Some Problems of Integration in the Hospital Service in N. Ireland

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(*Read before the Society in Belfast on April 20th, 1956*)

To attempt a comprehensive and analytical survey of the operation of the Hospital Service in N Ireland is a task beyond the scope of this paper Nevertheless the publication of the report of the Guillebaud committee of enquiry[1] into the cost of the National Health Service in Britain following the earlier publication of the Tanner committee's report[2] on the Health Services in N Ireland has raised many questions of importance, some of which need public discussion in such a society as this

The hospital and specialist services absorb the major portion of the Exchequer expenditure on the National Health Service, so it is not unnatural that they attract the greater attention

Table I gives the percentage distribution of estimated expenditure on the different branches of the Health Services from funds voted by Parliament for the year 1954–55 Although the expenditure on administration as such is a very small proportion of the total, it only includes the amount spent on the administration at the centre

TABLE I

Percentage distribution of gross expenditure estimated to be spent from Parliamentary votes on the Health Services in N Ireland in 1954/5

Type of Expenditure	%
N Ireland Hospitals Authority	
Hospital Services—Revenue	46 1
,, ,, —Capital	10 5
Eye Services and Laboratory Services	1 8
Special Care Service	1 1
Administration	0 7
TOTAL	60 2
N Ireland Tuberculosis Authority	
Hospital Services	4 5
Mass Radiography and other Services	0 3
Administration	0 3
TOTAL	5 1
Genaral Health Services Board	
General Medical Services	13 1
,, Dental ,,	4 1
,, Pharmaceutical Services	11 6
Administration	0 9
TOTAL	29 7
Grants to local Health Authorities	2 5
All other expenditure including Civil Defence	2 5
GRAND TOTAL	100 0

NOTE Gross estimated expenditure=£13,151 640 13 2 per cent of which would be offset by appropriations in aid represented by various charges for certain services

[1] Report of Committee of Inquiry into the cost of the National Health Service Cmd 9663 (1956)

[2] Report of the Committee on the Health Services in N Ireland Cmd 334 (1955)

The problem of co-ordinating and integrating the hospital service is one of importance, and although it may not be possible to indicate concretely the financial advantages of closer integration, several points of policy in relation to administration and structure arise If satisfactory decisions had been made on these, the result could have been greater efficiency and a more economic use of scarce resources

Numerous criticisms have been brought against the existing structure of management in the hospital service In particular the three-tier organisation of responsibility by the Ministry of Health and Local Government at the top level, by the Hospitals Authority at the second tier, and the Hospital Management committees below appear to be an unnecessary complication of administrative effort Although the pattern was copied from the English and Scottish structure, significant differences were deliberately introduced The basic legal difference was that unlike the English system, where the Minister owns the hospitals, is responsible for policy, and delegates his powers to the Regional Boards and the Management committees, the Hospitals Authority is not an agent but a statutory body, owning the hospitals, deciding policy and delegating some of its powers to management committees This did involve theoretically a greater degree of independence of Parliamentary and Ministerial control, though in practice this independence has not always been clearly established in view of some of the Parliamentary questions that have been put to the Minister and the relatively detailed control that has had to emerge as a consequence of ministerial control of expenditure

In presenting his proposals for the control of the hospitals in the public service in the House in October, 1947, the Minister of Health and Local Government emphasised two points, namely, that the transfer of voluntary hospitals was not being made to the State as such but to an Authority independent of the Government and that the refusal to follow " step by step " with the British legislation was deliberate Another unexpressed factor that must have influenced the decision was the reluctance of the consultants to have contracts of employment with a Government department with the possible consequence that they might thus find themselves legally classified as civil servants None the less the financial control of most of the expenditure on the Hospital Services lies ultimately with Parliament, since the necessary funds are voted annually The power to refuse finance must in practice mean the power to refuse consent to policy The enforcement of civil service practices of accounting and auditing rather than commercial forms combined with the fact that the practices of " surcharge " so dear to the hearts of the central government in its relations with the local authorities, has not been included in the pattern of accounting, all seem to indicate that the ultimate financial authority is clearly intended to rest with Parliament and its traditional forms of control of supply expenditure The interesting but perhaps hypothetical problem remains Who does in fact accept the final responsibility ? Will the Public Accounts Committee one day hold the Permanent Secretary of the Ministry of Health and Local Government responsible as " Accounting Officer " for the failure of the administration of Hospital X to account for the disposal of the " swill " and exercise its rarely used constitutional right of surcharging him as the only officer who may be legally compelled to pay ?

