

**Local Authorities and the Development of the
National Health Service (NHS) in Scotland, 1939 to
1974**

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Abstract

Local authorities were at the forefront of the provision of health services and health service planning before the establishment of the National Health Service (NHS) in Scotland and in Britain more generally in 1948. By 1929 the Local Government Act had consolidated the position of local authorities, who provided a range of hospital services and clinics and carried out public health duties. Furthermore, in Scotland local authorities were influential in the planning of health services. They gave evidence, through their associations and individually, to a range of committees including the *Committee on Scottish Health Services* in the 1930s and the *Committee on Post-War Hospital Problems in Scotland* in the 1940s. Yet, despite their centrality in the provision of health services and their influence on future planning, historians such as Morrice McCrae and Jacqueline Jenkinson have paid little attention to local authorities in their histories of the NHS which stress consensus and the domination of the medical profession and organisations. The Department of Health for Scotland (DHS) was also increasing their role within the provision of health services through the administration of the Highlands and Islands Medical Service (HIMS) and the war-time Emergency Medical Service. As a result the DHS believed that effective administration of health services, particularly the hospitals, could only be achieved through centralisation under their authority. This created competition between the DHS and local authorities over the administration of hospitals, the most prestigious part of the health services. This thesis provides evidence to support the view of Charles Webster and Rudolf Klein that conflict within consensus characterised the establishment of the NHS in Britain. The thesis argues that conflict was evident within the Scottish NHS as it was in the NHS in England and Wales.

The period between 1939 and 1974 witnessed the slow removal of local authorities from the Scottish NHS, initially through negotiations over policy formation. Policy network theory is utilised in this thesis as a tool to analyse the relationship between the DHS and local authorities. Policy network theory suggests that organisations with bargaining resources can influence policy formation in an area in which they have interests, and the policy formation process does not end with the passing of an Act but continues during the implementation process. On this basis local authorities would be expected to have been in a strong position to influence the NHS (Scotland) Act, 1947 and its implementation. This thesis argues that the DHS created a hierarchical relationship with local authorities which prevented them from influencing the development of the NHS in any significant way. The relationship between the DHS and local authorities was both a partnership and hierarchical, making it difficult for local authorities to oppose the proposals put forward by the DHS, particularly the removal of their hospital services. The local authorities' acceptance of assurances from the DHS, that the removal of services from their remit was temporary, resulted in an auxiliary role for them in the NHS (Scotland) Act, 1947.

The implementation process continued the slow removal of local authorities from the administration and planning of health services. Despite local authorities' attempts to increase their influence within the NHS, the DHS (later the Scottish Home and Health Department) regarded local authorities as service providers of peripheral health services. Only in the development of their own areas of responsibility were local authorities able to assert any influence, with the caveat that it did not have an impact on any other part of the NHS. Throughout its implementation, the NHS continually encountered problems of co-operation, co-ordination and clarity in division of responsibility throughout its implementation. The DHS tended to resolve these issues in favour of the hospitals and general practitioners, rather than the local authorities. Despite the DHS' attempt to promote the importance of the local authorities' role in the NHS through publicity, both the

attitude of the DHS and the relatively small proportion of NHS expenditure accounted for by local authorities, led local authorities to see themselves on the periphery of the NHS. The removal of local authorities from the NHS continued in the 1950s and 1960s, encouraged not only by the DHS but also by legislation such as the Social Work (Scotland) Act, 1968, which removed many of their health services including mental health services.

In 1960s the Scottish Home and Health Department (SHHD) came to the view that the inherent administrative problems within the NHS could only be removed through reorganisation. Local authorities had little bargaining power left by this stage and although they attempted to reassert their position within the NHS were effectively removed from the negotiating table. The reorganisation of the health services in 1974 achieved both the Department of Health for Scotland's goal of centralisation and the removal of local authorities from the Scottish health services.

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Abbreviations

ACA	Aberdeen City Archives
BMA	British Medical Association
Cathcart	Committee on Scottish Health Services Report
Cities	Scottish Counties of Cities Association
COSLA	Convention of Scottish Local Authorities
Counties	Association of County Councils
DCA	Dundee City Archives
DHS/Department	Department of Health for Scotland
ECA	Edinburgh City Archives
EHS	Emergency Hospital Service
EMS	Emergency Medical Service
GCA	Glasgow City Archives
GP	General Practitioner
Hetherington	Report of the Committee on Post-War Hospital Problems
HIMS	Highlands and Islands Medical Service
MOH	Medical Officer of Health
NA	National Archives
NAB	National Assistance Board
NAS	National Archives of Scotland
NHS	National Health Service
RHAC	Regional Hospitals Advisory Committee
RHB	Regional Hospital Board
Royal Burghs/Burghs	Convention of Royal Burghs
SHHD	Scottish Home and Health Department
WRVS	Women's Royal Voluntary Service

Introduction

The National Health Service (NHS) today is at the centre of controversies over management, lack of funding, the availability of treatments and the centralisation of specialist services. The problems of the NHS are at the centre of news headlines but they are not new to the evolving health services of the 21st century. Many of the problems in the provision of a comprehensive health care system for the nation have recurred since the inception of the NHS. The ways in which the NHS developed in Scotland from 1948 are particular to 'the health policy arena' and the way in which decision-making took place with regards to the health issues which arose.

The early twentieth century not only witnessed the development of Scottish health services but also the development of a distinctly Scottish state power. Lindsay Paterson argues that despite the establishment of the Secretary of State in 1926, 1920s Scotland was the only region within the UK to be governed by specialist boards, such as the Scottish Board of Health, which formed and implemented policy in an autonomous manner.¹ The reorganisation of these boards under the auspices of the Scottish Office in the 1930s affected the way in which local, regional and national government interacted. Furthermore, Paterson argues that the development of the Scottish Office was in response to three particularly Scottish political conditions: first, the nationalist campaigns of the late nineteenth and early twentieth centuries; second, the inefficiency of the boards and the small size of Scottish local authorities; and, finally, the threat of bolshevism which was epitomised in the support for 'Red Clydeside' in Glasgow.² The realignment of power to the Scottish Office was further bolstered in 1939 when it was relocated from London to Edinburgh and as Paterson comments 'the real power in Scottish politics came to lie with the Scottish Office bureaucrats'.³ Consequently, the development of power in the Scottish Office created a new layer of government with which Scottish local authorities and organisations interacted during the development and implementation of Scottish policies.

The health services were an area in which this realignment of power and political force within the Scottish Office, during the 1920s and 1930s, made an impact as a new stronger layer of government was built up. Prior to the establishment of the NHS, health care was administered at a local level through the Poor Law, local authorities and the voluntary hospitals. The central focus of the Scottish health services, however, began with the establishment of the Scottish Board of Health in 1919 which was later incorporated into the

¹ L. Paterson, *The Autonomy of Modern Scotland*, (Edinburgh, 1994), p. 107.

² Ibid, pp. 107-9.

³ Ibid, p. 109.

Scottish Office. By 1948 the renamed Department of Health for Scotland (DHS) had become a powerful entity in the shaping of health policy and, in conjunction with the Secretaries of State for Scotland, was promoting a new form of centralised administration. The administrative form was realised under the NHS (Scotland) Act of 1947 and the Department entered a new realm of regional power.

In 1939, Scottish local authorities were the main providers of the health services and had built up a range of services such as: infectious disease and general hospitals; specialist clinics for cancer, tuberculosis and venereal disease; maternity and child welfare clinics; and mental health services. As local authorities were at the forefront of provision, the majority of the local authorities thought that a national health service would be administered by them, utilising their expertise in the health field. The way in which local authorities reacted to policy developments in the health service sphere immediately before and during the first twenty-five years of the NHS, however, has not been examined systematically by historians of the NHS. During the period from 1939 to 1974, local authorities in Scotland were represented by three associations: the Convention of Royal Burghs (Burghs), established in the 16th century; the Association of County Councils (Counties), established in 1894; and the Scottish Counties of Cities Association (Cities).⁴ Histories of the Scottish health services by Morrice McCrae and David Hamilton, both doctors, emphasize the impact of the medical profession on the development of the NHS.⁵ They do not consider in detail the role of Scottish local authorities within the policy formation surrounding the Scottish NHS Act, its implementation or the development of the health services. In the two volumes of his official history of the health services in Britain, Charles Webster only touches on the developments of the health service in Scotland and the impact of Scottish local authorities.⁶

The period 1939 to 1974 is particularly significant for the relationship of local authorities to the provision of health services. During the early part of the period, discussions over a comprehensive health service within Scotland were gaining pace, with local authorities at the forefront of health service provision and heavily involved in the discussions over the

⁴ The date of the establishment of the Scottish Counties of Cities Association has been very difficult to obtain, however, counties of cities were officially founded through the Local Government Act, 1929.

⁵ D. Hamilton, *The Healers*, (Edinburgh, 2003) & M. McCrae, *The National Health Service in Scotland: origins and ideals, 1900-1950*, (East Linton, 2003).

⁶ C. Webster, *The Health Services Since the War Vol. I*, (London, 1988) & C. Webster, *The Health Services Since the War Vol II*, (London, 1996).

future of the health services. The impact of local authorities on the NHS policy formation of the 1940s and its implementation in the first 25 years of the NHS changed and the period witnessed the demise of local authorities from the health service sphere. Analysis of the way in which individual local authorities and their associations were involved in the development of the health services will broaden the historiography of the NHS in Scotland beyond the medical profession and voluntary hospitals to include other health service providers and their effect on the development of the NHS.

This thesis will examine the relationship between the formation of policy regarding the NHS, the changes in local authority administrative powers over the health services and the impact these policy and administrative changes had on the realignment of local authority health services. In doing so the thesis will test the hypothesis that local authorities were crowded out of the NHS, not only by the BMA as previous commentators suggest, but also by the Scottish Office through the negotiations which took place during the establishment of the NHS between 1943 and 1974. It will also consider the hypothesis that the removal of health services from local authorities led to realignment in the local authorities' priorities, most notably from the provision of mental health services towards maternity and child welfare services. Prior to considering these issues in later chapters, this chapter will give an introduction to the methodology of the thesis, summarize the archives utilised and outline subsequent chapters.

NHS: Conflict or Consensus?

The distinctiveness of Scottish health services in the early twentieth century is demonstrated through the reports and experiments in social medicine which were established during the period before 1945. At the forefront of ideas and administration of these health services were the Department of Health for Scotland, which had developed out of the Scottish Board of Health established in 1919, and the Scottish local authorities. Although historians agree about the distinctiveness of the health services in Scotland, there is disagreement about the distinctiveness of the NHS (Scotland) Act, 1947. Hamilton stressed that 'though a separate Scottish approach to the practice of medicine and medical education can still be identified in the early part of the century, the post-World War II NHS legislation removed any important decision-making from Scotland'.⁷ Webster also argues that although a separate Act for Scotland was never in doubt, the differences between the

⁷ D. Hamilton, *The Healers*, (Edinburgh, 2003), p. 234.

two Acts were relatively few.⁸ McCrae, like Webster, acknowledges that only two paragraphs of both NHS Acts were different, paragraph 15 excluding London teaching hospitals from the general scheme, and paragraph 46 allowing concessions for the local authorities in England and Wales.⁹ McCrae sees these two paragraphs as being crucial in developing the distinct nature of the Scottish NHS.¹⁰ From this, McCrae suggests that the nature of the Scottish health services was distinct even though the Acts themselves were barely different. Both Hamilton and Webster take the view that only small changes were required to be substituted in the NHS legislation to contend with some particularly Scottish issues, whilst administrative and financial control stayed in Westminster.

Jenkinson contests the views of Hamilton and Webster, arguing that Scottish legislation was distinctive in certain key features. These key features included the powers of the Secretary of State for Scotland who was given 'leading executive powers' over the health services. These are made clear in the first section of the NHS (Scotland) Act 1947, which states:

it shall be the duty of the Secretary of State to promote the establishment in Scotland of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the following provisions of the Act.¹¹

The authorities involved in the administration of the Act in Scotland also differed. In addition, there was no distinction between teaching and non-teaching hospitals: all hospitals, including teaching hospitals, came under the newly created Regional Hospital Boards (RHBs), and a Scottish Health Services Council was created as an advisory body to the Secretary of State.¹²

After the implementation of the NHS (Scotland) Act on 5th July 1948, Jenkinson points out that Scotland maintained its autonomy from the Ministry of Health, despite the pressures

⁸ C. Webster, *The Health Services Since the War Vol. I*, (London, 1988), p. 104.

⁹ M. McCrae, *The National Health Service in Scotland: origins and ideals, 1900-1950*, (East Linton, 2003), p.229.

¹⁰ Ibid, p.229.

¹¹ Scottish Office, *The National Health Service in Scotland 1948-1978*, (Edinburgh, 1978), p. 3.

¹² J. Jenkinson, *Scotland's Health, 1919-1948*, (Oxford, 2002), pp. 439-41.

for centralisation.¹³ Levitt argues that ‘the Scottish Office was never simply an ordinary experiment of state; it had also been created to symbolise the uniqueness of Scottish culture, incorporate Liberal devolutionists into the Union and keep Scottish interests in touch with Westminster’.¹⁴ The autonomy gained through the Scottish Office and Department of Health for Scotland, continued in the post-NHS era. Stewart notes the same features of distinctiveness as Jenkinson. In addition, he argues that official reports such as the Royal Commission on Scottish Affairs acknowledged that ‘the structure of the service in Scotland differs in several material respects from that in England’.¹⁵ The NHS (Scotland) Act 1947 was a distinctive piece of legislation; however, it is the degree of distinctiveness that is challenged in differing historiographies. Through the Highlands and Islands Medical Service (HIMS), the Clyde Basin project, the Committee on Scottish Health Services Report (Cathcart Report) and the distinct differences in the NHS legislation, Scotland managed to remain in control of the health services, which were very specific to the needs of the population.¹⁶

In light of such differences between Scottish and English legislation, the argument between conflict and consensus over the NHS Acts should be reviewed. Historians such as Eckstein, Jenkinson and McCrae argue that the NHS was the result of a consensus among political groups, bureaucratic groups and the medical professions. McCrae stresses that the NHS (Scotland) Act 1947 went through without any conflict as it was based on the Cathcart Report and characterized a consensus that had built up during the previous decades.¹⁷ The consensus that McCrae speaks of is seen through the HIMS, the Cathcart Report and the extension of services through the Emergency Medical Service (EMS) and its related hospitals.

Jenkinson also acknowledges the smooth passing of the NHS (Scotland) Act, attributing this to the autonomy Scottish health services had since before the Scottish Board of Health was established in 1919.¹⁸ She also attributes the relative smoothness of talks within

¹³ J. Jenkinson, ‘Scottish Health Policy 1918-1948 – Paving the Way to a National Health Service.’ in Nottingham, C., *The NHS in Scotland: The Legacy of the Past and the Prospect of the Future*, (Aldershot, 2000), p. 15.

¹⁴ I. Levitt, *The Scottish Office 1919-1959*, (Edinburgh, 1992), p. 65.

¹⁵ J. Stewart, ‘The National Health Service in Scotland 1947 – 74: Scottish or British?’, *Historical Research*, vol. 76, no. 193, (August, 2003), 390.

¹⁶ The HIMS, Clyde Basin Project and Cathcart Report are all Scottish based health services and investigations which will be considered in more depth later in the chapter.

¹⁷ McCrae, *The National Health Service in Scotland*, p. 229.

¹⁸ Jenkinson, *Scotland's Health*, p. 443.

Scotland on the new health services to the strong leadership of Thomas Johnston, Secretary of State for Scotland, and to the HIMS project, which from its inception in 1913, was centrally managed whilst providing a component of GP salaried practice.¹⁹ According to this view, the centralisation of health services dispelled the fears of the Scottish medical profession of local authority control and left no area for conflict as the Scottish medical profession had seen the example of the successes of centralised health services through the HIMS. Levitt argues that the Emergency Hospital Service (EHS), set up during the Second World War, unlike in England where control was given to local authorities, remained with the Department of Health for Scotland thus effectively creating a 'Scottish Hospital Authority'.²⁰ Consequently, centralisation within Scotland was occurring, thus furthering the confidence of the medical profession in the new health services.

Other historians, such as Hamilton, also adhere to the views put forward by McCrae and Jenkinson, noting that the opposition to the NHS proposals was 'muted' within Scotland.²¹ Levitt argues that Westwood, Secretary of State for Scotland, had an easier route to the creation of the NHS than his counterpart in Westminster, Bevan, as he centred the hospital service on the medical schools and their hospitals.²² Consequently, the Department of Health for Scotland upheld the Scottish tradition of 'the eminent specialist, the university teacher and the consultant'.²³

Although the distinctiveness of the Scottish health services is notable, the consensus that McCrae and Jenkinson highlight is not entirely substantiated. If comparing the Scottish discussions with its English counterpart then the Scottish NHS was created in a less hostile environment but conflict during discussions was still evident within Scotland. Also historians, such as Charles Webster, argue that the consensus argument fails to have any historical credibility in either Scotland or the UK as a whole.²⁴ Webster highlights the importance of the Labour Party in the formation of the NHS, rejecting the conclusions of Eckstein that the Labour party joined the deliberations of a comprehensive health service at

¹⁹ Ibid, pp. 423-44.

²⁰ Levitt, *The Scottish Office*, p. 60

²¹ Hamilton, *The Healers*, p. 262.

²² Levitt, *The Scottish Office*, p. 61.

²³ Ibid, p. 61-62.

²⁴ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth-Century British History* 1, (1990), 151.

a late stage of the game.²⁵ Eckstein notes that although the NHS in England was enacted by socialists, it was not pioneered by them but was supported by almost all interest groups to varying degrees over a long period.²⁶ Rejecting this view, Webster emphasizes that concessions were given on such a huge scale ‘in the interests of pacifying the medical profession, the voluntary lobby, the drug companies, or other forces reflecting the advances of advanced capitalism’ that consensus is not demonstrated.²⁷ It was the achievements of the Labour Party and the bureaucracy in developing a coalition that brought about the NHS. Fox disagrees with this, seeing the development of the NHS as a continuation of hierarchical regionalism, which was embedded in the efficient application of advancing medical science whilst playing down the effect of the political parties and interest groups including the medical profession.²⁸ The hierarchical regionalism highlighted by Fox is also illustrated in the work of Martin Gorsky on the Aberdeen joint hospital scheme implemented in the early 20th century, but Gorsky points out the conflicts involved. Gorsky argues that the ‘medical-governmental-academic network’ promoted, within Aberdeen, the scientific side of medicine through research, which was bolstered by the Medical Officers of Health holding positions in both the local authority and university.²⁹ Yet a smooth process of integration and cooperation did not exist as

ideological conflict between city, voluntary sector, and university centred around the extension of the rate-aided hospital’s remit beyond the institutional care of the infectious and the impoverished. Kinloch’s [Medical Officer of Health] scheme for municipal appropriation of the poor law accommodation threatened the voluntary hospitals’ position in the medical hierarchy, provoked fears for their financial survival, and raised the spectre of state control of medical research and teaching.³⁰

This type of conflict was also evident in the formation of the Scottish NHS. Concessions were made to the medical profession and voluntary hospitals suggesting consensus was not evident and the role of political parties and interest groups was important in the development of the NHS.

²⁵ C. Webster, ‘Labour and the Origins of the National Health Service’, in Rupke, Nicolaas, A., *Science, Politics and the Public Good*, (Basingstoke, 1988), pp. 185-6.

²⁶ H. Eckstein, *The English Health Service*, (Oxford, 1958), p. 161.

²⁷ Webster, ‘Conflict and Consensus’, pp. 150-1.

²⁸ D. M. Fox, *Health Policies, Health Politics The British and American Experience*, (Princeton, 1986), p. 114.

²⁹ M. Gorsky, ‘Threshold of a New Era’: The Development of an Integrated Hospital System in Northeast Scotland, 1900-39, *Social History of Medicine*, Vol. 17, No. 2, 265.

