties and ... the great interests in the nation" with a view to securing "the consent and support of all men and women of good will", and "invite people from outside the ranks of our party to join us in overcoming Britain's difficulties" (48).

(44) *ibid.*

(45) Howe/Fraser, 20/8/74, *ibid.*

(46) *Times*, 11/9/74, p. 1, col. a.

(47) Craig, 1975, p. 425.

(48) *ibid.*, pp. 425/7.

In the context of the economic crisis, the manifesto suggested that it would not be easy to "maintain existing standards" in the NHS. For this reason, in the Party's view it was "so wrong to reject any acceptable method of channelling additional resources" into the Health Service, and inappropriate to lose the £100 million a year generated through charges or the nearly £30 million a year by phasing out pay beds. In addition to the wish to retain the income generated, phasing out pay beds was "unacceptable in principle" and would "reduce the skills available to patients generally" (49).

Whether the Party leadership envisaged a substantive review of alternative financing arrangements for the NHS is unclear, though such a review would not have been inconsistent with the wording of the manifesto. What is clear is that no further significant change in the Service's structure or management arrangements was intended. In the Party's view, "what is now needed ... is a period of comparative stability, founded upon the reorganisation that we carried through, which must now be allowed to settle down" (50).

Other manifesto commitments, with less potential impact of the form of the NHS, included the promise of priority for services for the elderly, disabled, mentally ill and mentally handicapped, and Howe's proposal that the Whitley machinery should be reviewed (51).

(49) *ibid.*, p. 440.

(50) *ibid.*

(51) *ibid.*

#### 4. THE OCTOBER 1974 GENERAL ELECTION AND ITS AFTERMATH

Following the February election, Labour lacked an overall majority in the Commons, and a further election in the near future was likely. In the event, Wilson sought a dissolution on 18 September 1974, with 10 October as election day. At the outset of the campaign the opinion polls gave Labour a lead of between 4% and 14.6% (52).

Butler and Kavanagh characterised the October election as "the quiet campaign" (53) which is understandable, in part at least, given the nature of the Conservative Party's appeal to the people. Even before the date of the general election had been announced, Heath had apparently briefed candidates to avoid "confrontation" (54). With the Party campaigning on a policy of building national unity so that what it perceived as the "economic and political" dangers could be successfully addressed, it would have been incongruous if candidates, especially the Party's leaders, had been overly critical of Labour's six months in office.

(52) Butler D and Kavanagh D, *The British General Election of October 1974*, 1975, London, Macmillan, pp. 190/1.

(53) *ibid.*, p. 102.

(54) Heath to candidates, 12/9/74, quoted in Campbell, 1993, p. 644.

As the campaign went on, Heath came to the view that "the real hope of the British people in this [crisis] situation" was "a National Coalition government, involving all the parties" (55). His attachment to this idea was not, however, so strong as to lead him to accept the advice of close colleagues that, as a possible impediment to the formation of a coalition government, he should announce his willingness to stand down as Conservative leader (56).

The outcome of the election was that Labour secured 18 additional seats, and an overall majority of three in the Commons (57). On the face of it this seemed slender but, partly with the assistance of a pact with the Liberal Party, the Labour Government survived until it lost a vote of confidence on 22 March 1979, and the consequent general election on 3 May.

#### 4.1 NHS policy October 1974 to February 1975

Following the October election Howe remained as the LCC member with responsibility for social services. Raison was appointed to the LCC with responsibility for consumer affairs and succeeded as junior spokesman on social services matters by Cranley Onslow and Kenneth Clarke (58).

(55) Heath, 5/10/74, quoted in Butler and Kavanagh, 1975, p. 129.

(56) for example, *ibid*, pp. 124/7; Campbell, 1993, pp. 649.

(57) Butler and Kavanagh, 1975, p. 293.

(58) *Times*, 19/11/74, p. 2. col. a.

In its manifesto, Labour had committed itself to continuing "the progressive elimination of prescription charges" and the phasing out of pay beds. It had also referred to the "published proposals for greater democratic participation" in the running of the Service, (those in *Democracy in the National Health Service*), without committing itself to their implementation (59).

In the social policy element of the Debate on the Address, Castle, who remained Secretary of State for Social Services, mentioned only one of the three issues referred to above. She explained that, because of the general election, the Owen working party would now be reporting rather later than anticipated in her statement during the Charing Cross dispute (60).

In his contribution to the Debate, Howe described the Government's proposals in respect of pay beds as "wholly misconceived", because the existence of private practice within the NHS "makes a contribution to the cost of that service" and it provided consultants with a substantial proportion of their earnings. Taken together, Howe estimated that "these contributions amount to about £30 million a year". He also argued that separating private hospital facilities from the NHS "would waste time and resources on the part of consultants", risk the growth of medical emigration, and reduce the "personal freedom for the medical profession" and patients (61).

(59) Craig, 1975, pp. 459/60.

(60) Commons Hansard, vol. 880, col. 545.

(61) *ibid.*, cols. 561/2.

Howe noted that neither in the Queen's Speech nor Castle's contribution to the Debate had there been any mention of abolishing NHS charges, which he welcomed given the financial problems of the Service that had recently been highlighted in a statement by the Presidents and Deans of the Royal Colleges (62). This had referred to the "real danger of standards [within the NHS] declining"; called upon the Government "to recognize, and remedy to the best of its ability, the serious under-financing from which the NHS is suffering"; and asserted that "the time had now come for a careful scrutiny of the funding" of the Service (63).

Raison, still at that time the junior Opposition spokesman on NHS matters, had a history of favouring greater local authority control over the NHS, as noted in chapter 3. He used his speech in the Debate to question whether the proposals in *Democracy in the National Health Service* to increase the number of local authority members on AHAs would "genuinely extend local democracy", without giving any indication of whether the Conservative Party would oppose such a change (64).

The following day an assessment of the financing needs of the NHS made by the BMA and professional organisations representing dentists, nurses and midwives was published. This had been prepared following a deputation to the Prime Minister on 31 July, and argued for a real terms increase in NHS funding of £900m in four years, to be achieved by annual increases of £225m. It also renewed the request the professional bodies had made for an independent inquiry to "examine whether the system of financing introduced in 1948 is still entirely appropriate in 1974" (65).

(62) *ibid.*, cols. 560/1.

(63) *BMJ*, 26/10/74, p. 237.

(64) *ibid.*, col. 625.

(65) *BMJ*, 2/11/74, pp. 297/300 (quote from p. 299).

The growing concerns within the health professions about the state of the NHS seem to have been influential in the Conservative leadership's decision to instigate a debate specifically on the Service on 2 December.

In the light of the difficulties facing the NHS, Howe advised Castle not to press ahead with "the so-called democratisation of the service" as further change may "threaten a serious organisational breakdown" (66). He repeated the Conservative Party's opposition to what he regarded as "the folly" of phasing out pay beds, and expressed concern about the new form of contract the Government was seeking to negotiate for hospital consultants which, in his view, threatened their "professional independence", a theme he had explored in a speech a week earlier (67). Finally, Howe asked whether the Government was prepared to set up "an independent re-examination of alternative sources of finance of the NHS" (68).

In response, while noting that the Labour Government had been able to "restore some of the December [1973] cuts" in NHS funding made by the previous Government, Castle acknowledged that prospects for further increases were "not encouraging ... it will not be possible to maintain this increase in expenditure in real terms over the next few years" (69).

(66) Commons Hansard, vol. 882, cols. 1199/1200.

(67) *ibid.*, cols. 1206/7. On 24/11/74 Howe had explored what he regarded as the linked issues of the doctor's independence in matters of professional judgement, and private practice, in a speech to the National Federation of Self-Employed (Conservative Party press release 568/74).

(68) Commons Hansard, vol. 882, col. 1205.

(69) *ibid.*, col. 1214. Neither Castle, nor Owen, responded to Howe's question as regards an independent review of alternative funding.

The medical profession was clearly not re-assured by what Castle was able to say about future resources. At the BMA Council meeting on 22 January 1975 the Chairman commented that it was "extraordinary that the view should be taken by the Government that there was not case to review the financial structure of the Service", and intimated that, in conjunction with the other health professions, an early meeting was being sought with Health ministers (70).

Thus by early 1975 the Government had publicly stated that, in the prevailing economic circumstances, there might have to be a reduction of NHS resources in real terms over the coming years, while the major health professions were concerned that existing resources were inadequate for the demands they were currently facing, and wanted a review of funding. The Conservative Party was urging the Government not to proceed with its *Democracy in the National Health Service* proposals, in case they led to "organisational breakdown", or its proposal to phase out pay beds, partly on account of the revenue implications and partly because in its view the policy if implemented would severely limit doctors' freedom to practice privately.

#### 4.2 The Conservative Party leadership

Important though the issues referred to in the previous section were, among most Conservatives of much greater significance in the aftermath of the October election was the question of the Party leadership.

(70) BMAA, minutes of Council, 22/1/75, doc. 22, p. 4.

Having lost successive general elections, and with continuing discontent within the Party at the policy reversals between 1970 and 1974, that there was immediate speculation about Heath's position was unsurprising (71).

Possible alternative leaders were mentioned, including Joseph (72). As noted above, in the late 1960s Joseph had publicly identified himself as a believer in the beneficial effects for industry of market forces. Following the February election, he suspected that the Heath Government's difficulties, and indeed Britain's relative economic decline compared with other European countries, were in part at least due to ever increasing government intervention in economic and industrial matters.

According to his biographer, Joseph quite consciously embarked on a period of "self-education", in the course of which he re-established links with the IEA (73). Still a member of the LCC, initially he asked not to have a shadow portfolio so that he could examine the reasons for Britain's economic decline, though in June he agreed to become spokesman on home affairs (74).

To assist in his examination of Britain's economic decline, Joseph established the Centre for Policy Studies (CPS), which supported him develop his analysis of previous economic policies, and proposals for the future (75).

(71) for example, *Times*, 12/10/74, p. 13, col. c; *Daily Mail*, 12 and 14/10/74, p. 6 and pp. 1 and 6 respectively; *Daily Telegraph*, 14/10/74, p. 1.

(72) for example, "Tory MPs back Sir Keith as next leader, headline, *Daily Telegraph*, 14/10/75, p. 1.

(73) Halcrow, 1990, pp. 63/4.

(74) *Times*, 14/6/74, p. 1, col. a.

(75) on the CPS see Todd M, "*The Centre for Policy Studies: Its Birth and Early Years*", 1991, Colchester, Essex University; and Cockett, 1994, pp. 236/86

Joseph tried to interest his LCC colleagues in his emerging conclusions: what Campbell has described as "the monetarist critique of the late Government's record" (76). Having apparently had little success, Joseph judged that the issue needed public discussion (77). In speeches during 1974 he argued that government intervention since the end of the Second World War had debilitated "our industry, economic life and society" and that inflation, caused by governments, was "sapping the vitality of industry". In one speech in particular, shortly before the date for the October election was announced, Joseph effectively repudiated the incomes policy approach adopted by the Heath Government, by arguing that the Party had known since the 1960s that it offered "no cure" for inflation (78).

Within days of the election, from this very different perspective to that of most of the LCC, Joseph confirmed his interest in standing for the leadership "if Ted does decide to resign" (79).

(76) Campbell, 1991, p. 631.

(77) *ibid.*, pp. 631/2; also Anthony Seldon's interview with Joseph, *Contemporary Record*, vol. 1, no. 1, Spring 1987, p. 28.

(78) speeches on 22/6/74, 8/8/74 and 5/9/74, reprinted in Joseph K, *Reversing the Trend*, 1975, London, Rose, pp. 5/34.

(79) letter from Joseph, seemingly dated 16/10/74, quoted in Halcrow, 1989, p. 79. Similar words are quoted in Ranelagh J, *Thatcher's People*, 1991, London, HarperCollins, attributed to a letter from Joseph to Ian Gow MP, dated 18/10/74.

Shortly afterwards, however, Joseph made a speech described by his biographer as "on the moral and spiritual state of the nation", which drew considerable criticism (80). It has been suggested that the reaction to this speech gave Joseph a sense of the publicity and criticism he would have to face if he sought to challenge Heath (81).

On 21 November Joseph told Thatcher, who seemed to be the only other member of the LCC interested in the economic ideas he was exploring (82), and founding Vice Chairman of the CPS, that he would not stand for the leadership (83). She immediately decided to do so, and informed Heath of her intention (84).

The leadership contest has been described in some detail, much of which is extrinsic to this study (85). Two aspects warrant mention, however, as they had continuing significance after Thatcher's success.

(80) *ibid.*, p. 81. Even before the speech was delivered it had generated the newspaper headline "Sir Keith in "stop babies" sensation" (*ibid.*, p. 84).

(81) Cosgrave P, *Margaret Thatcher: A Tory and her Party*, 1978, London, Hutchinson, p. 31; Thatcher M, *The Path to Power*, 1995, London, HarperCollins, p. 266.

(82) Campbell, 1993, p. 632.

(83) *ibid.*, p. 663; Thatcher, 1995, p. 266.

(84) Thatcher, 1995, p. 267; Heath, 1998, p. 530. There is some disagreement over when Thatcher saw Heath. Cosgrave says the meeting was on the day Thatcher decided to contest the leadership, 21 November (Cosgrave, 1978, p. 31). The two principals agree that it was four days later, on 25 November (Thatcher, 1995, p. 267; Heath, 1998, p. 530).

(85) for example, Campbell, 1993, pp. 663/74; Ramsden, 1996, pp. 446/51; Thatcher, 1995, pp. 267/77; Heath, 1998, pp. 530/4.

First, unlike that in 1965, when Heath and Maudling had been the principal contenders, in 1975 the leadership election offered, and was understood to be offering, a choice not just between personalities but between markedly different approaches.

A flavour of the different approaches was given in the articles Heath and Thatcher (as well as other leading Conservatives, including Joseph) contributed to a *Daily Telegraph* series "My Kind of Tory Party", published in the fortnight prior to the first leadership ballot.

In Heath's article there was no suggestion that his Government had made mistakes, except perhaps that of failing to re-engage disenchanted young people with the political process. The emphasis was the need to continue to find ways of "preserving an open and healthy society" and sustaining "harmony" within society, at which readers might or might not have regarded Heath as having a convincing record. In a clear reference to Thatcher's position, concern was expressed about the Conservative Party taking on "the appearance of a purely business ... or middle class party, or one "that believes in a simple form of mechanistic economics instead of recognising all the complex interacting forces, both social and industrial" (86). It was an article whose unstated postulate was that the 1970/74 Government had been essentially right, which envisaged no particular change in policies, and which sought to criticise Thatcher's position as narrow in orientation and potential appeal and simplistic in its understanding of economic matters.

(86) *Daily Telegraph*, 3/2/75, p. 12.

By contrast, in her article a few days earlier Thatcher had acknowledged (and accepted her share of the responsibility for) what she regarded as the failures of the Heath Government. In her view, "to deny that we failed the British people is futile, as well as arrogant". She identified as "perhaps ... the first essential" re-connecting with the instincts of the people, some of whom believed that "too many Conservatives have become socialists". She implied a wish to lead a marked shift away from what she saw as the "socialist" approach of recent Conservative Governments (87). In so doing, she was picking up less directly a theme of Joseph's article in the same series two days earlier. In his view, "we have strayed from our principles and instincts, against the better judgement of our supporters, and taken to semi-socialism", but through "intellectual ... [and] moral courage, intellectual honesty, [and] willingness ... to acknowledge errors which are ... now obvious to all" it was possible "to reverse the trend" (88).

Although neither Heath or Thatcher went into any detail on future policy, it was clear to Conservative MPs that the difference between the two principal leadership contenders was not simply over the conduct of the Heath Government. It was about what ought to be the broad policy stance of the Party. Heath and his supporters saw themselves as the heirs of those who, in the mid/late 1940s, accepted collectivist solutions to the problems of unemployment and poverty that had seemed intractable in the 1930s. Thatcher and her supporters believed that the collectivist solutions had created different and potentially more damaging problems, particularly inflation, and favoured a more limited role for government with greater reliance on individual effort and market forces.

(87) *ibid.*, 30/1/75, p. 16.

(88) *ibid.*, 28/1/75, p. 14.

This difference became an enduring feature of Conservative politics. Behrens has suggested that the adherents of the two broad positions might be termed "Diehards" (those who "viewed post-war Conservatism as merely an alternative form of socialism") and "Ditchers" (those who had "ditched" adherence to "the eternal principles of limited government, sound money and moral rectitude" and judged intervention by the state to be "unavoidable in a society determined not to return to inter-war maladies") (89). In popular usage, however, by the early 1980s the terms used were "dries" and "wets" respectively.

The second aspect of the election contest of continuing significance, not unrelated to the first, was that it was acrimonious (90). Heath's supporters sought to characterise Thatcher as someone who would only appeal to the middle classes, compared with Heath's "One Nation" approach, and various "dirty tricks" were alleged to have been used to try to reduce her support (91). Thatcher and her supporters made increasingly explicit criticisms of the actions of the 1970/4 Government of which some, notably Thatcher herself and Joseph, had been members (92) which, from his perspective, Heath must have found galling. Such animosities as the campaigning aroused were not reduced by the reaction of some Heath supporters after Thatcher's success in the first ballot (93).

(89) Behrens, 1980, p. 7.

(90) see, eg, *ibid.*, p. 40 and Thatcher, 1995, p. 282.

(91) Ramsden, 1996, p. 446.

(92) for example, *ibid.*, and Thatcher's *Daily Telegraph* article, 30/1/75 ("To deny that we failed the people is futile, as well as arrogant. Successful Governments in elections ... We lost.")

(93) examples quoted in Ramsden, 1996, p. 450.

In that ballot, held on 4 February 1975, Thatcher secured 130 votes compared to Heath's 119 (94), at which point he resigned. A week later Thatcher was elected Leader ahead of Whitelaw, Howe, Prior and John Peyton (95), beginning a new phase in the Party's opposition to the Labour Government.

The legacy of the leadership election was, however, a Party where many leading politicians saw themselves in one of two broad policy camps, and where there remained a considerable degree of continuing personal animosity most clearly exemplified in Heath's conduct. In Campbell's view, for over fifteen years Heath "remained adamantly unreconciled" to Thatcher or the economic and social policies her Governments pursued, and "regularly denounced her leadership in the strongest terms as a grotesque aberration from the true Conservative tradition represented by his predecessors and himself" (96).

## 5. THE SITUATION BY FEBRUARY 1975

### 5.1 Policy development

In the year between the first election of 1974 and Thatcher's success in the Party leadership election, the responsibility for development of policy on the NHS lay with Howe.

(94) *Times*, 5/2/75, p. 1, col. e.

(95) *Times*, 12/2/75, p. 1, col. c.

(96) Campbell, 1993, p. 679.