Furthermore an examination of the Health Services Act (N Ireland), 1948, will reveal the numerous duties laid upon the Ministry to make regulations about a great variety of matters ranging from charges for appliances and travelling expenses for patients to the forms of accounts and the superannuation of officers in the employ of the Authority Similarly frequent statutory reference is made to the necessity of seeking the Ministry's approval for action by the Authority

The situation that existed in Britain at the time of the nationalisation of the hospitals made it clear that the direct administration of some 2,800 hospitals in England and Wales, and 410 in Scotland by a central government department was impossible and in default of handing the hospitals over to the local authorities, which was politically impossible, some form of regional planning authority was essential as the second tier, with a third tier of units grouped geographically to ensure local control of day to day administration None the less the second and third tier organisations remained agents of the Minister carrying out delegated functions Exceptions were made in England and Wales in favour of the teaching hospitals, whose Boards of Governors were given direct access to the Minister This policy was not followed in Scotland, where the removal of the teaching hospitals would have left the regions seriously handicapped in planning an adequate service, since 15 per cent of all hospital beds in Scotland are to be found in the twelve teaching hospitals, whereas in England and Wales the proportion is only 5 per cent

In N Ireland the need for a regional planning authority seems weak on the basis of efficient and economic administration, though its existence may be defended on other grounds Theoretically it appears that the balance between freedom and control of the smallest units of administration might equally have been achieved by a two-tier structure as a three-tier one The Tanner Committee's[3] dismissal of this proposal seems abrupt and does not take account of certain factors The assumption that little saving would be achieved in administrative staff is stated without much supporting evidence and a doubt is expressed about the more rapid conduct of business as a consequence It is not clear whether this view was based on the findings of the Authority's own committee whose report is reproduced in their Seventh Annual Report[4] In answer to the general query about the headquarters Administration a comparison of staffs employed is made with the staffs employed by the Liverpool and Manchester Regional Hospital Boards (See Table II) It is admitted that the population and numbers of hospitals and beds of these regions is far larger than in N Ireland (see Table III) , a number of qualifying factors are mentioned on the one hand the absence of any responsibility in N Ireland for the eight Tuberculosis hospitals under the N Ireland Tuberculosis Authority, and on the other, the additional responsibilities of the Authority for such services as the teaching hospitals, Ambulances, Eye Services, and Special Care Work and the more extensive capital programme that N Ireland has been permitted to develop The additional excuses of a larger membership and a record number of meetings of committees and sub-committees lead the Tanner committee in their subsequent

[3] op cit Cmd 334, p 28
[4] N Ireland Hospitals Authority, 7th Annual Report, pp 133-7

recommendations to suggest a reduction on both these points The other reasons for larger Headquarters staff, such as greater responsibility for the work and the accounts of Management committees, are hard to evaluate without a detailed enquiry by " organisation and methods " technique The final conclusion of the Authority's committee to reduce the legal department which is recorded as having only four members appears on the surface to be almost a sop to Cerberus

TABLE II

Comparison of officers employed by the N Ireland Hospitals Authority and three English Regional Boards

Departments	N Ireland Hospitals Authority	Liverpool Regional Board	Manchester Regional Board	Oxford Regional Board
General Administration	39	37	33	59
Accounts	24	20	15	
Engineering	11	18	5	16
Architectural	9	25	16	
Legal	4	3	3	—
Typists	19	13	14	9
Registry, etc	9	6	11	8
Cleaners	5 (P T)	6 (P T)	12 (P T)	10 (P T)
Audit	8	—	—	—
Eye Services	20	—	—	—
Canteen	—	—	6	3 (P T)
TOTAL	148	128	115	105

TABLE III

Comparison of Population, Hospitals, Beds and Management Committees of same areas—31st December, 1953

	N Ireland Hospitals Authority	Liverpool Regional Board	Manchester Regional Board
Population of Area	1,370 932	2,103,000	4,373,000
Number of Hospitals	67 (*a*)	95 (*b*)	192 (*b*)
Number of Beds	14 307	23 549	45,507
Number of Hospital Management Committees	30	19	33