³⁰ *Ibid*, 265.

Historians, such as Hardy, also adhere to the view put forward by Webster. Hardy notes that from the beginning of discussions surrounding the planning of the NHS, there was a 'continuing tension between provision and financing that threatened to overwhelm the original ideals behind the service'.³¹ Webster acknowledges that during the discussions it was the local authority representatives from Glasgow and Edinburgh who were first to voice objection to the NHS plans.³² However, he goes on to note that the Scottish Secretary of State faced fewer pressures than his English colleague due to Johnston's acceptance of regionalisation and a three-tier organisation.³³ This seems to conform to the view of Fox that hierarchical regionalisation increased throughout the Second World War culminating in the NHS. Webster, however, notes that Fox did not refer to areas such as Scotland, nor to the way in which regionalisation was seen as a way to bolster voluntary health services, nor to the fact that regionalisation only took off in one of the five regional areas within Scotland.³⁴ Consequently Fox's view does not seem to provide a plausible explanation for the creation of the NHS, whilst Webster's acknowledgement of the conflict and concessions that were evident during discussions seems to provide a clearer assessment of the process by which the health services were born. Therefore, to evaluate the extent to which conflicts were evident, further examination of the Scottish discussions is necessary.

In his discussions of the welfare state, Lowe notes that the planning of the NHS was 'overshadowed by a permanent sense of crisis'.³⁵ Lowe agrees with Webster to the extent that the discussions surrounding the NHS White Paper do not support the consensus view, as conflict was a predominant feature until the concessions were made to the medical profession and the voluntary hospitals. However, what Lowe also suggests is that consensus was evident on the basic principles of the NHS and the acrimonious debates between the different parties were not necessary.³⁶ Berridge, who also acknowledges that there was a general opinion that some sort of collective provision was necessary in the post-war era, highlights the tensions that ran through the discussions.³⁷ The underlying

³¹ A. Hardy, *Health and Medicine in Britain Since 1860*, (Basingstoke, 2001), p. 140.

³² *Ibid*, p. 47.

³³ Webster, *The Health Services Since the War*, p. 65.

³⁴ Webster, 'Conflict and Consensus', pp. 126-7.

³⁵ R. Lowe, *The Welfare State in Britain Since 1945*, (Basingstoke, 2005), p. 178.

³⁶ *Ibid*, p. 178.

³⁷ V. Berridge, *Health and Society in Britain Since 1939*, (Cambridge, 1999), p. 13.

view that Lowe and Berridge portray is one of conflict within consensus. Their view coincides with the opinion of Rudolf Klein.

Klein states that although consensus on the overall aim of the creation of a comprehensive health service is evident, the mechanics of this was a source of conflict between differing political and medical groups.³⁸ Klein succinctly depicts the planning of the NHS as a 'conflict contained, and limited, by an overarching consensus – a constraint which forced compromise and caution on all the protagonists'.³⁹ Therefore, the argument of conflict within consensus does encapsulate the beginnings of the NHS, not only within England, but also within Scotland. Conflict within Scotland is evident to a lesser degree than in England; however, the conflict is still evident and cannot be dismissed.

In considering the conflict within Scotland, the local authorities provide a good case study of opposition that was present initially but faded in the discussions due to the dominance of the medical profession. The histories of the NHS overlook the importance of the local authority acquiescence during the discussions held within Scotland. As previously noted, Webster acknowledges that the local authority representatives from Glasgow and Edinburgh did put forward objections to the NHS plans. Webster also notes that Johnston was dedicated to the Department of Health being responsible for the new hospitals built under the EMS and was firm that they would be passed to the local authorities for administration.⁴⁰ He does not, however, go on to examine the discussion between the local authorities and the Department of Health for Scotland that led to the removal of services, such as hospitals, from local authority control. The question of how this key change in the role of local authorities took place remains to be answered.

The local authority issue can also be considered from a public sector management viewpoint. In his assessment of the NHS, Duncan McTavish emphasizes both the strength of central government within Scotland and the lack of enthusiasm for local authority control, as the defining factors in the management structure evident in Scotland.⁴¹ He highlights the dominance of the medical profession within the management structure of the NHS, which was established through the 1947 Act. Jenkinson also notes that although the

³⁸ R. Klein, *The New Politics of the NHS*, (Harlow, 2001), p. 5.

³⁹ *Ibid*, p. 5.

⁴⁰ Webster, *The Health Services Since the War*, p. 33.

⁴¹ D. McTavish, 'Scottish and English Health Policy from 1948 to 1973', *Scottish Affairs*, No 51 (Spring 2005), 66-7.

local authorities were consulted in the discussions surrounding the NHS, they felt they had been overlooked as some health services were removed from their control.⁴² Although Jenkinson adheres to the same view as McTavish that centralisation was a more practical administrative option, she acknowledges that the local authorities felt abandoned by the concessions made to the medical profession which created the internal management system highlighted by public sector management viewpoints.

Centralisation through the HMS and the EMS dominate the administrative structure that carried on into the NHS. McTavish sees this as being inevitable as the medical profession dominated health services in the decades prior to the establishment of the NHS and the profession was opposed to local authority control.⁴³ McTavish's research, however, only focuses on Glasgow. In Glasgow, the local authorities may have been willing to cooperate with the Regional Hospital Boards and the Department of Health, but no mention is made of the Local Authority Associations who dealt with the Department of Health and the Scottish Secretary of State at the stage of negotiations over the establishment of the NHS. To establish the nature of local authority opinions throughout Scotland and how this influenced the negotiations that took place, it is necessary to examine the records of the negotiations.

The dominance of the medical profession is noted through many histories of the NHS, including that of McCrae. Although McCrae acknowledges the discussions held with the local authority associations, he examines the NHS plans from a medical point of view and firmly sees the negotiations as based on the consensus gained from the recommendations of the Cathcart Report.⁴⁴ McCrae notes the failure of the *Report of the Committee on Post-War Hospital Problems in Scotland* (the Hetherington Report) in 1944 to conclude the negotiations by putting forward firm recommendations for the administration of the hospital system within Scotland.⁴⁵ Since the 1930s, the British Medical Association (BMA) had been calling for reform of the administration of the hospital system, as many local authorities were too small to efficiently administer hospitals.⁴⁶ Honigsbaum also recognises the importance of the EMS as it provided a regional dimension to hospital

⁴² Jenkinson, *Scotland's Health*, pp. 423-35.

⁴³ D. McTavish, 'Case Studies in British Management, Public and Business Sectors, 1900 – present', (PhD Thesis, University of Glasgow, 2002), p. 234.

⁴⁴ McCrae, *The National Health Service in Scotland*, p. 221.

⁴⁵ Ibid, p. 225.

⁴⁶ F. Honigsbaum, *Health, Happiness and Security: The Creation of the National Health Service*, (London, 1989), p. 133.

provision.⁴⁷ The EMS in Scotland provided 16,000 extra hospital beds administered by the Department of Health.⁴⁸ Consequently, the outcome of what was to happen to the extended services established during the war concerned the Secretary of State Thomas Johnston.

Therefore the events which led to a regionalisation of hospital services must be considered from the local authority viewpoint. If the local authorities were willing to relinquish the power they had over the health services, the need for discussions over a period of time would not have been necessary. The records of the discussions between the local authority associations and the Department of Health must be reassessed. The historiography of the NHS should be reconsidered with the local authorities given greater consideration in the outcome of the negotiations within Scotland.

The historiography of the NHS in Scotland is largely dominated by the consensus approach. The HIMS, EMS and Cathcart Report provide evidence for the consensus view; however further examination of archives is necessary to determine to what extent consensus was a feature of the negotiations for the NHS proposals. The main historical writings highlight the importance of the medical profession in dominating negotiations; however, the concessions made to this group only confirm the existence of conflict. The medical profession was not the only group which raised concerns over the new NHS. The voluntary hospital system and the local authority associations also raised concerns over the plans being put forward for the new health services. The English local authorities were more intense in their objections to the administrative system proposed for the NHS than their Scottish colleagues; however, the Scottish local authority associations cannot be discounted. As will be demonstrated within this chapter, local authorities were at the forefront of developments within the Scottish health services. Consequently, local authorities deserve special attention in the historiography of the development of the NHS within Scotland. The research undertaken in this thesis will focus on the relationship between the local authorities, the Secretary of State for Scotland and the Department of Health during discussions over the plans for the NHS and their reaction to its subsequent implementation up until 1974.

⁴⁷ Ibid, p. 133.

⁴⁸ Webster, *The Health Services Since the War*, p. 23.

Approaches to policy analysis

As state involvement in the economy and welfare issues changed, so too did the way in which policy-making and central-local relations were analysed by political scientists such as Rhodes, Marsh, Jordan and Richardson in the 1980s.⁴⁹ Through utilising theories such as pluralism, corporatism, Marxism and policy network theory, the interactions between central government, local government and interest groups have been studied for a wide range of policy issues. In considering the way in which policy is developed, the structure of governance must be considered. Although the term ‘governance’ was historically used as a synonym for ‘government’, social scientists now use it to denote a change in the processes of governing.⁵⁰ Governance is an important area of study as the processes of governing shape the institutions which decide on policy.

When discussing early twentieth century government in Britain, most political scientists refer to the era of the ‘Westminster Model’. The ‘Westminster Model’ indicates a period when the process of policy-making was top-down. According to this model the government decides upon a policy it wishes to enact; it then requests the civil service to draft the bill. Once drafted the bill is pushed through parliament and implemented. Richards and Smith note that the model defines a hierarchical system that ‘encapsulate[s] the notion that it is the Government that governs in the interests of the nation and that power rests with the Government’.⁵¹ Governments, therefore, do not interact with outside groups during the policy-making process; instead they govern a country in the way they see fit. Although Richards and Smith argued that the Westminster model dominates policy-making in the twentieth century, it was not the only process used to form policy. Government sought advice from groups outwith the political domain. One prominent example of this is the inclusion of a variety of groups, including the medical profession, in the formation of the NHS. Richards and Smith also point out that although the process of policy-making has changed over time, the government still remains the dominant actor in any policy formation.⁵² Consequently governance is seen as an evolutionary process in

⁴⁹ R.A.W Rhodes & D. Marsh, *Policy Networks in British Government*, (Oxford: 1992) and J.J. Richardson & A.G. Jordan, ‘Overcrowded Policy-making: Some British and European Reflections’, in *Policy Sciences*, 15, (1983).

⁵⁰ G. Stoker, ‘Governance as theory: five propositions’, *International Social Science Journal*, 155, (March 1998), 17.

⁵¹ D. Richards and M.D. Smith, *Governance and Public Policy*, (Oxford: 2003), p. 4

⁵² Richards and Smith, *Governance and Public Policy*, p. 271.

which policy-formation developed to encompass changing attitudes to government and how society should be governed.

Throughout the twentieth century the view of the way in which society was governed changed. Theories of policy formation developed to consider the influence of external pressures on governments and policies. Kooiman summarises the governance approach as 'focus[sing] on the interactions taking place between governing actors within social-political situations'.⁵³ Governance, therefore, presents a multifaceted process of policy making, whereby groups outwith government are able to influence a policy area they have interests in. The varieties of theories which provide an explanation of the policy processes are diverse and follow the changes in governance which have evolved throughout the decades of the twentieth century.

Throughout this thesis an institutional approach to policy networks will be utilised as an analytical tool to consider the development of the Scottish NHS. The approach taken will provide a wide framework for analysing negotiations between the Department of Health for Scotland and Scottish local authorities. Policy network theory categorises relationships between governments and interest groups. Smith notes that policy networks occur when information is exchanged between interest groups and the government, and that this information leads to the acknowledgement that the interest group has a concern over a policy area.⁵⁴ Therefore policy networks consider all links established between groups and government within a policy area. Atkinson and Coleman see policy networks as recognition 'that the world of state-society relations is richly varied and [they] deny that there is any advantage in working toward a single model'.⁵⁵ Policy networks, however, can become very complex and accordingly analysts categorise them by the most dominant group. Changes can occur over time with regards to the dominant group and the focus on the dominant group can in some cases cause other influential groups within the network to be overlooked.

The use of policy network theory does not ignore other forms of policy analysis but attempts to incorporate them into a more comprehensive theory of policy formation. Policy network theory incorporates a pluralist and corporatist approach to policy-making.

⁵³ J. Kooiman, *Governing as Governance*, (London, 2003), p. 7.

⁵⁴ M. J. Smith, *Pressure, Power and Policy*, (Hemel Hempstead, 1993), p. 56

⁵⁵ M.M. Atkinson and W.D. Coleman, 'Policy networks, policy communities and the problems of governance', *Governance: An International Journal of Policy and Administration*, Vol. 5 No. 2, (April 1992), 156.

Pluralist writers concentrate on the role of groups in influencing policy-making through examining their resources and access to the political arena. Groups with better resources have easier access to the political arena and therefore are able to influence policy-making. Grant notes that pluralism rests on the 'assumption that access to the political system is relatively easy'.⁵⁶ This, however, is not necessarily the case. In considering pluralism, Smith observes that the analysis of groups is far more sophisticated than many critics give it credit, as pluralists note that not all groups have equal access to the political system and that some groups have advantages over others depending on their resources.⁵⁷ Furthermore, Smith points out that pluralists recognise the state as an active participant in which groups have access to the political system and influence policy-making.⁵⁸

The acknowledgement of an active state or of the various degrees of influence of a group does not address the problems with a pluralistic approach to policy-making. Within policy network theory all possible relationships are considered in the analysis of any policy area. As pluralists focus on the resources and influence of groups in the policy-making process they often by-pass other factors, such as access to the political arena, the influence of the state and the existence of an elite set of interest groups, which may determine a policy decision. Dowding argues that the existence of other factors in policy-making, or other theories towards it, is not necessarily in opposition to the pluralist approach but can be seen to complement it.⁵⁹ Although, pluralist assumptions do not always allow for such analysis, if the pluralist approach is accompanied by another analytical theory such as corporatism or policy networks, the pluralist approach becomes more robust.

Policy networks also incorporate the corporatist approach. The corporatist premise is that in advanced capitalist societies power is shared between the state and only a few powerful interest groups.⁶⁰ Corporatism does not work on the assumption that access to the political arena is open to all groups but on the assumption that the political arena is relatively closed to most interest groups except the most powerful, for example, business. Corporatism has often been associated with authoritarian regimes as a means of controlling society through interest groups such as trade unions. The interest groups who gain power are monopolistic and hierarchical; therefore, they can implement any decisions negotiated with government

⁵⁶ W. Grant, *Pressure Groups, Politics and Democracy in Britain*, (Hemel Hempstead, 1995), p. 30

⁵⁷ Smith, *Pressure, Power and Policy*, pp. 15-16.

⁵⁸ *Ibid*, p. 16

⁵⁹ K. Dowding, *Rational Choice and Political Power*, (Aldershot, 1991), p. 117.

⁶⁰ R. Lowe, *The Welfare State in Britain Since 1945*, (Basingstoke, 2005) p. 37

and are responsible for their members adhering to the agreements.⁶¹ Corporatism sees the interaction between the state and interest groups as an exchange; in return for access to the policy-making process groups 'provide legitimacy for the state, information and assistance in implementation of policies'.⁶² Social control of particular groups can then be obtained by the state through the exchange highlighted by the corporatist viewpoint. Critiques of corporatism, however, note that it is a narrow conception of policy-making. Smith points out the limitation of corporatism as an analytical tool, because it is a particular form of policy-making which can occur within certain parts of the state at specific times and is not a general theory of the state.⁶³ Consequently, analysts developed policy network theory to incorporate pluralism and corporatism and remove some of their deficiencies in analysing policy formation.

The literature on policy networks comes from two distinct backgrounds: first, from European inter-organizational literature; and second, from American political science literature. The variations in the theory are diverse, but these two strands form the main background to the policy networks literature and it is dominated by the Rhodes typology. Rhodes, who is associated with the European inter-organizational literature, utilises policy network theory as a meso-level concept which is affected by the conditions of national government and therefore considers the relationships between government and organisations.⁶⁴

By focussing on the relationship between organisations and government, Rhodes developed criteria by which a network could be detected. His five criteria are:

- (1) Any organisation is dependent upon other organisations for resources.
- (2) In order to achieve their goals, the organisations have to exchange resources.
- (3) Although decision-making within the organisation is constrained by other organisations, the dominant coalition retains some discretion. The appreciative system of the dominant coalition influences which relationships are seen as a problem and which resources will be sought.

⁶¹ Smith, *Pressure, Power and Policy*, p. 31

⁶² Ibid, p. 31

⁶³ Grant, *Pressure Groups*, p.38

⁶⁴ Rhodes & Marsh, *Policy Networks in British Government*, pp. 8-14.

(4) The dominant coalition employs strategies within known rules of the game to regulate the process of exchange.

(5) Variations in the degree of discretion are a product of the goals and the relative potential of interacting organisations. This relative power potential is a product of the resources of each organisation, of the rules of the game and of the process of exchange between organisations.⁶⁵

The five criteria indicate that the exchange of resources is a key factor in the development of a policy network. Over a period of time the policy network can change depending on the goals of the organisations and the resources needed in the exchange. From these criteria Rhodes identifies five types of network: policy/territorial community, professional network, intergovernmental network, producer network and issue network.⁶⁶ Depending on the policy area studied, each type of network can be recognised by key features such as membership, dependence and stability. A professional network, for example, is stable, has restricted membership, vertical interdependence, limited horizontal articulation and serves the interest of the profession.⁶⁷ An intergovernmental network has some similar attributes such as limited membership, but differs in that it has limited vertical interdependence and extensive horizontal articulation.⁶⁸ The participants in the professional network have responsibilities for providing a service or resource and are limited to the one policy area, while the participants in the intergovernmental network do not have the responsibility of service provision to any great extent, and cover a wide range of issues so they can explore a variety of policy issues. The analyst must ensure that domination by one category of network does not obscure other influential networks within the policy arena. Consequently each network has a variety of differing resources, responsibilities and policy areas in which they can operate.

Rhodes' emphasis on the structural relationships between institutions underplays the role of individuals within any particular network. In discussion of this criticism, Rhodes stresses that organizational networks provide the context which limits interpersonal relationships but does not describe the behaviour within these relationships.⁶⁹ Rhodes and Marsh acknowledge further criticisms, such as that the typology ignores social interests, has an inadequate conception of the state and does not explain the causes or consequences

⁶⁵ R.A.W Rhodes, *Control and Power in Central-Local Government Relations*, (Farnborough, 1981), pp. 98-9.

⁶⁶ R.A.W Rhodes, *Understanding Governance*, (Buckingham, 1997), p. 38

⁶⁷ Ibid, p.38.

⁶⁸ Ibid, p.38.

⁶⁹ Rhodes and Marsh, *Policy Networks*, p. 22

of variations between policy areas.⁷⁰ Dowding criticises the Rhodes and Marsh typology for claiming to be a meso-level concept which explains the properties of policy networks, whilst ‘the explanatory work is largely done in terms of properties of the actors and not in terms of properties of the network’.⁷¹ He goes on to criticise the way in which the typology of Marsh and Rhodes does not distinguish between dependent and independent variables in the policy networks.⁷² Dowding sees the weaknesses as being fundamental to the success of policy networks, as the typology does not consider the wider context in which they may occur and develop, providing only a label for the differences between policy networks and not the explanation behind such differences.⁷³ The later statement of policy networks theory by Rhodes does, however, include a conception of the state as the link between this meso-level concept and the macro-level issues of power. Atkinson and Coleman argue that the structural view of policy networks can be extended further to incorporate the ideological resources which underpin the actors within the network.⁷⁴ This would incorporate the political ideology of the actors and the ideological nature of the state which in turn sets the institutions by which the networks are ruled.