Howe sought to defend the restructuring of the Service initiated by Joseph, in the face of early criticisms, and indicated possible Conservative opposition to the proposals to change the composition of the new AHAs signalled in the Government's consultative paper, *Democracy in the National Health Service*. He also sought to explore with colleagues the possibility of opening up for consideration the issue of alternative financing arrangements, seemingly without success. However, the Labour Government had, in its proposals relating to pay beds, opened up a new issue relevant to the form the Service, and on that Howe sought and obtained the LCC's agreement to a policy of opposition, which was reflected in the manifesto for the October 1974 general election.

## 5.2 The arrangements for policy review

During the twelve months for which Howe was the principal Opposition spokesman, there seems to have been very little active consideration of policy relating to the NHS's form, except in response to the Government's pay beds policy. Although Howe established some advisory groups, the author has been able to discover virtually no details of their composition or contribution to policy thinking. Indeed, it is open to question as to whether, with preparations for a coming general election, and then the Party leadership contest occupying much of the twelve months, any substantive work was undertaken by these groups (97). Neither, in the CPA or among Howe's papers, is there any evidence of other sources of advice to the Party on issues relating to the form of the NHS over this period.

(97) at a meeting with the author on 16/12/1999, Howe could not recall any substantive activity by these groups relating to the form of the NHS.

1. APPOINTMENTS UNDER THATCHER

Few members of Heath's LCC seem to have supported Thatcher during the leadership election (1), and it has been suggested that some believed for a long time after the election that "the party would eventually come to its senses" and recall Heath as leader (2). Heath is said to have described himself as "in reserve", presumably for such a recall (3).

Against this background, and the division within the Conservative Party referred to in Chapter 4, it was understandable that Thatcher regarded it as necessary for there to be "sufficient continuity to keep the Party together" (4). Her first LCC appointments were "rightly seen as a compromise" (5). While some who shared her views were given senior positions, she also included some of those who had supported Heath's re-election from whom, she later wrote, she "could not assume agreement – even on basic principles" (6).

In Thatcher's view, however, she was able to "shift the balance of opinion within the Shadow Cabinet as a whole somewhat in my direction", partly by creating "a Treasury team that shared my and Keith's [Joseph's] views on the free-market economy" (7).

- (1) Behrens, 1980, p. 40; Ramsden, 1996, p. 453.
- (2) Campbell, 1996, p. 681.
- (3) Heath, quoted *ibid.*, p. 675.
- (4) Thatcher, 1995, p. 282.
- (5) *ibid.*, p. 290.
- (6) *ibid.*, p. 291.
- (7) *ibid.*, p. 290/1.

Howe, who from his longstanding attachment to the economic liberalism of the IEA noted in previous chapters, was sympathetic to Thatcher's approach, headed the Treasury team as shadow Chancellor. Joseph was given overall responsibility for policy and research (8). With Powell by now an Ulster Unionist MP, following his break from the Party in February 1974 (9), the two senior Conservatives who, arguably, had reflected most on the NHS over the previous ten years were thus in key positions and close to Thatcher.

Howe's promotion meant that a new LCC spokesman on social services matters needed to be appointed, and Thatcher chose Norman Fowler, a former *Times* journalist who had specialised in home affairs, seemingly without knowing where he stood "in relation to the balance of opinion between left and right of the Party" (10). Vaughan and Kenneth Clarke were appointed as junior frontbench spokesmen on social services (11).

(8) *Times*, 19/2/75, p. 1, col. a.

(9) see Heffer, 1998, pp. 698/70.

(10) Thatcher, 1995, p. 289. Thatcher's comment is understandable, given Fowler's own account of his political position at the time. He has stated that he subscribed to RA Butler's view of Conservatism, yet after the October 1974 election he initially supported Joseph for the leadership as best representing that view. Given that, in his well-publicised speeches in the Summer of 1974 referred to in Chapter 4, Joseph had criticised the "socialism" of the previous thirty years, which for him most certainly included Butlerian Conservatism, this was an incongruous choice (Fowler N, *Ministers Decide*, London, Chapmans, 1991, pp. 9/10).

(11) *Times*, 25/2/75, p. 1, col. g.

Both Howe and Joseph occupied their positions until the 1979 general election. Fowler was, however, replaced by Patrick Jenkin in January 1976 (12). Vaughan continued throughout the period as the main junior frontbench spokesman on NHS matters.

Although Thatcher's first appointments meant that her erstwhile opponents were well represented in the LCC, she was able to restructure the higher levels of the Party organisation so as to give substantial influence to those sympathetic to her position. Lord Thorneycroft, who as Chancellor in 1958 had resigned because of what he perceived to be the then Government's lack of will to control public expenditure, became Party Chairman. Joseph was appointed as Chairman of the ACP, and Angus Maude, one of Thatcher's closest supporters, was appointed Chairman of the CRD (13). Several of Heath's appointees were replaced, including Michael Wolff, the Director General of the Party's Central Office, who was believed to have worked actively against her election as leader (14).

(12) *Times*, 16/1/76, p. 1, col. b. Jenkin had been a minister during the Heath Government, and was an "old friend" of Thatcher (Thatcher, 1995, p. 289).

(13) Ramsden, 1996, p. 455. Maude had helped write what Thatcher later described as "the crucial Daily Telegraph article ... "My Kind of Tory Party" (Thatcher, 1995, p. 273), referred to in Chapter 4.

(14) *ibid.*, pp. 446 and 455.

## 2. THE POLICY REVIEW PROGRAMME

As suggested in Chapter 4, Thatcher had offered Conservative MPs not just the opportunity to replace a leader who had proved electorally unsuccessful, but a different approach to policy. Through her own statements (15), and the speeches that Joseph had made during 1974 which she was assumed to support, few could have doubted the broad nature of the approach she favoured, especially in the sphere of economic policy. What was not clear was the impact her election would have on Party policy across the board, which would need to be set out in the manifesto for the next general election.

As noted above, Joseph was appointed to oversee policy development. He argued that it was necessary "to have ... an acceptable philosophy" and "clear policy" in respect of those subjects where it was needed "if we are to win the election and govern effectively" (16). To develop these he proposed a review programme between what he saw as the "impressionistic and highly selective" one undertaken after 1945 and the "detailed and more comprehensive" one initiated in 1965 (17).

(15) for example, her "My Kind of Tory Party" article in the *Daily Telegraph*, 30/1/75, p. 16 and extract from letter to constituents, reproduced in the *Sunday Times*, 2/2/75, p. 1, col. c.

(16) Joseph's paper *Policy-Making*, 1975, 10/3/75, LCC/75/68, on CPA LCC 52-60.

(17) *ibid.*

Joseph's approach was agreed at the LCC meeting on 12 March 1975, with the aim of completing the policy reviews so that, if desirable, a mid-term document could be produced for the 1976 Party Conference. In the event, policy groups were asked to provide interim reports by 23 July 1975, and more substantial ones by the end of May 1976 (18).

Following the LCC discussion on procedural matters, Joseph produced a further paper, *Notes Towards the Definition of Policy*. That addressed substantive issues, suggesting "a new start" (asserting that recent Conservative Governments had, "by ignoring history, instincts, human nature and common sense ... intensified the very evils which we believed ... we could wipe out"); offering a vision of the sort of society to be promoted (one "embodied in social market policies, which recognise economic life as something organic but largely autonomous"); and proposing some general desiderata (eg "this time we must surely allow prices, subject to competition, and dividends to operate freely" and "cut government functions") (19).

The paper also provided an opportunity for Joseph to move from his vision of "a new start" to set out some preliminary thoughts on a wide range of subjects, including the NHS, sometimes indicating where he thought a policy group should be established.

(18) LCC(75)53rd, CPA LCC 52-60; Joseph/Policy Group Chairmen, 15/7/75, CPA CRD 4/7/78.

(19) *Notes Towards the Definition of Policy*, 4/4/75, LCC/75/71, CPA LCC 52-60.

The LCC discussion of Joseph's paper on 11 April 1975 demonstrated the strength of those within the LCC concerned about the notion of the "new start" he favoured. Some members thought the paper was "too critical of ... recent Conservative policy"; argued that "the Party should not repudiate its previous attempts to reach a national consensus", and asserted that "stability in approach was ... important as people became more bewildered by events". Overall, "it was generally felt that the Conservative Government of 1970-74 had, on the whole, tried to do the right things, but had failed to explain its intentions adequately" (20).

Against this background of differences both within the Party and the LCC, numerous policy groups were established, including (rather later than most) one specifically on the NHS. It has been suggested that, "unlike the Heath groups [of the period 1965-70] they were not tightly controlled" (21), and there does not seem to have been a comparable process for the central approval of the membership of groups to that referred to in Chapter 1 in relation to the HPG. The LCC did, however, seek to ensure that the policy groups worked within the broad framework of the developing policy on public expenditure, something that was central to its thinking on economic matters.

(20) LCC(75)57th meeting, CPA LCC 52-60.

(21) Norton, 1996, p. 56.

## 2.1 Policy on public expenditure

Two of the first policy groups established were those on Economic Reconstruction (ERPG) chaired by Howe, and Public Sector Policy (PSPG) chaired by John Nott, a shadow spokesman on Treasury and Economic Affairs (22). It was the work of these two groups that provided the basis for the LCC's policy on public expenditure.

The ERPG met for the first time on 20 June 1975 and discussed a paper prepared by Adam Ridley of the CRD. This suggested five "basic principles of our economic policy" which "probably command widespread if not unanimous support and agreement", including that "public expenditure is too high both in the short and long run, and must be cut in both cash and resources terms" (23).

The putative "widespread ... support" attaching to this proposition among Conservatives was in practice confirmed by the agreement to it, with the modification (proposed by David Howell) that within an overall reduction some elements of public expenditure might have to rise, by the ERPG, among whose members was Ian Gilmour (24). Gilmour viewed himself as in "the main Tory tradition" (25), at the time of Thatcher's election as leader was known to have been particularly concerned at what he anticipated as the consequences (26), and came to be regarded as a leading "wet".

(22) *Times*, 25/2/75, p. 1, col. h.

(23) PG/10/75/1, undated but pre 20/6/75, Lord Joseph Archive (LJA) KJ 10/6.

(24) note of first meeting, ERPG, 20/6/75, as amended by note of second meeting, 27/6/75, LJA KJ 10/6.

(25) Gilmour I, *Dancing with Dogma*, 1992, London, Simon & Schuster, p. 3.

(26) Ramsden, 1995, p. 446.

The day after the first EPRG meeting, Howe gave a speech in respect of which the Party issued an extensive press release. This sought to explain why a reduction in public spending was essential and where spending could be reduced (27).

Howe pointed out that the public sector borrowing requirement (PSBR) (28) was, on the Government's estimates, running at 10% of the gross national product, a situation he regarded as "frightening", particularly in view of its significance for inflation. In his view, this could be remedied by abandoning proposed nationalisations; reducing subsidies (on items such as bread, railway fares and council house rents, as well as industry); bringing forward reductions the Labour Chancellor had already proposed for future years; curbing "extravagant council housing costs"; and possibly through "reductions in expenditure on the investment programmes of the nationalised industries and on education, health and other parts of the social services" (29).

Howe circulated his speech to LCC colleagues in July with the hope that "you will ... be able to conduct your own policy reviews within this tentative framework" (30). This was emphasised by Joseph when, on the same day, he sent policy group chairmen "a handful of guiding requirements, priorities and themes which should be taken into account". The first of these was the "paramount need to cut public spending ... The Shadow Cabinet will look to policy groups to make considered proposals to this end" (31).

(27) Conservative Party press release 625/75, 21/6/75.

(28) essentially, total public expenditure less revenues such as the product of taxation.

(29) Conservative Party press release 625/75, 21/6/75.

(30) LCC/75/81, 15/7/75, CPA LCC 61-72.

(31) LCC(75)53rd, CPA LCC 52-60; Joseph/Policy Group Chairmen, 15/7/75, CPA CRD 4/7/78.

The PSPG presented its initial analysis of public expenditure to the LCC on 28 July 1975. In the Group's view, "to avoid the acute inflationary dangers which arise from a borrowing requirement at present levels", the PSBR needed to be reduced by about £3 billion a year to 1978 (32). The LCC agreed that the objective should be "no further increases in overall public expenditure and substantial cuts wherever possible". The PSPG was authorised to discuss with other policy groups what cuts could be achieved, and LCC members were asked to find means of fixing cash and manpower ceilings and ensuring value for money in respect of their areas of responsibility (33).

The importance attached to the broad framework of policy on public expenditure was underlined a week later when, during a LCC discussion of the work of policy groups, "Mrs Thatcher and Sir Geoffrey Howe stressed once again the importance of restraining public expenditure and shedding some functions at present carried out by government" (34).

The PSPG sent Thatcher and William Whitelaw, the Deputy Leader, an interim report in December 1975, reiterating its conclusions (35), and a substantive one was prepared in July 1976. In this latter report, the Group suggested reductions in spending programmes of about £2 billion in the first full year, rising to £4.5 billion in the fifth year; noted that this would not reverse what it regarded as the "excesses of Labour's spending ... which have added £6 billion or so" to the plans put forward by the Conservative Government in 1973; and drew attention to the fact that the discussions with "spending" policy groups held so far had identified "economies [which] fall far short of the minimum required" (36).

(32) PG/11/75/5, 22/7/75, LJA KJ 10/16.

(33) LCC(75)73rd meeting, 28/7/75, CPA LCC 73-76.

(34) LCC(75)75th meeting, 4/8/75, *ibid.*

(35) PG/11/75/24, 10/12/75, LJA KJ 10/17.

(36) LCC(76)/124, July 1976, CPA LCC 113-123.

Nott attended the LCC discussion and afterwards minuted PSPG members that "in general terms, our proposals for individual programmes were accepted". However, in his view "there was a considerable sense of shock that in spite of the substantial cuts in programmes proposed, there still did not seem room for major tax cuts" (37). The formal LCC minutes recorded that the figures in the PSPG report could not yet be "agreed", that the Labour Government should be pressed to make further reductions "as this would make our own task on obtaining power easier", and that more work should be done on such matters as ways of reducing over-manning in the public sector and legislative changes needed to implement the cuts that had been identified (38).

Against this background, and Thatcher's view that "it was wrong to publish in too much detail ones policies before the election ... [because] that put the Opposition party into the position of having to defend its policies instead of attacking the Government" (39), it was understandable that the major mid-term policy statement *The Right Approach*, published prior to the 1976 Party Conference, addressed the issue of public expenditure in fairly generalised terms.

*The Right Approach* set out explicitly the Party's view that "public spending cuts are essential if we are to bring the economy back into balance", and indicated three means of doing so - reversing a number of "identifiable Socialist policies", reducing subsidies, and more effective control of costs (40).

(37) PG/11/76, 29/7/76, CPA CRD 4/13/10.

(38) LCC(76)123rd, 12/7/76, CPA LCC 113-123.

(39) note of Thatcher's address to the ACP, 7/4/76, ACP(76)144th, CPA ACP 2/4.

(40) *The Right Approach*, 1976, London, Conservative Party, pp. 24/5.

This approach was continued in later policy documents, notably *The Right Approach to the Economy*, published in October 1977, and the manifesto for the 1979 general election. The former restated as the Party's view "that public spending cuts are essential if we are to bring the economy back into balance", and repeated the three areas for achieving economies referred to in *The Right Approach* (41). In the manifesto, the commitment was to "a gradual reduction in the size of the Government's borrowing requirement", in part through "substantial economies" including "the reduction in waste, bureaucracy and over-government" (42).

In private, however, Joseph sought to achieve greater specificity as regards reductions that would be practicable. Nott was appointed LCC spokesman on trade in December 1976 (43), and was succeeded as chairman of the PSPG by Howell. Joseph wrote to LCC members, including Jenkin who had recently become social services spokesman, advising them of the change, and saying that Howell and he would like to meet them individually ("with any colleagues you wish from your team"), "to discuss proposals for reducing Government spending when we come to office" (44).

This approach led to a series of "bilaterals" between March and May 1977, though there seems to be no evidence that one was held with Jenkin in respect of social services (45).

(41) *The Right Approach to the Economy*, 1977, London, Conservative Party, pp. 24/7.

(42) Craig F, *British General Election Manifestos 1959-87*, 3rd ed. 1990, Aldershot, Dartmouth Publishing, p. 269.

(43) *Times*, 10/12/76, p. 2, col. d.

(44) Joseph/LCC members, 27/1/77, LJA KJ 19/4.

(45) the CPA contains notes of meetings with LCC spokesmen on foreign and Commonwealth matters (14/3/77), home affairs (14/3/77), agriculture (15/3/77), trade and industry (18/3/77), energy (28/3/77) and environmental and local government matters ((16/5/77). CRD 4/13/11.

If, indeed, there was no social services bilateral, the reason may have been that, from its inception, Jenkin had been a member of the PSPG, and able therefore to discuss the NHS authoritatively in Group meetings. The possibility of cost reductions at the DHSS was indeed discussed at a meeting of the PSPG on 5 May 1977 - within the period of the bilaterals - at which Sir Philip Rogers, the former Permanent Secretary of the Department, was present (46).

Thus not only were LCC members asked at the outset to examine closely the scope for reductions in spending in the areas for which they were leading policy reviews, initially through the PSPG, and later through Joseph and Howell, they were pressed to keep the objective of an overall reduction in public spending in mind. Effectively, as Howe had indicated to his LCC colleagues in his memorandum of July 1975, the Party had established "(so far as is possible for an opposition) a PESC exercise" (47).

The machinery for considering public expenditure issues - the ERPG, the PSPG and the PSPG's Manpower Sub-group - not only sought to contribute to an overall target for reductions in public expenditure, and targets for main sectors, but also produced policy suggestions for sectors. The contributions of, particularly, the PSPG and its Manpower Sub-group in this regard will be examined below.

(46) PG/11/77, minutes of meeting held 5/5/77, CPA CRD 4/13/11.

(47) LCC/75/81, 15/7/75, CPA LCC 61-72. "PESC" stood for Public Expenditure Survey Committee, which oversaw the annual bilateral discussions between the Treasury and individual government departments over future levels of public spending.

## 2.2 The policy review machinery for the social services

A Social Services General Policy Group (SSPG) was established under Fowler's chairmanship and held its first meeting on 25 September 1975 (48). Jenkin became chairman when he succeeded Fowler. The Group met seven times between September 1975 and February 1978 (49) and it appears to have been discontinued as a result of the LCC's decision in June 1978 that "the remaining policy groups should be wound up as soon as possible" (50).

Throughout its life, the SSPG seems to have consisted solely of Conservative parliamentarians (51), and to have been concerned with reaching an overview of social services policies, often in the light of the work of policy groups on particular issues. It was sometimes referred to as the Social Services (or DHSS) Steering Group (52).

Several groups on more specific issues were established, three on aspects of social security policy, one on voluntary organisations and three relating to health issues. Of these "health" groups, two were on specific services, for the deaf and the mentally ill. The third (chaired by Vaughan) was on the NHS (53).