(*a*) Excluding 8 Tuberculosis hospitals but including 3 Special Care Institutions

(*b*) Excluding Teaching Hospitals

A comparison with the three regions whose population and bed complement is more closely related in size to N Ireland gives some interesting points (see Table IV) One fact that does emerge is the failure to merge the local units of administration into reasonably sized groups The S East Scottish region with the teaching hospitals in Edinburgh included has more hospitals with a lower bed complement to administer and yet does so with nearly half the number of management committees

TABLE IV

Comparison of N Ireland with one Scottish and two English Regional Hospital Board areas, 31st December 1953

	N Ireland	S East Scotland	East Anglia	Oxford
Population	1,370,932	1,136 000	1 463,000	1,458,000
Number of Hospitals	67(*a*)	85	108(*b*)	105(*b*)
Number of Beds	14,307(*a*)	12 677	14,584(*b*)	14,120
Number of Management Committees	30	16	14	16

(*a*) Excluding 8 Tuberculosis hospitals with 1,000 beds and including 3 special care Institutions with 302 beds

(*b*) Excluding the Teaching Hospitals

The Authority were presented with a difficult task in organising the management committees in 1949 Two broad principles were used in England and Wales, the first produced a mixed or "all-purpose" group in which all hospitals in a particular district were brought under a single management committee, and the second divided the hospitals on functional lines so that specialist hospitals were grouped separately In N Ireland the Authority adopted the first principle for all hospitals in the country areas outside Belfast with the exception of the mental hospitals, which have separate management committees This decision does involve the danger of failing to integrate the mental hospitals into the general system and perhaps presenting the double standard of hospital care which was one of the legacies of the past in some areas The tuberculosis hospitals outside the Belfast area had already been taken over and were administered separately by the N Ireland Tuberculosis Authority None the less the span of management that was chosen was rather limited as 16 management committees were set up for 43 hospitals often with only two hospitals under one committee (see Table V) This was a degree of decentralisation beyond that contemplated under the English and Scottish schemes and raises the issue whether a group of two hospitals with less than 250 beds under its control can be considered as an efficient third-tier unit, both from the point of view of attracting the right kind of staff to administer it and of achieving the economy of spreading other overhead costs over larger units Only eight of the existing management committees outside Belfast have more than 250 beds under their control, and only two out of eight have more than 500 beds Two of these management committees control a single hospital, and seven of the remaining fourteen have introduced a fourth tier of administration by appointing hospital committees for individual hospitals No doubt the pressure of local loyalties in the countryside created a resistance to wider units of administration but the proliferation of management and hospital committees has been criticised by the Tanner Committee[5] and by implication was rejected by the Regional Hospitals Council's Red Book[6] pub-

[5] op cit Cmd 334, pp 37 8

[6] N Ireland Regional Hospitals Council The Red Book, a Plan for Hospital Services, 1946

lished two years before the Health Services Act (N Ireland) was passed Its recommendations for nine Hospital Catchment areas outside Belfast based on developing nine provincial hospitals sited in selected towns were more appropriate to the development of an efficient regional service

TABLE V

Management Committees under the N Ireland Hospitals Authority Expenditure for public and "free" funds for the year ending 31st December, 1954