In assessing the Rhodes typology as a framework for policy-making analysis, Smith develops the typology acknowledging that the groups involved in the policy process can then assist in implementation of the policy thus achieving the goals of the state.⁷⁵ Furthermore, Smith argues that as different types of policy network can affect the ability of government to implement a policy, it is in the interest of the government and groups involved in the network to establish a consensus as a means of controlling the outcome of policy formation.⁷⁶ Without consensus, governments find it more difficult to implement a policy as it does not have the assistance from the groups involved in the implementation process.⁷⁷ Therefore, Smith recognises the link between policy and implementation which should be explored to distinguish between what is agreed through policy and what is actually implemented in practice. Smith does recognise that governments have the authority to overrule groups; however, the cost of doing so can be high and governments

⁷⁰ Ibid, p. 20

⁷¹ K. Dowding, ‘Model or Metaphor? A Critical Review of the Policy Network Approach’, *Political Studies*, 43, (1995), 141.

⁷² Ibid, 141.

⁷³ Ibid, p. 142.

⁷⁴ Atkinson and Coleman, ‘Policy Networks, Policy Communities’, 161.

⁷⁵ Smith, *Pressure, Power and Policy*, p. 53

⁷⁶ Ibid, p. 54.

⁷⁷ Ibid, p. 54.

‘prefer developing institutional relationships with groups as a means of extending autonomy’.⁷⁸ The main group actors within the network are therefore important factors in governments implementing particular policy outcomes. By exploring policy implementation, the organisations which are not dominant in the network may have greater informal influence through the implementation process, as they are essential to the policy goals of government.

In contrast to Rhodes and Marsh, Jordan and Richardson consider policy networks as a micro-level concept. This framework is based on the American literature which disaggregates policy issues to sub-governments. They consider the British approach to policy-making as ‘a predilection for consultation, avoidance of radical policy change and a strong desire to avoid actions that might challenge well-entrenched interests’.⁷⁹ The approach is also from a pluralist background. Some basic features of the Jordan and Richardson typology are similar to the Rhodes typology, such as the view that policies are the outcomes of bargaining between government and interest groups and that policy is conducted in specialist sectors (Rhodes’ policy communities).

Although interpersonal relationships can affect a policy outcome, Smith argues that micro-level analysis only serves to describe a network and does not provide an explanation as to how these affect policy outcomes.⁸⁰ He does, however, note that the actors’ perceptions of the organisation of a network are important for understanding how they develop and are recreated.⁸¹ Dowding also criticises Jordan and Richardson for their use of policy networks as metaphorical, as they made no attempt to ‘categorize policy networks, policy communities, issue networks or other similar terms into formal typology’.⁸² Furthermore, Smith goes on to state that ‘little attempt has been made to distinguish between types of community, so the term policy community is used liberally’.⁸³ This problem, however, is inherent in both the typology by Jordan and Richardson and the Rhodes typology. As networks vary across a horizontal continuum it is difficult to highlight where one network ends and the other begins. There can also be a crossover of networks in any one policy area. Jordan and Richardson use policy network analysis in a descriptive manner, which if

⁷⁸ Ibid, p. 56.

⁷⁹ Richardson & Jordan, ‘Overcrowded Policy-making’, 249.

⁸⁰ Smith, *Pressure, Power and Policy*, p. 57

⁸¹ M. J. Smith, *The Core Executive in Britain*, (Basingstoke, 1999) p. 17

⁸² K. Dowding, ‘Model or Metaphor?’, 139.

⁸³ Smith, *The Core Executive in Britain*, p.17.

joined with the concept at a meso-level may begin to provide a formal typology which analyses all aspects of policy networks and their development over time. The use of networks is still useful for identifying the context in which policy-making takes place.

Policy networks can be utilised as a framework for meso- or micro-level analysis of policy formation. There are inherent problems with the concept at either level. Dowding's main criticism is that although networks can be used metaphorically in considering policy processes, these processes can be analysed without reference to networks. He sees the language used in analysing policy networks as 'that of bargaining strategies, power resources and coalition possibilities'.⁸⁴ For Dowding policy networks are a useful way to map interactions between government and groups, but they do not provide a theory of the policy process which can be explored by considering bargaining, power resources and coalitions.

Some extensions in policy network analysis are necessary, such as incorporating the implementation of policies and considering changes in networks over time. Blom-Hansen promotes a 'new institutional' perspective on policy networks and includes in the analysis a model of the actor. He argues that policy networks should be considered as institutions which constrain actors in the policy-making process.⁸⁵ The actors are assumed to be using opportunities within a network to achieve their goals. Furthermore, Blom-Hansen argues that actors search for advantages in policy-making and this search explains the emergence of institutionalisation within interest group politics and constitutes a bargaining between groups.⁸⁶ The 'rules of the game', however, are recognised in other policy network theories, such as that of Rhodes, and bargaining is central to all policy network variations. Blom-Hansen goes on to discuss changes within networks, arguing that as the bargaining power of actors changes, so too will the institutional arrangements.⁸⁷ Utilising an institutional approach to policy networks, which includes bargaining amongst the actors and development of the network, not only categorises the network evident in any policy arena but also incorporates a model of the actor which allows more robust analysis of policy formation.

⁸⁴ K. Dowding, 'Model of Metaphor?', 145.

⁸⁵ J. Blom-Hansen, 'A 'New Institutional' Perspective on Policy Networks', *Public Administration*, Vol 75, Issue 4, (Winter 1997), 669.

⁸⁶ *Ibid*, 682.

⁸⁷ *Ibid*, 685-6.

Throughout the course of the thesis, policy network theory will be used as an analytical tool as it provides a wide framework for analysing the negotiations between the Department of Health and the local authorities in Scotland. The policy network approach is valuable in examining the development of the NHS in Scotland as it encompasses other forms of policy analysis and considers the relationships between, and within, all groups involved in policy formation. The approach also recognises the nuances in inter-governmental relationships and the relationships the government holds with 'outside' organisations. Policy network theory also allows for developments and changes in a network through the implementation period of an Act, thus acknowledging the changing balance of power among groups. As relationships in policy formation and implementation are considered over time, policy networks can provide a wide, flexible framework by which to analyse the development of policy in the health service and the effect this has on the influence of key groups involved. As a range of groups were involved in the development and implementation of the Scottish NHS, policy network theory was chosen as the most appropriate and effective framework for the analysis conducted within this thesis.

Policy networks will therefore be considered as an institutional framework for policy-making in which the 'rules of the game' are established. Policy network theory will also provide a framework for analysing the development of the relationship between the actors throughout the period 1939-1974. It will be assumed that the actors are rational in their approach to policy-making and utilise bargaining power within the policy negotiations and policy implementation. The implementation of policy will be crucial in understanding the development of the relationship established and the effect of the relationship on the long-term viability of the policy network. As such the approach throughout the various chapters within this thesis will consider a number of issues:

- (1) Why was the network established?
- (2) What was its central function?
- (3) Who participated in the network?
- (4) What types of networks were evident within the policy arena?
- (5) What part did Scottish local authorities play in the network?; and

- (6) How did the network which local authorities were involved in develop over time?

Archives

Utilising policy network theory and addressing the above questions will provide a framework by which the development of the Scottish NHS can be assessed. The policy network approach provides an opportunity to consider the relationships which were developed within the Scottish health service sphere during the formation and implementation of the NHS. In order to identify the policy networks, their participants and functions, with regards to the development of the Scottish NHS, a wide range of archives were used. The National Archives of Scotland (NAS) provided extensive archival material relating to the Cathcart Report, the Hetherington Report, the Convention of Royal Burghs, the Association of County Councils and the Department of Health. The Association of County Councils and the Department of Health files were comprehensive in their coverage of the local authority associations' and the Department's discussion over the provisions for the NHS and its subsequent implementation. A detailed list of the files used is given in the bibliography.

The files of the Convention of Royal Burghs, held in Edinburgh City Archives (ECA), had very little correspondence from individual local authorities to the Association or from the Association to the Department of Health. Consequently, the part played by the Royal Burghs was more difficult to determine. The archives of the Scottish Counties of Cities Association held at Edinburgh City Archives (ECA) were also disappointing. The archives of both Associations relied on the last Secretaries of the Associations to deposit their files with an archive when the Associations merged to become the Convention of Scottish Local Authorities (COSLA) in 1975, and the files were heavily culled. Glasgow City Archives (GCA), however, hold a substantial collection of papers from the Scottish Counties of Cities Association and the Corporation of Glasgow which illuminate the role of these bodies in the lead up to and implementation of the NHS (Scotland) Act. Aberdeen City Archives (ACA) and Dundee City Archives (DCA) provided some information about these two cities. The National Archives (NA) at Kew holds information on the relationship between the Scottish Office and Department of Health for Scotland and their Westminster colleagues. These archives provided an insight into the central-local relations between Westminster, the Scottish Office and local authorities.

The biggest problem was the magnitude of the available sources. It was therefore necessary to focus the research on the Department of Health papers in the NAS, the local authority associations and in-depth analysis of the four cities. Although the volume and availability of archive material raised problems, the archives provided a basis for the analysis of the relationship between the local authorities, the Secretary of State and the Department of Health during the discussions over the establishment of the NHS and its implementation.

Chapter Outline

Chapter One considers the historiography of the Scottish health services from the early twentieth century. By analysing the most influential reports of the early twentieth century, such as the Cathcart (1936) and Hetherington Reports (1944), their influence on the development of the health services within Scotland, the evidence given by local authorities and their reaction to the reports, it is evident that local authorities were central to the development of the Scottish health services. The chapter also considers archival material which emphasizes the important role played by Scottish local authorities, which, to date, has not been analysed in the historiography of the Scottish health services. The chapter will draw attention to the role and importance of Scottish local authorities in the provision of both curative and preventive health care in Scotland in the first half of the twentieth century. The chapter concludes that the development of the health services within Scotland was unique in comparison to England and Wales. Through experiments in social medicine and health service reports, Scotland was creating a distinctive path to a comprehensive health service. Scottish local authorities were very influential in creating this distinctive path as they not only provided a wide range of health services but were also heavily involved in all of the planning of the future of the health services. By considering the development of the Scottish health services through the HIMS, Clyde Basin Experiment, wartime health provisions and governmental health services reports, the forgotten influence of local authorities is expounded within the distinctive Scottish health service arena.

Consideration of the role of local authorities in the provision of health care and formation of health policy in Scotland continues in the second chapter. Attention is drawn to the members of the policy network, including the medical profession, voluntary hospitals and the associations representing the local authorities during the formation of NHS policy. The use of policy network theory in this chapter provides an analytical tool to consider issues

such as: why the network was established, what was its central function, who participated in the network, what types of network were evident within the policy arena and what part Scottish local authorities played in the network. The chapter goes on to explore the relationship between the Secretary of State for Scotland, the Department of Health for Scotland and the local authorities through the policy network established. Analysis of the archives reveals the discussions which took place in the 1940s with regard to the NHS White Paper and Bill, the relationships established and their outcomes, and demonstrating the lack of influence local authorities had within the formation of NHS policy. Furthermore, the relationships among the three local authority associations are examined, through analysis of the association archives. The way in which they interacted affected the negotiations over the health services and the resultant NHS (Scotland) Act, 1947. Chapter two concludes that the Scottish NHS was created in a time of conflict within consensus. Consensus was evident over the need for a comprehensive health service but conflict was apparent over the way in which it would be established and administered. This is highlighted by the negotiations between the Department of Health for Scotland and the local authority associations over the NHS (Scotland) Act 1947. Furthermore, the chapter concludes that the relationship established between the Department of Health and the local authority associations created an environment which affected the way in which local authorities could express their concerns over the White Paper proposals. The relationship was both hierarchical and portrayed local authorities as equal partners. Thus it is concluded that a number of reasons were evident in the local authorities inability to influence the NHS (Scotland) Act 1947: the dynamic created in the discussions; the assurances made by the Department of Health for Scotland that local authorities would have administrative authority over the NHS; and, the inability of local authorities to work together to create a united front against proposals which removed the health services from their administrative sphere. By examining the discussions over the NHS (Scotland) Act 1947, it is evident that local authorities were central in health service planning for the NHS, and despite their attempts to influence the Act, local authorities were ultimately unsuccessful and lost the most important aspects of their health services.

The approach to policy network theory in this thesis, however, states that policy formation does not end with the passing of an Act. Implementation is central to the interpretation of any Act, as the informal and formal influences on those implementing the Act shape the services established. Chapter three analyses the implementation process of the NHS (Scotland) Act, 1947, the way in which local authorities influenced this process and their reaction to the implementation process. The archives of the Department of Health for

Scotland, the local authorities' associations, and the local authorities in Glasgow, Edinburgh, Aberdeen and Dundee were utilised to examine the implementation process for local health authority services. By analysing these archives the problems of finance, staffing, co-ordination among local health authorities, the hospitals, GPs and welfare authorities, and the reaction of local authorities to NHS policy are illuminated. Furthermore, the relationship developed within the policy network between the Secretary of State, the Department of Health and the local authorities is examined to highlight the development of the relationships within the policy network and the negative effect these relationships had on the ability of local authorities to increase their influence in the health service. The chapter concludes that the transition to the NHS in 1948 was not as smooth as historians such as McCrae and Hamilton believe. It is evident that many problems arose during the implementation of the NHS Act such as: the reaction towards the Act by local authorities; the finances of the NHS; and the problems over the division of responsibilities. By examining these areas it is clear that the subordinate position of local authorities to the Department of Health for Scotland continued from the negotiations into the implementation of the Act and impacted on the ability of local authorities to influence the path the NHS took. The Department of Health, however, underestimated the effect that demoralised local authorities could have on the administration of their part of the NHS and continually encouraged them to participate in the NHS by extending their health services.

The development of the relationships, set out in the previous chapters, and the policy process from 1960 until the reorganisation of 1974 is set out in chapter four. As the policy process develops the exchanges between players change and the influence of particular groups change. The chapter continues the themes of the previous chapter analysing the development of the relationships between the Secretary of State, the Scottish Home and Health Department (SHHD) and local authorities; the way in which this affects the development of the NHS and the reaction of local authorities to such developments. The themes of finance, staffing, co-ordination, division of responsibility and changes in mental health policy are considered through the analysis of the local authority archives, the annual reports of the Scottish Home and Health Department, the association archives and the Scottish Home and Health Department archives. Chapter four also demonstrates that local authorities were no longer favourably positioned within the policy network as the Scottish Home and Health Department recognised their lack of bargaining power and placed them as service providers within the health services. Furthermore the chapter presents an analysis of the reaction of local authorities through their realignment of the priorities of the health care services they provided.

Chapter four concludes that the period 1960 to 1974 was a time in which developments were made to the health services and it became apparent that the administrative structure of the NHS required reorganisation. It is evident throughout this period that some local authorities were at the forefront of developments, both in their mental health and child health services. The advances within local authorities were based on three variables: the support given to the Medical Officer of Health (MOH) by the health and welfare committee; the innovative ideas of the Medical Officer of Health; and the availability of finances and staff. Developments came in varying degrees but despite the expansion within the local authorities, the Scottish Home and Health Department were concerned over the lack of integration amongst the tripartite NHS. Co-ordination between the three administrations of the NHS was slowly increasing during the period with links between hospitals, GPs and local authorities. Nevertheless the period also highlighted the time when local authorities lost their bargaining power within the NHS as they no longer administered the most influential part of the NHS, hospitals, and also no longer held the experience that the Scottish Home and Health Department required when the NHS was established. 1960 to 1974 saw local authorities enter uncertain times as reorganisation redefined their role within the structure of government and the NHS.

The result of the development of the NHS between 1948 and 1974 was the recognition by the Scottish Home and Health Department and the Ministry of Health that reorganisation of the NHS was necessary. Chapter five examines the policy negotiations over the 1974 reorganisation and their outcome. The policy negotiations are examined taking into account the wider reorganisation of local authorities and the uncertainty over its outcome. Local authority reorganisation was seen as a way to demonstrate that local authorities would be in a position to play a larger part within the administration of the NHS. The relationships developed within the policy network between the Scottish Home and Health Department, Westminster, local authorities and the medical profession are also analysed. The archival research demonstrates that although local authorities had little bargaining power and had effectively been excluded from the policy network within the 1960s, they attempted, individually and through their associations, to reassert their influence within the policy discussions to retain a position within the NHS. Local authority archives also highlight the attitude of local authority staff to the reorganisation and the concern that reorganisation would result in local authority job losses.

Chapter five concludes that reorganisation was a dominant feature of the 1960s and 1970s. The Department of Health for Scotland was reorganised in the early 1960s to become the

Scottish Home and Health Department and local government reorganisation created uncertainty about the future of local authorities. The reorganisation of the NHS was also undertaken during this period and it is concluded that it provided the Scottish Home and Health Department with the opportunity to remove local authorities from the health services. Local authorities, however, did not go quietly and attempted to reassert their influence within the negotiations over the NHS (Scotland) Act 1972. Local authorities had lost their bargaining power in the negotiations of the 1940s and were not able to recover it. Thus the reinstatement of the dynamic of the network established in the 1940s meant that local authorities were not a main player in the reorganisation of the 1970s. The reorganisation of local government had not provided any encouragement for the Scottish Home and Health Department to include local authorities in the future of the NHS as the finances available for local authority health services were still under question. The chapter concludes that the slow removal of local authorities from the NHS, which began in the 1940s, was brought to an end with the NHS (Scotland) Act 1972.

The archival research for the period 1939 to 1974 reveals the demise of local authorities from the health service arena. The final chapter concludes that the policy network established placed local authorities in a subordinate position to the Scottish Home and Health Department thus reducing their ability to influence the health services during this period. Furthermore, local authorities attempted to reinstate their influence within the NHS, partly by creating a specialism within the child health services. Nevertheless, local authorities remained in their auxiliary role within the NHS and the benefits of their inclusion within the health services diminished over the period. The concluding chapter summarises the main conclusions of the preceding chapters, and demonstrates that by 1974, local authorities had been slowly removed from the Scottish NHS by the medical profession and the Scottish Home and Health Department.

Chapter 1

The Development of the Scottish Health Services

Introduction

Economic and social regeneration was at the top of the post-Second World War political agenda in the United Kingdom. The new Labour Government of 1945 embraced the growing consensus that government had a place to intervene in society to increase living standards, through the establishment of the welfare state. The development of Scottish health services before 1945 was crucial in the approaches to social medicine which were taken in later years, culminating in the National Health Service (Scotland) Act, 1947. This chapter will explore some of the themes surrounding the development of the Scottish health services such as: the influence of local authorities in the development of the Scottish health services; and, whether there was conflict or consensus among political parties and interest groups in setting up the NHS.

Local Authorities and the Development of the Scottish Health Services

Scottish health service provision was distinctive from that in England and Wales. The early 20th century saw the continuation of the poor law as a means of providing medical care on both sides of the border. In England the poor law administration supplied GP and hospital care through workhouses, only accessed by a rigorous means test. By 1911, 75 separate poor law infirmaries had been established to offer those not insured, unable to gain entry to a voluntary hospital, or unable to afford medical consultations, with the treatment they required.¹ Anne Crowther argues that the medical services provided under the English Poor Law had to contain the belief that ‘relief must be made as unattractive to the poor as possible’.² Rosalind Mitchison, however, argues that whilst the system of reducing the amount of poor law assistance in England was instituted, within Scotland the aim was to increase assistance.³ The Act legislating for the New English Poor Law in 1834, made no mention of medical provision, whilst the Scottish Act in 1845, inserted a small, but significant, proviso for statutory medical services for the poor.⁴ Within England it was believed that the cause of ill-health for the poor was miasma, a toxic vapour in the

¹ F. Honigsbaum, *The Division in British Medicine*, (London, 1979), p. 11.

² A. Crowther, ‘Health Care and Poor Relief in Provincial England’, in O.P. Grell, A. Cunningham and R. Jütte, *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, (Aldershot, 2002), p. 207.

³ R. Mitchison, ‘Poor Relief and Health Care in 19th Century Scotland’, in O.P. Grell, A. Cunningham and R. Jütte, *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, (Aldershot, 2002), p. 246.