(48) PG/60/75/1, minutes of meeting on 25/9/75, CPA CRD 4/7/78.

(49) on 25/9/75, 10/2/76, 19/10/76, 30/6/77, 3/10/77, 13/2/78 and 28/2/78. Minutes of these meetings, consecutively numbered from 1 to 7, are in the CPA, *ibid.*

(50) LCC/78/208th, 7/6/78, CPA LCC 194-215.

(51) the initial members, apart from the Chairman, were Gerard Vaughan, Kenneth Clarke, Jill Knight, Lynda Chalker, Sir George Young, Robert Boscawen, Robert McCrindle and Tony Newton. Later meetings were attended by Cecil Parkinson, Paul Dean, Lady Young, Peter Bottomley and Robin Hodgson.

(52) eg CRD list dated 3/2/76, LJA KJ 26/2.

(53) *ibid.*

The view that a policy group on the NHS was necessary seems to have been reached very early in Thatcher's leadership. On 22 April 1975 the Party's Health and Social Security Committee resolved that such a group should be set up, with Vaughan as chairman (54). In practice, however, the Group was not established for nearly a year. A CRD list of policy groups dated 3 February 1976 included the NHS Group (number 65 on the list) as "planned or expected" (55). A week later, at a meeting of the SSPG, it was "agreed that ... Dr Vaughan should go ahead with his policy group as soon as possible" (56).

An embryo NHS Policy Group (NHSPG), consisting of Vaughan and Sir George Young, together with two CRD officers (Bidly Passmore and Christopher Mockler) seems to have met for the first time in March 1976 (57). By May 1976 the Group had been expanded. Vaughan wrote to Jenkin referring to it as "quite ... large and loose", enclosing a list of members which should be treated "as private because some of them feel very strongly that they do not want to be openly associated with a political party". Vaughan made it clear that the Group would work "without overall meetings": instead, he would "obtain the individual's views personally ... and would then prepare a working paper which could then be circulated for comment" (58).

(54) CRD memorandum, doc. 83 in CPA CRD 4/7/22.

(55) LJA KJ 26/2.

(56) PG60/75/2, 10/2/76, CRD 4/7/78.

(57) a note of a meeting dated 23/3/76, is referenced PG/65/71/1, which clearly implies it was the first document of that group's series. The situation is confused because the note gives "23 March 1976" as the date of the next meeting. CPA CRD 4/7/55.

(58) Vaughan/Jenkin, 25/5/76, *ibid.*

Attached to Vaughan's letter to Jenkin was a list of the NHSPG's members but this was not enclosed with the copy sent to the CRD (and now included in the CPA), as a manuscript note by Vaughan on that copy makes clear (59).

Research to date has yielded only incomplete information about the composition of this "quite ... large" Group. In addition to Vaughan, members seem to have included Alan Maynard, an economist who had been one of those commissioned to undertake research for the BMA Advisory Panel; Dr Paul Vickers, a consultant in accident and emergency care working in Gateshead; Dr David Tod, a GP and initiator of the Conservative Medical Society (see below); and George Bunton, a London-based consultant surgeon (60). Other names were mentioned to the author as Group members, but enquiries of the individuals concerned have failed to establish that they were indeed members.

(59) *ibid.*

(60) Maynard and Tod confirmed their membership to the author at meetings on 8/4/99 and 19/10/00, respectively. Vickers (whom the author has been unable to trace) and Bunton (deceased) were remembered as members by at least two of the those to whom the author has spoken (Maynard, Tod and Vaughan).

While there is evidence that at least two meetings of the Group were held (61), there seem to have been no notes of the meetings, nor any records in the CPA which would provide a basis for a more definitive statement about the Group's contribution (62). Much of the Group's business seems to have been undertaken by Vaughan through individual consultations and meetings with perhaps one or two others present, as envisaged in his letter of 25 May to Jenkin. Thus individuals whom Vaughan regarded as Group members may well have thought of themselves as experts occasionally consulted, and not as members of a formal Party working group.

In the absence of meeting notes, the work of the NHSPG can only be described in a very incomplete fashion. In his letter of 25 May 1976 to Jenkin, referred to above, Vaughan said that a general paper "with some overall points which can if required go into a manifesto" could be ready "whenever you want it", with "a more detailed paper with options" before the Summer Recess, though he warned that the pay-beds issue "may set us back a little" (63).

- (61) a CRD note dated 14/6/77 referred to a meeting of the Group, attended by Maynard, on 9/2/77 (CPA CRD 4/7/55). Tod's diary for 1977 includes an entry for a Group meeting on 24/5/77, which he recalls as being disputatious (meeting with author, 19/10/00). This latter date, and Tod's memory of the character of the meeting, tie in with the minutes of the SSPG meeting on 30/6/77, which record that "Dr Vaughan said that there were serious differences of opinion in the NHS Policy Group" (PG/60/77/4, CRD 4/7/78).
- (62) there are no copies of NHSPG meeting minutes - apart from the embryonic one - in the CPA, and Tod cannot recollect there being any (meeting with author, 19/10/00).
- (63) Vaughan/Jenkin, CPA CRD 4/7/55.

That warning proved to be well judged, for in mid October 1976 Vaughan was anticipating "a document for the social services team [by which he almost certainly meant the SSPG] by the end of November" (64).

There seems to be no evidence in the CPA that such a document was discussed by the SSPG, though there is an undated and unsourced paper *Proposals for Health Services in Great Britain* which may well have been a draft (65).

A memorandum from Mockler to SSPG members in June 1977 noted that a NHSPG report was "planned" (66). At the SSPG meeting on 30 June, Vaughan reported "serious differences of opinion in the NHS Policy Group", sought a full SSPG meeting discussion on them which was agreed for 11 July, and promised to "circulate a paper beforehand" (67). Following that meeting Jenkin advised Joseph that "our Policy Paper on the National Health Service will be ready within a fortnight" (68).

Although the CPA seems not to contain either a copy of the paper or a note of any SSPG discussion of it (69), a CRD memorandum dated 25 July 1977 recorded that "the report of this [NHS] group is currently being re-written by request of the general policy group on Social Services" (70).

(64) PG60/76/3, 19/10/76, CPA CRD 4/7/78.

(65) on CPA CRD 4/7/55. In meetings with the author on 8/4/99 and 20/1/00 Maynard and Vaughan respectively thought that the paper in question was indeed a draft of the document.

(66) Mockler, 17/6/77, CPA CRD 4/7/78.

(67) PG60/77/4, 30/6/77, *ibid*.

(68) Jenkin/Joseph, 1/7/77, LJA KJ 29/6.

(69) There may have been no note of whatever SSPG discussion took place. The note of the meeting on 30/6/77 was numbered PG60/77/4. A SSPG meeting on 3/10/77 "to discuss the family policy debate at the Party Conference on 12 October" was numbered PG60/77/5.

(70) John Houston/James Douglas, 25/7/77, LJA KJ 18/2.

Whether there ever was a final report of the NHSPG is open to doubt. There is an undated and unsourced document within the CPA which could be a late draft of such a report (71). However, in the extensive briefing pack prepared by the CRD in 1979 for incoming ministers to present to DHSS civil servants, the reports of nine policy groups were included or listed, but not one from the NHSPG (72).

As noted above, the original intention was that the work of the numerous policy groups should be completed in time to contribute to a mid-term policy statement. Much was duly completed and reflected in *The Right Approach*. (The chairman of the policy group on housing has, for example, commented that the social policy sections of *The Right Approach* "by and large reflected the policy work of the previous year" (73).) Plainly, however, this was not the case with the NHSPG, which began its work a year or more later than many groups and did not present its conclusions until the second half of 1977 at the earliest. Rather than being central to the Party's deliberations on the NHS as presumably envisaged, the NHSPG seems to have been just one contributor to policy thinking that drew on a wide range of sources, as discussed below.

(71) *Proposals for Health Services in Great Britain*, CPA CRD 4/7/55, thought by Mockler, Maynard and Tod (meetings with author 6/4/99, 8/4/99, and 19/10/00 respectively) to be a draft of the NHSPG's report. Vaughan told the author at a meeting on 20/1/00 that he thought there had been a final report, and offered to check his files as time allowed. Despite sending a reminder in August 2000, at the time of writing (February 2001) the author has received no more definite information.

(72) appendix II to the brief, a copy of which is on CPA CRD 4/7/89.

(73) *Raison*, 1990, p. 99.

### 2.3 The Conservative Medical Society

Although not part of the formal Party policy review machinery, the formation of the Conservative Medical Society (CMS) provided frontbench spokesmen on NHS matters with a source of advice which, in the period to the 1979 general election, was perhaps as influential as the NHSPG.

The idea that there should be an organisation for Conservative-supporting health professionals, parallel to the well established Society of Conservative Lawyers, was suggested to successive ministers and shadow ministers by Dr David Tod, a London-based GP, Conservative councillor and parliamentary candidate.

Tod first made his proposal in a discussion with Maurice Macmillan in the late 1960s, and in 1973 he had put it to Joseph whilst the Secretary of State for Social Services. Neither saw sufficient advantage in the idea to be encouraging (74).

However, Tod continued to see merit in his idea and in July 1974 he approached Howe, with more success. Howe agreed that it might be useful to establish such an organisation after the election widely regarded as imminent, and passed the correspondence to Vaughan (75).

(74) Tod, meeting with author, 19/10/00.

(75) Tod/Howe, 16 & 23/7/74, Howe/Tod, 23 & 29/7/74, Tod papers.

Tod and Vaughan met on 19 September 1974 (76). Vaughan was interested in Tod's proposal, but matters went into abeyance for several months, first due to the general election and then the Party leadership election (77).

A further meeting between Tod and Vaughan took place on 16 April 1975 (78), by which time Vaughan had sounded Fowler, who had succeeded Howe, and found him supportive of the idea. The intention to found the CMS was announced by Fowler on 21 May (79), and at an LCC meeting that day he invited colleagues to bring its existence to the attention of "medical practitioners who might be interested in joining" (80).

During the Summer several meetings were held under Vaughan's chairmanship to plan the development of the Society, and on 5 August a meeting open to potential members was held at the House of Commons (81). "Over 100 persons" attended the meeting and, given the level of support, it was clear that the Society would be viable. The meeting appointed a steering committee chaired by Vaughan to draft a constitution (82).

(76) Tod's diary for 1974, Tod papers.

(77) Tod, meeting with author, 19/10/00.

(78) Tod's diary for 1975, Tod papers.

(79) Conservative press release 495/75.

(80) LCC(75)63rd, CPA LCC 61-72.

(81) Tod's diary for 1975, Tod papers.

(82) "The Origins of the Conservative Medical Society", in *The Conservative Medical Society Anniversary Brochure*, 1995, London, CMS.

The formation of the Society was confirmed at its inaugural annual general meeting on 27 March 1976, when the proposed name and draft constitution were formally adopted and officers were elected (83).

Thus although matters were not formalised until March 1976, from May 1975 an embryonic CMS existed and was available as a source of advice to the Party's frontbench spokesmen, especially Vaughan who was intimately involved in the early stages of setting up the Society. The CMS's contributions to the Party's policy considerations will be noted below.

#### **2.4 NHS policy issues from February 1975**

Despite the apparently rather limited contribution the NHSPG, the body formally appointed for the task, seems to have made to the Party's policy review programme instituted in April 1975, extensive consideration was given to issues relating to the form of the NHS, especially following Jenkin's appointment as LCC spokesman on social services.

(83) *ibid.*

Three main issues were considered. The first, the future of private practice within the NHS, had been brought into political controversy by what Powell described as the Labour Government's "reopening of the compromise between the public and private practice of medicine ... embodied in the founding Act of 1946" (84). The second, financing the NHS, was an issue which, as noted in previous chapters, had been under consideration by the Conservative Party since the 1940s. In the period 1975 to 1979 it came into public prominence due to the concern of the medical profession at reductions in resourcing from 1974. The third issue was the structure of the NHS, which became an issue as widespread concern developed about aspects of the reorganisation enacted during the period of the Heath Government.

### 3. THE RELATIONSHIP BETWEEN THE PUBLIC AND PRIVATE PRACTICE OF MEDICINE

As noted in Chapter 4, at the October 1974 election the Labour Party had committed itself to the phasing out of pay beds from the NHS, while the Conservative Party had made it clear that it opposed such a policy, both on grounds of principle and practice.

The intention to phase out pay beds was confirmed by the Government in the Debate on the Address (85). The vehicle for the exploration of the issue with the medical profession remained the working party chaired by Owen.

(84) Powell E, *Medicine and Politics: 1975 and After*, 1976, London, Pitman, p. 79.

(85) Commons Hansard, 1/11/74, vol. 880, col. 545.

The Conservative position prior to the change in Party Leader was to oppose the Government's policy, as noted above. This position was maintained, for example in a Commons debate he initiated in May 1975, Fowler said that the Conservatives would oppose the policy "at every stage", characterising it as one which "threatens to increase the disillusion which many doctors already feel, ... throws away resources at a time when the National Health Service needs every penny it can get ... and ... brings no benefit to the National Health Service" (86).

In parallel with the proposed phasing out of pay beds, the Government announced in the 1975 Budget that "for social reasons" all those who benefited from private medical insurance schemes where the premiums were paid by their employers would be taxed on the benefit (87). This was opposed by Howe in his capacity as shadow Chancellor as "a mean piece of discrimination" (88), but the measure was enacted (89).

On 11 August 1975 the Government issued a consultative paper on phasing out pay beds, which also proposed licensing arrangements for private hospitals, both to ensure minimum standards of quality and control the size of the private hospital sector (90).

The consultative paper proposals were criticised as "dangerous and irrelevant" by Fowler. In his view they would "encourage emigration of doctors, already at a dangerously high rate, and did nothing to tackle the desperate lack of hospital resources" (91).

(86) Commons Hansard, vol, 891, col. 1092.

(87) Commons Hansard, 15/4/75, vol. 890, col. 312.

(88) Commons Hansard, 8/5/75, vol. 891, col. 1654.

(89) as section 35 of the Finance (No. 2) Act 1975

(90) *The Separation of Private Practice from NHS Hospitals*, 1975, London, DHSS, paras. 4 (phasing out) and 8/10 (licensing arrangements).

(91) *Daily Telegraph*, 12/8/75, p. 1, col. 6.

There was also a very critical response to the consultative paper by representatives of the BMA and the HCSA. Both saw the proposals as evidence of the Government's wish to abolish private practice altogether (92). A month later the recently formed CMS issued a statement criticising the proposals for the loss of revenue to the NHS, and as an interference "with the professional and personal freedom of the caring professions and of the public" (93).

These reactions from the BMA and HCSA were but the opening shots in a sustained campaign of opposition by many within the medical profession, which Webster has characterised as "vitriolic ... backed up by a threat of industrial action, including mass resignation from the NHS" (94).

Despite the statements of Conservative spokesmen and the CMS, Vaughan, who attended meetings of the BMA and Royal Colleges group co-ordinating the campaign "as an observer", reported to the SSPG in September that "the doctors felt that the Tories were very weak and might not support them in opposing Mrs Castle" (95). Perhaps in part by way of response to Vaughan's report, in his Party Conference speech two weeks later Fowler said that the Party would "fight [Mrs Castle] all the way on her pay beds policy ... on the ground of principle and on the ground of common sense. We fight for freedom for the medical profession; we fight for choice for the patient; and we fight for resources for the Health Service" (96). Thatcher also referred to the issue in her Conference speech, undertaking that "when we return to power we shall reverse Mrs Castle's stupid and spiteful attack on hospital pay beds" (97).

(92) Times, 12/8/75, p. 3, col. a (BMA); 13/8/75, p. 2, col. c (HCSA).

(93) Conservative press release 800/75.

(94) Webster, 1998, p. 623.

(95) minutes, 25/9/75, PG/60/75/1, CPA CRD 4/7/78.

(96) *Conservative Conference Report 1975*, London, Conservative Party, p. 123.

(97) *ibid.*, p. 151.

On 20 October 1975 the Prime Minister, Harold Wilson, announced the setting up of a Royal Commission on the NHS (the background to which is considered below), making it clear that the implementation of the pay beds policy was not to be suspended while the Royal Commission deliberated. Rather, Wilson emphasised that the Government's commitment to phasing out pay beds remained unchanged and that legislation would be introduced as soon as the parliamentary timetable allowed (98). This opened up another line of argument for the Conservatives, and in her response Thatcher suggested that the Commission would be unlikely to "command the co-operation and respect of the medical profession" if the Government went ahead with its pay bed policy before it had reported (99).

A week after the Royal Commission had been announced, Fowler opened a Commons debate on the NHS, pursuing Thatcher's argument that the phasing out of pay beds should be postponed while the Royal Commission deliberated (100). Castle rejected this on the ground that the policy reflected a point of principle, which "must be decided by Parliament and not by the Royal Commission" (101).

Legislation to "phase out private practice from National Health Service hospitals" was included in the Queen's Speech on 19 November, and in the Debate on the Address Fowler pursued the same line as in the October debate. Referring to the "strife" within the NHS, over doctors' pay and conditions as well as the pay bed policy, Fowler argued that "it was ludicrous to set up a Royal Commission but not allow it to consider [what he regarded as] the problem causing most trouble in the Health Service" (102).

(98) Commons Hansard, vol. 898, cols. 35/7.

(99) *ibid.*, cols. 37/8.

(100) *ibid.*, cols. 1039/40.

(101) *ibid.*, col. 1058.

(102) *ibid.*, vol. 901, cols. 8 (Queen's Speech) and 361/2 (Fowler).

At the beginning of December the LCC decided to continue to "urge the Government to refer the pay beds issue to the Royal Commission" (103). However, by then Wilson shared the doubts about the pay bed policy that others within the Cabinet had expressed earlier (104). At a meeting with representatives of the medical and dental professions on the same day a compromise on the substantive issue was identified and, over the next few days, developed into a basis for a provisional agreement which was announced on 15 December (105).

This compromise, which Castle accepted only with great reluctance (106), involved the Government expressing "its commitment to the maintenance of private practice", and agreement that, after an initial reduction of 1,000 pay beds, the remainder would be phased out only as "the reasonable availability of alternative facilities for private practice" allowed (107).

A Bill incorporating the provisional agreement was drafted during the early months of 1976 but before it was presented to Parliament Wilson had resigned as Prime Minister and been succeeded by James Callaghan. A few days before the Health Services Bill was due to be introduced, Callaghan dismissed Castle and appointed David Ennals as her replacement (108). In Webster's judgement, Ennals' appointment produced "a much better atmosphere of co-operation with the medical profession" (109).

(103) LCC(75)86th, 3/12/75, CPA LCC 77-94.

(104) Webster, 1996, pp. 623/5

(105) Commons Hansard, vol. 902, cols. 971/3.

(106) Webster, pp. 625/6.

(107) Commons Hansard, vol. 902, col. 972.