Management Committee		No in Group of		Expenditure from		Expenditure from Endowments and gifts as	
		Hospitals	Beds	Public Funds	Endowments and Gifts	Percentage of total expenditure	Per bed in group
	1	2	3	4 £	5 £	6	7 £
1	Belfast	4	1,149	1,049,674	63,246	5 7	55 044
2	Belfast Opthalmic and Benn	2	92	48,574	200	0 4	2 174
3	Forster Green Hospital	1	207	97 961	1,168	1 2	5 643
4	N I Fever	2	394	167,279	79	0 005	0 2
5	Samaritan Hospital	1	56	35,508	4,907	12 1	87 625
6	South Belfast	3	2,050	1,149,970	223	0 0002	0 108
7	Ulster Hospital	1	109	62,680	615	0 9	5 642
8	Banbridge and Dromore	2	194	105,435	482	0 46	2 485
9	Coleraine and Portrush	4	187	107,094	1,444	1 33	7 722
10	Downpatrick	2	134	71,583	544	0 75	4 06
11	East Antrim	4	260	120,978	762	0 63	2 930
12	Fermanagh	2	222	120,444	1,088	0 90	4 901
13	Mid Antrim	5	593	208,819	458	0 22	0 772
14	Mid Ulster	1	173	95,785	944	0 98	5 457
15	North Antrim	3	278	100,360	12	*	*
16	North Armagh	2	283	152,762	1,368	0 89	4 834
17	North Down	2	348	210,169	—	—	—
18	North West	4	514	255,812	7,666	2 91	14 914
19	South Antrim	2	236	105,152	917	0 86	3 886
20	South Armagh	2	161	56,308	137	0 24	0 851
21	South Down	3	283	143,931	—	—	—
22	South Tyrone	1	157	75,040	—	—	—
23	West Tyrone (Mental Hosps)	4	306	152,118	326	0 21	1 065
24	Downshire	1	1,008	270,786	—	—	—
25	Holywell	1	799	228,270	17	*	*
26	Londonderry and Granshaw	1	637	187,918	99	0 053	0 155
27	Purdysburn	1	1,780	394,187	—	—	—
28	St Luke's	1	673	203,226	55	0 027	0 082
29	Tyrone and Fermanagh	1	998	273,516	278	0 1	0 279
30	Special Care	3	294	146,915	20	*	*

Summary of Expenditure from Endowments and Gifts accounts by area and groups 1954

	Total Expenditure from Endowments and Gifts	Bed Complement	Expenditure per bed
	£		£
Belfast Area	70 438	4 057	17 362
Belfast area without Belfast H M C	7 192	2,908	2 43
Country areas excluding Mental Hospitals	16 148	4,320	3 738
Mental Hospitals	469	6,189	0 076
Total for all Hospitals	94 474	17,474	5 394
Total for all Hospitals without Belfast H M C	31,001	16,325	1 899

In the Belfast area the pressure of the voluntary hospitals appears to have ensured a grouping which bears little relation to geographical considerations nor does the theory of complementary functions to be played by different hospitals in each group seem to have been followed except in the teaching hospital group Apart from the two large units of control under the Belfast and the South Belfast Management committees, five separate units were created for specialist hospitals two of which have a bed complement of less than 100 One of the larger units adopted a system of hospital committees, and the largest group with 2,050 beds is the only one to reach the size considered appropriate by the Institute of Hospital Administrators for an urban group [7]

The group system of administration has been generally accepted as the necessary price of effective co-ordination in a modern hospital service Even in parts of the United States, where the term " a national health service " is anathema, the pressure of developments has made voluntary hospitals in some of the large cities enter into negotiations for the provision of co-ordinated facilities There are undoubted difficulties to be faced in the group system The integration into a single unit of hospitals with different traditions and background is a task requiring skill and tact At the outset the Authority had to face legal proceedings about a proposed merger of a voluntary hospital and a former Poor Law institution under the one management committee The Court could find no grounds on which to issue the injunction to restrain the Authority in its action[8] and the merger became effective A similar grouping based on much closer proximity in Belfast was skilfully avoided—no doubt on the grounds mentioned

[7] Administration of the Hospital Service (Institute of Hospital Administrators), 1951, p 20

[8] Second Report of N Ireland Hospitals Authority, pp 28 9

in the case above that character and association of the voluntary hospitals concerned would not be preserved by such unity

The report of the Institute of Hospital Administrators[9] asserts that the experience of the group system has proved to be successful Sectional loyalties of separate hospitals have been successfully subordinated to the ease of belonging to the group in spite of a fairly large scale growth of house committees In some cases these exercise executive functions with an important range of delegated powers though in others they are only advisory Any detailed examination of this problem in N Ireland would require the patience of a Job and the tact of an Admirable Crichton The deep and sometimes passionate local and institutional loyalties of the Ulsterman may be a strong factor in delaying successful integration Similarly the high representation on management committees of the consultant profession, whose loyalties in the past have been given to a single institution, has been a factor in delaying effective integration Where one large hospital dominates the group, there must always be a tendency to forget the smaller units on the periphery, unless they have some form of direct representation, which itself may lead to a form of sectionalism