⁴ D. Hamilton, *The Healers*, p. 200.

air, and the elimination of this would tackle pauperism which in turn would eliminate diseases in the community.⁵ This led to the principle, within England, that as disease would be prevented by the removal of miasma, the need for medical provision within the English Poor Law Act was not necessary.

Within Scotland, however, the principles of medical provision through the Scottish Poor Law were not based on the idea that miasma-caused ill-health. Morrice McCrae argues that ‘physicians in Scotland had long held that poverty – through poor diet, inadequate clothing and shelter, overwork and overcrowding – led to “debility”’.⁶ The idea that basic medical services were a statutory duty of the poor law institutions was embodied in the Poor Law (Scotland) Amendment Act, 1845.⁷ Sir John Brotherston argues that ‘for the first time, statutory provision was made for the treatment of ill health within part of the community’.⁸ The Scottish principle that poverty led to ‘debility’ was embodied in the provisions which Scottish physicians, such as W.P. Alison, advocated, e.g. the establishment of Poor Law hospitals and the employment of full-time Medical Officers by all parishes.⁹ Although the 1845 Act did not include provisions to build Poor Law hospitals, by 1848 the Government agreed to provide annual grants of £10,000 to the Board of Supervision, to be divided amongst parishes which raised an equivalent amount to employ a Medical Officer.¹⁰ Morrice McCrae highlights that the many parishes were unable to raise enough funds to gain a central grant and consequently ‘the distributions of Poor Law medical officers had little relation to the parish structure of the counties’.¹¹ Nevertheless, the changes made with the 1845 Act demonstrate the difference in principles of medical provisions between Scotland and England.

The responsibility for the Poor Law and its medical services, included in the Scottish Act of 1845, were passed from the Kirk to Parochial Boards. Ian Levitt argues that the 1845 Act ‘represented an important departure in the ordinary administration of Scotland’.¹² A Board of Supervision for the Relief of the Poor was also established as a department of the

⁵ McCrae, *The National Health Service in Scotland*, pp. 129-30.

⁶ Ibid, p. 130.

⁷ Sir J. Brotherston, ‘Scottish Health Services in the Nineteenth Century’, in G. McLachlan, *Improving the Common Weal*, (Edinburgh, 1987), p. 9.

⁸ Ibid, p. 9.

⁹ McCrae, *The National Health Service in Scotland*, p. 131.

¹⁰ Ibid, p. 131.

¹¹ Ibid, p. 132.

¹² I. Levitt, *Government and Social Conditions in Scotland 1845-1919*, (Edinburgh, 1988), p. xi.

Home Office which was in control of the welfare system within Scotland. Furthermore, Levitt argues:

From 1845 onwards there was always a Scottish institution able, and indeed with a statutory responsibility, to monitor the condition of the poor and ensure their needs were met. This responsibility was added to by the 1867 Public Health Act; the Board also supervised 'nuisance' removal, the regulation of common lodging houses and the control of epidemic disease. It was a wide remit which meant that after 1867 the Board had a duty to monitor sanitary conditions and ensure some modicum of public health.¹³

The 1845 Act demonstrates the beginning of local authority involvement in the provision of Poor Law health care. Furthermore, the Board of Supervision membership included the Sheriffs of Perthshire, Renfrewshire and Ross and Cromarty; the Lord Provost of Edinburgh and the Lord Provost of Glasgow; along with a Chairman and two other members which were all appointed by the Crown.¹⁴ Morrice McCrae argues that the Board of Supervision did not have the strong central control advocated by Scottish physicians but was merely advisory.¹⁵ Nevertheless, the establishment and membership of the Board demonstrates that as early as the 1840s, the towns and counties were central to the development of the early health provisions made available through the Scottish Poor Law.

Although the Board of Supervision did not have official involvement in the public health sphere until the Public Health Act, 1867, it advocated, from its creation in the 1840s, the establishment of provisions for those suffering from infectious diseases.¹⁶ Levitt argues that as Scotland had very few voluntary hospitals, 'when an outbreak of fever did occur, there was often no alternative' than to use the parish's amenities.¹⁷ It was not until the Public Health Act, 1867 that local authorities were given responsibility to prevent and contain infectious diseases and to provide hospital facilities for those suffering from infectious diseases. However, it was not until the late 1890s that local authorities were compelled to build hospitals. A series of Acts - the Notification of Diseases Act, 1889; the Local Government Act, 1889; and, the Public Health Act, 1897 - gave the Board of Supervision (renamed the Local Government Board in 1894) increased power over local authority health provisions.¹⁸ Levitt argues that although these provisions stimulated the

¹³ Ibid, p. xi.

¹⁴ Ibid, p. 256.

¹⁵ McCrae, *The National Health Service in Scotland*, p. 131.

¹⁶ Levitt, *Government and Social Conditions in Scotland*, p. xxvii.

¹⁷ Ibid, p. xxvii.

¹⁸ Ibid, p. xxix.

extension of infectious disease hospitals, attitudes had not changed leaving facilities and staffing in an inadequate condition.¹⁹ Only in the twentieth century was the disincentive and stigma attached to treatment within poor law institutions removed.²⁰ Services throughout Scotland and the UK were patchy. Charles Webster notes that within the UK,

Guardians nevertheless retained important responsibilities with respect to the poor. They were under no obligation to provide extensive medical services, although by the inter-war period a minority of these authorities had established hospitals providing an almost full range of services, from maternity care to emergency services and even radiotherapy, as well as catering for the heterogeneous masses of the chronic sick.²¹

Nevertheless, the nineteenth century witnessed the beginnings of a health service for the poor, as well as those who could pay privately. Furthermore, the nineteenth century witnessed the establishment of local authorities at the centre of local health care provisions and in a position of prominence within the centralised Local Government Board (née Board of Supervision) which oversaw and encouraged the developments in medical provisions.

Medical provisions were, however, still rudimentary and were working in conjunction with the voluntary hospital system. The voluntary hospitals were held in high esteem by the community in which they functioned, and ranged from large teaching hospitals to small cottage hospitals.²² Nonetheless, the hospitals had constant funding problems which were offset by allowing private patients admission to special private wings of the hospital, along with contributions from local authorities and workmen's schemes.²³ The voluntary hospital system provided medical services, filling the gap which was not covered by the poor law institutions. By the twentieth century many voluntary hospitals were working in conjunction with local authorities, although their financial problems increased until they were eventually incorporated in to the NHS. The nineteenth and early twentieth centuries, therefore, saw the beginning of medical services which were expanding from both the voluntary and local government spheres throughout the UK.

¹⁹ Ibid, p. xxx.

²⁰ J. Kinnaird, 'The Hospitals' in G. McLachlan, *Improving the Common Weal*, (Edinburgh, 1987), p. 229.

²¹ Webster, *The Health Services Since the War*, p. 5.

²² Ibid, p. 3.

²³ Ibid, p. 4.

The access to medical services was further extended through the National Insurance Act 1911. The Act made contributory health insurance compulsory for a large section of the manual workforce. The Act, however, only provided medical care for manual and non-manual workers in insured industries and did not cover dependents. Charles Webster notes that ‘because the system was administered through some 7,000 Approved Societies there was considerable diversity in additional benefits offered’.²⁴ Some workers received partial costs for ophthalmic and dental treatment, whilst others did not receive such additional benefits. Furthermore, National Health Insurance only provided for care by a GP and effectively closed off hospital treatment under the scheme.²⁵ Workers requiring hospital treatment, other than for tuberculosis, had to go to the services provided by local government. Authorities within Scotland, however, recognised that the vast geography and social deprivation of the region meant health service provision under the Act would be inadequate.

The Highlands and Islands were of particular concern to the Scottish Office and were the centre of many investigations regarding the health of the people in the region. The most notable of these investigations was by the Dewar Committee, which published a report in 1912 regarding the health and welfare of the area. Judged by infant mortality rates and tuberculosis rates, the health of the highland people was extremely poor.²⁶ Poor health was exacerbated by poor housing, poor nutrition and a high turnover of general practitioners (GPs) in the region. Although the Committee recognised the need for a comprehensive health service which included a state funded hospital service, their recommendations were within what could be achieved through Government avenues at the time. The Committee’s recommendations included: salaries for both general practitioners and nurses, the expansion of the nursing service, payment of travel expenses for general practitioners and allowing them to receive a small fee from patients who were able to pay. To receive this package, GPs were obligated to visit any patient requesting medical care, to attend maternity cases, and to assist with public health and school medical service work. The Dewar Report was thus advocating the transition from a medical service based on private, voluntary and local authority provisions to a free health care system for all.

²⁴ Ibid, p. 11.

²⁵ Ibid, p. 11.

²⁶ The account of the Dewar Committee in this paragraph is derived from D. Hamilton, ‘The Highlands and Islands Medical Service’, in Gordon McLachlan, *Improving the Common Weal*, (Edinburgh, 1987), p. 486.

In practice, the Act of 1913 which established the Highlands and Islands Medical Service (HIMS) brought in a system very similar to what was advocated in the report with some modifications in the method of payment to GPs. The Highlands and Islands Medical Service Board consisted of nine members, six of whom were medical professionals.²⁷ In place of a salary for GPs, the Board paid a treasury grant to each medical practice in the area, calculated to ensure that the GP would gain a minimum salary through the practice.²⁸ This grant would also cover all expenses for medicines provided to patients and travel expenses.²⁹ In some cases, GPs were helped in purchasing appropriate transport necessary for making home visits in the area in which they worked.³⁰ In addition, the homes of GPs and nurses were built or refurbished and the District Nursing Association received a grant covering 70 % of all of their approved expenses.³¹ The HIMS, therefore, provided state funded free health care for those in the Highlands and Islands regions, as the medical services provided by the free market, local authorities and voluntary sectors were not sufficient.

The HIMS highlights the distinctiveness of the health services within Scotland, as this experiment in social medicine was one of many which were to be established in the forthcoming years. Webster notes that later, in discussions around the establishment of the NHS, the HIMS was used by the government as an argument for the extension of health services throughout Scotland, particularly because the HIMS paid grants to general practitioners.³² During the House of Commons debates the Secretary of State for Scotland, Joseph Westwood, often referred to the distinctiveness of Scottish health services as an argument for a separate act. Additionally, GPs who worked within the HIMS had not made any representation against the scheme being extended to the rest of Scotland through

²⁷ The HIMS Board included: Sir John A. Dewar, Bt., M.P., Chairman; The Lady Susan Gilmour; Sir Donald MacAllister, K.C.B., Principal and Vice-Chancellor of Glasgow University, and President of the General Medical Council; Dr W. Leslie Mackenzie, Medical Member of the Local Government Board for Scotland; Dr John Macpherson, Senior Medical Commissioner in Lunacy for Scotland; Dr John C. McVail, Deputy Chairman of the Scottish Insurance Commission; Dr J. L. Robertson, Senior Chief Inspector of Schools in Scotland; Dr Norman Walker, Direct Representative for Scotland on the General Medical Council; and Mr Lewis M'Quibban, of the Scottish Education Department, as secretary.

Highlands and Islands Medical Service Board, *The British Medical Journal*, 2(2854), (11th September 1915), 402.

²⁸ McCrae, *The National Health Service in Scotland*, p. 15.

²⁹ *Ibid*, p. 15.

³⁰ *Ibid*, p. 15.

³¹ *Ibid*, p. 15.

³² Webster, *The Health Services Since the War*, p. 104.

the NHS.³³ By making such statements, Westwood highlighted the distinctiveness of health care within Scotland and the acceptance of this by a proportion of the medical profession who had worked within it. Stewart holds the view that the nature of Scottish health services prior to the NHS White Paper, and the use of this by Scottish Secretaries in discussions of the White Paper in 1944, reveal the extent to which Scotland remained autonomous in the administration of the health services.³⁴ This autonomy is further demonstrated by the establishment of the Scottish Board of Health in 1919, later the Department of Health for Scotland. The Board promoted co-ordination and expansion of the health services. Sir John Brotherston argues;

The Highlands and Islands Medical Service was the cherished concern of the Scottish Board of Health and of its successor, the Department of Health for Scotland. The scheme's administrators in Edinburgh enjoyed excellent relations with the doctors and others involved in providing the services. This cordial relationship did something to foster confidence among the medical profession in Scotland in the central department, which was to be important both during the setting up of the National Health Service in 1947-48 and subsequently.³⁵

Furthermore, Jenkinson argues that the NHS (Scotland) Act followed the practice started with the HMS in supplementing GP incomes for doctors in remote areas.³⁶ Lindsay Paterson also argues that as the health services had been the 'ultimate responsibility of the Scottish Office' placing the NHS with the Scottish Office was therefore a logical step.³⁷ Through schemes such as the HMS and its use in discussions surrounding a separate NHS Act for Scotland, the distinctive development of the health services within Scotland is notable.

In 1929, the role of local authorities within the health services was extended through the Local Government (Scotland) Act. The Act laid a duty upon local authorities to provide medical services in their area with large royal burghs, counties and cities administering these services. One of the main changes which occurred with the Local Government Act, in Scotland, England and Wales, was the transfer of the poor law hospitals to the local authorities. The services passed to the local authorities through the 1929 Act, also

³³ Jenkinson, *Scotland's Health*, p. 434.

³⁴ Stewart, 'The National Health Service in Scotland', p. 389.

³⁵ J. Brotherston, 'The Development of Public Medical Care 1900-1948', in G. McLachlan, *Improving the Common Weal*, (1987), p. 55.

³⁶ Jenkinson, *Scotland's Health*, p. 413.

³⁷ L. Paterson, *The Autonomy of Modern Scotland*, (Edinburgh, 1994), p. 128.

included those for mentally ill and mentally defective patients. Consequently, by 1929, state-controlled health services had been brought together under the auspices of local authority control and the Medical Officer of Health, with the intention of creating a local authority hospital service. As Christopher Ham argues:

Although uneven progress in this direction was made before the outbreak of the Second World War, the 1929 Act was important in placing the Poor Law infirmaries in the same hands as the other public health services which were under the control of medical officers of health. These services included not only those already mentioned, but also the provision of specialist hospitals – for example, for infectious diseases and tuberculosis – which local authorities had developed rapidly from the last decades of the nineteenth century.³⁸

Ian Levitt argues that the Department of Health realised, soon after the passing of the 1929 Act, that it had three major problems with the provision of health care through local authorities: the lack of hospital accommodation; the lack of local authority co-operation; and, the lack of co-operation from the voluntary hospitals.³⁹ Even at this stage, the Department of Health for Scotland was finding it difficult to encourage the co-operation and co-ordination necessary to expand the health services. Despite the deficiencies in the health services in the 1930s, local authorities were attempting to provide some extensions in their services, which will be discussed more fully later in the chapter. What is evident from the 1929 Act is that throughout the United Kingdom, the step towards a centralised, state health service was beginning, and local authorities were central to the required extensions in health care.

Within England, the acknowledgment that a comprehensive health service was required was evident through the Dawson Report (1920) and later through conferences held within the Ministry of Health on the development of the health services.⁴⁰ The recognition that a centralised, comprehensive health service was required in Scotland is also evident through the establishment of many committees such as the Committee on Scottish Health Services and the Committee on Post-War Hospital Problems in Scotland. As will be discussed in the following section these committees were the basis of planning for extensions within the Scottish health services. It was not until the post-war era that the recommendations of the committees were implemented in the formation of the NHS. The Second World War,

³⁸ C. Ham, *Health Policy in Britain*, 5th Edition, (Houndmills, 2004), p. 12.

³⁹ I. Levitt, *Poverty and Welfare in Scotland 1890-1948*, (Edinburgh, 1988), pp. 162-8.

⁴⁰ Webster, *The Health Services Since the War*, pp. 21 & 241.

however, did not stop the Scottish Office from extending the centralisation of the health services through the use of the Emergency Medical Service (EMS), established in 1939.

The EMS in Scotland provided 16,000 extra hospital beds administered by the Department of Health.⁴¹ These were not only used for war related medical emergencies but were also extended to the civilian population. By 1941, the Department of Health annual report noted that the scope of the Emergency Hospital Service (EHS) had been widened to provide hospital accommodation for:

air raid casualties; persons injured by enemy action at sea; civil defence personnel injured in course of their duty; workers in war industries suffering from fractures; for essential war workers living in lodgings or billets away from home; for evacuees of all classes and for Service sick and casualties whether occurring at home or overseas.⁴²

The extension in hospital services due to the EHS was evident in the 1941 and 1942 annual reports. In 1941, it was stated that 7,100 beds would be provided in newly built hospitals and that the building of these hospitals would be complete by the summer of 1941.⁴³ The influence of the EHS did not stop there. By 1942 an experiment in social medicine had begun.

The Clyde Basin Experiment was unique in that it allowed industrial war workers to use EMS hospital beds for their medical care and recuperation.⁴⁴ As the EMS was under the control of the Secretary of State, it allowed effective central co-ordination between GPs, consultants and hospitals.⁴⁵ The Experiment was initially available to workers in West Central Scotland aged 15 to 25 years, later extending to workers of all ages throughout Scotland, except the Highlands.⁴⁶ Patients referred under the scheme were found to suffer from general aches, pains, tiredness, loss of appetite and anxiety.⁴⁷ By 1944, 13,000 patients had been treated under the scheme, 44% of patients with treatable illnesses, 22% of patients were admitted to hospital and 22% of patients were admitted to homes to

⁴¹ Webster, *The Health Services Since the War*, p. 23.

⁴² Department of Health for Scotland, *Summary Report by the Department of Health for Scotland 1st January 1939- 30th June 1941*, (1941), Cmd 6308, p. 8

⁴³ Ibid, p. 9

⁴⁴ Jenkinson, *Scotland's Health*, p. 405.

⁴⁵ Ibid, p. 405.

⁴⁶ Ibid, p. 405.

⁴⁷ McCrae, *The National Health Service in Scotland*, p. 209.

convalesce.⁴⁸ Of these patients 52% were female.⁴⁹ Therefore, the Clyde Basin Experiment brought about an unprecedented avenue for workers to gain hospital medical treatment which was not available throughout the UK. McCrae argues that the Experiment was established as a direct result of recommendations within the Cathcart Report.⁵⁰ Jenkinson, however, attributes the extension of medical services to the strong leadership of Tom Johnston, Secretary of State for Scotland, who was not willing to relinquish them after the end of the war. Along with the extension in medical services during World War II through the EMS, centralisation of health services through the Department of Health for Scotland was evident.

The EHS also released 800 beds for tuberculosis patients helping to ease the voluntary hospital waiting lists. By 1942, the Department of Health controlled 75 hospitals, with 98 voluntary and 29 local authority hospitals included in the scheme.⁵¹ By the end of the war, the EHS had provided 16,000 new hospitals beds within Scotland. Furthermore, the EHS, and Emergency Medical Service as a whole, provided the means by which centralisation of the health services could be attempted between the GPs, consultants and hospitals. The Experiment shows that the Secretary of State for Scotland and the Department of Health for Scotland were considering alternative ways to provide health services which were centrally organised but still included local authorities. The experimentation with greater central control of the health services through the Department of Health for Scotland may have given some indication of the future administration of the health services, although it was widely thought by local authorities that they would still be in overall administrative control in the post-Second World War era.

By considering the development of the Scottish health services prior to the NHS it is evident that a distinctive health culture in Scotland existed from the nineteenth century, as the principles underlying the development of the health services differed from those in England. As a result, local authorities were central to the provision of health services, especially after the Local Government Act of 1929, and participated in the discussion and formation of future health policy. They advocated a comprehensive, free health care system from an early stage and were therefore part of the consensus that was gaining

⁴⁸ Ibid, p. 209.

⁴⁹ Ibid, p. 209.

⁵⁰ Ibid, p. 209.