(108) *Times*, 9/4/76, p. 1, col. a.

(109) Webster, 1996, p. 627.

The Health Services Bill passed its Second Reading in the Commons on 27 April, and was enacted in November 1976, largely free from the "vitriolic campaign" that had followed publication of the consultative document (110).

The Conservative Party opposed the Bill on Second Reading, arguing that it was "wholly irrelevant to the real problems of the Health Service", would cost the NHS "millions of pounds a year", and would make "no contribution to restoring the morale of the medical profession" (111). In June 1976 the LCC explicitly agreed that "private health services needed to be integrated into the NHS, and not kept isolated from it", a policy which found place in the October 1976 policy document (112).

From Autumn 1976 Jenkin regularly made it clear that the next Conservative Government would reverse Labour's policy (113), though without any very specific description of the form the reversal would take, given that the number of pay beds was being reduced under the provisions of the Health Services Act (114).

- (110) though not without some acrimony. For example, on 16 July 1976 the BMA ARM resolved to "invoke the intervention of the Prime Minister" about, inter alia, the proposed guillotining of discussion on the Bill, as a result of which a meeting with Callaghan was held on 26/7/76. BMAA, minutes of ARM 15-17/7/76, minute 182.
- (111) Commons Hansard, vol. 910, col. 234.
- (112) LCC(76)117th, 21/6/76, CPA LCC 113-123; *The Right Approach*, 1076, p. 60.
- (113) for example, in his speech to the annual conference of the Association of Health Service Treasurers, 26/3/77 (Conservative press release 352/77); his *Nursing Times* article (3/11/77 edition, p. 1701), and his speech in the Commons, 20/4/78, when he referred to "the system of medical apartheid embodied in the foolish Health Services Act 1976. We are committed to reversing it" (Commons Hansard, vol. 948, col. 690).
- (114) from about 4,500 in 1974 to about 2,800 by the 1979 general election, Webster, 1996, pp. 620 and 627.

Reversal was included in the Party's 1979 election manifesto, where the commitment was to "allow pay-beds to be provided where there is a demand for them; [and] end Labour's vendetta against the private health sector", the latter a reference to the controls established by the Health Services Act over private hospitals. A commitment was also made to restore income tax relief on employer-employee medical insurance schemes, thus reversing the decision enacted as Section 35 of the Finance (No. 2) Act 1975 (115).

#### 4. THE FINANCING OF THE NHS

##### 4.1 Health Service resources and the establishment of the Royal Commission on the NHS

As noted in Chapter 3, in the last weeks of the Heath Government some reduction in the planned level of spending on the NHS was announced as part of the measures taken to address the deteriorating economic situation.

In the economic circumstances of 1974 and early 1975, the Government judged that it was not possible to restore the levels of NHS expenditure planned by the Heath Government prior to the December 1973 reductions (116). With further deterioration in the economic situation, including the need to seek a loan from the International Monetary Fund, substantial reductions in planned levels of NHS expenditure from 1976/7 were announced in February 1976 (117).

(115) Craig, 1990, p. 280.

(116) *Public Expenditure to 1978/79*, Cmnd. 5879, 1975, London, HMSO, pp. 106/7.

(117) *Public Expenditure to 1979/80*, Cmnd. 6393, 1976, London, HMSO, p. 141.

Against the background of increased pressure on constrained services that the reductions in planned spending that started in December 1973 implied for a Service which many health professionals regarded as already inadequately funded, as early as July 1974 representatives of the medical, dental, nursing and midwifery professions sought a meeting with Wilson. At that meeting, on 31 July, the representatives sought an independent enquiry into the NHS, a request repeated in a document prepared by the professions as a follow up, and at a further meeting between the BMA and Castle on 2 July 1975 (118).

Following her meeting with the BMA on 2 July 1975, Castle wrote the Association a letter that was discouraging both about the prospects about additional resources for the NHS ("We cannot look forward to the regular annual growth that we have been accustomed to") and the establishment of an independent enquiry, though in a manuscript final sentence she undertook "to keep your proposal for an enquiry under review" (119). The BMA responded on 24 September, arguing that nineteen years after the Guillebaud Report a further enquiry was fully justified, and that the main health professions "all feel that the case for an impartial enquiry into the financing of the Service is overwhelming ... to provide a sounder basis for the future" (120).

(118) Castle, 1980, pp. 161/3 (31/7/74 meeting); *BMJ*, 2/11/74, pp. 297/300 (follow up document); Castle, 1980, pp. 443/4 (2/7/75 meeting).

(119) Castle/BMA, 5/7/75, BMAA, file 3/53/11.

(120) *ibid.*

While concerns about the resourcing of the Service were central to the health professions' request for an enquiry (121), deteriorating relationships between the Government and the medical profession over aspects of terms and conditions of employment within the NHS, and the proposed phasing out of pay beds, meant that during the Summer and early Autumn of 1975 a cluster of issues about the NHS was under public discussion.

It seems to have been the extent of the concerns about the NHS, and the publicity that they were receiving, that led the Government to meet the professions' request. For, summarising an as yet not publicly available letter from Wilson to Castle on 14 October 1975 signalling his view that an enquiry should be established, Webster noted Wilson's intentions as being to "improve relations with the medical profession and take the NHS out of the headlines" (122).

The enquiry, in the form of a Royal Commission on the National Health Service (RCNHS), was announced on 20 October 1975, with the remit "to consider ... the best use and management of the financial and manpower resources of the National Health Service" (123). This was welcomed by Thatcher (124), with the reservation about proceeding with the implementation of the pay beds policy referred to above.

- (121) see *BMJ*, 2/11/74, pp. 297 and 300, and Castle, 1980, p. 444, as well as the BMA's letter of 24/9/75.
- (122) Webster, 1996, p. 616.
- (123) Commons Hansard, vol. 898, col. 35.
- (124) *ibid.*, col. 37.

The RCNHS's chairman (Sir Alec Merrison, Vice Chancellor of Bristol University) was announced in January 1976, and its members in May (125). The Commission deliberated throughout the remaining lifetime of the 1974 Labour Government, and reported in July 1979 (126). Its conclusions are thus outside the scope of this study.

#### 4.2 Conservative policy thinking prior to the establishment of the RCNHS

In his paper *Notes Towards the Definition of Policy* put to the LCC in April 1975, Joseph had identified moving NHS financing to a system involving an element of insurance as a possible means of easing what he referred to as the "present strains" in the Service (127). Although the minutes of the LCC meeting record no specific discussion on the NHS, given Joseph's role and known closeness to Thatcher it would not have been surprising if Fowler, present as social services spokesman, gave the idea serious consideration.

Whether or not he was influenced by Joseph's views, when Fowler presented his ideas to Joseph and Maude in their roles of overseeing the Party's policy review and Chairman of the CRD, respectively, he included "re-examin[ing] NHS finances" with continuing "to fight against the abolition of NHS pay beds", as his two NHS priorities (128).

(125) Commons Hansards, vol. 904, col. 126 (questions) (Chairman) and vol. 910, cols. 377/8 (questions) (members).

(126) Cmnd 7615, 1979, London, HMSO.

(127) *Notes Towards the Definition of Policy*, 1975, pp. 14/5. CPA LCC 52-60.

(128) note of meeting, 23/6/75, CPA CRD 4/7/78.

No immediate action seems to have been taken to get such a re-examination under way, though in July Joseph wrote to Fowler confirming the latter's agreement "to talk to Norman Lamont [by then an Opposition spokesman on prices and incomes] about help from him in studying alternative finances for the NHS - starting, perhaps, with the BMA study" [presumably the Advisory Panel report] (129).

The LCC endorsed the idea of an examination of the financing of the NHS, but it was argued that "we should be careful to avoid publicising any proposals for radical change until the subject had been fully considered" (130).

Following the LCC meeting, Fowler responded to Joseph that he had "seen Norman Lamont and the result is that he and Gerry Vaughan will be heading an inquiry into financing the National Health Service. I will give you further details of this when they are settled" (131).

The LCC's view that caution should be exercised in making public any proposals for radical change in financing arrangements was not altogether heeded. On 8 October the *Evening Standard* is said to have reported Vaughan as saying that "the next Tory Government would also aim for a mixed public and private financing of the NHS, channelling a large proportion of funds from private sources on the lines of the French Health Service" (132).

(129) Joseph/Fowler, 23/7/75, LJA 29/1.

(130) LCC(75)76th meeting, 6/8/75, CPA LCC 73-76.

(131) Fowler/Joseph, 18/8/75, LJA 29/1.

(132) the CRD noted and dated the quotation in its list of "pledges" by Party spokesmen (in paper PI(77)9, 21/11/77, CPA CRD 4/7/78). The author has, however, been unable to trace it in the *Evening Standard* of 8/10/75 (or in the days immediately before and after). The explanation may be that the paper printed several editions each day, with changing contents. The quotation may have been included in early editions but left out of the "Closing Prices" edition stored within the British Newspaper Library.

Shortly after the Conference the establishment of the RCNHS was announced, and there seems no evidence to suggest that the planned Vaughan/Lamont re-examination was under way at that stage, though there is evidence that some work was undertaken later (see below). It seems probable that, late in 1975, the opportunity for a review of NHS financing by the RCNHS was judged to render a specific Party enquiry unnecessary.

#### 4.3 Conservative policy alternative financing of the NHS following the establishment of the Royal Commission

From June 1975 Joseph and Maude met on a fortnightly basis to discuss the development of Party policy. At a meeting shortly after the decision to establish the RCNHS was announced, they agreed "that it would be worth encouraging the IEA, BMA et al to submit evidence on alternative means of financing the NHS. (Action - KJ)" (133). (It was not the Conservatives' practice to submit evidence to Royal Commissions, something the Party Chairman confirmed to the Secretary of the RCNHS in June 1976 (134).)

Within the IEA, Seldon, a member of the BMA Advisory Panel chaired by Jones, had been particularly interested in alternatives to taxation for funding health services. As noted in Chapter 3, Seldon had been in correspondence with Joseph on the issue in 1965, and again when Joseph was Secretary of State for Social Services.

(133) note of meeting 6/11/75, LJA KJ 18/1.

(134) Thorneycroft/de Peyer, 8/6/76, PRO BS 6/1115.

In Opposition Joseph had re-established links with the IEA, and clearly followed up the meeting with Maude by making contact with Seldon. For explicitly at Seldon's suggestion, Joseph wrote to George Bunton (who was to become a member of the NHSPG), asking whether proposals for new financing arrangements were "going to be prepared and tabled" (135).

By this time Jenkin had succeeded Fowler. Like Thatcher, Joseph and Howe, Jenkin had been one of a relatively small number of Conservative politicians "of a free-market inclination [who] ... had sought intellectual support and encouragement from the IEA during the 1960s" (136). It was therefore not surprising that, early in his period as LCC social services spokesman, Jenkin expressed interest in exploring alternatives to taxation-based finance for the NHS (137). In an interim report to the LCC, the SSPG, which Jenkin chaired, stated that it was examining "continental systems of health finance" and, like Joseph and Maude, favoured encouraging others, "probably through the Conservative Medical Society", to put submissions to the RCNHS (138).

The LCC agreed that "we should encourage BUPA, etc, and the doctors to give evidence to the Royal Commission on the case for increasing health insurance, with, as a long term aim, the possibility of raising 20 per cent to 25 per cent of the NHS costs via insurance" (139).

(135) Joseph/Bunton, 24/2/76, LJA KJ 19/1.

(136) Cockett, 1994, p. 176.

(137) eg the minutes of the PSPG meeting on 19/5/76 record that "Mr Jenkin thought ... There should be a systematic shift in the way the NHS is financed: from taxation to insurance" (PG/11/76/38, CPA CRD 4/13/10).

(138) LCC/76/117, CPA LCC 113-123.

(139) LCC(76)117th, 21/6/76, CPA LCC 113-123.

The early indications were that alternative financing would indeed be one of the issues proposed to the RCNHS for consideration. In July 1976 the BMA's ARM called upon the Association's Council to press for, inter alia, "alternative and supplementary methods and sources of finance to be urgently considered" by the RCNHS (140). In August 1976 *An Analysis of Preliminary Evidence* prepared by David de Peyer, a DHSS civil servant acting as the Commission's Secretary, stated that the Commission had received "approaching 900 letters" and, among the subjects covered, there were four "high scorers", one of which was "alternative methods of finance", which had been mentioned in 81 letters (141).

The Conservative Party's hope that the RCNHS would indeed examine alternative financing options was expressed publicly in *The Right Approach* in early October: the Commission "should be looking at other ways of increasing the funds available to the [NHS], including the systems of health finance that exist in other countries" (142).

Shortly after publication of *The Right Approach*, the RCNHS issued *The Task of the Commission*, a list of topics to be considered, which included "what methods there are of financing the NHS other than from direct taxation" (143).

Joseph, invited to give personal evidence to the RCNHS at the end of November, reported to Jenkin that he had "begged them to examine the varying services abroad most of which are at least as good, if not better, than ours though no one of them is all financed as ours is by the taxpayer". The Commission's note of the meeting confirmed this (144).

(140) BMAA, minutes of ARM 15/7/76 - 17/7/76, pp. 16/7.

(141) PRO BS 6/2513.

(142) *The Right Approach*, 1976, p. 60.

(143) 1976, London, HMSO, p. 8.

(144) Joseph/Jenkin, 8/12/76, LJA KJ 29/6; RCNHS note of meeting, 30/11/76, PRO BS 6/3222.

In the event, those whom the Conservatives hoped would submitted evidence to the RCNHS on alternative financing arrangements - the BUPA, the IEA (at least Ralph Harris and Seldon, the Institute's Directors, in their personal capacities) and the BMA - did so.

The BUPA argued that "the encouragement of independent medicine to play a larger part ... would be helpful to the state of the public health"; noted recent Government initiatives which had the opposite effect (such as making taxable the benefit of employer-provided private health insurance schemes); and drew attention to ways in which other countries encouraged private finance in health care (145).

Harris and Seldon of the IEA submitted evidence jointly, offering an economic analysis to support their urging of the Commission "to take a longer view than many of its predecessors by making clear the logical shortcomings of the dependence of the NHS on public finance that now seems to be running out" (146).

The BMA proposed that in future NHS revenue should come from two sources - a basic compulsory contribution paid by, or on behalf of, every member of the population, and charges for using services, including increased prescription charges and "a substantial contribution" to hotel costs in hospital" (147).

(145) PRO BS 6/489, pp. 19/29.

(146) PRO BS 6/1898, p. 38.

(147) PRO BS 6/253, p. 24.

The CMS recommended that in the longer term "an item of service payment ... with appropriate exemptions, and reimbursement for those in need", should be introduced, together with "the encouragement of tax deductible private insurance schemes for those not qualifying for full reimbursement" (148). In February 1976 the SSPG had agreed that, if the CMS was to give evidence to the RCNHS, "there should be proper liaison, via Doctor Vaughan, with Patrick Jenkin" (149), and at the time the Society developed and submitted its recommendations on financing Vaughan was its President and a member of its Executive (150). It thus seems likely that the Party leadership would have been comfortable with the CMS's recommendations, though in the press release Jenkin issued, welcoming the Society's evidence on organisational and financial matters, he did not explicitly refer to the recommendations on financing arrangements (151).

And these four were not alone. For example, in a submission that was trailed in the *Times* (152), McKinsey & Co. proposed a "properly funded Social Insurance scheme" as the long term solution (153).

(148) *Evidence of the Conservative Medical Society, Part I*, London, CMS, p. 12, BMAA box 3/177/9 (dated December 1976 but submitted to RCNHS under cover of a letter dated 25/7/77, PRO BS 6/341).

(149) minutes of SSPG meeting 10/2/76, PG60/75/2, CPA CRD 4/7/78.

(150) *Evidence of the CMS, Part I*, p. 13

(151) Conservative Party press releases 778/77 (CMS evidence) and 783/77 (Jenkin's statement), both dated 28/7/77.

(152) *Times*, 24/1/77, p. 3, col. a.

(153) *Realising the Promise of a National Health Service*, January 1977, PRO BS 6/985.

By mid 1977 the Party could thus be certain that the RCNHS was receiving proposals for alternative financing arrangements for the NHS some, at least, of which were probably supported by the frontbench social services spokesmen.

In parallel with the submissions to the RCNHS being made by the CMS and others, there is some evidence that the alternative financing options were explored within the Party's policy machinery (probably by the NHSPG), as Jenkin had indicated they would be, both to the LCC in June and the ACP in November (154).

The CPA contains two undated and unsourced documents, one of which, *Proposals for Health Services in Great Britain*, may well be a draft of the NHSPG's report (155), as noted earlier in this Chapter. The other, a two page note, entitled *Health Services in Britain*, seems to be a summary prepared by Vaughan (156).

The former described a number of alternative financing options considered (157), indicating a preference for an insurance system, an option listed as a "longer term option" in "Vaughan's" note.

(154) *Social Services Policy Groups' Report*, June 1976, CPA CRD 4/13/10; *Social Services Policy*, October 1976, ACP(76)4, CPA ACP 3/21.

(155) see note 65 above.

(156) CPA CRD 4/7/55. At a meeting with the author on 8/4/99 Mockler, in whose writing the note is annotated "GV", thought it likely that the note had been drafted by Vaughan.

(157) "insurance cover for all with incomes over £3,000 pa, with free services for those below this level"; "all minor illnesses should be free, [with] compulsory insurance for major illness"; "a Voucher system"; "the points system"; and "a range of insurance cover linked to income with a claw-back". With the lack of any supporting papers in the CPA, it is impossible to be sure of the exact nature of some of these options.

There seemed, however, to be no intention of making any substantive policy announcement on alternative financing in advance of the report of the RCNHS.

In February 1978, that "additional or alternative forms of finance should await the report of the Royal Commission which is currently examining these matters" was added to the SSPG's note of points for the manifesto for the next general election (158), and survived unchanged to the version considered by the LCC in May (159). From there it found place, in slightly redrafted form, in the second draft of the full manifesto considered by the LCC in September 1978 (160), and into the manifesto itself, thus becoming the Party's formal policy. The manifesto wording was that "the Royal Commission on the Health Service is studying the financing of health care, and any examination of possible longer term changes - for example greater reliance for NHS funding on the insurance principle - must await their report" (161).

The manifesto wording was ambiguous, in that it was not clear if an incoming Conservative Government would examine "the financing of health care" after the RCNHS had reported, or only if the Commission recommended that it should be explored.

- (158) minutes of SSPG meeting, 28 & 29/2/78, PG/60/78/7, CPA CRD 4/7/78.
- (159) *Draft Notes for the Manifesto* and minutes of LCC(78)203rd meeting, 8/5/78, CPA LCC 194 - 213.
- (160) LCC(78)186, second draft, considered at LCC/78/219th meeting, 4/9/79, CPA LCC 16a. Regrettably, the CPA seems not to contain the first draft, LCC(78)183, discussed at the LCC/78/216th meeting, 19/7/78, which probably also included the reference to awaiting the RCNHS's report.
- (161) Craig, 1990, p. 280.