This paper is not the appropriate place to examine in the detail the subtle and ever present administrative problem of the relationship between the officers in all tiers of the hospital service, but in relation to the points that have already been made there is need to emphasise the fact that an integrated and unified service for all classes of officer has not been created or contemplated Theoretically the Hospitals Authority are the employers of all hospital officers, and in addition to appointing the Headquarters staff, are responsible wholly or in part for all senior medical staff and other appointments which carry a salary of more than £700 per annum Otherwise hospital management committees make the junior appointments and are taken into consultation in the case of senior appointments Consequently no uniform and effective standard of entry can be laid down for junior administrative appointments and few management groups are large enough to organise an appropriate form of entry, training and promotion, which can equal that of the Civil Service or a large local authority such as Belfast A service common to all the hospitals as well as to the Headquarters staff, with interchange and interhospital promotion, might have rapidly developed a common loyalty to a unified service The practical difficulties in the way of adopting such a scheme were enormous, since the staff of all the hospitals, that were taken over in 1948, were tied by contract and sentiment to their separate hospitals and few would have been willing to risk the chance of a transfer No doubt management committees, although aware of the Authority as their principal and the employer of their staff, view with grave concern any infringement of their close relationship with their administrative staff and would be more than reluctant to see any system of interchange of promotion from one group to another by decree of the employing body The absence of any Whitley council machinery for the negotiation of salaries and conditions is another factor in delaying any feeling of integration in the administrative and allied branches of the Hospital service Decisions of the Whitley

[9] op cit , p 16

council in England are accepted and applied The Authority has a special committee for negotiating with the trade unions, but joint consultation as it has developed in other branches of the public service is untried and largely unknown

Another problem which influences the general picture of integration springs from Parliament's decision in 1948 to leave hospital endowments under the control of the separate Management committees or, where they so determined, under the control of an individual hospital committee Subsequent legislation[10] drew a distinction between " general " and " special " endowments Special endowments were those that could be used only for a specific purpose laid down by the donor General endowments were not so limited and could be used for any purpose in connection with the hospital A hospital's liabilities in 1948 which should have been met from endowment funds would not have to be paid out of special endowments but only out of any sum in excess of £3,000 of general endowments This arrangement was in strong contrast to both the English and Scottish schemes for dealing with endowments In both cases a measure of redistribution has been achieved whereby each hospital in the service has some income from endowments to spend The Tanner committee[11] in its report made a very strong recommendation that a measure of redistribution should take place in N Ireland Table V, compiled from facts given in the latest published report of the Hospitals Authority, illustrates the wide disparity of resources from endowments and gifts with a consequent difference in standards of amenity On the assumption that the basic needs of the hospital are now covered by public funds (though even in this respect there are some disturbing differences of standards), the expenditure from free funds must represent definite advantages to a patients in the form of such amenities as flowers, pictures, armchairs and wireless and television service or grants for after-care, or on the other hand better amenities for the staff Differences in accommodation for nursing and other resident staff are already a cause of dismay since the same deduction is made from a nurse's salary regardless of differences in standards of accommodation in nurses' homes Further expenditure from free funds for the privileged hospitals in such forms should not be approved until the leeway elsewhere has been made up The comparison given to Table V based on expenditure per bed is the only one that can be made in view of the paucity of information available, but it is reasonable in the light of the above consideration regardless of whether it is spent for revenue or capital purposes The Authority does expect contributions from hospitals with substantial endowments towards capital developments In the projected capital programme for the ten years from 1st April, 1954, out of a total of more than £18,800,000 estimated to be spent on capital development £688,000 (3 7 per cent)[12] is to be found from free funds No clear indication is given in the analysis of capital works completed or in progress during 1954[13] of the proportion of