⁵¹ Department of Health for Scotland, *Summary Report by the Department of Health for Scotland Year Ended 30th June 1942*, (1942), Cmd 6372, p. 6

momentum during this time. Nevertheless, it is crucial to rethink the prevailing consensus theory by which the principle of a comprehensive, free health care system was translated into policy. Local authorities were central to the transfer and extension of health services throughout the early twentieth century, yet they have been excluded largely from the historiography of the establishment of the NHS.

Local Authorities and the Development of the Mental Health Services

Mental health services also developed within Scotland and under the administration of local authorities. In this chapter, mental health services are discussed separately as, until the establishment of the NHS, they were not administered in conjunction with the physical health services. In the health planning of the 1930s and the planning for the NHS, those involved in the care of patients with mental illness argued that it should be joined to the development of the physical health services.

The eighteenth century witnessed the rise of institutionalisation of the insane. A 'trade in lunacy' began in this period, which provided madhouses for the most acute lunatics at a lucrative price.⁵² Scull notes that although information on eighteenth century madhouses is limited, the existence of free trade in lunacy 'created a social space within which therapeutic experimentation could proceed; and while neglect may indeed have been the norm, individual madhouses seem to have made genuine efforts to secure their inmates' well-being and comfort'.⁵³ Nevertheless, it was the image of brutal treatment of the insane which dominated the public perception of madhouses and caused complaints by concerned citizens.

Scull argues that changes in the treatment of the insane were due to the capitalist market economy and commercialisation of existence, which unravelled the traditional ways in which the poor and insane were dealt with, establishing an institutional response to the control of sections of society.⁵⁴ The change in social order caused a change in the responses to social problems through the rise of institutionalisation of sections of society, not only the insane but also the poor through workhouses. The establishment of the Poor

⁵² R. Porter, 'Madness and its Institutions', in A. Wear (ed), *Medicine in Society: Historical Essays*, (Cambridge, 1992), p.284.

⁵³ A. Scull, *The Most Solitary of Afflictions: madness and society in Britain, 1700-1900*, (London, 1993), p. 23.

⁵⁴ Scull, *The Most Solitary of Afflictions*, p. 29-33.

Law served to bolster this response in the late eighteenth and nineteenth centuries. Porter, however, views the emergence of the asylum as a number of 'renegotiations of responsibilities, in an economy in which services were increasingly provided by cash payments'.⁵⁵ Furthermore he sees the eighteenth century as a turning point for 'practical psychiatry' as the institutions established at this time allowed doctors and laymen experience of treating insane patients at close contact and in sizeable numbers.⁵⁶ Within Scotland, care for the insane was provided primarily through poorhouses until 1781, when a separate asylum was built in Montrose, founded, and also funded by Mrs Susan Carnegie; it became a royal asylum in 1810.⁵⁷ Although private madhouses existed in Scotland, by the late eighteenth century, a purpose built asylum was established, changing the pattern of the type of institution in which the insane within Scotland were housed. Therefore, the eighteenth century saw the rise of asylum care and 'practical psychiatry' by both philanthropic and entrepreneurial means, due to both the changes in social order and the expansion of a consumer society.

By the nineteenth century, asylum provision within Scotland was growing with the opening of Aberdeen Royal Asylum in 1800, Royal Edinburgh Asylum in 1813, Glasgow Royal Asylum in 1814 (later known as Gartnavel Royal Hospital), Dundee Royal Asylum in 1820, Murray Royal Asylum, Perth in 1827 and Crichton Royal Asylum, Dumfries in 1838.⁵⁸ The rise of purpose-built asylums was therefore not unique to the development of English mental health services, but also occurred in varying degrees throughout Britain in the early years of the nineteenth century. It was not until the Lunacy Act of 1845 that asylums were built on a large scale. The Lunacy Act 1845 only applied to England and Wales, and was mostly concerned with the registration and conduct of madhouses, as were other lunacy acts of this period.⁵⁹ The Act of 1845 set up a permanent Board of Commissioners who were assigned the task of regulating all private and public institutions. Rogers, in his assessment of the Act, saw it as the demise of lay administration as many of the institutions were awarded to medical practitioners.⁶⁰ The mid-nineteenth century was a turning point for the provision of services for the mentally ill, as the medicalisation of

⁵⁵ Porter, 'Madness and its Institutions', p. 288.

⁵⁶ Ibid, p. 289.

⁵⁷ The Foundation of Montrose Asylum, University of Dundee, <http://www.dundee.ac.uk/museum/medical/sunnydays.htm>.

⁵⁸ Hospital History: Modern Asylums, <http://www.dundee.gov.uk/liff/history5.html>.

⁵⁹ W.E. Lloyd, *A Hundred Years of Medicine*, (London, 1971), p. 308.

⁶⁰ A. Rogers & D. Pilgrim, *Mental Health Policy in Britain*, (Basingstoke, 2001), p. 46.

treatment occurred. Porter notes that the image of madhouses as horrific institutions of cruelty and neglect gave way to a nineteenth-century image of new asylums 'as a progressive institution, indeed the one truly effective site for the treatment of insanity'.⁶¹ It was also at this time that the term psychiatry began to be used within medical circles.

It was not until over a decade after the Lunacy Act 1845 that legislation was passed for Scotland. A Royal Commission on Lunacy in Scotland was established in 1855 due to the concerted efforts of an American, Dorothea Dix.⁶² Dix visited Scotland in 1855 on a tour of the asylums and requested that a commission be set up to consider the care of the insane.⁶³ Andrews suggests that the fact that it took outside pressure demonstrates 'the level of resistance that has existed in Scotland towards central control of lunacy provision, and towards anything that smacked of importing the English Poor Law system'.⁶⁴ Nevertheless, the Commission found that there were many problems with the services for the mentally ill within Scotland, such as evidence of neglect and ill treatment of patients and profiteering in private institutions, as well as the criticism of restraints in all institutions.⁶⁵ As with the physical health services, mental health services were made available through a combination of private and local authority provisions. The Commission converted their findings into the Lunacy (Scotland) Act 1857 which stated that all mentally ill patients should be admitted to an asylum or similar institution, whilst also allowing the admission of voluntary patients. The Scottish Board of Lunacy was also established under the Act; it was the equivalent of the English Board of Commissioners. The Scottish Board consisted of an unpaid chairman, two paid medical commissioners and three unpaid legal commissioners.⁶⁶ The Commissioners inspected both private and public institutions to ensure the proper care of mentally ill patients was upheld. Institutions with over 100 patients had a resident medical attendant, whilst a medical attendant visited institutions

⁶¹ R. Porter, *The Greatest Benefit to Mankind A Medical History of Humanity from Antiquity to the Present*, (London, 1999), p. 494.

⁶² J. Andrews, "They're in the Trade...of Lunacy They 'cannot interfere' – they say": *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland*, (London, 1998), p. 6.

⁶³ T. Walmsley, 'Psychiatry in Scotland', in G.E Berrios & H. Freeman, *150 Years of British Psychiatry, 1841-1991*, (London, 1991), p. 300.

⁶⁴ Andrews, "They're in the Trade", p. 7.

⁶⁵ Hamilton, *The Healers*, p. 218.

⁶⁶ Walmsley, 'Psychiatry in Scotland', p. 300.

with 50 patients or more daily.⁶⁷ Families were also allowed visitation rights to the asylums.

The Scottish Act, however, gave a greater emphasis, than in England and Wales, to the use of the boarding-out system. The boarding-out system allowed mentally ill patients to live within their community either with their family or with a designated carer. Mentally ill patients could either be placed in a house singly or with up to four other mentally ill patients. In considering mental health services within the nineteenth century, Hamilton, notes the more liberal nature of the Scottish Act in comparison to its English equivalent.⁶⁸ Sturdy and Parry-Jones highlight the significance of the boarding-out system within Scotland, as it was innovative for its time, receiving attention from doctors around the world.⁶⁹ The innovative health service within Scotland is something that has been highlighted, more significantly through general practitioner and hospital services, but also occurs in the treatment of mentally ill patients.

A network of mental health services grew after the passing of the Act. The available institutions for the treatment of the mentally ill included royal asylums, district asylums, parochial asylums, licensed wards in poorhouses, private madhouses, two schools for the training of imbecile children and the lunatic department at Perth prison.⁷⁰ Between 1860 and 1910, nineteen asylums were built as a result of the 1857 legislation.⁷¹ Although the boarding-out system was used to a significant extent, asylums were still the dominant feature of mental health services within this period.

By the early twentieth century, there was pressure from the National Association for Promoting the Welfare of the Feeble-Minded for a Royal Commission on mental health services within Britain. The Commission considered evidence from all over Britain, including Scotland, over a period of four years and published its findings in 1908. The Commission recommended that the protection of mentally ill patients be of utmost importance, as was the change in attitudes towards those suffering from mental illness. For the Commission, sterilisation was not an option, as the protection of mentally ill patients

⁶⁷ Ibid, p. 301.

⁶⁸ Hamilton, *The Healers*, p. 218.

⁶⁹ H. Sturdy & W Parry-Jones, 'Boarding-out insane patients: the significance of the Scottish system 1857-1913' in P. Bartlett & D. Wright, *Outside the Walls of the Asylum*, (1999), pp. 86-7.

⁷⁰ Ibid, pp. 86-7.

⁷¹ Hamilton, *The Healers*, p. 218.

was the goal rather than the purification of the race.⁷² Furthermore, the Royal Commission recommended that: a central Board of Control should be established, consisting of medical and legal representatives and at least one woman; and local authorities should constitute a statutory committee for mental defectives which would be responsible for the recognition of mental illness, the provision and maintenance of institutional care and the guardianship of those boarding-out in the community.

The resulting Mental Deficiency and Lunacy (Scotland) Act 1913 was largely similar to its English counterpart. It divided mental deficiency into four categories; idiots, imbeciles, the feeble-minded and moral defectives. Certification was required by two medical practitioners, or in the case of patient neglect, with a magistrate. A Central Board of Control was established and local authorities were obliged to provide an extensive range of services for identifying and providing care for mentally deficient and mentally ill adults and children. The main difference between the English and Scottish Acts was the specification that parish councils within Scotland would have a prominent role in local administration as well as on district boards of control.⁷³ Thomson, however, notes that the passage of the 1913 legislation was not easy, and opponents of the legislation made it stormy and controversial.⁷⁴ Jones, in considering the effect of the Act in England, suggests that it ‘made possible the rapid expansion and development in provision for defectives’.⁷⁵ In practice, the Act did very little to change the administration of services for mentally ill patients within Scotland. The titles of the boards changed, for example the General Board of Commissioners in Lunacy for Scotland became the General Board of Control for Scotland and the District Boards of Lunacy became the District Boards of Control; however their membership remained relatively unchanged. Therefore the 1913 Act only provided some clarification of definitions of mental deficiency not mental illness, and provided local authorities with greater responsibilities for the provision of care for mentally ill adults and children.

Thomson observes a continuity between the period prior to the 1913 and that after the Act in that many of the ideas which shaped interwar policy on mental deficiency were those

⁷² K. Jones, *Mental Health and Social Policy 1845-1959*, (London, 1960), p. 53.

⁷³ M. Egan, ‘The ‘manufacture’ of mental defectives in late nineteenth and early twentieth century Scotland’, (unpublished PhD thesis, University of Glasgow, 2001), p. 118.

⁷⁴ M. Thomson, *The Problem of Mental Deficiency: eugenics, democracy and social policy in Britain c. 1870-1959*, (Oxford, 1998), p. 50.

⁷⁵ Jones, *Mental Health*, p. 71.

which shaped the way in which those with mental deficiencies were cared for.⁷⁶ For instance, psychiatric social workers based their assessments on morality and individual responsibility; individual liberty was considered more important by the Board of Control than medical interests; and, debates over policy circled around the rights and duties of citizenship.⁷⁷ In addition, Thomson goes on to argue that the problems encountered in passing the 1913 Act through Parliament caused a reluctance to reassess the question of mental health during the interwar period, avoiding substantial reform until the 1959 Mental Health Act.⁷⁸ Consequently the 1913 Act upheld views which were rooted firmly in the nineteenth century, whilst providing a new system of care most notably for patients with mental deficiency. Furthermore, the provisions, which were at the centre of mental health services, still predominantly remained in the asylums and boarding-out system.

The Local Government Act 1929 and the Mental Treatment Act 1930 also led to change within the provision of mental health services. These Acts introduced the facilitation of early treatment for voluntary patients and gave local authorities power to set up out-patient clinics.⁷⁹ The establishment of local authority clinics for the mentally ill was a large step for mental health services, placing greater emphasis on the health services they administered. Nevertheless, institutional care was still at the forefront of mental health care and by 1938, 3,900 institutional places were available within Scotland for mentally ill patients.⁸⁰ Webster notes that during the inter-war period, only two new mental hospitals were built, the Bethlem Hospital was rebuilt for the fourth time and a new hospital in Runwell, Essex was built which was divided into small units as an attempt to humanise conditions within the hospital.⁸¹ Furthermore, Webster goes on to point out that the failure to rehabilitate patients, along with the longevity of mental patients increasingly created an overcrowded and understaffed system.⁸² The development of mental health services was still seen to be inadequate during the wartime period, as were many of the health services within England and Scotland.

⁷⁶ Thomson, *The Problem of Mental Deficiency*, p. 303.

⁷⁷ Ibid, p. 303.

⁷⁸ Ibid, p. 50.

⁷⁹ J. Busfield, 'Restructuring Mental Health Services in Twentieth Century Britain', in M. Gijswijt-Hofstra & R. Porter, *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, (Amsterdam, 1998), p. 15.

⁸⁰ Webster, *The Health Services Since the War*, p. 10.

⁸¹ Ibid, p. 10.

⁸² Ibid, p. 10.

The development of the mental health services, again, shows a distinctive culture in the way in which mental health was treated in Scotland. Furthermore, the mental health services are a further example of the central position local authorities obtained in the delivery of health services. As with the physical health services, local authorities were central to the planning and transfer of the mental health services to the NHS, as will be discussed in later chapters. Consequently, the historiography of the physical and mental health services within the planning and development of the NHS must be reconsidered to include the local authorities who were central in their delivery prior to 1948.

Local Authorities and Health Planning in Scotland

The dominance of local authorities within the health services was prevalent in the early twentieth century and was consolidated through the Local Government Act of 1929. Local authorities were at the forefront of provision in conjunction with the private and voluntary medical services. From the 1930s, the local authorities were represented on the main committees investigating health services, including the Committee on the Scottish Health Services (Cathcart), the Nuffield Provincial Hospitals Trust Committee and the Committee on Post-War Hospital Problems in Scotland (Hetherington).

These committees and their reports recognised the deficiencies of Scottish health service provisions and considered only Scottish health service problems. The Committee on Scottish Health Services (the Cathcart Committee) was appointed in 1933 to consider:

The existing health services of Scotland in the light of modern conditions and knowledge, and to make recommendations on any changes in policy and organisation that may be considered necessary for the promotion of efficiency and economy.⁸³

The remit allowed the committee to consider all areas of the health services including GPs in private practice, voluntary hospitals, the HIMS and local authority health services. The Report pointed to the growth of health services within Scotland prior to 1933 as a basis for the future of the health services. The Report states that the health services, which were established, were justified and that ‘public opinion [was] carrying them forward in a continuous process of extension’.⁸⁴ The Committee, however, found that in light of what

⁸³ Department of Health for Scotland, *Committee on Scottish Health Services Report*, (1936), Cmd 5204, p. 9

⁸⁴ *Ibid*, p. 312

was required for a 'modern' health system, the health services required significant modification.

The local authorities were called to give evidence through their associations: the Scottish Counties of Cities Association; the Convention of Royal Burghs; and, the Association of County Councils.⁸⁵ Although it was mainly through these associations that the representations of local authorities were made, the four cities of Glasgow, Edinburgh, Aberdeen and Dundee were invited individually to give their representations on the health services. The representations made by the local authorities and their associations covered many areas, such as sanitation, water supply, housing and public health, as well as the health services. Although the original papers of the Committee were destroyed at St Andrew's House, during the Second World War, as a fire precaution, the detailed minutes of evidence given to the Committee gives insight into the thoughts of the local authorities and how these influenced the final report.⁸⁶

There was agreement over a number of general issues concerning the extension of the Scottish health services. The local authorities were in general agreement that there should be some sort of regional health scheme which included the local authority health services, GPs and voluntary hospitals; a regional hospital scheme was desirable; the health services should include mental health services; and, the functions of the Board of Control be transferred to the Department of Health for Scotland. Although the local authorities were in general agreement over these broad principles, disagreements occurred between the local authorities. Furthermore, in discussing the role of mental health services Dr McAlister, Mental Health Services Medical Officer for Edinburgh, stated:

I think there is no longer any excuse whatever, in the case of a man who is mentally ill, for insisting on his approach to the mental hospital through the Public Assistance Department. I think it is subversive to all our ideas of what medical treatment should be.⁸⁷

The Royal Burghs also advocated that the functions of Board of Control be transferred to the Department of Health. They felt as the services of those two central departments were administered by the same local authority, they could not see a reason against the same

⁸⁵ The three associations represented all local authorities within Scotland from the small burghs to the large cities.

⁸⁶ The archives for the Cathcart Committee can be found in the National Archives of Scotland, series HH76/10.

⁸⁷ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Corporation of Edinburgh*, 15th of February 1935, p. 24.

functions being administered by one central authority.⁸⁸ The two examples of the evidence given by the Royal Burghs and Edinburgh Corporation indicates that local authorities were looking to a comprehensive health service which was administered under one authority and included the mental health services.

All of the local authorities agreed that the lunacy laws required a review and that mental health services be incorporated into the physical health services. As with the majority of the local authorities, Edinburgh Corporation for example, felt that the lunacy laws made provisions legalistic and that a review of the definition of lunacy should be instigated. This would begin by defining a voluntary patient as ‘someone with mental illness who seeks treatment’.⁸⁹ The Corporation also felt that out-patient departments at general hospitals would be beneficial in the diagnosis of patients being admitted to a mental hospital.⁹⁰ Furthermore, the Board of Control was no longer efficient in their role of overseeing the mental health services.⁹¹ The Corporation was therefore in favour of a complete overhaul of the mental health services beginning with the law on lunacy, the administration of the service and its affiliation to all other health services which were provided by the local authority.

The Association of County Councils considered that a regional scheme would be beneficial to the counties and burghs. In discussing, this they argued that ‘a regional scheme [was adopted] in Aberdeenshire, Aberdeen City and Kincardineshire, whereby the counties and the city are all under one chief medical officer of health, and we have had that regional scheme working for some time very successfully’.⁹² The regional scheme in Aberdeen brought together the municipal and voluntary hospitals in the provision of hospital care for patients within the Aberdeenshire, Aberdeen and Kincardineshire areas. The scheme was thought to be very successful by the Association and would be beneficial if instituted throughout the country. Furthermore, they recommended that local authorities be given powers to carry out all the ‘modern’ commitments as regards these diseases.⁹³ This was in

⁸⁸ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Convention of Royal Burghs*, 8th of February 1935, pp. 2-3.

⁸⁹ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Corporation of Edinburgh*, 15th of February 1935, pp. 22-3.

⁹⁰ *Ibid*, p. 32.

⁹¹ *Ibid*, pp. 22-4.

⁹² NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services (Forty First Day) by the Association of County Councils*, 1st of February 1935, p. 3.