Initially, Jenkin seemed to suggest the latter. At a CMS symposium on health care finance in October 1977, he "confidently" stated that a future Conservative Government "would be prepared to consider positively and sympathetically any proposals put forward by the Royal Commission for transferring some of the cost of health care from tax to insurance" (162). In a Commons' debate in April 1978, Jenkin said that the Party would wait for the RCNHS's report as "it would be very unwise for any party to commit itself in advance either way" (163).

By March 1979, however, Jenkin referred to the decision to adopt a tax-financed NHS in 1946 as "the wrong turning" (164). In a *Conservative News* article in April 1979 he stated that a Conservative Government "will undertake a thorough study of the pros and cons of a switch to [an insurance] system as part of the longer-term reform of the NHS" (165) (author's underlining).

While Jenkin seemed clearly to favour an examination of alternative financing if the Conservatives were elected (166), others, including Joseph, may have been more doubtful about pursuing that course.

- (162) Conservative Party press release 1078/77, 29/10/77. Jenkin used similar terms in his *Nursing Times* article, 3 November 1977 edition, p. 1701.
- (163) Commons Hansard, 20/4/78, vol. 948, col. 691.
- (164) Jenkin's speech at Louth, 2/3/79, Conservative press release 304/79.
- (165) *Conservative News*, April 1979, p. 4. col. f.
- (166) and, as Secretary of State from 1979, Jenkin did indeed establish such an examination (Webster C, *The National Health Service*, 1998, Oxford, Oxford University Press, p. 154.

As noted in previous chapters, Joseph had a history of seeming to favour such an examination, and indeed was instrumental in setting one up in 1970, seemingly only to decide against seeking to make any change. In 1974 he had again floated the prospect of radical change in his *Notes Towards the Definition of Policy*. A year later he had determined to prompt the IEA to present ideas to the RCNHS. And in April 1978, he was reported as expressing to a CMS conference the hope of seeing a more extensive private health sector in the very long term (167).

As work on drafting the manifesto for the next election got under way in earnest, however, Joseph's cautious side came to the fore. The manuscript note of a meeting of the Party's Strategy and Tactics Committee on 13 June 1978 recorded him as commenting that "we haven't got intellectual backing in the country on certain areas: NHS above all. Country not ready for any shift towards a non tax-borne service" (168). The wording of the manifesto was, however, sufficiently imprecise to accommodate both Jenkin's enthusiasm and Joseph's caution (the latter, on past history, perhaps only temporary).

The Party's policy in respect of longer term funding possibilities did not, however, preclude it from considering changes within the existing financing framework, and its deliberations on these are considered in the following section.

(167) *Sunday Times*, 16/4/78, p. 2, col. d; *Sunday Telegraph*, 16/4/78, p. 40, col. 6; *Times*, 17/4/78, p. 2, col. c;

(168) CPA LT 6/2.

#### 4.4 Conservative policy on financing of the NHS in the short term

Both Fowler and Jenkin were explicit that it was unrealistic to expect to see the NHS's funding situation eased through significant real increases in tax-based funding until the economy improved (169).

While not envisaging any increases in tax-based funding beyond the plans announced by the Government in successive public expenditure statements, after initial but short-lived reluctance by Thatcher (170) a commitment not to make any further reductions in planned NHS spending was included in the early drafts of the manifesto for the next election and the manifesto itself. It was emphasised during the election campaign by Thatcher (171).

Recognising that NHS funding was likely to be constrained until the economic situation improved significantly, and that any shift to an alternative funding basis was, even if practicable, a relatively long term matter, Conservative spokesmen addressed themselves to what could be done in the short term within the planned levels of tax-based funding. Three areas of thinking can be identified: sustaining, indeed increasing, existing non tax-based sources of NHS revenue; finding new sources; and making better use of resources.

(169) for example, Commons Hansards vol. 898, col. 1031 (Fowler, 27/10/75) and vol. 948, col. 689 (Jenkin, 20/4/78).

(170) Mockler recorded that, at a meeting with the social services spokesmen the previous day, "Mrs T was not willing for us to make a public commitment not to reduce NHS expenditure below what is currently spent. Despite some protests, she was very firm on this point" (Mockler/Patten, 14/7/78, CRD 4/7/78.)

(171) the second draft, LCC(78)186, considered by the LCC on 4/9/78, LCC(78)219th, CPA LCC 16a; the manifesto itself, Craig, 1990, p. 280; Thatcher's speech at Beeston, 18/4/79, Conservative press release GE588/79.

The Conservative manifesto for the October 1974 election had identified two non tax-based sources of revenue that Labour's policies would have reduced or eliminated - income from prescription charges and pay beds. As noted in Chapter 4, the Conservative view was that, with NHS resources under pressure, it was inappropriate to lose the £130m a year secured from these sources (172).

As it became clear that, in current economic circumstances, Labour was not in a position to propose the abolition of prescription charges, the Conservative argument became that there was no case for holding such charges down, with the implication that the Party would raise them at least in line with inflation. Both this and the argument that the Service could ill afford the loss of income from pay beds regularly featured in Conservative publications and speeches (173).

While both the continuation of pay beds (and therefore of pay bed income) and increasing prescription and other charges were included in the notes on possible NHS items for the manifesto considered by the LCC in May 1978 (174), only the former found a place in the full drafts considered during the Summer and the general election manifesto itself.

(172) Craig, 1975, p. 440.

(173) for example, *The Right Approach*, 1976, p. 60 and Jenkin's articles in the *Nursing Times* (3 November 1977, p. 1701) and *Audit, Finance and Accountancy* (February 1978, vol. 5, no. 2, p. 70).

(174) *Draft Notes for the Manifesto*, May 1978, CPA LCC 194-213.

Throughout 1978 the Treasury, which monitored speeches and articles by Conservative frontbench spokesmen, was assuming that the Party would propose a 50p increase in prescription charges which, on Treasury estimates, would have generated an additional £50m a year (175). This would have compared favourably to the potential income from pay beds – the £30–40m pa often referred to in Jenkin's speeches and articles. It is not clear from the papers in the CPA why raising this potential additional £50m pa was not included in the manifesto; the obvious presumption is that it was viewed as likely to be electorally damaging.

Consideration was also given to the possibility of introducing new charges, particularly a hospital bed charge which, as noted in previous chapters, had been regularly considered (and rejected) since the 1950s.

At an early meeting with Fowler, Joseph suggested that it would be necessary to look again at the question of "boarding charges", but that the most that could be raised was about £100m pa and "the question was whether it was worth it" (176). Fowler, too, was sceptical, the minutes recording that in his judgement "this policy could prove very unpopular and we should proceed cautiously" (177). Nevertheless, "NHS New Charges Bill?" was a provisional item on a list of "essential legislation for incorporation in first few Queen's speeches" being compiled by the CRD (178).

(175) submission to Chief Secretary, 20/3/79, Treasury file 2SS 199/462/02A.

(176) note of meeting, 23/6/75, CPA CRD 4/7/78.

(177) *ibid.*

(178) CRD paper, 23/7/75, LJA KJ 18/1.

There seems to be no evidence that new charges such as for boarding were seriously considered by the Opposition social services team under Fowler, or in the early days of Jenkin's period as frontbench spokesman. The issue of charges was, however, raised in a paper for the PSPG by Nicholas Ridley, a keen supporter of Thatcher who had resigned as a minister during the Heath Government. Ridley estimated that £530m pa could be raised by introducing board and lodging charges for hospital stays, and £200m pa through charges for visiting GPs (179).

The paper was discussed by the PSPG in April and May 1976, with Jenkin present. From the minutes, it is clear that Ridley's estimate of the potential income was regarded as unrealistic. The general view was that, "after administrative costs, Government help for the poor and above all bad debts", the yield would be "very low" (180).

Given the difficulty, noted above, that the PSPG had found in identifying scope for reductions in public spending, it is understandable that, in presenting its proposals to the LCC in July 1976, the introduction of boarding charges (at £2 a day) was included, with an estimated yield of £50m in a full year (181). However, the PSPG paper made it clear that this charge was not proposed by those responsible for NHS policy, with the implication that, at that stage, Jenkin was opposed to such a charge (182). (This is supported by the fact that in the section on "Prescription and other health services charges" in the SSPG's report to the LCC a month earlier there had been no reference to the possible introduction of new charges (183).)

(179) *The National Health Service*, 27/4/76, CPA CRD 4/13/10.

(180) minutes of meetings 28/4/76 and 19/5/76, *ibid.*

(181) paper LCC 76/124, pp. 11 and 13, considered at LCC(76)123rd, 12/7/76, CPA LCC 113-123.

(182) LCC 76/124, p. 12, *ibid.*

(183) LCC/76/117, 16/6/76, *ibid.*

There was no specific reference to the PSPG's recommendation for boarding charges in the minutes of the LCC's discussion of the Group's report in July 1976, though a later PSPG paper, while continuing to include the estimated yield from a bed charge, identified it as one of "the cuts proposed in the original report ... [which] encountered strong opposition in Shadow Cabinet" (184).

Given this "strong opposition", it was not surprising that the mid term policy document *The Right Approach* published three months after the LCC's discussion of the PSPG's report contained no reference to new NHS charges.

If Jenkin was initially opposed to new charges, his position seems to have changed during 1977. In a speech to NHS treasurers in March 1977, Jenkin acknowledged that the Service "needs more money" and that one possibility was to charge for certain services. Specifically, he asserted that "it cannot be right that the only people who have to pay for their keep in hospital are pensioners" (185), a view he expressed, almost word for word, in a speech to a CMS symposium on health care finance in October 1977 and his *Nursing Times* article the following month (186). (Jenkin's reference was to the fact that, after a pensioner had been in hospital for a certain period his or her old age pension was reduced for the duration of the stay in hospital, reflecting that food etc. was being provided by the NHS.)

(184) PG/11/77, 1/6/77, p. 1, CPA CRD 4/13/11.

(185) Conservative press release 352/77.

(186) Conservative press release 1078/77; *Nursing Times*, 3/11/77, p. 1701.

By the time Jenkin addressed its symposium on health care finance, however, the CMS itself had presented its views on financing to the RCNHS. Having "examined the question of hotel charges ... we have rejected them on the grounds of administrative cost" (187). Possibly lack of support by the CMS may have contributed to what seems to have been a slight shift in Jenkin's position in 1978. For although in his *Audit, Finance and Accountancy* article in February he raised the issue, he added that "the Royal Commission on the NHS will give us helpful guidance on this thorny problem" (188), indicating that, as with longer term alternatives to tax-based funding, the Conservatives would not be making any firm proposals until the RCNHS reported.

Consistent with this, no proposals for a boarding charge, or any other new charge, were considered during 1978 in the process of drafting the manifesto for the forthcoming general election, or included in the manifesto itself.

In the light of Jenkin's speech to the CMS symposium in October 1977, however, there was a basis for expecting that the Conservatives would introduce such a charge, and possibly a charge for visiting GPs. For example, the parliamentary correspondent of the *Lancet* commented in July 1978 that "Conservative Party plans for increasing existing health charges and levying new ones are likely to be the most controversial health issue at the General Election" (189).

(187) CMS evidence, pt. 1, p. 7, BMAA box 3/177/9.

(188) *Audit, Finance and Accountancy*, February 1978, p. 70.

(189) *Lancet*, 29/7/78, p. 274.

The issue was raised during the election campaign in April 1979. In response, Thatcher gave an undertaking that was often to be cited during her period as Prime Minister, that "the Conservative Party has no plans for new NHS charges: no plans to make people pay to visit their doctor, no plans to introduce hotel charges for those in hospital" (190). In a CRD brief for DHSS civil servants following the Conservative electoral success, Thatcher's statement was referred to as "a firm commitment" (CRD underlining) (191).

In parallel with expressing concern not to lose revenue from existing sources, and giving some consideration to alternatives to tax-based funding and new changes, Conservative frontbench spokesmen addressed the question of the efficiency within the NHS.

As early as November 1975, Fowler drew attention to possible savings to be achieved through preventive medicine and greater emphasis on community, rather than hospital, care (192). Jenkin shared Fowler's concern to use NHS resources to best effect, though in his view "the best approach should be to try to devise administrative and organisational machinery to improve efficiency" (193).

In contrast to Joseph, who drew upon his own business experience and advice from experts (such as Hamilton and Payne in the days of the HPG, and Meyjes when Secretary of State), Jenkin developed a wide range of contacts among those with intimate knowledge of the NHS, mainly administrators.

(190) speech at Beeston, 18/4/79, Conservative press release GE588/79.

(191) CPA CRD 4/7/89.

(192) Commons Hansard, vol. 901, col. 364.

(193) minutes of PSPG meeting, 19/5/76, G/11/76/38, CPA CRD 4/13/10.

One was Brian Edwards, a senior NHS administrator, who subsequently wrote that in Opposition, Jenkin "had worked hard ... with many of the leading figures in the NHS" (194). In his early years as social services spokesmen, in addition to meeting Edwards (195) and other administrators, Jenkin established a relationship with Roger Dyson, an academic specialising in NHS industrial relations. Dyson had offered his services to the Party and, after "vetting" by Chris Patten, Director of the CRD, was introduced to Vaughan and Jenkin (196).

Perhaps through discussions with Dyson (who would have known a great deal about NHS working practices), and NHS administrators (who had to observe procedures not conducive to efficiency, such as spending allocations by the end of a financial year, even if this meant the money was spent on less essential items (197)), Jenkin became convinced that "there is a great deal of waste" in the NHS (198).

- (194) Edwards B, *The National Health Service - A Manager's Tale*, 1995, London, Nuffield Provincial Hospitals Trust, p. 55.
- (195) Edwards had been a District Administrator in Leeds from 1974 and in 1976 became Area Administrator, Cheshire AHA. Edwards' diary for 1976 records a meeting with Jenkin and Vaughan on 16/7/76, Edwards' papers.
- (196) Dyson/Thatcher, 20/2/75 (KJA KJ 18/1); Patten/Fowler, 12/5/75 and Mockler/Dyson, 17/10/75, CPA CRD 4/7/23, doc. 143). Dyson became a special adviser to Jenkin on his appointment as Secretary of State for Social Services in 1979.
- (197) Jenkin later tended to refer to this as the "colour-televisions-in-March syndrome" (speeches to the IHSA, 7/6/78, as reported in *Hospital and Health Services Review*, August 1978, p. 273, and the Party Conference, 13/10/78, Conservative press release 1306/78).
- (198) speech to CMS symposium, 29/10/77, Conservative press release 1078/77.

As a former Chief Secretary, Jenkin may even have been aware that the Treasury had longstanding concerns about the efficiency of the NHS (noted in Chapter 3), concerns which apparently remained long after the reorganisation of the NHS (199).

Jenkin's proposals for achieving greater efficiency, like Joseph's in 1970, included further change to the structure of the NHS, examined below. However, he also emphasised improving efficiency by changing financial practices.

First, as a response to what he termed the "colour-televisions-in-March syndrome" (see note 197 above), Jenkin proposed to change the rule requiring financial allocations to be spent by the end of the year for which they were made. In a note to George Cardona in the CRD, he reported agreement on this with Howe, the shadow Chancellor. The rule on carry-over related "not to the management of the NHS, but to the management of public expenditure by the Treasury". Given the margins of error in overall Treasury control of public spending and the small sums "likely to be at issue within the NHS as carry-over", the rule could safely be ended. Jenkin was clear that this would be popular within the NHS: "few of the proposals which I make gain wider acclaim among my audiences than the pledge to end the rule" (200).

(199) Webster, 1996, p. 602.

(200) Jenkin/Cardona, 16/3/79, CPA CRD 4/7/78.

Jenkin's second principal idea for improving efficiency was through incentives, which stressed in speeches and articles throughout 1978, though without offering any indication of the value of the improvement in efficiency he expected to see as a result (201).

Overall, therefore, while retaining pay beds and increasing prescription charges in line with inflation (though the latter was not a commitment in the general election manifesto) would have increased the NHS's revenue, it seems unlikely that the aggregate impact of the various measures favoured by Jenkin would have had a substantial effect in relieving the pressures on the Service. As had Joseph in 1970, Jenkin believed that structural change offered a perhaps more substantial means of improving efficiency.

(201) for example, Commons Hansard, 20/4/78, vol. 948, col. 693/5; *Hospital and Health Services Review*, August 1978, p. 273; "A Conservative Look at the Health Service", *Contemporary Review*, September 1978 (vol. 223, no. 1352, p. 125); Conservative press release 1416/78, 10/11/78.

## 5. THE STRUCTURE OF THE NHS

The third issue of form addressed from 1975 to 1979 was the Service's structure which, as implemented on 1 April 1974, was that developed by Joseph as Secretary of State and enacted under the Heath Government in the face of Labour opposition.

As noted in Chapter 4, the Labour Government had decided it had no option but to implement its predecessor's structure. However, ministers never sought to disguise their criticisms (202), which did not provide the most favourable circumstances for the new arrangements to become established (203).

Howe had initially argued that the reorganisation needed time to settle down (see Chapter 4). However, before the structure had been in place for a year, criticisms were beginning to appear (204), and were monitored by the CRD. In a policy paper in June 1975 Mockler noted that "the reorganisation ... has recently given rise to a whole range of teething troubles, of which the most usually quoted is the difficulty of getting decisions made" (205).

(202) eg Castle's speeches during the 1975 Debate on the Address (Commons Hansard vol. 870, cols. 530/1) and to the National Association of Health Authorities, 11/7/75 (copy in BMAA file 3/53/11).

(203) in a private memorandum to Joseph dated 28/4/76, Rogers, the DHSS Permanent Secretary during the first seven months of the new structure, commented "it really was most difficult with an incoming government, which openly disapproved of the reorganisation". LJA KJ 19/3.

(204) eg in the *Health and Social Services Journal* editions of 4/1/75 (p. 15), 18/1/75 (p. 128) and 15/2/75 (p. 351).

(205) *Conservative Social Services Policy*, 9/6/75, CPA CRD 4/7/88).

Mockler's view was that the "new structure should be given 2/3 years to settle down", and only "if there are still widespread complaints" should a Conservative Government undertake a "limited re-appraisal and iron out the difficulties" (206).

Fowler identified one possible change - cutting out one of the tiers of the NHS structure - in his paper on *Social Services Policy* in July 1975. He concluded, however, that given "the obvious political point that we carried out the reorganisation, and the practical point that it has hardly been given time to settle down", the option of giving a commitment to cutting out a tier should be left open (207).

The minutes of the LCC meeting at which Fowler's paper was considered do not indicate that the issue of the NHS's structure was discussed. In the absence of any clear expression of LCC policy Vaughan who, as noted in Chapter 3, had had reservations about the need for the regional tier, went on record proposing that one tier, probably the region, should be abolished (208).