[10] Health Services (Hospital Endowments) Act, 1951
[11] op cit , p 40 § 129
[12] Seventh Annual Report—N Ireland Hospitals, p 82
[13] Seventh Annual Report—N Ireland Hospitals, p 83

expenditure derived from free funds In the Belfast group the expenditure on capital projects for which the whole or part of the cost was met from free funds was £34,950 which represents 55 3 per cent of the expenditure from free funds recorded during that year One project for rewiring a small specialist hospital cost £2,370 which represented 48 3 per cent of that hospital's expenditure from free funds To compare the list of capital projects financed wholly or partly out of free funds with those financed from public funds fails to show any principle of differentiation Essential developments such as a neurosurgical unit or a biochemistry laboratory were financed from free funds side by side with such " amenity " expenditure as a relatives' rest room and a concert hall On the other hand the provision of a tennis court out of public funds appears unobjectionable The Tanner committee's comments are relevant [14] A hospital with free funds in a large scale is able to secure an element of priority in capital development and build on a more lavish scale, and hence an element of redistribution is necessary if a public service is to have a reasonably uniform standard among the different hospitals Without further information on the extent of special endowments for particular purposes it is impossible to arrive at an accurate estimate of the results of a redistribution on the lines suggested by the Tanner committee, but in the summary at the end of Table V an average based on redistribution of expenditure from these sources in a given year has been worked out and the final figures may be compared with the average amount available for distribution to non-teaching hospitals in England and Wales In the two financial years 1952/3 and 1953/4 the Endowments Fund paid out £666,000, which represented a rate of £1 8s 0d per bed The special position of the teaching hospitals could be safeguarded, though not necessarily on the English pattern by which all their endowments were excluded from the redistribution The Scottish system recommended by the Tanner committee transferred endowments to a specially created Research Trust to produce an income of £100,000 per annum and attempted to secure a minimum endowment income of £2 per bed per annum for each board of management The Guillebaud committee[15] approved the policy of the Ministry of Health in London in not discouraging the expenditure of free funds on purposes for which Exchequer money could properly be used They also appear to see no objections to the principle of spending free funds to secure higher standards of construction or furnishing in projects that are largely financed from Exchequer grants

These facts present a dilemma of policy In 1948 the Minister in introducing the bill at Stormont is understood to have made a binding promise that no redistribution would take place in N Ireland and that individual hospitals, not even management committees, would control their existing endowments Such a promise was possibly part of the price of securing the accession of some of the wealthier hospitals to the scheme, but it has at the same time provided a continuing basis for non-uniform standards and sectional loyalties The same problem is raised by the continuation of appeals for voluntary funds

[14] op cit Cmd 334, p 40, § 129
[15] op cit Cmd 9663, pp 134 136

by bodies other than management committees Parliament rightly considered that public authorities should not be permitted to appeal for funds even for expenditure on the " frills " of the service None the less a number of voluntary organisations closely linked with particular hospitals have either continued to operate since 1948 or have come into existence since then, and raise money from the public by various means Where the expenditure of funds raised by such means is limited to such matters as libraries, radio or television for patients in hospitals and convalescence expenses when they leave hospital, there can be no objection in principle to such subsidies of a public service But, where as the Guillebaud committee implies, expenditure from such source, is an additional subsidy to Exchequer moneys then serious questions are raised What is the line of demarcation between " amenity " and necessity ? Is it a question merely of degree ? To what extent is there a danger that the usual interpretation of the law of charity, whereby charitable funds in general shall not be used to relieve the tax-payer or the ratepayer, is being subtly changed ? It is doubtful whether enough thought has yet been given to the solution of these problems, but in general it can be said that the needs of the patient for extra amenities and satisfactory after-care, and the needs of medical research, should take precedence over staff amenities and elaborate gadgets in the claims on the free funds available In addition more information on how these funds are spent should be generally available

A third major problem, which is of particular significance to N Ireland, has arisen out of the original step to bring all the existing hospitals under a single ownership and control In Britain any intention of setting up a complete state monopoly was disavowed, but in order to be sure of establishing an efficient and adequate service the Minister did take powers to acquire all existing hospitals, which by definition excluded nursing homes run for profit Management boards of hospitals could request the Minister to " disclaim " them as unnecessary to the adequacy of the service in their particular region In England and Wales some 200 such institutions were " disclaimed " with some 10,000 beds These were mostly small hospitals staffed by religious communities or catering for limited sections of the population They included such general hospitals as the Royal Masonic Hospital, the Manor House Hospital maintained for and by the Trade Unions and such mental hospitals as the " Retreat " at York run by the Society of Friends and St Andrew's, Northampton, which used to advertise boldly as for the use of the upper and middle classes only In a number of cases Regional Hospital Boards were permitted to make contractual arrangements with some of these independent hospitals for the treatment of patients, especially convalescent cases One authority[16] mentions a figure of £2 million being spent from public funds in the year 1952/3 on such cases