⁹³ *Ibid*, p. 3.

relation to preventive and curative health care including the provision of clinics and hospitals. The power to permit the local authority to provide hospitals, consultants and these various general services should only be a power not a duty.⁹⁴ The Convention of Royal Burghs also advocated a regional comprehensive health care system, centred on the family doctor and administered under a public health committee by local authorities. In discussing the health service envisioned, Councillor Rutherford of Kirkintilloch stated:

In my view a preventive service should definitely be under control and administered by the local authority – hospitals, hospital treatment and service. General hospitals should be increased in number and be placed regionally and be of sufficient size to carry a first-class staff. The system of convalescent or secondary hospitals should be raised to relatively highly equipped institutions whether voluntary or otherwise, where rest and nursing can be given. These should be large and the region would of course contribute according to its need. But a really highly equipped medical service should definitely be regional.⁹⁵

As with other local authorities, Aberdeen advocated a health service which incorporated GPs and the co-operation between local authority and voluntary hospitals. A regional scheme was already in place between the Corporation, the Town of Aberdeen and Kincardine under the leadership of Dr Rae, Medical Officer of Health for the three areas since 1930.⁹⁶ Gorsky attributes the co-operation achieved in Aberdeen to the policies embraced by the local authority which committed Aberdeen to developing their municipal services. Furthermore, he goes on to argue that in Aberdeen the Medical Officers of Health were not only pursuing a course with the backing of their local authority but also, in their view, with the backing of the Department of Health for Scotland.⁹⁷ Thus Aberdeen were demonstrating the way in which local authorities could provide municipal services within the health sphere and co-ordinate other health services within their area.

The Corporation of Dundee advocated, as a preventive measure, a comprehensive, free medical service which included a GP service and a comprehensive hospital service.⁹⁸ The Corporation of Dundee highlighted the importance of preventive medicine ‘as far as the medical services [were] concerned, to detect disease at the earliest possible moment and

⁹⁴ Ibid, p. 64.

⁹⁵ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Convention of Royal Burghs*, 8th of February 1935, p. 14.

⁹⁶ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Town Council of Aberdeen*, 1st of March 1935, p. 2.

⁹⁷ M. Gorsky, ‘Threshold of a New Era’, pp. 255-64.

⁹⁸ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Town Council of Dundee*, 8th March 1935, p. 5.

deal with it at a time when it can be efficiently dealt with'.⁹⁹ The Corporation promoted both institutional and domiciliary health services to be administered by the Public Health Committee.¹⁰⁰ Therefore, the majority of the local authorities agreed that a regional scheme was necessary to provide a comprehensive health service although they were advocating different administrative formats to undertake this.

Edinburgh Corporation, however, were not averse to a regional scheme but noted that co-operation between local authorities was already being undertaken with regards to health provisions for venereal diseases. In connection with this they noted that:

We have in Edinburgh a great many public health institutions, and for many years we have made it our business to give the benefit of these institutions to outside areas on two conditions; first, that we can without detriment to the citizens of Edinburgh take in their cases, and secondly, that the outside authorities pay our bare expenditure. We do not seek to make any profit. In that way we have made arrangements with regard to venereal diseases and other services; we make our institutions available to these other authorities as far as we possibly can on these conditions. These are very simple conditions, and are regarded as very satisfactory. There is no complication about administration or anything else, and in point of fact they get the services at a much less rate than otherwise could be provided. That is really what we have in view; but we recognise that the situation might fail to be altered if a regional authority would be set up.¹⁰¹

Edinburgh considered the health services separately and was more in favour of a regional hospital scheme. Glasgow Corporation, however, were in favour of local authority co-operation, but found that this could be difficult as 'each local authority thinks that it is the centre of the universe, and it is difficult to get round that'.¹⁰² Glasgow Corporation saw that a general understanding by local authorities that some regional co-operation was necessary would be advantageous especially in the realm of infectious diseases hospitals. In later discussions, the Corporation did qualify this statement by saying that at that particular time they did not think that a regional scheme was feasible as many local authorities were unable to provide the funds necessary for what Glasgow was suggesting.¹⁰³ The Corporation advocated a national health service which would provide free medical

⁹⁹ Ibid, p. 4.

¹⁰⁰ Ibid, p. 21.

¹⁰¹ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Corporation of Edinburgh*, 15th of February 1935, p. 19-20.

¹⁰² NAS, HH76/10, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Glasgow*, 22nd of February 1935, p. 5.

¹⁰³ NAS, HH76/11, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Glasgow*, 22nd of March 1935, p. 80.

care to the population of Scotland through GPs, clinic services and a hospital service but saw many difficulties in achieving this. The expansion of a regional medical scheme was in principle favoured by the local authorities, although the differences in opinion over if and how this would have worked are apparent through the evidence given by each of the associations and the cities.

The regionalisation of hospital services was another area which in principle the local authorities agreed on. Glasgow, for example, thought a regional hospital scheme could be operated by joint committees as long as finance did not come into it.¹⁰⁴ The Committee, however, did not see finance as Glasgow's problem and thought it was one of representation on the joint committee. In questioning the Corporation representatives the Committee stated

Your difficulty is not really the poverty of the local authorities forming the combination, but that your representation is so small compared with the representation of the combined body that your voice does not bear any proportion of the responsibility you are carrying? - That is so.¹⁰⁵

The Corporation maintained their stance that they favoured a regional scheme for hospitals and that this should be done by negotiation among the various local authorities.¹⁰⁶ With regards to hospital provision, Dundee saw the benefit of central control of the service and saw this as desirable but not necessary for a good service.¹⁰⁷ Again, it is shown that the general principles were agreed upon but the effectiveness and necessity of them was not.

Aberdeen Corporation also advocated a regional hospital scheme. Martin Gorsky argues that Aberdeen was the 'trail-blazer' in hospital co-ordination as the Corporation took over the poor law hospitals prior to the Local Government Acts. Furthermore, the joint hospital scheme that was established included voluntary hospitals, local authority clinics and the university's medical school relocated to a new joint site; and, agreements were made with neighbouring counties and burghs to combine infectious disease and laboratory services in

¹⁰⁴ Ibid, p. 81.

¹⁰⁵ Ibid, p. 82

¹⁰⁶ NAS, HH76/10, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Glasgow*, 22nd of February 1935, p. 44.

¹⁰⁷ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish health Services by the Town Council of Dundee*, 8th of March 1935, p. 25.

the city.¹⁰⁸ In discussing the co-operation achieved between the local authority and voluntary hospitals the Aberdeen representatives stated:

the Royal Infirmary had a very heavy waiting list of patients that could not get into the hospital; we arranged that regular interviews between our medical officer and the officials of the Royal Infirmary, for instance, should be held, and that we should relieve their waiting list of patients as agreed.¹⁰⁹

Such co-operation was what the Corporation advocated. Aberdeen demonstrates that the experience of the local authorities formed the evidence they gave to the Committee about the way in which the health services could be improved and extended. Edinburgh Corporation indicated that they might not be averse to a regional scheme if suitable arrangements were made, but would prefer to administer the hospitals themselves. Furthermore, the Corporation was not averse to combining all hospitals in an area.¹¹⁰ The Corporation however, wanted to keep control of any hospitals extended or built and wanted other local authorities in the region to contribute on a customer basis.¹¹¹ The Corporation noted that co-operation between local authorities already existed with regard to health provisions for venereal diseases. Therefore, the Corporation was willing to participate in some form of regional hospital scheme, based on its previous experience of hospital co-ordination, if given assurance that it would have ownership and administrative control of the hospitals within its area.

The Royal Burghs also advocated the regional planning and administration of hospitals.¹¹² With regards to hospitals they suggested a distinction between the smaller fever hospitals and the larger more specialist hospitals. The Royal Burghs thought the smaller hospitals should be administered locally, whilst the larger hospitals should be administered on a regional basis.¹¹³ The Royal Burghs noted the lack of no coordination between the local authority and voluntary hospitals. They were however, aware that voluntary hospitals filled a void in the medical services provided by local authorities and that co-operation was required to incorporate voluntary hospitals into the new service.¹¹⁴ The Association of

¹⁰⁸ M. Gorsky, 'Threshold of a New Era', p. 249.

¹⁰⁹ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Town Council of Aberdeen*, 1st of march 1935, p. 17.

¹¹⁰ *Ibid*, p. 16.

¹¹¹ *Ibid*, p. 18-19.

¹¹² NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Convention of Royal Burghs*, 8th of February 1935, p. 9.

¹¹³ *Ibid*, p. 14.

¹¹⁴ *Ibid*, p. 35.

County Councils also thought there was room for both local authority and voluntary hospitals. The Association put forward the view that the two could coexist 'if there is co-ordination. I do not see room for two hospital systems which are antagonistic. So long as the two are co-ordinated I think both can exist for a very long time'.¹¹⁵ Furthermore, the Association thought there should be 1.5 to 2 hospital beds per 1000 of the population, allowing all the infectious disease, pneumonia, serious measles and whooping cough cases to be dealt with.¹¹⁶ Regional co-ordination between voluntary and local authority hospitals was crucial for the establishment of a health service which was comprehensive, but the issue again shows the variations in local authority ideas on how it could be achieved.

The inclusion of GPs into a comprehensive medical service was the issue which demonstrates the largest variance of opinions among the local authorities. On the question of cooperation between local authorities and GPs, the Association of County Councils thought 'the general practitioner ought to be recognised as having a duty on the whole field of public health, and that he ought to have his place in it, varying according to the conditions of the area'.¹¹⁷ Therefore, the Counties felt that the GP was also central to providing a comprehensive service and co-operation had to be obtained to provide the medical care necessary for the Scottish population. The Royal Burghs also saw the need for a family doctor for every family within Scotland.¹¹⁸ Aberdeen Corporation saw the family doctor as central to the health services and the Corporation argued that they should be provided through the local authority. The Corporation encouraged GP access to the hospitals in a bid to provide continuity with their patients.¹¹⁹ Dundee promoted a scheme whereby patients would be able to choose a GP¹²⁰ and the GP would examine children periodically, inoculate against infectious diseases as a preventive measure but not force himself upon a family, and families would be educated to take children to GPs.¹²¹ Like many of the other representations made by local authorities, Dundee agreed that the health service should be centred around the family doctor.

¹¹⁵ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services (Forty First Day) by the Association of County Councils*, 1st of February 1935, p. 63.

¹¹⁶ *Ibid*, p. 2.

¹¹⁷ *Ibid*, p. 19.

¹¹⁸ NAS, HH76/10, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Convention of Royal Burghs*, 8th of February 1935, p. 45.

¹¹⁹ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Town Council of Aberdeen*, 1st of March 1935, p. 12.

¹²⁰ NAS, HH76/11, *Minutes of Evidence taken before the Committee on Scottish Health Services by the Town Council of Dundee*, 8th of March 1935, p. 27.

¹²¹ *Ibid*, p. 16.

Unlike Dundee, Edinburgh Corporation saw the GP as having the duty to immunise children against diphtheria and scarlet fever if the parent wanted this. Therefore, the GP would be undertaking preventive work that he would be required to do if he were involved in a general medical service. Furthermore, if the GP had a supervisory role, rather than waiting until his patients were ill, this would comply with the public health agenda.¹²² It was noted that in a general medical service, the GP 'would be part of the medical officer of health's staff... so that there will be some sort of control and hold over the practitioners at their work'.¹²³ GPs would consequently be held responsible for the welfare of their patients within a general health service. Such provisions would run in conjunction with maternity and child welfare clinics which were provided by the Corporation. Glasgow also did not see the need for a family doctor and felt that the system of clinic doctors in which a patient would see any available doctor was sufficient for a successful scheme.¹²⁴ The doctors would also work for the Corporation on a salaried basis and be unable to work in private practice.¹²⁵ Therefore, Edinburgh and Glasgow were promoting the use of the GP through the local authority's public health department, which would give some control over the GP. Glasgow went one step further including the GP in a salaried position within the local authority consequently removing the GP from private practice.

After consulting many organisations, including the local authorities, voluntary hospitals and medical profession, the Committee made many recommendations towards the provision of a comprehensive health care system. First, the state should rely on the GP service more to bolster the services provided by local authorities. Through a system of family doctors, women and children who are unable to secure medical treatment at home would be brought within the healthcare system.¹²⁶ The proposals required an extension of the existing medical services to incorporate the GP service as a provision for the dependents of the insured population. Furthermore, the comprehensive health services required changes to the administrative system as the committee found that many of the administrative areas were too small to provide effective services.¹²⁷ Second, it proposed

¹²² NAS, HH76/10, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Edinburgh*, 15th of February 1935, pp. 56-7.

¹²³ *Ibid*, p. 66.

¹²⁴ NAS, HH76/10, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Glasgow*, 22nd of February 1935, p. 54.

¹²⁵ NAS, HH76/11, *Minutes of Evidence taken by the Committee on Scottish Health Services by the Corporation of Glasgow*, 22nd of March 1935, p. 74.

¹²⁶ Department of Health for Scotland, *Committee on Scottish Health Services Report*, (1936), Cmd 5204, p. 313.

¹²⁷ *Ibid*, p. 309.

that the central department should have greater powers to secure schemes of co-operation between local authorities and that liaisons should be established between departments administering the industrial health services and the central health department. Third, the functions of the General Board of Control dealing with the liberty of the patient should be transferred to the Sheriff, whilst the other functions would be transferred to the Department of Health for Scotland. Fourth, the Department of Health for Scotland should be given legal and organisational powers to provide guidance and administer the whole of the health services. Finally, the functions of the insurance committees should be transferred to local health authorities and appointments of Medical Officers of Health should be subject to the approval of the Department of Health.¹²⁸ The changes recommended by the Committee would establish a centralised health service, in which local authorities would combine to provide comprehensive services to the population.

The administrative changes accompanied changes within each of the services themselves. Along with the extension of GP services, extensions were recommended to: the services for maternity and child welfare; infectious diseases; hospital services; mental health services and the poor law medical service. Within maternity and child welfare, it was suggested that maternity services be based on the doctor and midwife combination, supplemented by consultant obstetricians and institutional facilities. Additionally, adequate training for doctors and midwives should be instituted, along with better hospital facilities for ante-natal care.¹²⁹ For child welfare, the GP should be central to the examination of children under five years of age, and any schemes to provide domiciliary care should be developed in conjunction with the GP service.¹³⁰ With regards to infectious disease, the committee recommended that: facilities for domiciliary care should be extended to the dependents of insured workers; the law of isolation for infectious diseases should be amended for a flexible service; and, hospital accommodation should be extended to provide specialist facilities for 'modern' treatments.¹³¹ The hospital service should be extended by co-operation between local authority and voluntary hospitals, with local authorities making up any financial shortfall. In addition, the hospital service should be viewed regionally and be regarded as one service to provide a coherent hospital service for

¹²⁸ Ibid, p. 339.

¹²⁹ Ibid, p. 178.

¹³⁰ Ibid, p. 182.

¹³¹ Ibid, pp. 328-9.

patients.¹³² Therefore, the beginning of a regional hospital service was envisioned prior to the NHS.

Mental health services also required changes according to the Committee, beginning with the review of lunacy laws to disassociate lunacy from pauperism, the removal of restrictions for temporary and voluntary patients, and the encouragement of early treatment. Again, the Committee saw the GP as the first line of contact for patients suffering from mental illness and it recommended that psychiatric units should be incorporated into general hospitals for the co-operation of all branches of medicine in the treatment of mentally ill patients.¹³³ Finally, the poor law medical service should be reviewed to remove medical treatment from the poor law and give local authorities the power to provide medical care for the poor. The provision would ensure that the GP service would not be removed from those who could not afford to pay for medical care.¹³⁴ The main recommendations, summarised above, demonstrate the beginnings of a movement towards centralised, comprehensive health services within Scotland.

McCrae notes that within discussions of funds allocated to the Department of Health for Scotland, Scottish MPs and the Scottish Secretary of State had no hesitation in supporting the scheme.¹³⁵ He also goes on to point out that the Secretary of State at the time, Walter Elliot, pledged some of the recommendations would be implemented under the Local Authority (Scotland) Act 1929.¹³⁶ Jenkinson also acknowledges that the report promoted increased state funded medical services, but she argues that legislation as a consequence of the report was not forthcoming.¹³⁷ Nevertheless, the Cathcart Report seemed to epitomise a growing consensus in which a state funded comprehensive health service was necessary to provide increases in health standards throughout the population. Moreover, the Cathcart Report greatly influenced the changes that came within the health services within Scotland culminating in the NHS (Scotland) Act of 1947.

After the publication of the Cathcart report, the Department of Health for Scotland acknowledged that modification of the health services was required. In the 1936

¹³² Ibid, p. 247.

¹³³ Ibid, p. 256.

¹³⁴ Ibid, p. 331.

¹³⁵ McCrae, *The National Health Service in Scotland*, p. 201.

¹³⁶ Ibid, p. 203.

¹³⁷ Jenkinson, *Scotland's Health*, p. 428.

Department of Health annual report, the Department reported repeated calls for improvement in hospital services and pointed out the reiteration of this within the Cathcart Report.¹³⁸ According to the *Annual Report*, modification was to be universal throughout the health services and a more comprehensive system would be established. World War II, however, stopped any changes being brought in immediately following the Cathcart Report.

It was argued by the Department of Health for Scotland that ‘modern’ medicine required a ‘modern’ hospital system, which was comprehensive and co-ordinated between local authorities. The ability to provide such a system was possible as provision for local authorities to provide medical services was made within the Local Government (Scotland) Act of 1929. The 1936 Department of Health annual report noted that discussions aimed at providing co-ordination were occurring, especially in Lanarkshire, and there were signs of agreement among local authorities about combining their services.¹³⁹ These signs were not only noted in Lanarkshire, but also between Dumbarton and Clydebank and the County and Town Councils of Perth. The following year, the *Annual Report* returned to the issue of hospital provision. The need for a coherent system between voluntary and local authority hospitals was crucial in providing the ‘modern’ system. An inventory of the number of hospitals owned by local authorities and by voluntary hospitals was included in 1937 (see Table 1) which also provided figures on the number of beds available in these hospitals.

Table 1.1: Number of hospitals and beds owned by Local Authorities and Voluntary Hospitals

Hospitals				Beds		
Region	Local Authority	Voluntary	Total	Local Authority	Voluntary	Total
Northern	22	18	40	666	501	1167
North-eastern	27	28	55	1471	1379	2850
Eastern	33	39	72	2050	1732	3782
South-eastern	48	44	92	3985	3319	7304
Western	126	90	216	12848	7145	19993
Scotland	256	219	475	21020	14076	35096

(Source: Department of Health for Scotland, *Ninth Annual Report of the Department of Health for Scotland*, (1938), Cmd 5713, p. 100)

¹³⁸ Department of Health for Scotland, *Eighth Annual Report of the Department of Health for Scotland*, (1937), Cmd 5407, p. 95.

¹³⁹ *Ibid.*, p. 95.

For a cohesive service, it was crucial for these two sets of hospitals to combine. The Voluntary Hospitals Commission noted this need for co-operation and consideration of the needs of particular areas.¹⁴⁰ The discussion over hospital provision continued into the 1940s. What is shown by the Cathcart Report and by the Department of Health for Scotland's investigations was that local authorities were central in providing health care and in its future planning.

The representation of local authorities on Committees which were investigating the extension of health services within Scotland did not end with the publication of the Cathcart Report. Local authorities were also involved in an Advisory Committee on the Regionalisation of Hospital Services within Scotland, in conjunction with the Nuffield Provincial Hospitals Trust. The extension of the Trust's investigation into the hospital services of Scotland stemmed from an experiment in regional co-ordination in the Oxford district in 1935. In 1940, the Trust, appointed under the convenership of the Rt. Hon. Thomas Johnston, M.P.,¹⁴¹ the then Regional Commissioner for Scotland, an Advisory Committee composed of representatives of the voluntary hospitals and local authorities in Scotland.¹⁴² The remit of the Advisory Committee was to consider the advisability of a scheme for the regionalisation and co-ordination of hospital services within Scotland and to assist in the promotion of such a scheme.¹⁴³ In October 1941, the Trust sent out an introductory memorandum to the local authority associations and the voluntary hospitals in a bid to gain acceptance of the idea of co-operation between the two bodies prior to any plans being formed.¹⁴⁴ This letter also included a preliminary report by the Sub-Committee on Medical Services which proposed a scheme for hospital provision within Scotland. The Sub-Committee included members from Glasgow University, the Department of Health for Scotland, the British Medical Association and the Medical Officers of Health for

¹⁴⁰ Department of Health for Scotland, *Ninth Annual Report of the Department of Health for Scotland*, (1938), Cmd 5713, p. 101

¹⁴¹ Thomas Johnston was the Regional Commissioner for Scotland at the time but resigned from the Committee when he became Secretary of State for Scotland.