The establishment of the RCNHS provided the Government with a vehicle through which an assessment of the working of the NHS structure, and any recommendations for change felt appropriate, could be expected.

(206) *ibid.*

(207) *Social Services Policy*, 24/7/75, CPA CRD 4/7/78.

(208) *Hospital Life*, August 1975, quoted in Commons Hansard, vol. 898, col. 1053.

In a Commons debate a week after the intention to establish the Commission had been announced, Castle implied that no substantial change in the structure would be made until after it had reported (209). Although some changes were made in the membership of health authorities following consultation on *Democracy in the NHS*, and some merging of health districts within AHAs was approved, "waiting for the Royal Commission to report" became Labour's position in respect of significant structural change, albeit not without some strains among ministers (210).

To adopt a similar "wait for the Royal Commission" policy was clearly a possible option for the Conservatives. As noted above, it was the position taken in respect of alternative financing, and in the short term it would have avoided the potential embarrassment of proposing modifications so soon to a structure put in place by the recent Conservative Government and so personally identified with Joseph. Early in 1976, it seemed possible that the Party would adopt just such a policy.

(209) 27/10/75, Commons Hansard, vol. 898, col. 1054. In an effort to re-assure NHS staff, on 31/10/75 a DHSS press notice (75/2207) was issued, setting out a letter from Rogers to RHA Chairmen, drawing attention to Castle's statement.

(210) Webster, 1996, pp. 728/730, records differences of view among the Cabinet in the Autumn of 1978.

A CRD memorandum identified "the future of the NHS" as an "area of apparent neglect within the Party", but suggested that "perhaps we should be cautious and hide behind the ... Royal Commission?" (211). Two days later, Joseph wrote to a parliamentary colleague suggesting that the RCNHS's remit was sufficiently wide "to cover the administrative reforms that may be needed when the new structure has settled down", implying no action before the Commission reported (212). A month later, Joseph advised the ACP that "it was too early to say how the re-organisation was going to turn out. He had heard that the single and multi-district areas [AHAs] were working quite well, but the two and three district areas were not so successful". (213).

In the early days of his period as LCC spokesman on social services, Jenkin defended the re-organisation against the charge that it had led to higher numbers of administrators. While there were "just 921 more support staff" than prior to the re-organisation, "there were 100 fewer" senior administrative staff (214). However, there continued to be evidence of concern about the new structure. McKinsey & Co. had, as noted in Chapter 3, been contracted to help develop the structure, and in January 1976 John Banham of McKinsey was instrumental in preparing an early appraisal of how it was settling down. While the author has been unable to trace a copy (215), Rogers prepared a detailed commentary on it for Joseph, from which it is possible to identify some of the findings of Banham's fieldwork. These included the perception that there was an "over-elaborate statutory framework", within which was included difficulties due to the distinction made between districts and areas (216).

(211) Forman/Joseph, 6/1/76, LJA KJ 18/4.

(212) Joseph/Sir Edward Brown MP, 8/1/76, LJA KJ 29/1.

(213) ACP(76)143rd meeting, 18/2/76, CPA ACP 2/4.

(214) 28/2/76, Conservative press release 209/76.

(215) sources approached have included Sir John Banham, and McKinsey & Co.

(216) 28/4/76, LJA KJ 19/3.

Joseph edited many of Rogers' views into a letter to Jenkin (217) who, in addition had available some feedback from local Conservative groups, as well as published academic studies (218).

In the light of this material, Jenkin seems to have reached the conclusion that neither a policy of allowing the re-organised structure the "2/3 years" to settle down before re-appraising the situation (the CRD in Summer 1975) or "waiting for the Royal Commission" (as implied in the CRD memorandum in January 1976) seemed adequate.

At a PSPG meeting in April 1976, Jenkin was reported as commenting that "it was not really possible to decide which tier of administration could be abolished" (219). Given that the issue seemed to be "which", rather than "whether" a, tier needed to be abolished, the implication is he was moving towards favouring substantial change of the kind Vaughan had proposed the previous August (220).

(217) Joseph/Jenkin, 4/5/76, *ibid.*

(218) in October/November 1975, as part of the "Three Way Contact programme referred to in chapter 3, local Conservative Groups had been asked for views on several NHS issues. In the summary of comments received from 612 groups, the Central Office noted concern about "the reorganisation of the NHS, which had proved disastrous", and instanced specific criticisms such as that the AHAs were "too remote". (Undated summary, CPA CCO4/10/81). Among academic appraisals were Brown R, Haywood S and Griffin S, *The Shadow and the Substance*, 1974 and *New Bottles: Old Wine*, 1975, both Institute of Health Studies, University of Hull.

(219) 28/4/76, PG/11/76/34, CPA CRD 4/13/10.

(220) the word "tier" was seldom used with precision in discussions of NHS structure, either within the Conservative Party or generally. As noted above, there were three statutory levels - the Secretary of State, RHAs and AHAs, the majority of AHAs being divided into two or more geographical districts. Some seem to have used "tier" to denote the three statutory levels; others to include the districts as a tier. Unless the specific context was unambiguous, it is impossible to be certain what was intended in phrases such as "abolishing a tier".

This inference is supported by the fact that in June the SSPG reported concerns about the working of the new structure to the LCC, "on balance" recommending, subject to "more consultation", a policy of piloting the removal of AHAs in one NHS region (221). The SSPG was probably aware, through Vaughan, that the CMS was about to recommend to the RCNHS that AHAs, "and probably the Region" should be abolished, "both for efficiency and economy" (222).

The minutes suggest that the LCC was sympathetic to this view, as the conclusion was that "we should encourage the Regions to experiment on what administrative structures best met their particular needs" (223).

In September 1976 Jenkin set out (though without specific attribution) the LCC's policy in a speech to health service administrators. In giving examples of possible local solutions he suggested that "in some parts of the country, it may be possible to eliminate a management tier, or to break down an area into smaller district tiers" (224).

By Summer 1976 problems perceived as arising from the re-organised structure were of concern much more widely than in Conservative circles. For example, the BMA's ARM had resolved that among the matters the Council should press on the RCNHS was for "the administrative channels to be streamlined - for example, by pruning of committees, by rationalisation of tiers, and maximum delegation from DHSS to the Service" (225). And the summary made by de Peyer, referred to above, identified "structure and tiers" as the issue which had been mentioned most frequently in letters to the RCNHS (226).

(221) 16/6/76, PG/60/76/3, CPA LCC 113-123.

(222) 24/6/76, CMS/RC, PRO BS 6/341.

(223) LCC/76/117th, CPA LCC 113-123.

(224) 18/9/76, Conservative press release 878/76.

(225) BMAA minutes of ARM 15/7/76 - 17/7/76, pp. 16/7.

(226) PRO BS 6/2513.

In the light of the extent to which the issue was mentioned, it was not surprising that NHS structure was included in the RCNHS's list of topics on which evidence would be welcomed, published in October 1976 (227).

The RCNHS invited a number of people, including Joseph and Heath, to meet them privately to discuss the NHS. Joseph's report to Jenkin of his meeting did not mention discussion of the re-organised structure, though the RCNHS's note recorded him as offering essentially the same comment he had made to the ACP meeting in February (228). Heath told the RCNHS members that "the Conservative Cabinet had been divided in its views on NHS Reorganisation between those who advocated efficiency and those who advocated a system which provided for the consumer to be represented: the compromise reached had satisfied neither party", but in his view "the problems of the NHS could probably not be solved by changes in its organisation: the main need was for additional resources, and that depended on an improved performance by the national economy" (229).

Late in 1976 and early in 1977, ideas about changes in the structure of the NHS were legion as individuals and professional bodies prepared evidence for the RCNHS.

(227) *The Task of the Commission*, 1976, pp. 6/7.

(228) Joseph/Jenkin, 8/12/76, LJA KJ 29/6; RCNHS note of meeting, 30/11/76, PRO BS 6/3222.

(229) RCNHS note of meeting, 16/12/76, PRO BS 6/3220.

The BMA's draft evidence, published in the *BMJ* in January 1977, was very critical. After making due allowance for "teething troubles", the Association concluded that "reorganisation (particularly as it affects England) has proved to be extravagant and inefficient". Echoing the views the CRD had picked up by mid 1975, in the Association's view "since reorganisation ... it has become increasingly difficult to get matters dealt with satisfactorily and speedily and for problems to be solved "on the spot" without the need for reference upwards or downwards" (230).

Among the BMA's recommendations to remedy the problems as it saw them was that "below the regional level there should be only one administrative and functional unit" (231). At a SRM on 9 March 1977 that recommendation was amended, "by a large majority", by one which explicitly proposed "the removal of Area Health Authorities" (232).

The CMS broadly shared the BMA's view. It judged that between the existing district level and the DHSS, only one level of management was needed, having "the functions of the present areas and many of the functions of the present regions ... [including responsibility] for planning, co-ordination, and financial control" (233)

(230) *BMJ*, 29/1/77, pp. 311/4.

(231) *ibid.*

(232) BMAA, minutes 31-33 of SRM, 9/3/77.

(233) *Evidence of the CMS, Part I*, p. 2.

McKinsey's evidence to the Commission, which Banham had been instrumental in drafting, trailed in the *Times* and sent to the Commission within days of publication of the BMA's draft evidence, was clear that "there is at least one management tier too many" (234). The Association of Chief Officers of Health Authorities' evidence was published later in the same month, also proposing essentially the establishment of a single tier at local level (235).

In addition to access to the publicly available evidence, Conservative social services spokesmen were the recipients of private advice, not all proposing the same solution. In December 1976 Joseph passed on to Jenkin a personal letter he had received from Norman Lamb, an NHS Regional Administrator, clearly favouring "having only one lower tier below Region, based on in the present health district" (236). At a PSMPG meeting in February where Rogers and Tony Kember, an Area Administrator (237), attended, their advice seemed to be to retain all the existing tiers, although to have "as many single-district AHAs as possible" (238).

The draft report of the PSMPG, circulated on 18 March 1977, reflected the advice seemingly given by Kember and Rogers. The report recommended that "as many Area Health Authorities as possible should be single district AHAs, but there can be no single rule for all the country" (239).

(234) *Times*, 24/1/77, p. 3, col. a; PRO BS 6/985, para. 2.8.

(235) BMAA file 3/177/18.

(236) Lamb/Joseph, 30/11/76, enclosed with Joseph's letter to Jenkin, 8/12/76, LJA KJ 29/6.

(237) Kember, Area Administrator of the Kensington, Chelsea and Westminster AHA, was invited by Baker, having previously been Secretary of the 2000 Club, a non-Party discussion group chaired by Baker, based in Acton (conversation with Kember, 19/10/00.)

(238) minutes of PSMPG meeting, 9/2/77, CPA CRD 4/13/77.

(239) CPA CRD 4/13/12.

In a speech on 26 March Jenkin went beyond the position proposed in the draft PSMPG report. While arguing that the 1974 re-organisation "was not the starting point" for the seemingly inexorable growth in bureaucracy, he said that change was clearly needed, and that he had two "watchwords".

The first watchword was "simplicity": what was needed was "a simpler administrative structure with one tier of management removed". Below the DHSS, "there need be only two tiers, a Regional tier ... [and] a local tier, perhaps called a District Health Authority". The second watchword was "decentralise", by which he meant that "as many as possible of the day to day decisions on health care [should] be taken at the point where health care is delivered", rather than drawn up to higher levels of authority within the structure. In relation to decentralisation, Jenkin found himself "much attracted by the concepts and reasoning of last year's report by the three Regional Chairmen" (240).

- (240) Conservative press release 352/77. The Three Chairmen's Report was published in December 1976, following an enquiry by three RHA Chairmen, at the invitation of the Minister of Health, Dr David Owen, into "the functions of the Department of Health and Social Security in its relations with RHAs" with a view to seeing whether "economies of operation could be effected by means of a transfer and/or reduction in the scale of functions as between the Department and Regions". (*Regional Chairmen's Enquiry into the working of the DHSS in relation to Regional Health Authorities*, 1976, London, DHSS.)

By late March 1977 Jenkin had thus indicated that the Party was in favour of a considerable modification of the arrangements introduced in 1974, and in so doing had established additional common ground with the BMA (the other key area of agreement being in relation to the retention of pay beds). Further, an analysis of responses to the RCNHS prepared in May 1977 by its secretariat suggested that the position Jenkin had taken in March in relation to simplifying the structure was widely shared. In a paper entitled *One Tier too Many?*, it was reported that "the weight of argument in the evidence is that there is a need for a regional organisation below which there should be one operational level of management (the single district area pattern)", though with the possibility of local variations (241).

Jenkin re-iterated the two themes of simplification and decentralisation in speeches and statements from Spring 1977 right up to the 1979 general election (242), though without setting out exactly how these objectives (especially decentralisation) would in practice be achieved.

Possibly it was the wish to explore practicalities which led Jenkin into perhaps the most extensive of his various consultations with NHS administrators, that with a group he was later to refer to as "the Weaver Group" (243).

(241) PRO BS 6/2586.

(242) for example, 1977: 16/5, 28/7, 29/10, 1/12; 1978: 26/1, 3/3, 16/5, 7/6, 2/9, 28/10, 10/11; 1979: 25/4 (Conservative press releases 538/77, 783/77, 1078/77, 1267/77, 92/78, 308/78, 667/78, 751/78, 1134/78, 1370/78, 1416/78, GE668/79).

(243) Jenkin/Robert Nicholls (a Group member), 6/6/79, Weaver papers.

This was a loose-knit group of NHS administrators (244), brought together by Nigel Weaver, the District Administrator of the South Hammersmith Health District, following a chance conversation he had had with Jenkin (245). Weaver and those he invited to attend meetings saw themselves contributing in a professional capacity, and in no sense as Conservatives (246).

At Jenkin's suggestion, several of his articles were circulated to those invited to the meetings to, in Weaver's phrase, "indicate the skeleton that we have got to clothe if we are to do anything worthwhile" (247).

After an initial meeting with Jenkin on 25 April 1978, there was one, and probably two, further meetings in the Summer (248). With the general election widely expected in the Autumn until Prime Minister James Callaghan's announcement on 7 September (249), there was a hiatus before a further meeting in January 1979, and possibly up to two others prior to the election (250).

(244) those who attended included five Area Administrators (Robert Nicholls, Newcastle; Duncan Nicol, Salford; Brian Smith, Lincolnshire; John Spencer, Oxfordshire, and Kenneth Walker, Buckinghamshire) and four District Administrators, (David Knowles, NE District of Kensington, Chelsea and Westminster; Andrew Wall, Bath; Nigel Weaver, and Christopher Velloneweth, Eastern District of Liverpool). Minutes of meetings with Jenkin and Vaughan, 16/5/78 and 30/1/79, Weaver papers.

(245) as explained to the author by Weaver, 9/2/00.

(246) *ibid.*

(247) Weaver/Group members, 29/3/78, *ibid.*

(248) *Notes of Discussion of a meeting at the Commons on 16/5/78; Accountability in the NHS*, "a discussion paper for meeting with Mr Patrick Jenkin ... June 6 1978", Weaver papers.

(249) *Times*, 8/9/78, p. 1, col. a.

(250) *Notes of a Meeting - 30th January 1979; An Administrative Structure for the Unitary Authority*, "for meeting with Mr Patrick Jenkin ... on 13 March 1979"; Weaver/Group members, 15/3/79, referring to "our next meeting with Mr Jenkin ... will be on 10 April". Weaver papers.

In the year or so during which meetings took place, members of the Group produced at least a dozen papers to aid discussion, most of which addressed the practical problems of implementing the kind of "simplification" Jenkin clearly favoured. For example, papers addressed such issues as the criteria for determining the geographical areas to be served by health authorities at the operational level; the process of moving from the present structure to the "simplified" one; the composition and accountability of the proposed new authorities; and the pros and cons of establishing a chief executive role at the operational level (251).

It is likely that Jenkin found the detailed attention paid by senior NHS administrators to such practical issues a useful complement to the various other sources of advice available to him (252). The papers and the discussions (as judged by the notes of two of them) would have confirmed not simply that the approach he had outlined in March 1977 was in sympathy with the views of a number of senior NHS administrators, as well as doctors (as reflected in the BMA's evidence to the RCNHS), but seemed practicable.

(251) papers by Group members, Weaver papers.

(252) this impression is clearly conveyed in letters Jenkin wrote to two Group members shortly after the general election. To one he wrote "I found the discussions I had with yourself and your colleagues of enormous value in helping us to put some flesh on the bones of our ideas" (Jenkin/Walker, 1/6/79). To another he wrote that "it is satisfactory that we may have the chance of putting into practice some of the ideas which we discussed over so many months" (Jenkin/Nicholls, 6/6/79). Copies in Weaver papers.

One of the difficulties with the proposals Jenkin had outlined in March 1977 was that they involved a considerable re-casting of those developed by Joseph as Secretary of State and implemented less than three years previously.

As noted above, during 1976 Joseph was of the view that it was too early to judge the structure implemented on 1 April 1974, though he had expressed worries about how the situation was working out in two and three district areas. By April 1978, he had reached a fuller judgement, describing the reorganisation as "in part patchy, in part awful, in part not bad and in part curable" (253).

This acknowledgement by Joseph would have made it easier for Jenkin, a few days later, to state during a Commons debate that the "reorganisation has not fulfilled the hopes of its progenitors" and to set out his proposals, essentially as in his March 1977 speech (254). Thereafter, he submitted them for consideration for inclusion in the manifesto for the coming general election.

In a note for an LCC meeting in May 1978, Jenkin proposed that "in many areas ... Area Health Authorities [should be merged] into local District Health Authorities, with lay representatives at that level", as the means of reducing [NHS] bureaucracy, simplifying administration and ensuring that more decisions on health care were taken at local level (255).

(253) quoted in Commons Hansard vol. 948, col. 691. Jenkin stated that Joseph had made the comment "last Saturday", 15/4/78, presumably at a CMS conference he addressed, which was reported in respect of remarks on future financing (see note 167 above). The author has yet to trace a newspaper report of the comments on NHS reorganisation.

(254) *ibid.*, vol. 948, cols. 691/3.

(255) *Draft Notes for the Manifesto*, sent under cover of Jenkin's letter to Maude, 6/3/78, CRD 4/7/78.

Jenkin's note was not unambiguous, but the essence of his proposal seems to have been generally to replace those AHAs with two or more districts by a new set of authorities each covering the geographical area of an existing district.

The LCC accepted the proposal, and in meetings with Thorneycroft and Thatcher in July it was agreed that, if the proposals for structural change came under criticism for anticipating the report of the RCNHS, "we should answer that there is now wide agreement among experts on the necessity of doing what we propose" (256).