In N Ireland the Mater Hospital presented a controversial issue, since it was the only Roman Catholic teaching hospital in the United Kingdom If the Minister or the Hospitals' Authority had been given power to disclaim a teaching hospital, the pressure to exclude other hospitals might have given rise to unnecessary controversy Hence

[16] T E Chester Background and Blueprint (Acton Society Trust), 1956, p 18

the decision was taken to go much further than the English legislation and give any hospital the absolute right to opt out of the scheme This decision must have been made in the certain knowledge that no other large hospital would take this step, and in the event the Mater and the U V F hospital were the only two to exercise this right Some may consider it a slight difference that in N Ireland two hospitals opted out whereas in Britain 200 hospitals were disclaimed, but there is the difference in theory that in one case an absolutely free choice was given, in the other the decision was taken by the controlling authority Having decided that a hospital was not necessary to the service in 1948, it is not illogical that subsequently some part of that hospital's facilities should be used and paid for when it was found to be necessary In N Ireland in 1948 any hospital that decided to opt out was warned that it made the choice on the understanding that it would not benefit from the developments of the public service Hence any comparison with the situation in Britain that does not take this into account is not appropriate, nor is any comparison with the State's treatment of voluntary schools or voluntary children's home In these cases the principle adopted was grant aid to voluntary institutions as an alternative to transference to public authorities, but it is clear that Parliament did not consider this as an appropriate alternative in the case of hospitals either in Britain or in N Ireland

A basic conflict of social philosophy thus appeared between the State that demanded ownership of hospital property as the price of efficient control and the board of management which considered that they could not transfer to State ownership property belonging to religious organisations The resultant situation produced two serious anomalies The Mater hospital, in spite of its religious affiliations, had catered for a large mixed population especially in the provision of extern and casualty facilities and was thus faced with serious financial difficulties in view of the rising costs of all types of medical treatment Yet without its facilities a serious problem in providing similar services would have had to be met by the Hospitals Authority in the Belfast Area The second anomaly arose out of the position of the consultant staff of the Mater Hospital Consultant posts advertised by the Authority though theoretically open to all applicants tended to be given to those already associated with hospitals in the National Health Service Although the consultants attached to the Mater were admitted to the Authority's Domiciliary Visits scheme, this did not provide adequate compensation for other opportunities lost and the serious reduction of private practice due to the introduction of the National Health Service Hence this group of consultants found themselves excluded from the status and pecuniary rewards which the new service had made available for this branch of the medical profession not by their own choice but by the decision of the board of management Thus the problem was to what extent within the structure of the Health Services could voluntary organisations, which claim independence, be expected to pay the price of freedom, since public subsidy must involve a degree of public control Could a separate arrangement be made for a single voluntary institution, when all the other voluntary institutions in the same field of social administration accepted the state scheme ? In spite of these

basic considerations the Tanner committee did recommend that some form of contractual relationship should be established whereby the full cost of treating and accommodating patients taken from the Authority's waiting list should be paid from public funds and that a proportion of the Mater Hospital's beds should be reserved for this purpose Thereby it was hoped on what could only be described as grounds of expediency that part of the resources of the independent hospital could be made available to the public service at the price of some control by the public authority over these limited facilities The committee justifiably felt that the continued isolation of a major teaching hospital and the lack of intercourse in medical affairs between the staff of this hospital and the other hospitals in the area was to be regretted and if possible ended