¹⁴² NAS, CO1/4/138, Advisory Committee on the Regionalisation of Hospital Services within Scotland in association with the Nuffield Provincial Hospital Trust. Memorandum for the Information of the Committee on Post-War Hospital Problems, March 1942, p. 2.

¹⁴³ *Ibid*, p. 2.

¹⁴⁴ DCA, TC/SF/H49, Box 21, *Letter to J. Storrar, Secretary to Counties of Cities Association, from C. Gumley, Secretary to the Advisory Committee on the Regionalisation of Hospital Services in Scotland. Enclosing Introductory Memorandum and Preliminary Report of the Sub-Committee on Medical Services*, 21st October 1941.

Edinburgh and Glasgow.¹⁴⁵ The list of members indicates that the Cities were represented by their Medical Officers of Health on the Sub-Committee and the other local authorities were consulted through their Associations.

The Sub-Committee noted that the members were in favour of a national hospital scheme which integrated the voluntary hospitals, as promoted by the Sankey Voluntary Hospitals Commission, and the Committee on Scottish Health Services, in 1941.¹⁴⁶ The hospital service would be based on specialist services such as neuro-surgery, orthopaedics and ophthalmic conditions.¹⁴⁷ The hospital service would be regional around the South-Eastern, Eastern, North-Eastern, Northern and Western areas.¹⁴⁸ The Local Authority Associations were requested to submit their thoughts on such a scheme; however, before this was completed Thomas Johnston announced the establishment of the Hetherington Committee. In response to this the Nuffield Provincial Hospitals Trust stated;

Appreciating that the object of the Committee on Post-War Hospital Problems is wider than that of the advisory committee, being in fact a general review of hospital services in Scotland, the Advisory Committee now feel that further consideration by them of a regionalisation scheme for Scotland should be postponed until the Secretary of State's Committee has had an opportunity of making such general recommendations of the Committee on Post-War Hospital Problems include the adoption of such a regionalisation scheme as the Advisory Committee has in mind, the progress of the latter committee in their relations with the interests involved will be made very much easier.¹⁴⁹

¹⁴⁵ Membership of Sub-Committee: Professor Sir John Fraser, M.C, K.C.V.O; Professor J.M Mackintosh, Glasgow University; Dr A. Greig, Aberdeen; Dr W.G. Clark, Medical Officer of Health, Edinburgh; Dr R.W. Craig, Scottish Secretary, British Medical Association; Dr A. Davidson, Chief Medical Officer, Department of Health for Scotland; Professor James Hendry, Glasgow; Professor C.F.W. Illingworth, Glasgow; Dr J. Crawford Knox, Aberdeen; Professor J.R. Learmonth, Edinburgh; Dr Duncan G. Leys, Inverness; Sir Alexander S.M. Macgregor, Medical Officer of Health, Glasgow; Professor Charles McNeil, Edinburgh; Dr A.F. Wilkie Millar, Glasgow; Professor Noah Morris, Glasgow; and Professor Adam Patrick, Dundee.

DCA, TC/SF/H49, Box 21, *Preliminary Report of the Sub-Committee on Medical Services*, 21st October 1941, p. 2.

¹⁴⁶ Ibid, p. 3.

¹⁴⁷ Ibid, p. 6.

¹⁴⁸ South Eastern: Edinburgh, the Lothians, Peebles, Berwick, Roxburgh and Selkirk.

Eastern: Dundee, Angus and Perth.

North-Eastern: Aberdeen City, Aberdeen County, Kincardine, Banff and Moray.

Northern: Inverness, Ross & Cromarty, Sutherland, Caithness, Orkney and Shetland.

Western: Glasgow, Argyll, Dunbarton, Stirling, Clackmannan, Renfrew, Lanark, Ayr, Bute, Dumfries, Kirkcudbright and Wigtown.

¹⁴⁹ NAS, CO1/4/138, *Advisory Committee on the Regionalisation of Hospital Services*, p. 4.

Although the Nuffield Provincial Hospitals Trust was unable to complete their investigation into the provision of a regional scheme for Scotland, the incorporation of local authorities at the forefront of furthering the health services is evident. Local authorities were seen as crucial in the formation of future policy by the Trust and were represented on the Sub-Committee which formed proposals through their Medical Officers of Health. As this investigation was incomplete, the Committee on Post-War Hospital Services must be considered and the influence of local authorities on the recommendations put forward by this Committee.

The Minister of Health intimated in Parliament that a review of hospital services would occur and this was taken up by the Secretary of State for Scotland, Thomas Johnston. This was not a new issue to Scotland as we have seen above, the Nuffield Provincial Hospitals Trust already had been investigating the idea of regionalisation of hospital services within Scotland for a year and was liaising with local authorities and the voluntary hospitals. The Secretary of State approached the local authorities and the British Hospitals Association prior to establishing the Committee. The intention was to gather initial thoughts on the regionalisation of hospital services within Scotland, which was within the larger issue of hospital provision in the post-war period within the UK. The three local authority associations, i.e. the Counties of Cities Association, the Convention of Royal Burghs and the Association of County Councils, were called to St Andrews House in Edinburgh. Prior to this meeting, the three Associations met with each other to discuss their representations. They all agreed that a committee should be set up, but the Cities wanted time for local authorities to be consulted on a larger scale; the Counties and Royal Burghs thought that local authorities should be represented on the committee and not dictated to by any other body.¹⁵⁰ It was agreed at this meeting that each Association would make their representations to the Secretary of State separately. At the meeting, the Local Authority Associations made their separate representations to the Secretary of State. He responded by emphasising that speed was essential for setting up the committee and local authorities would be free to submit evidence to the committee in their own way.¹⁵¹

The Committee on Post-War Hospital Problems (The Hetherington Committee) was established

¹⁵⁰ NAS, CO1/4/138, *Joint Meeting between the Three Associations*, City Chambers, Edinburgh, 31st October 1941.

¹⁵¹ GUA, DC8/1101, *Note of Meeting between Secretary of State and Representatives of Local Authority Associations (Association of Counties of Cities, the Convention of Royal Burghs; and the County Councils Association) held at St Andrews House*, 31st October 1941, p. 1-2.

to consider and make recommendations within a policy aimed at the post-war development of a comprehensive and co-ordinated hospital service in Scotland on a regional basis as to the future administration of new hospitals built by the Government and now administered by them as part of the Emergency Hospital Service; the arrangements most likely to secure the maximum co-operation between voluntary hospitals, local authority hospitals and the hospitals referred to...above; and the financial arrangements between voluntary hospitals and local authorities and between voluntary hospitals and patients and contributors best fitted to enable those hospitals to co-operate in the co-ordinated hospital service.¹⁵²

In choosing the Committee, Hetherington advised the Secretary of State for Scotland, Thomas Johnston, that he would try to steer clear of members who were closely involved in the voluntary hospitals or local authorities.¹⁵³ The membership of the Committee included: Sir John Fraser, D. A. Anderson, James Cook, J. M. Erskine, Neil M Gunn, Charles Murdoch, David Robertson, Miss Beatrice Rose, Mrs C. McNab Shaw and J. M. Vallance.¹⁵⁴ The Committee met 31 times, beginning on the 3rd February 1942. In considering the post-war hospital issue, the Committee gained evidence from a variety of interests including local authorities, voluntary hospitals, medical and nursing organisations, the Scottish branch of the British Hospitals Association, the Universities and Government Departments. The Committee also visited a selection of hospitals in the voluntary, local authority and state sectors.¹⁵⁵ From these representations and investigations, the Committee produced a report which covered all the areas in their remit. The Committee qualified the report by stating that it was not their intention to 'design a hospital policy for Scotland, but to try to solve certain administrative problems which will arise when the Government proceeds to implement a hospital policy'.¹⁵⁶

The Committee on Post-War Hospital Services (Hetherington Committee) gathered evidence from the local authorities both individually and from the Associations. It also took evidence from the British Hospitals Association, the Nuffield Provincial Hospitals Trust and the medical profession. In addition, it considered the post-war situation in England and the powers which English local authorities had compared to their Scottish counterparts. Scottish local authority representation was immense within the committee as they had the means to represent themselves individually, by both written evidence and

¹⁵² H. Hetherington, *The Report of the Committee on Post-War Hospital Problems in Scotland*, (Edinburgh, 1943), p. 2.

¹⁵³ McCrae, *The National Health Service in Scotland*, p. 217.

¹⁵⁴ Hetherington, *The Report of the Committee on Post-War Hospital Problems*, p.2.

¹⁵⁵ *Ibid*, p. 3.

¹⁵⁶ *Ibid*, p. 3.

through representations made directly to the committee through a series of meetings. Furthermore, they were represented through their associations and by their representation on the Nuffield Provincial Hospitals Trust committee. The local authorities brought out many similar issues but did not entirely agree with one another on how the new integrated hospital system should be administered. Furthermore, they were unable to agree on which of the EMS hospitals should be integrated into the new scheme (the most controversy surrounded Raigmore Hospital in Inverness) or who should own the hospitals. Finance was also an area of contention. They disagreed over whether patients should be liable for charges and whether the hospitals should be integrated into the Public Health Department, as it was argued that preventive and curative medicine should and could not be separated.

The Cities were unanimous in their view that the hospital service should be regional and administered by the local authorities.¹⁵⁷ The scheme, they argued, should be within a complete health service, including clinics, out-patient services and mental health services.¹⁵⁸ The Cities also thought that a Scottish National Hospital Authority could be beneficial in a purely advisory role for the co-ordination of a regional service.¹⁵⁹ Comparing the individual evidence of Edinburgh, Glasgow and Dundee, it can be seen that they were in general agreement over the main principles of a regional hospital scheme. (Aberdeen Corporation submitted a statement which only dealt with the issue of financial arrangements.) All three authorities asserted at their meetings that the EMS Hospitals should be under local authority control and that the scheme should be a comprehensive health service for all those requiring medical care. They approved of some form of regional co-ordination, and they believed that the local authorities and voluntary hospitals should continue to be the administrative authorities on a day-to-day basis.¹⁶⁰ Thus, it is evident that the Cities were advocating a comprehensive medical service which would include a regional hospital service, as they had been for the preceding decade.

The Counties and Royal Burghs also submitted their evidence to the Committee, both individually and as organisations. The Counties Association supported a regional hospital scheme administered by a series of Regional Committees, with EMS Hospitals under local

¹⁵⁷ DCA, TC/SF/H49, Box 21, *Counties of Cities Association Memo of Evidence by the Association for submission to the Hetherington Committee on Post War Hospital Policy*, p. 1.

¹⁵⁸ *Ibid*, p. 2.

¹⁵⁹ *Ibid*, p. 3.

¹⁶⁰ DCA, TC/SF/H49, Box 21, *Comparison of Statements by Edinburgh, Glasgow and Dundee (Aberdeen have submitted a statement on the financial side only)*.

authority ownership.¹⁶¹ Furthermore, the Association advocated additional powers for local authorities to treat all patients not only through hospital provision, but also through clinics and palliative care.¹⁶² These representations were supported by counties, such as Ayr and Ross & Cromarty, who in memoranda regarding the regional health service, put forward the same general ideas for a post-war hospital service.¹⁶³ The Royal Burgh of Kirkcaldy also advocated a regional hospital system around the teaching centres of the Cities. Furthermore, Kirkcaldy supported the system used in Aberdeen whereby hospitals were grouped on one site.¹⁶⁴ These attitudes were also reflected by Inverness Burgh. The Burgh thought that preventive and curative medicine could not be separated; that the service should be free for patients; and that voluntary hospitals should be brought under municipal control.¹⁶⁵ When discussing voluntary hospitals the representative for Inverness Burgh stated:

At the meeting of the northern local authorities a few weeks ago somebody from Wick said that it was high time we ceased to depend on the rattling of a tin box for the maintenance of our hospitals, which I think just puts in a nutshell what everyone was prepared to admit but not everyone was prepared to say.¹⁶⁶

The representative for Inverness County Council also highlighted the success of having specialists visit the local hospitals, an arrangement which was executed through the HMS, and requested this arrangement be extended.¹⁶⁷ Therefore, the time of the voluntary hospitals was thought to have ceased and an exchequer funded hospital system administered by local authorities was seen as the way forward. The Counties and Royal Burghs advocated a system which was in essence the same as the Cities, but at the initial meeting of the three associations it was decided that they should make their representations individually.

¹⁶¹ NAS, CO1/4/138, *Association of County Councils in Scotland Memorandum of Evidence to the Committee on Post-war Hospital Problems*, 23rd March 1942, p. 1.

¹⁶² *Ibid*, p. 2.

¹⁶³ NAS, CO1/4/138, *County of Ayr, Memorandum by the Medical Officer of Health regarding Post-war Hospital Policy*, and HH65/65, *County Council of Ross and Cromarty, Memorandum by the Hospitals Sub-Committee to the Public Health Committee on Post-war Hospital Policy*.

¹⁶⁴ GUA, DC8/1100, *Kirkcaldy Burgh Memorandum to the Committee on Post-war Hospital Problems*, 26th of March 1942, pp. 1-3.

¹⁶⁵ NAS, HH65/63, *Notes of Evidence on behalf of Inverness Burgh before a delegation of the Committee on Post-war Hospital Problems*, 16th of June 1942, p. 4.

¹⁶⁶ *Ibid*, p. 6.

¹⁶⁷ NAS, HH65/63, *Notes of Evidence on behalf of Inverness County Council before a delegation of the Committee on Post-war Hospitals Problems*, 16th of June 1942, p. 3.

The Report of the Hetherington Committee proposed that Regional Councils be set up for the five regions around Glasgow, Edinburgh, Aberdeen, Dundee and Inverness. Glasgow, Edinburgh, Aberdeen and Dundee would provide the medical schools which the regional hospital system would be centred on.¹⁶⁸ The Regional Councils were to be set up only on an advisory basis with local authority and voluntary hospitals still separate. The EMS hospitals would be transferred to local authority administration as they became available for general medical use.¹⁶⁹ Each Council would consist of 30 members with an independent chairman, with membership being composed of 12 representatives each from local authority and voluntary hospitals, and representatives from the medical profession.¹⁷⁰ The South-Western region (centred on Glasgow) was to be composed of sub-regional councils as part of the establishment of a large Regional Council for the area.¹⁷¹ The separate arrangement for the South-Western region was due to the high concentration of the population in the industrial central belt. The first duty of the Regional Councils would be the preparation of a hospital scheme to be submitted to the Secretary of State for Scotland for approval.¹⁷² Therefore, the Committee advocated a regional scheme for hospital provision, based on co-operation between the local authorities and voluntary hospitals.

To achieve such co-operation, the Committee put forward several recommendations. With regards to medical staff, the Committee recommended that payment to doctors and all grades of medical staff were uniform throughout the country. Full clinical responsibility was to be given to a senior specialist within a specialist unit, who along with other senior medical staff would be given access to the Public Health Committee. Finally, local authorities were to be given powers to provide clinics, out-patient departments and ambulances for hospital purposes.¹⁷³ The recommendations would bring Scottish local authority power in line with their English counterparts.

The final area covered by the remit of the Committee was that of the financial arrangements for the new regional hospital system. The Committee supported a compulsory contributory scheme to finance the hospital service, rather than the assessment

¹⁶⁸ Hetherington, *The Report of the Committee on Post-War Hospital Problems*, p. 9.

¹⁶⁹ *Ibid*, p. 38.

¹⁷⁰ *Ibid*, p. 35.

¹⁷¹ *Ibid*, pp. 35-6.

¹⁷² *Ibid*, p. 35.

¹⁷³ *Ibid*, p. 35.

of patients for their ability to pay and recovery of payment thereafter. The financial status of the scheme would be enhanced by an Exchequer grant and the fund would be administered centrally by the Department of Health for Scotland.¹⁷⁴ Local authorities would also contribute to the funds of the voluntary hospitals and accordingly would be allowed representation on their governing boards. The Committee also offered an alternative to this recommendation suggesting that payments to voluntary hospitals might not be made by the local authorities but by a national fund from the Exchequer.¹⁷⁵ Therefore, the Committee was recommending a Scottish hospital service which would be free for patients and financed by the Exchequer and a compulsory contributions scheme. Levitt argues that

by the middle of the war, Scottish hospital policy was looking to the government to undertake three things: grants for voluntary hospitals; the control of all development; and the building and maintaining of State hospitals. The political debate over voluntarism, public sector stigma and local accountability had been resolved. It was a complete reversal of Scottish tradition. The pursuit of the people's health – their 'personal fitness' – over-ruled other considerations.¹⁷⁶

The *Annual Report* of the Department for 1944 barely mentioned the Hetherington Report. By the time of the publication, the preparations for the National Health Service White Paper had begun. The lack of acknowledgement of the Hetherington Committee's recommendations may also have been due to the fact that the Committee did not recommend centralisation through the Department of Health; instead the Committee recommended that the local authority system should be continued. It should be noted, however, that the White Paper incorporated the recommendations from the Report along with the recommendations of the Cathcart Report.

The examination of the representations of the local authorities again highlights that they were at the forefront of discussions over future hospital and indeed health policy. The local authorities were not merely administrative bodies which had policies imposed upon them, but were active within the formation of the future health and hospital services.

As a result, local authorities were central to the provision of health services, especially after the Local Government Act of 1929, and participated in the discussion and formation

¹⁷⁴ Ibid, p. 36.

¹⁷⁵ Ibid, p. 37.

¹⁷⁶ Levitt, *Poverty and Welfare in Scotland*, p. 172.

of future health policy. They advocated a comprehensive, free health care system from an early stage and were therefore part of the consensus that was gaining momentum. Nevertheless, it is crucial to rethink the prevailing consensus theory by which the principle of a comprehensive, free health care system was translated into policy. Local authorities were central to the transfer and extension of health services throughout the early twentieth century, yet they have been excluded largely from the historiography of the establishment of the NHS.

Conclusions

In the early twentieth century, Scottish health services developed in distinctive ways through experiments in social medicine and various Scottish orientated reports, culminating in the NHS (Scotland) Act 1947. The distinctive nature of the Scottish health services was highlighted in the HIMS and the Clyde Basin Experiment. In conjunction with these schemes, the EMS hospital beds were utilised to reduce the voluntary hospital waiting lists and for tuberculosis cases. These schemes were instigated by an acknowledgement in Scottish political and medical circles that the system of private, voluntary and local authority medical care was not sufficient to meet the needs of the Scottish people. Committees were also established throughout the period to investigate the health of the nation and the needs in Scotland which were not being met. The Committee on Scottish Health Services and the Committee on Post-war Hospital Problems were the most prominent of these committees. As solely Scottish committees, these investigations highlighted the problems throughout the country, advocating a comprehensive medical and public health service together with a regional hospital service.

At the forefront of the medical services in the early twentieth century were the Scottish local authorities and the Department of Health for Scotland. The HIMS signalled the beginning of a centrally administered health service from 1913 onwards but only in the Highlands and Islands region. The majority of the country remained under the poor law system which was available in conjunction with local authority health services, private practice and voluntary hospitals. By 1929, the position of local authorities was consolidated within the provision of health services as they were obligated, under the Local Government Act, to provide hospital services for their area. The 1929 Act, however, was not extensive and did not make provisions for general practitioner services, clinic services or ambulance services. Nevertheless, local authorities were at the forefront of health provision within Scotland prior to the establishment of the NHS.

The strong influence of local authorities before the 1944 White Paper is highlighted by considering the representations made to committees such as the Cathcart Committee and the Hetherington Committee. Not only did they provide individual representations, as in the case of the four cities, but also through their associations and the Nuffield Provincial Hospitals Trust Committee, which gave evidence to the Hetherington Committee. Such influence, however, seems to have been lost in the historiography of the establishment of the Scottish NHS.