Following these meetings, Jenkin's proposals on structural change were included in the second draft of the manifesto in the following terms:

"We must see that the resources we have are more wisely spent. We will therefore simplify and decentralise the Service and cut back bureaucracy. Central government should interfere less in the details of NHS administration and leave as many as possible of the day-to-day decisions to be taken locally. We will retain the Regional Health Authorities in England and Wales as a co-ordinating and planning tier, but below that there should in most cases be only one tier responsible for the actual provision of health care. In many places, this will involve merging the Areas and Districts to create truly local health authorities" (257).

- (256) LCC(78)203rd meeting, 8/5/78, CPA LCC 194-213; meetings with Thorneycroft, 12/7/78, and Thorneycroft and Thatcher, 13/7/78, CPA CRD 4/7/78.
- (257) LCC(78)186, discussed at LCC(78)219th meeting, 4/9/78, CPA LCC 16a. The wording may also have been included in the first draft - see note 160 above.

In the published version, this draft was shortened to the less specific "... we intend to make better use of what resources are available. So we will simplify and decentralise the service and cut back bureaucracy" (258).

## 6. THE CONSERVATIVE POSITION AT THE 1979 GENERAL ELECTION

### 6.1 NHS policies

On the three issues relating to the form of the NHS examined by the Party in Opposition, two resulted in general election manifesto commitments.

On private practice, there were commitments to "restore tax relief on employer-employee medical insurance schemes", and that pay beds would continue to be provided where there was a demand for them.

On structure, Jenkin's two watchwords from his May 1977 speech were incorporated into the commitment to "simplify and decentralise the service and cut back democracy", again without any specific indication of how in practice that would be achieved.

On the issue which, more perhaps than the other two, might have led to substantial change to the form of the NHS, a move from tax-based funding to alternative arrangements, it was clearly felt inexpedient to go beyond acknowledging that it was under study by the RCNHS and "any examination of possible longer term changes" must await that report.

(258) Craig, 1990, p. 280.

As this set of policies took shape, Jenkin clearly regarded it as potentially popular. In March 1978 he advised Thatcher that "attitudes which we have been taking in public in speeches up and down the country and in Press articles have won a wide measure of support with their emphasis on making the Service more local, getting rid of bureaucracy, cutting out waste, making patient care the main concern and generally "stopping the rot" (259).

In November 1977, the LCC Policy sub-committee had agreed that *The Right Approach* and *The Right Approach to the Economy* should be followed by a series of "Right Approaches", including one on social policy (260), but the draft was not regarded as satisfactory and in June 1978 it was decided not to proceed (261). As an alternative in respect of the NHS, Jenkin saw "considerable advantage" in publishing a paper specifically on the Service, as "there are a great many NHS interests which would be very anxious to see such a document and we do not feel that there need be hostages to fortune in it" (262). Joseph agreed, and Vaughan was commissioned to produce a draft which Jenkin would "look over" (263).

By late July 1978 "Dr Vaughan was rumoured to have submitted a draft to Patrick Jenkin" (264), but in November the decision was taken that "Dr Vaughan's ... paper should not be revived", with no reason recorded (265).

- (259) Jenkin/Thatcher, 17/3/78, CPA CRD 4/7/88.
- (260) note of sub-committee meeting, chaired by Joseph, 7/11/77, CPA CCO 20/31/5.
- (261) note of meeting of Joseph's Policy Committee, 21/6/78, LJA KJ 18/3.
- (262) Jenkin/Joseph, 22/6/78, CPA CRD 4/7/72.
- (263) note of meeting of Joseph's Policy Committee, 5/7/78, LJA KJ 18/3.
- (264) note of meeting of Joseph's Policy Committee, 28/7/78, LJA KJ 18/3.
- (265) note of meeting of Joseph's Policy Committee, 22/11/78, LJA KJ 18/3.

No paper on Conservative policies for the NHS was therefore published prior to the 1979 election, when such issues were just one element among the Party's whole range of policies, so Jenkin did not have the opportunity of finding out whether, in aggregate, they "won a wide measure of support" within the Service.

## 6.2 The general election manifesto as a whole

On NHS matters, although the manifesto committed the Party to the reversal of two of the Labour Government's policies (on pay beds and taxing the benefit derived from employer-employee private health insurance schemes) it would be difficult to characterise it as radical. The two "reversals" were aimed at restoring what had long been the status quo. The proposed changes to the structure of the NHS were, judged by Jenkin's speeches, likely to reflect the developing consensus within the Service. And leaving "any examination of possible longer term changes" on forms of financing until the RCNHS had reported carried no commitment to radical change. Was this essentially conservative approach characteristic of the manifesto?

The early Thatcher Governments have been characterised as having "completely transformed" Party policy (266) and "by post-war standards ... radical" (267). However, to the extent that those judgements might be considered to be well-founded, a matter outside the scope of this thesis, the 1979 election manifesto only anticipated part of that policy transformation and radicalism.

(266) Holmes M, *The First Thatcher Government*, 1985, Brighton, Wheatsheaf, p. 211.

(267) Kavanagh D, *Thatcherism and British Politics*, 1987, Oxford, Oxford University Press, p. 316.

Writing years after the 1979 general election, Thatcher herself emphasised the "mixed" nature of the Party's manifesto. She described both the need to hold the Party together in Opposition which, she judged, involved the need to appoint to the LCC colleagues with whom she "could not assume agreement - even on basic principles" (268), and the compromises this required in the drafting of the election manifesto (269).

According to Thorneycroft, the Party Chairman during the period Thatcher was Leader of the Opposition, "the key changes were to get a grip of the finances [and] a return to free collective bargaining but only with tough union legislation after the abuses of the last 10 years" (270).

It was widely recognised that, compared with recent governments, the manifesto had a significantly different approach on economic policy, "the main proposals ... includ[ing] a strict control of the money supply and a reduction of both the government's borrowing requirement and the state's share of national income. Cuts in public expenditure were promised in almost every area" (271).

Whether the approach on trade unions was as radical was, at that stage, less clear. The manifesto implied, but did not state, that the law would be used to place obligations on unions and curb picketing (272).

(268) Thatcher, 1995, p. 291.

(269) *ibid.*, pp. 436/9.

(270) quoted in Holmes, 1985, p. 8.

(271) Butler and Kavanagh, 1980, p. 156. The *Daily Telegraph* regarded the manifesto's economic proposals as "an advance on the last two Conservative manifestos, not to mention an advance on the last Conservative Government", leader, 12/4/79, p. 18, col. a. Holmes, 1985, p. 13, put the manifesto in a longer historical perspective, commenting that it included "a radical approach to economic policy compared to that of post-war Conservatism".

(272) Craig, 1990, p. 271.

The day after the manifesto was published, the *Daily Telegraph*, perhaps sensing tensions within the LCC (which Thatcher was later to describe (273)), contrasted the "simply not specific enough" wording of the manifesto with Thatcher's "rather impressive ... speech last night [which] went further, emphasising the need for the unions to be subjected to "a legal framework". The *Daily Telegraph* went on to hope that Thatcher's speech, rather than the manifesto, "was a true guide to Tory policy" (274).

In other respects, the manifesto has been described as one where "across the broad range of policies ... continuity was the order of the day" (275). Far from a wholesale shift away from the policies of pursued by the Heath Government, even on incomes policy (which, as noted above, had been one of Joseph's targets in the period after the February 1974 general election (276)), Thatcher described herself as scoring "no better than a draw", with a commitment to avoid incomes policy in the private sector but not necessarily in the public sector (277). Indeed, so far was the manifesto from being a programme of what Gilmour has characterised as "Thatcherism ... nineteenth-century individualism dressed up in twentieth-century clothes" (278), that Butler and Kavanagh were able to note "many points of continuity" with Labour's manifesto (279).

(273) Thatcher, 1995, p. 436/8.

(274) *Daily Telegraph*, 12/4/79, p. 18, col. a.

(275) Behrens, 1980, p. 118.

(276) the section "Incomes Policy No Cure" in his Preston speech, 5/9/74, reprinted in Joseph, 1975, pp. 19/32.

(277) Thatcher, 1995, pp. 438/9.

(278) Gilmour, 1992, p. 9.

(279) Butler D and Kavanagh D, *The British General Election of 1979*, 1980, London, Macmillan, p. 161.

In its essentially conservative character, therefore, the NHS section of the Conservative Party's manifesto for the 1979 general election was of a piece with many others. On the form of the NHS, radical policies, if they were to come, were to come later.

### 6.3 Arrangements for policy review under Mrs Thatcher's leadership

As had been the case between 1964 and 1970, from 1974 to 1979 the Conservative Party social services spokesmen had groups examining policies on the NHS. In practice, however, it is open to question whether the groups had any substantial existence until the NHSPG was established under Vaughan's Chairmanship in the Spring of 1976, or whether the NHSPG had much impact on the Party's policy making.

Rather, apart from on the issue of responding to the Labour Government's policy on pay beds, the evidence suggests that work in reviewing policies on the form of the NHS did not begin in earnest until Jenkin became the LCC social services spokesman, and that he personally took the lead in formulating the policy to modify the structure of the NHS that had been enacted under the previous Conservative Government.

In reaching his views on structure, Jenkin seems to have involved many more "outsiders" than his predecessors between 1964 and 1970 - both regularly visiting hospitals and other NHS services to speak to staff, and forming close working relationships with a number of people with substantial experience of the NHS (for example, Dyson, and members of the "Weaver" group). He also had available as a source of advice the newly formed CMS. Again, though, it is notable that there seemed to be no on-going relationships with professional bodies, such as those representing doctors and NHS administrators.

There is clear evidence that the NHS was of concern at local level: in summarising the response to a consultation with local groups held in October and November 1975, Conservative Central Office reported that "a record number of groups" had met, with twenty percent more groups responding than had done so on the previous, and at the time controversial, issue of trade unions (280). Jenkin has confirmed, from his experience of talking to Conservative constituency groups, that there was indeed considerable local interest in NHS issues (281). (This provides a different perspective than might be gained from study of Conservative Annual Conference reports of the period. At the 1975 and 1976 Conferences there were just brief references to the Labour Government's pay beds policy. There was no discussion of the NHS at the 1977 Conference. Only at the 1978 Conference was there a wide-ranging, though brief, discussion on the Service.)

Although the evidence is too limited to draw a firm conclusion, it seems possible that the views of local Conservatives had more impact on policy development from 1975 than they had had in the 1960s.

- (280) *Summary of Reports on Topic Number 72: The National Health Service*, undated, CPA CC04/10/81.
- (281) conversation with author, 19/11/99. The CPA includes about 150 press releases of Jenkin's speeches and statements as LCC social services spokesman (not all on NHS matters), to which could be added numerous talks given for which there were no press releases.

## CHAPTER 6 - FINAL OBSERVATIONS

In this Chapter, the author has three main objectives: to comment briefly on the evidence upon which the account in the previous chapters is based; to summarise the conclusions he draws from the evidence; and to consider what light the study sheds on contentious issues of interpretation in recent Conservative Party history.

### 1. THE EVIDENCE - STRENGTHS AND DEFICIENCIES

Any study of past events necessarily depends for its evidence on what might be termed relevant survivals - those primary materials and subsequent commentaries which seem to its author to be relevant.

This study is based in large part on archival research, mostly in the CPA (and the related Lord Joseph Archive), the PRO, and the BMAA. In addition, the author was granted access to papers held by the Treasury and Cabinet Office, due to be sent to the PRO in the fullness of time; IEA papers lodged in the Hoover Institution on War, Revolution and Peace, and some papers in private hands listed in the Preface. The author also became aware of other papers likely to be relevant, which were not available to him (1).

From the sources he was able to access, the author has been able to identify, and incorporate into this study, much that seemed to him to be relevant. In all cases his requests to be allowed to quote extracts from material in papers not open to the public were granted without qualification.

(1) especially those of the late Enoch Powell (unavailable while waiting transfer to Churchill College, Cambridge), and Sir Gerard Vaughan (see Chapter 5, note 71).

There are some "gaps" in the evidence: instances where there is clear evidence that a potentially relevant paper had existed but could not be traced by the author (2). Whether this is because the papers no longer exist, or they exist but the author failed to locate them, is uncertain. Within the context of the relevant evidence identified, however, the "gaps" seem relatively minor.

In addition to the archival and other written sources referred to above, the author had the opportunity of discussion with some of those directly involved in the events to which reference has been made. While these discussions were invariably useful, the events to which they related were typically twenty to thirty years ago, and relatively minor in the lives of those involved. Unsurprisingly, individuals' memories were often patchy, and sometimes recollections seemed clearly to be incorrect when checked against other sources. For these reasons, and with no disrespect to the individuals concerned, the author has sought not to rely upon recollections unsupported by other evidence. Where such evidence has not available, recollections have been used with caution (3).

- (2) examples include: Joseph's copy of the report of the Working Party on NHS Finance (see Chapter 3, notes 121 and 122), and the first full draft of the 1979 general election manifesto (Chapter 5, note 160).
- (3) see, for example, the material on the members of the NHSPG, Chapter 5, p. 264.

## 2. CONCLUSIONS

Conclusions on specific issues, such as why Joseph seemed not to have taken any follow up action on the report of the WPNHSF, have been offered in chapters 1 to 5 as appropriate. In this section the author is concerned with conclusions on broader matters.

### 2.1 Was the period one "rich in reflection"?

The period examined in this study was chosen as one likely to be "rich in reflection about the form of the NHS" (4). As with any research endeavour, whether this would prove to be the case was necessarily uncertain at the outset.

As has been shown in the previous chapters, in opposition the NHS, and particularly issues about its form, featured explicitly in the major policy reviews initiated in 1964 and 1975 (and not solely in the discussions of the groups established specifically with the NHS as their remit, but also in those of the ERPG and PSPG and its Manpower Sub-group, for example). In government, two major issues of form - organisational arrangements and funding - were examined extensively, in the former case up to and including cabinet level. In both opposition and government, the discussions included a wide range of views on the issues.

Overall, therefore, in the author's view the period studied was indeed as "rich in reflection" as he had thought likely although, naturally, reflection did not always lead to policy change.

(4) Introduction, p. 2.

## 2.2 The extent to which policy changed

In the author's view, the most striking finding of the study is how difficult the Conservatives found it to move away from the consensual position on the NHS that had become apparent during the 1950s. And this is the more striking given the fact that, among those who contributed to thinking about NHS policy, were Joseph, Howe and Powell, widely regarded as among the more radical of Conservative politicians of the period.

This conservatism was most evident in relation to the financing of the NHS. There is ample evidence that leading Conservatives were clear both that the NHS needed more resources to enable appropriate services to be provided, and about the difficulty of providing those resources when the great majority of funding was via taxation. Despite that clarity, whenever possibilities for change were considered, the potential pitfalls seemed always to loom much larger than the perceived benefits of moving to a more pluralistic funding base, as the Conservatives were aware applied elsewhere, for example in Australia (5).

How is this to be understood? The evidence, right from Macleod's December 1948 memorandum (6), suggests that the Conservatives were aware that the NHS was very popular. It was therefore unsurprising that the Party was cautious about adopting policies that might be viewed as calling into question its commitment to the Service.

(5) see, for example, Chapter 2, p. 84 (note 89) and p. 112.

(6) Introduction, p. 31 (note 91).

Thus for potentially radical Conservatives such as Joseph, there was a constant tension between the belief that change would prove beneficial in the long run, and its possible short term consequences on public opinion. At times Joseph's radicalism seemed to be dominant (for example, in his response to Balniel's paper of September 1968 and his initiative in establishing the WPNHSF (7)). At other times his doubts about how proposals for change would be received by the public were clearly dominant (for example, in his letter to Seldon of November 1965, and his June 1978 comments on the draft of what became the Conservative manifesto for the 1979 general election (8)). If these concerns about public reaction were so great for someone as potentially radical as Joseph, it is unsurprising that over the period as a whole no change in policy resulted.

That the Party was able to adopt and implement major policy change in respect of the organisation of the NHS contrasts with the situation with respect to financing. But so, too, did the wider context. For, as made clear in the previous chapters, during the 1960s there was increasing support for the administrative unification of the NHS, both among health service interests and politicians. Although, as noted, aspects of the precise proposals the Conservative Government sought to enact came under criticism from the Labour Opposition, the end - administrative unification - was a consensual one.

(7) Chapter 2, pp. 92/3 and Chapter 3, p. 152

(8) Chapter 1, p. 43 and Chapter 5, p. 292.

Thus on organisational change the Party's position moved from apparent scepticism about administrative unification (when first considering the Porritt proposals (9)), to one where by early in 1970 the Party's principal spokesmen had indicated broad support for the idea (10). In office after the 1970 general election, Joseph found the DHSS civil servants enthusiastic for unification, which then became arguably his major priority in relation to the Service.

It is important to note the potential linkage between the two issues of financing and organisation for Joseph and, later, Jenkin. There is little doubt that both would have favoured a move away from the largely tax-based financing arrangement for the Service if they could have identified one free of what Joseph referred to as "political difficulty" (11). In the absence of such a way, organisational change at least offered the prospect of improved efficiency and thus enabling some of the pressures for more resources to be met without the allocation of additional tax-derived funding. To that extent, the enthusiasm that both Joseph and Jenkin showed in organisational change can perhaps be viewed as compensating for their inability to see a satisfactory way forward as regards changing the financing basis of the Service.

(9) for example, Chapter 1, p. 48 (Powell), and p. 51 (Joseph).

(10) Chapter 2, pp. 119/120

(11) Chapter 1, p. 43.

### 2.3 The significance of the NHS to the Party

In the previous sections it has been suggested that, for the Conservative Party, the period 1964-1979 was one rich in reflection about the form of the NHS, but that reflection about changes that would have involved a shift from the consensual position reached in the 1950s was simply too radical to lead to policy change. What can be inferred from this about the significance of the NHS for the Party?

By way of context, what might be termed the adequacy of the NHS only began to surface as a public issue in the 1960s, and arguably did not become a significant one until the mid 1970s. Thus concerns about the adequacy of the funding of the Service were initially raised by the medical profession at BMA ARMs in mid 1960s, and gave focus to the work of the Association's Advisory Panel (12). Those concerns were more muted during the Heath Administration, perhaps because of the increases in funding that were announced (13), but became more voluble with the economic difficulties from 1973. By mid 1974 other health professions had joined the doctors in pressing publicly for an independent enquiry into the NHS (14), which the Government conceded in Autumn 1975 with the setting up of the RCNHS (15).

(12) Chapter 2, p. 86.

(13) Chapter 3, pp. 136 and 139.

(14) Chapter 5, p. 280.

(15) *ibid.*, p. 281.

The Conservative Party was, arguably, beginning to give consideration to the issue of the adequacy of the NHS before it had emerged as a public issue. Although the decision to include the NHS in the policy review initiated in 1964 seems to have been a marginal one (16), from the time the HPG was established the NHS was under almost constant consideration by the Party, in opposition and in government. As noted above, a great deal of time was spent in exploring issues of funding and structure.