The main difficulty, to which the Tanner committee scarcely refers centres round the right of admission to the beds which would be reserved for national health service patients from the Authority's waiting list Is a free choice to be given to the independent hospital to choose from those waiting lists the most interesting cases for the purpose of teaching medical students ? The old problem of the relation between the voluntary teaching hospitals and the local authority hospitals before 1948 raises a warning on that issue If the teaching hospitals in the public service have theoretically no right to pick and choose, should the independent hospital have that right ? On the other hand if the independent hospital were to accept the patients sent to it by the Authority's officers, would its staff find themselves occupied more and more with chronic cases only ? This might be a possible arrangement in a non-teaching hospital, though it is none the less frustrating from a medical point of view, as the history of the former poor-law hospitals shows Furthermore it is difficult to understand the kind of control that the Tanner committee envisaged when it used the phrase "subject to the Authority's right of inspection to satisfy itself that adequate standards were being observed "[17] Presumably the nursing standards of the Mater Hospital are already subject to inspection and the University Authorities have something to say on the standards of clinical teaching Medical treatment as such is not amenable to inspection especially when it is in the hands of persons of such eminence as consultants To suggest that the lectures of university teachers should be subject to inspection would be an almost comparable case of *lésè majesté* Standards of ward and theatre accommodation no doubt could be inspected but where they proved to be unsatisfactory a mere contractual relationship to pay for treatment and accommodation could do little to improve capital equipment

These considerations amongst others such as further examples of strong sectional loyalties that grew up before 1948 must have prevented a successful outcome to the negotiations which followed the Tanner committee's recommendations The absence of any reasonable *modus vivendi* is another example of the lack of co-ordination in the hospital service in the Belfast area

This paper has been concerned more with raising certain questions rather than providing cut and dried solutions to the problems involved

[17] op cit Cmd 334, p 53, § 181

No one who has taken even a small part in the development of the hospital service in N Ireland since 1948 is unaware of the great advance that has been achieved Capital expenditure on developing existing hospitals and building new ones has been three times as great proportionally as that in England and Wales, the atmosphere of old poor-law hospitals has been decisively improved and the expansion of facilities in the rural areas would have been beyond contemplation in 1939 In particular the number of consultant staff outside Belfast was more than doubled in five years The bare recital of these achievements does not do justice to those who have planned and organised this achievement None the less problems remain and only a limited field has been selected for consideration in this paper An integrated and properly co-ordinated service making full use of the scarce resources available is surely the beginning to the period of consideration that must follow the expansion of the past

DISCUSSION

Mr Andrew Millar proposed a vote of thanks to Mr Neill Referring to the three-tier administration, he said that it had some merit, but it depended entirely upon what each tier did The Ministry should be the co-ordinating power and should be concerned with improvements and capital expenditure There was room for a purely planning body and if the hospitals had been grouped more thoroughly more progress would have been made He was of the opinion that there should be a much better link between the General Practitioner and the hospital service

Professor Alan Stevenson said that he had long had the feeling that the administrative side of hospital work had become so ponderous and self-conscious that they had lost touch with the problem of the quality of the service

Referring to Civil Service control as " the cold hand at the top," he said " It is quite possible the time will come when it will be impossible to get people to serve on management committees or the Hospital Authority, unless a means is found of stopping their ideas being turned down "

He added that but for its endowments, the standard of the Royal Victoria Hospital as a teaching hospital would have fallen greatly under the health service Expenditure on teaching hospitals per bed in Northern Ireland was only about two-fifths what it was in London, though costs there were slightly higher " That cannot go on," he added

Mr T Elwood said that progress in Social affairs since 1911 had been mainly brought about by the administration and not by the medical profession In 1947 the medical profession were opposed to the schemes of the Minister of Health When it was decided to introduce a panel scheme of medical service in Northern Ireland in 1930 the scheme was directly administered by the Ministry of Labour, although there was a three-tier scheme in operation in Great Britain The general view was that direct administration had been very successful

Dr O'Malley said that changes in administration had led to medical progress in a few short years The Mater Hospital Authorities,

however, had not had a free choice, as stated in the paper, but were compelled by circumstances to opt out the scheme Although the medical staff wished to co-operate fully in the service

Mr Mulvey had been assured by Mr Chuter Ede that a clause similar to the Stokes clause in the English Act would be inserted in the Northern Ireland Act This pledge was not honoured by the Northern Ireland Parliament The Authorities of Stormont had also refused to meet the medical staff The hospital was compelled to opt out of the situation and they had done so most reluctantly Relations with the University were one of the bright spots

Mr Neill, in reply, expressed thanks for the comments, and said that the existence of the middle tier must be preserved, but whether it should be preserved in its present form was a matter for further consideration An extension of the University system would hardly be possible owing to the scale of expenditure involved