Further, there is evidence that as the NHS became a matter of public concern, the Party gave it even greater attention. For example, recognising that aspects of the reorganisation effected while in Government were a cause of concern both in the Service and among Party members (17), Jenkin clearly put in a great deal of personal effort to explore matters within the Service and identify proposals for modification that would command wide support. Indeed, there is evidence that Jenkin believed that he had been sufficiently successful in this to warrant publication of a Party policy paper specifically on the NHS (18).

While not in any sense arguing that by 1979 the NHS had become a political issue of dominating importance, either for the electorate or the Conservative Party, there is thus evidence to suggest that it had become markedly more significant for both than it had been in 1964, and that throughout the period it had received close attention by the Party leadership. Further, simply by study of the relevant sections of the Conservative and Labour general election manifestos of the period, it is far from self-evident that the NHS was any less significant to the former than to the latter.

(16) Chapter 1, p. 34.

(17) see, for example, Chapter 5, note 218.

(18) Chapter 5, p. 319

## 2.4 The nature of Conservative Party policy making

This study is primarily concerned with the reflection given to issues relating to the form of the NHS, on which specific conclusions have been presented in Chapters 1-5, and some conclusions on broader issues offered in sections 2.1 to 2.3 above. Seeking the evidence necessarily involved studying the Party's policy making arrangements. What conclusions can be drawn about them?

### 2.4.1 Policy making in opposition

In 1964 and 1975, as described in Chapters 2 and 5, the Party leadership instituted wide-ranging formal policy review programmes, and in both cases the NHS was one of the subjects. The intention of the programmes was that policy groups would be established, their deliberations reviewed by the Party leadership and, if accepted, included in overarching policy documents such as *Putting Britain Right Ahead* or *The Right Approach*, prior to finding place in the general election manifesto.

Both the HPG and the NHSPG were formed much later than most of the groups examining other policy areas, and it is arguable whether either fulfilled the hopes of the Party leadership. As noted in Chapter 2, after Balniel succeeded Pike the HPG was effectively allowed to lapse. As noted in Chapter 3, there is barely evidence that the NHSPG met, still less reported.

Rather than being undertaken via the (broadly similar) models envisaged by the Party leadership in 1964 and 1975, in practice, for much of the time, the conduct of consideration of NHS policies in opposition seems to have become very much a matter for the individual frontbench spokesmen.

From 1967, Balniel and Macmillan personally carried forward the development of policies on structure and financing, and sought to agree these (with only limited success) with the LCC, for example at the Selsdon conference. There does not seem to have been any extensive consultation with either what might be termed the wider Party, or health interest groups such as professional associations and the pharmaceutical industry (this is discussed in section 2.4.3 below).

As Opposition spokesman from 1976, Jenkin met regularly with colleagues in the SSPG, when sometimes NHS policy would be discussed, but he spent much time talking with people in the NHS, and seems to have formed his judgements as to what policy changes were necessary in the light of those discussions. There is no evidence he had any direct contact with the NHSPG as a group, or looked upon it as the primary means through which new policies would be developed, though discussions with Vaughan would have kept him abreast of any emerging conclusions. Although Jenkin spoke to many professional gatherings, and corresponded with, for example, the BMA, as with the period prior to 1970 there is little evidence of any extensive relationships with such bodies.

Overall, for the greater part of the periods of opposition, although notionally part of formal, systematic policy review procedures, the Party's policy making on NHS matters seems to have been characterised more by what might be termed the personal approaches and proposals of the frontbench spokesmen than adherence to the policy group approach envisaged by the Party leadership.

#### 2.4.2 Policy making in government

In office from 1970 to 1974, there were the well-established procedures of cabinet government for policy consideration, and these were followed in respect of the reorganisation of the NHS.

Initially there was discussion between Joseph, as the Secretary of State, and DHSS officials. That was followed by inter-departmental consultations; the issue of a consultative document; meetings with key interests such as the local authority associations and the BMA; discussion and eventual agreement at cabinet level on policy; and publication of a White Paper setting out that policy. As aspects of the policy were contentious among ministers, the process included extensive discussions in cabinet committees and the cabinet itself, as documented in Chapter 3.

As the files in the PRO show, there were extensive discussions about NHS reorganisation with a wide range of professional bodies and other organisations concerned with the NHS, which would appear to be in marked contrast to the situation in opposition. However, as made clear in Chapter 3, much of that was after key decisions had been taken within government, so the contrast is perhaps less marked than might initially be supposed. On the other hand, in these "within government" discussions, it can be hypothesised that DHSS civil servants, knowledgeable about the views of professional and other bodies, were able to ensure that these were taken into account (19).

(19) Chapter 3, p. 222.

### 2.4.3 Policy making - pluralist?

The author's starting frame of reference was a pluralist one - the core assumption of which is that political power is widely distributed.

The evidence set out in Chapters 1-5 suggests that policy review, especially in opposition but also to an extent in office, was an activity involving relatively few people. In opposition, for example, these included the relevant frontbench spokesmen, members of policy groups, and associated CRD officers - perhaps a dozen or so individuals at any point in time.

As to the wider Conservative Party, the evidence is mixed. The Party's ACP discussed aspects of the NHS periodically, and a Parliamentary Party Health and Social Security Committee existed throughout the period. There is, however, little evidence that the PHSSC was particularly active though, as noted above, this may simply be a matter of written records not having been kept. The one clear initiative taken by the Committee was the preparation of the report put to ministers in Spring 1971, referred to briefly in Chapter 3.

At local level, if judged by the contributions to the Party's Annual Conferences (and in some years the NHS was not specifically discussed), it would be difficult to conclude that NHS issues were regarded as of significance. Even when there was a discussion specifically on the Service, typically there were only about six speakers apart from the frontbench spokesman. This may, however, not give a realistic impression of the significance of NHS policies to local Conservatives, and owe more to the constraints on time at the Conferences given the range of subjects to be discussed.

As regards individuals and organisations outside the Party, to the author a surprising finding was how little contact frontbench spokesmen seemed, from the evidence, to have had with key professional bodies such as the BMA, Royal College of Nursing and those representing NHS administrators. There were few indications in the CPA of such contacts, and research in, for example, the BMAA provided little by way of addition. Rather, the evidence suggested that Party spokesmen sought advice from individuals, and on occasion from small, informal groups.

Thus, as documented in Chapters 1-5, there were "outside" experts on policy groups, such as Wiseman and Freeman (HPG) and Rogers and Kember (the PSPG Manpower Sub-group); and contacts with individuals (for example Seldon and Dyson) and groups (the six GPs and Weaver's) knowledgeable about the NHS. In government, too, the Conservatives were able to draw on expert advice other than from the career civil service, for example Meyjes and Jaques.

Overall, the Party's policy making was clearly pluralist in character, though the evidence suggests rather more limited in terms of the involvement of the wider Party and outside interests than the author had expected.

#### **2.4.4 Policy making - the contribution of "outsiders"**

Given that individuals and groups from outside the Party, exemplified above, seem clearly to have been part of the Party's policy consideration process, can any conclusions be reached as to the significance of their contributions?

From the available evidence - and particularly minutes of meetings where frontbench spokesmen discussed papers by, for example, Wiseman and, later, members of the "Weaver" group referred to in Chapters 1 and 5 respectively - there is no very clear indication that these discussions were major contributors to the development of policy.

On the issue of financing, for example, Wiseman's ideas for moving aspects of the NHS to an insurance basis seem not to have been picked up at all, and his membership of the HPG was, as noted in Chapter 2 (20), relatively short-lived, whether at his instigation or the Party's is unclear. Similarly, the IEA's involvement with Joseph, both in opposition and office, seems to have had little impact, as noted in Chapters 1 and 3, even if, as suggested, Cockett was incorrect in reporting a falling out between Joseph and Seldon (21).

The situation seems to have been broadly similar in respect of NHS organisation. In office, expert advisers such as Meyjes and Jaques seem clearly to have had less impact on Joseph's thinking as Secretary of State than his civil servants. In opposition, although Jenkin, for example, had numerous contacts with outside experts such as Rogers and Kember, it is not at all clear from the available evidence that any played a major part in the development of his policy proposals.

(20) p. 62 (note 20).

(21) Chapter 3, p. 162 (note 126).

Why the various outside experts involved in Conservative thinking about the NHS in opposition and in government seem to have had only minor impact on the development of policy is far from fully clear. The basic presumption can only be that their ideas were out of line with the responsible minister or shadow minister's sense of what was politically desirable and/or feasible. And this was not always because they seemed too radical. For while Wiseman and Seldon's ideas in respect of NHS financing, and Meyjes and Jaques' in relation to NHS organisation, might be thought of as having been too radical for Joseph, the advice about organisational change from Rogers and Kember, for example, in the context of the PSPG Manpower Sub-group, was clearly more conservative than Jenkin thought was required adequately to address the difficulties being experienced with aspects of the reorganised NHS.

#### 2.4.5 Policy making - conclusions

It has been suggested above that, in opposition, and arguably in government, policy making was pluralist in character, albeit with less involvement of the wider Conservative Party and outside interests by Party frontbench spokesmen than the author had expected.

The evidence also suggests to the author that the potential significance of the individual in role as Party spokesman could be very great. Thus, while it is difficult to identify any of the Party's policy changes - or decisions not to change policy - to some of those who were the principal frontbench spokesmen over the period (for example, Pike, Balniel and to a lesser extent Howe and Fowler), the personal contributions of others (Joseph and Jenkin) seem to have been substantial.

Joseph's principal contribution was in respect of the reorganisation of the NHS. In government from June 1970, the Party had no formal policy commitment to unify the administration of the NHS. However, as described in Chapter 3, Joseph, an initially sceptical Secretary of State, became personally committed to such a policy, was able to gain Cabinet agreement to it, and was central to the key decisions (22).

Similarly, the evidence suggests that Jenkin, as LCC spokesman from 1976, can be identified as having made a significant personal contribution to the adoption of proposals to address difficulties experienced in practice with the re-organised structure; proposals that were more radical than that of the Labour Government, despite the concerns they had expressed in opposition; and proposals which he was later to carry forward into formal government policy.

### **3. THE STUDY AND ISSUES OF INTERPRETATION IN RECENT CONSERVATIVE PARTY HISTORY**

There is agreement among commentators on the broad history of the development of what Lowe has termed the Conservative Party's political strategy, though there is considerable disagreement on some aspects. The broad history and areas of disagreement can be summarised as follows.

- a) During the 1940s (with disagreement over exactly when), the Party seemed to commit itself to a greater role for government than had hitherto been the norm in peacetime. Key elements of the enhanced role were the management of the economy to secure high and stable levels of employment, and to make Britain into a "Welfare State".

(22) Chapter 3, p. 220.

- b) That commitment was shown to be real when the Conservatives next achieved office, in 1951, and was sustained by successive Conservative Governments to 1964. During this period of thirteen years there was broad consensus between the two major parties on the appropriateness of "the managed economy" and the "Welfare State" (though the exact nature and extent of this consensus are matters of contention).
- c) At some point after the 1964 general election, (exactly when being another subject of contention), the interest of some within the Party in reducing the role of government called into question the nature of its commitment to "the managed economy" and the "Welfare State" (the extent to which the commitment was called into question, and to which it was modified, being further issues of contention).

The Introduction to this thesis offers some comments on (a) and (b) above suggesting, for example, that from the point of view of favouring a national health service, the Conservative commitment was a product of thinking during the Second World War, and owed nothing to the subsequent policy reviews associated with RA Butler.

The body of the thesis covers the period relevant to (c) above, and it is to offer some tentative conclusions from the narrow perspective of the research summarised in this thesis that the remainder of this Chapter is concerned.

To develop the thinking summarised in (c) more fully, there seem to be two main views. Some have seen the shift in the political strategy of the Conservative Party as dating from Thatcher's election as Leader in February 1975, while others date it up to ten years earlier.

As noted above, writing specifically about the Conservative approach to welfare (including the NHS), Lowe has characterised the political strategy of the Party from the 1940s as "reluctant collectivism", an essentially pragmatic approach following the realisation in the 1940s that "for a variety of economic and political reasons, the market was no longer working in the ideal way assumed by classical economic theorists" and that "greater state regulation" was necessary to avoid "an unacceptable level of economic waste and social distress". Although renewed enthusiasm for markets (the basis of a different political strategy which Lowe has termed "the New Right") "temporarily influenced Conservative government policy between 1970 and 1972", "reluctant collectivism" as a political strategy "dominated the Party until Margaret Thatcher's election as leader in 1975" (23).

Behrens, writing about the Conservative political strategy generally, has taken broadly the same view. As noted in Chapter 4, he has characterised those taking part in "debate about what to conserve" after the loss of office in 1974 as "Diehards" and "Ditchers", the former favouring "the eternal principles of limited government", the latter (essentially Lowe's "reluctant collectivists") judging after the Second World War "that intervention by the state [was] ... unavoidable in a society determined not to return to inter-war maladies". In Behrens' view, "the Diehards viewed post-war Conservatism as merely an alternative form of socialism", and were only able to achieve some measure of change in the Party's policy strategy after Thatcher became leader (24).

(23) Lowe, 1999, pp. 16/9 and 23/4.

(24) Behrens, 1980, p. 3.

Among Conservative politicians, it is clear that both Thatcher and Joseph held views consistent with Behrens' interpretation. Before Thatcher succeeded Heath as Party Leader, both she and Joseph had publicly stated that, over the previous decade there had been too much "socialism" in Conservative policies (25).

Lowe and Behrens share the view is that from the 1940s to 1975 the dominant political strategy within the Conservative Party was essentially "reluctant collectivism", and that thereafter "the New Right" became influential, perhaps even dominant.

A rather different view has been expressed by Blake, for whom the shift from "Butskellism, if it had ever existed", came after Heath was elected Party Leader. For Blake, the policy strategy Heath developed as Leader marked "a clear ideological cleavage", and Thatcher's strategy was essentially similar to Heath's in "content and theme". Blake has supported his view by specifying what he saw as the main themes of Heath's programme: "lower direct taxation; less governmental interference; reduction in public expenditure; selectivity in the social services and a shift in the burden from the Treasury to the employers; legislation to restrain the power of the unions; and entry to the EEC" (26). With the exception of shifting the burden of social service costs to employers, all of Heath's other themes were included in the first Conservative general election manifesto under Thatcher's leadership (27).

(25) for example, Joseph's speech at Upminster, 22/6/74 (Joseph, 1974, pp. 5/10) and Thatcher's "My Kind of Tory Party" article, *Daily Telegraph*, 30/1/75.

(26) Blake, 1985, p. 301.

(27) 1979 general election manifesto, Craig, 1990, p. 272 (lower direct taxation); p. 267 (less governmental interference); p. 269 (reduction in public expenditure); p. 268 (selectivity in the social services); pp. 270/1 (legislation to restrain the power of the trade unions); pp. 281/2 (membership of the EEC).

Ramsden has broadly agreed with Blake's view. In his judgement, "Thatcher's rhetoric and programme in 1979 were not at all unlike that offered by Heath in 1970" (28). For Ramsden, what distinguished the programme developed under Heath's leadership from that developed under Thatcher's was not its content. Rather, it was that Thatcher's "was underpinned by an intellectual and media consensus ... that Heath never enjoyed in his first two turbulent years in office", which enabled the Thatcher Government to stick with policies rather than bend to criticism (29).

Among politicians, Tebbit seemed to share the Blake/Ramsden view. As noted in Chapter 2, he referred to the programme adopted at the LCC weekend at Selsdon as "the Tory Party's first repudiation of the post-war Butskellite consensus ... [a commitment] to the new liberal economics" (30).

Thus there would seem to be broad agreement that the dominance of the political strategy of "reluctant collectivism" was challenged by those who favoured an at least partial drawing back from what some have referred to as "socialism". The disagreement is over when the challenge impacted.

Does the research summarised in Chapters 1 to 5 throw any light on these matters? In the author's view, the answer has to be "only to a very limited extent". From 1965 to 1979 there were regular considerations both of different structures for the Service, and alternatives to the essentially tax and Contribution based funding arrangement enacted in 1946.

(28) Ramsden J, *An Appetite for Power*, 1998, London, HarperCollins, p. 401.

(29) *ibid.*, p. 402.

(30) Tebbit, 1988, p. 94.

As discussed in Chapters 1 to 3, the Party's developing policy on the structural integration of the NHS was, in broad terms, part of an emerging political and NHS-interests consensus, and therefore not a distinctively radical policy. Proposing an alternative financing basis to taxation and Contributions would, however, have represented radical changes.

In the period prior to 1970, both Balniel and Macmillan developed such ideas which were put to Heath, but secured no support. During the early years of the Heath Government, Joseph's interest resulted in the establishment of a civil service Working Party on NHS Finance but, as noted in Chapter 3, by the time its report was completed Joseph seemed to have decided not to pursue matters.

By contrast, under Thatcher's leadership, as noted in Chapter 5, although the economically liberal-inclined Jenkin expressed dissatisfaction with existing funding arrangements and interest in alternatives, he seems not to have led any substantial work to explore possibilities.

This could be seen as support for Blake's view that, from as early as 1965, policies could be considered from a different perspective. As noted in the Introduction and Chapter 1, however, consideration had been given to alternative financing possibilities during ministerial discussions, and in the Party officer-based PCFSS, well before Heath became Leader. To the author, the evidence suggests that the considerations given to alternative funding arrangements under Heath's leadership sprang more from the same practical concern - how to find ways of easing the pressure on the Exchequer for more NHS funding - than from a distinct shift in political strategy or ideological cleavage.

The work put in hand in 1970 by Joseph may have had more of an ideological origin - for Joseph has clearly had some sympathy with economic liberalism since the mid 1960s. The fact that Joseph seemed to have decided not to pursue the issue after the WPNHSF reported suggests that, at this stage, any ideological wish for change was far from strong.

The timing of work on what could, potentially, have been radical change in the form of the NHS thus seems to offer no very clear support to either what for convenience might be termed the Lowe/Behrens interpretation, or to the Blake/Ramsden one.

In fact, as evidenced in Chapters 1 to 5, no proposals for change in financing arrangements became Party policy between 1964 and 1979. Does this call into question the common ground of the two interpretations, namely that at some stage before 1979 the political strategy of "reluctant collectivism" came under challenge?

Here, the answer has to be an unequivocal "no". Neither of the broad interpretations argues that, prior to 1979, those within the Conservative Party dissatisfied with its "reluctant collectivism" became sufficiently dominant as to be able to secure radical change in Party policy across the board. Behrens, for example, has suggested that policy change "was limited by the consensus over the form of conversation in Conservative politics, by the existence of a consensus between Diehards and Ditchers in some policy fields and by the caution of Mrs Thatcher's Diehard leadership" (31).

(31) Behrens, 1980, p. 5.

While all are agreed that there was change in respect of some key policies, that the financing arrangements of the NHS was not one of them in no way invalidates the broad interpretation of a modified overall political strategy.

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