Throughout the development of the Scottish health services before the NHS, local authorities were at the forefront of provision. Not only did they provide the health services, but throughout the representations to the committees which were investigating the future of the health services, local authorities were again largely involved in Scottish health service planning. With local authorities at the front of provision and involved in the committee process through their representations, they should have been in a strong position when it came to negotiating the terms under which the NHS would be established. Within the historiography of the NHS, local authorities are not highlighted as being central to the discussions as the consensus view and medical domination are in the forefront. Consequently, a reassessment of their role is necessary to include the Scottish local authorities in the historiography of the NHS.

Chapter 2

Central-local Relations and the Creation of the NHS, 1943-1948

Introduction

Scotland was unique within the British context in the abundant support for a comprehensive health service prior to 1943. From 1943 the move towards a comprehensive health service, which included hospitals, GPs and local authority health service, began on a bigger scale. UK-wide acknowledgement of the need for improvements came to the fore in the wake of the Beveridge Report. The input from the Scottish policy sphere was crucial in the final NHS Acts, which were passed for England and Wales as well as Scotland. Special attention, however, has yet to be given to the role Scottish local authorities played throughout the policy process. Throughout this chapter policy network theory will be utilised for the analysis of the discussions over the NHS proposals between 1943 and 1948. The discussions took place between the three local authority associations (the Convention of Royal Burghs, the Scottish Counties of Cities Association and the Association of County Councils), the Department of Health for Scotland and the Secretary of State for Scotland.

Given their extensive provision of health services and their prominent role in health policy discussions and proposals, it is not unreasonable to expect local authorities to extend their influence and role in the discussions and proposals that resulted in the NHS Acts which came into effect in 1948. Instead, the period 1943-1948 witnessed the beginning of the removal of local authorities from the administration of the health services within Scotland. This chapter will consider the White Paper proposals, negotiations between the Department of Health for Scotland and the local authorities, the outcome of discussions between 1944-1947 and the reaction of local authorities to the NHS (Scotland) Bill prior to the Acts' implementation in 1948.

White Paper Proposals

Although discussions began prior to the publication of the 1944 White Paper, the provisions proposed in it must first be examined. The White Paper explained the provisions mainly in terms of the health service which would be set up in England and Wales. Scottish provisions were placed in a few pages at the end of the document. In terms of central administration, the Scottish health service differed from its English counterpart in that the Secretary of State for Scotland, rather than the Minister of Health, would be accountable to Parliament for the administration of the new service.¹ Otherwise

¹ Department of Health for Scotland, *A National Health Service*, (London, 1944), Cmd.6502, p. 42.

the central administration had similar structures to assist the Secretary of State, a Central Health Services Council for Scotland would be established along the same lines as that in England and Wales.² The Council would consist of representatives from the medical, dental, pharmaceutical, nursing and midwifery professions and from local authority hospitals and voluntary hospitals. These representatives would advise the Secretary of State on any technical matters regarding the health service. In addition to this, a Central Medical Board would administer the GP service on a day-to-day basis and would consist mainly of the medical profession.

It was not until the White Paper mentioned local administration that differences between Scotland and England appear. The Government stated that it would adopt the recommendations of the Committee on Scottish Health Services (Cathcart Committee) and the Hetherington Report. A Regional Hospitals Advisory Council (RHAC) would be established in the five regions of Glasgow, Edinburgh, Aberdeen, Dundee and Inverness.³ These regions were established round the main teaching hospitals, together with an additional region set up in Inverness due to geographical problems of treating patients in the more remote areas of the north of Scotland. The RHAC was to be an advisory body, which advised the Secretary of State on how coordination could be achieved between hospitals and other health services in planning hospitals and consultant services. The members of the Council would be made up of representatives from the voluntary hospitals and the new Joint Hospitals Board of combined local authorities in the region.⁴ The Joint Hospitals Board would be a new layer of administration, established by combining neighbouring major health authorities. It would be the Boards' task to provide an appropriate hospital service for their areas through taking ownership of the hospitals in their constituent authorities and making arrangements with other Joint Hospitals Boards and voluntary hospitals if necessary. Clinic services such as the tuberculosis dispensaries would also be part of the Joint Hospitals Boards' responsibilities.⁵ This began the dilution of individual local authority responsibility for administering hospitals and clinics and the separation of the services in Scotland into a tripartite organisation.

Many of the clinic services that were historically placed with the local authorities through the Local Authorities Act of 1929 remained under their jurisdiction. Maternity and child

² Ibid, p. 42.

³ Ibid, p. 43.

⁴ Ibid, pp.43–4.

⁵ Ibid. p. 44.

welfare, venereal disease services, midwifery and health visitor services were but a few of the services still placed with local authorities. The Secretary of State for Scotland, however, would provide GP services and health centres through the Department of Health for Scotland.⁶ The idea of GP services and health centres being administered by the Department of Health was put forward as a temporary measure in which the Secretary of State could delegate any of these functions to the local authorities. A Local Medical Services Committee would also be established to assist the Secretary of State.⁷ This Committee would consist of representatives of local health authorities, local medical, dental, pharmaceutical and nursing professions, and would advise the Secretary of State on any questions affecting administration of the GP service and its relations with other health services. The local authorities seem well represented throughout the proposals, but the authorities had quite a number of functions removed from their control and many of the boards and committees on which they were represented were primarily consultative. The local authorities submitted their views on the proposals through the Local Authority Associations that represented them.

Central-local Relations: Membership of the Network

The central-local relationships in the Scottish health services can be examined by adopting a theoretical perspective, such as policy network theory, developed in other literature. Policy network theory, discussed in the introduction, helps us to consider the different relationships which can occur in a policy network such as central-local relations. Central-local relations are generally typified by the relationship between government and local authorities. Central-local relations are characterised by territorial politics and inter-organisational relations. Rhodes considers territorial politics as a policy network, which is specific to a region, for example Scotland, Northern Ireland and Wales.⁸ Smith notes that policy networks provide a way to categorise relationships that exist between the government and interest groups. Policy networks occur when information is exchanged between interest groups and the government, and this information leads to the acknowledgement that the interest group has a concern over a policy area.⁹ As we saw in the introduction, Rhodes developed five criteria by which a network could be detected

⁶ Ibid, p. 45.

⁷ Ibid, p. 45.

⁸ R.A.W. Rhodes, 'Territorial Politics in the United Kingdom: The Politics of Change, Conflict and Contradiction', *West European Politics*, 10 (Oct 1987), 22.

⁹ M. J. Smith, *Pressure, Power and Policy*, (Hemel Hempstead, 1993), p. 56.

when considering the relationships between organisations and the government. Rhodes identified five types of network: policy/territorial community, professional network, intergovernmental network, producer network and issue network.¹⁰ Key features can be recognised in each type of network such as membership, dependence and stability.

Although policy formation can incorporate different aspects of all of the political science theories, policy networks can become very complex and accordingly are categorised by the most dominant group. Changes can occur over time with regards to who constitutes the dominant group and can in some cases cause the overlooking of other influential groups within the network. As the Department of Health for Scotland and the local authorities are being analysed throughout this thesis an intergovernmental network is evident in conjunction with a professional network.

Prior to considering central-local relations, through the intergovernmental network, the regional relationship between Scotland and Westminster must first be examined. The relationship between Westminster and Scotland has been characterised over the years by the existence of the Scottish Office and the Secretary of State for Scotland. The Scottish Office was established in 1885 and by 1909 an office within Parliament Square, Edinburgh had been opened.¹¹ It was a Whitehall Department which was established to ensure Scottish interests were taken into account in policy formation. After 1939, the Gilmour Report on Scottish Administration amalgamated all the different Scottish Departments under the Scottish Office. The remit of the Scottish Office included areas such as agriculture, health, local government, education, police, criminal justice and police.¹² In discussing the role of the Scottish Office, Ian Levitt argues;

...it should be noted that the Departments remained separate entities, with their own Secretaries and their own Vote. Subject to Ministerial authority they remained free to deal with other Departments in Whitehall as in the Civil Service generally. The Permanent Under Secretary's principal function was to provide advice to the Scottish Secretary where there was a difference of opinion between Departments, ensure that they were informed of each other's problems and activities, and generally promote the 'Scottish interest'.¹³

¹⁰ R.A.W Rhodes, *Understanding Governance*, (Buckingham, 1997), p. 38.

¹¹ I. Levitt, *The Scottish Office 1919-1959*, (Edinburgh, 1992), p. 1.

¹² Ibid, p. 5.

¹³ Ibid, p. 6.

As a layer of sub-central government, the Scottish Office was responsible for the implementation of policy through Scottish governmental bodies. Although there were some purely Scottish governmental bodies, such as the Highlands and Islands Development Board, Hogwood notes that the Scottish case was significant as the Scottish Office was consulted on decision-making in British governmental bodies.¹⁴ Therefore the Scottish Office was not only influential in Scottish political circles but also influenced UK policy that had specific Scottish elements. Rhodes sees this expansion of the Scottish Office as an accommodation to unite central (UK) and sub-central (Scottish) interests.¹⁵ Furthermore, Rhodes cites the establishment of the welfare state as the embodiment of this consensus as professional groups also became more prominent in policy-making and agencies such as the NHS were removed from regional control.¹⁶ Lindsay Paterson, however, argues that the welfare state which developed within Scotland was distinctive as they had their own 'welfare-state bureaucracy'.¹⁷ In expanding this argument Paterson states:

the politics that mattered were those of the bureaucracy, in the sense that the autonomy and the distinctiveness of any country in the mid-twentieth century rested more on the way that its bureaucracy interpreted legislation than on the legislation itself.¹⁸

Rhodes' explanation of territorial arrangements in the establishment of the welfare state does not take into account the prominence of the Scottish Office in the policy formation or implementation of particular issues such as the NHS. Although Paterson focuses on the interpretation of legislation, he also acknowledges that the Scottish Office was also able to influence policy formation.¹⁹ Consequently, the way in which the Scottish Office can influence policy requires examination in connection with the relationships it forms with interest groups in particular policy networks.

Although professional organisations were prominent in policy-making during the mid-twentieth century, their existence did not remove territorial links especially those between the Scottish Office and Westminster. When considering policy networks, such as that

¹⁴ B.W. Hogwood., 'Quasi-government in Scotland: Scottish forms within a British setting', in A. Barker, *Quangos in Britain*, (London, 1982), pp. 70-1.

¹⁵ Rhodes, 'Territorial Politics in the United Kingdom', 28-9.

¹⁶ *Ibid*, 27-8.

¹⁷ L. Paterson, *The Autonomy of Modern Scotland*, (Edinburgh, 1994), p. 103.

¹⁸ *Ibid*, p. 103.

¹⁹ *Ibid*, p. 103.

established for NHS policy formation, the Scottish Office took over the role of Westminster in negotiating with the Scottish professional groups. Therefore the policy network was territorial in that the groups involved dealt with Scottish governmental bodies and not directly with Westminster. The network for Scottish territorialism, however, does not end with the Scottish Office. Local authorities within Scotland must also be considered as their interaction with the Scottish Office and Westminster had influence on the policy-making process. Therefore central-local government relations must also be considered when looking at the Scottish example. Central-local government relations consider the relationship between Westminster and local authorities. Throughout the twentieth century the Scottish Office undertook an intermediate relationship in place of Westminster. Therefore local authorities have not only had relations with central government but also with regional government and this must be kept in mind when examining local authority policy.

Local authorities in some form have been around since the middle ages. Modern local authorities are thought to have come into existence since the Industrial Revolution. By the twentieth century, local authorities undertook many functions in local society, including the provision of health care, education, housing and transport. Within Scotland, three associations represented local authorities: the Scottish Counties of Cities Association, the Convention of Royal Burghs and the Association of County Councils. By the end of the twentieth century local authorities had been reformed, which in turn saw the amalgamation of the three associations into the Convention of Scottish Local Authorities (COSLA) in 1975. With reforms of local authority responsibilities, central-local relations have changed considerably over the last century.

The relationship between central government²⁰ and local authorities has inherent conflicts as central government seeks to implement national policies on a local level, prevent local expenditure policies that are in contrast to those of the Chancellor of the Exchequer and ensure an even standard of local services throughout the country.²¹ This raises the question of the purposes of local authorities. Two lines of argument are suggested. First, local authorities are the agents of central government and are responsible for implementing

²⁰ In considering the central-local relations between central government and local authorities, the Scottish Office is seen as the 'central government' in this discussion as within the health sphere all negotiations within Scotland took place between interest groups and the Scottish Office.

²¹ H. Elcock, *Local Government*, (London, 1994), p. 4.

central government policies.²² Second, the relationship between central government and local authorities is a partnership in the provision of local services.²³ The powers of central and local government are crucial in determining the formation of particular policies. However, when other more influential organisations exist within the policy network, the nature of central-local relations can alter. Analysis of the central-local relationship is then crucial in determining the role of local government in any policy network.

When considering the two modes of relationships which can occur in central-local relations, the first suggests that the hierarchical nature of central government allows them to impose policy on local authorities. It is argued that the loss of local authorities' powers and the control by central government over expenditure in the post-war period led to this hierarchical relationship.²⁴ Stoker however argues that, although some responsibilities were removed from local authorities, they also gained new responsibilities. Furthermore, he considers the attempt by central government to control local authority expenditure as having been unsuccessful.²⁵ Local authorities, therefore, were able to retain some autonomy from central government, regardless of the attempts of central government to gain control. The second line of argument is that the central-local relationship is a partnership between central government and local government. Elcock notes that although it has been suggested that local authorities are in danger of losing their autonomy, as long as local authorities exist and continue to be the central point of solutions to local problems then they will not merely become an agent of the state.²⁶ Therefore, the connection between local authorities and issues for their particular territory will continue to provide some autonomy from central government.

In considering central-local relations, Rhodes used his typology to examine the relationship between the two as a third option in the agent-partnership debate. In his analysis of central-local relations, he employed a power-dependence model, which 'suggests that these relations are simultaneously rational, ambiguous and confused'.²⁷ The relations are only rational within one particular policy area, whilst being ambiguous between policy areas and, if considering the system as a whole, are generally confused. When a power-

²² Ibid, p. 6.

²³ Ibid, p. 7.

²⁴ G. Stoker, *The Politics of Local Government*, (Basingstoke, 1991), p. 6.

²⁵ Ibid, p. 6.

²⁶ Elcock, *Local Government*, p. 14.

²⁷ Rhodes, *Control and Power*, p. 2.

dependence model²⁸ is used, Rhodes suggests that central-local relations can be viewed as a type of policy network, as no matter how hierarchical the relationship may be, both central and local government are still reliant on each other. Power can therefore be negotiated through different resource components whether they be political, financial or information.²⁹

Some critiques of Rhodes focus on the hierarchical nature of government.³⁰ Elcock, however, notes that the political costs of central government imposing its will on local authorities often outweigh the return. Furthermore, he goes on to remark that Rhodes demonstrated that the autonomy that both central and local government experienced enabled them to be on an equal footing when policy-making and implementation of policy was discussed.³¹ Consequently central-local relations cannot be solely regarded as hierarchical, although at times this may be the case, and is analysed most fruitfully by considering the relationship as a network which influences not only local but also national policy. Local policy networks are also considered important and are viewed as being different from the central-local relations that Rhodes discusses. Cole and John state that the adaptation of policy networks to studying local government is centred on the recognition that local actors are dependent on each other and can benefit through cooperation with each other.³² Local policy-making and implementation is taken in the policy areas which are recognised at national level with the same specialisation and professionalisation.³³ Therefore the benefits, which are recognised at national policy network levels, are also recognised at local levels. This can affect the way in which local authorities and the actors within them react to each other and to national bodies, consequently having an effect on other policy networks.

Within the context of Scotland in the post-war years, central-local relations were not only characterised by resources which could be exchanged, but also by the territorial relationship between Westminster and the Scottish Office. Stoker emphasizes the territorial nature of central-local relations and notes that a distinctive pattern emerges in Scotland. Actors involved in the Scottish Office and local authorities developed a closer

²⁸ Rhodes' power-dependence model considers central and local government to be more or less equal partners who use resources and knowledge to negotiate outcomes.

²⁹ Rhodes, *Control and Power*, p. 97-101.

³⁰ Rhodes & Marsh, *Policy Networks*, p. 22.

³¹ Elcock, *Local Government*, p. 16.

³² A. Cole & P. John, 'Local policy networks in France and Britain: policy co-ordination in fragmented political sub-systems', *West European Politics*, 18 (4), (October 1995), 90.

³³ *Ibid*, 91.

relationship and consequently ‘develop[ed] a mutual comprehension of policy preferences and constraints’.³⁴ Furthermore, territorial ministries, such as the Scottish Office, only adhere to national policies within a range of manoeuvrability in which local concerns are taken into account.³⁵ Central-local relations for Scotland were therefore more local in nature as the Scottish Office provided a link between Westminster and individual local authorities. Although the Scottish Office mainly adhered to Westminster policies, the distinctive Scottish nature of implementation cannot be ignored. Central-local relations were therefore distinctive within Scotland and when policy-making for any given area is analysed, the distinction must be considered. Membership of the network included a range of interests most notably the Scottish branch of the British Medical Association and the Scottish Local Authority Associations.

The dynamics of group discussions are crucial in understanding why particular policy outcomes occur. Policy network theory focuses on resources as being a key factor in the development of a policy network, in which groups are allowed entry and in the domination of the network. Rhodes’ five criteria demonstrate that the exchange of resources is a key factor in the development of a policy network. As resources are key to which group dominates a policy network, over a period of time the network can change depending on the goals of the organisations and the resources needed in the exchange. Policy networks provide an analytical frame by which to examine policy formation and those groups who utilise their resources and knowledge to influence policy outcomes. Scottish local authorities should have been at an advantage within the discussion forum as they had been administering the health services for many years, bringing resources and knowledge to the formation of health policy. The nature of Scottish policy formation, however, was complicated by the three tiers of government; central government, the Scottish Office and local authorities. Consequently, policy formation within Scotland can be seen as a part of the central-local relationship while it also had some autonomy from central government through the networks established to conduct policy discussions.

Therefore policy network theory provides an analytical tool to examine the relationships which were established within the health policy network and the ‘rules of the game’ which were established during the discussions over NHS policy formation. The health policy arena is usually characterised as a professional network due to the dominance of the BMA

³⁴ Stoker, *The Politics of Local Government*, p. 133.

³⁵ *Ibid*, p. 133.

throughout discussions. It can be argued that there is a dual network at play within the health arena. In conjunction with the professional network, an intergovernmental network was established, in 1943, between the Department of Health for Scotland and the local authorities through a liaison committee. The liaison committee consisted of 15 members from all three local authority associations. For the Association of County Councils the five members included the County Clerk for Stirling, the County Treasurer for Lanark and three local authority figures for East Lothian, Lanark and Peebles.³⁶ The Convention of Royal Burghs' five members were the Provosts of Perth, Kirkcaldy and Inverness, the Town Clerk of Paisley and the Town Chamberlain of Kirkcaldy.³⁷ The final five members were from the Scottish Counties of Cities Association, including Councillors from Edinburgh and Aberdeen, the Bailies of Glasgow and Dundee and the City Chamberlain of Edinburgh.³⁸ Secretaries of each individual local authority association were also present.³⁹ In addition to these representatives five members of the Department of Health for Scotland were present led by G. H. Henderson and T. D. Haddow.⁴⁰ The Local Authority Liaison Committee represented the range of local authorities within Scotland, both large and small.

Department of Health for Scotland and the Local Authorities

Rhodes' criteria for detecting a network included the dependence of organisations on one another for resources and having to exchange those resources to the attainment goals. It is clear that the Department of Health for Scotland, in 1943, recognised that in order to establish a national health service they would require the assistance of the organisations which currently administered the health services. In notes for one of the meetings with the local authorities a DHS official stated that

the aim of Government policy is to secure a new service which will be comprehensive in its scope and which will ensure to all citizens medical, surgical and rehabilitative treatment in the form in which they need it and at the time they need it. The smooth working of such a service will depend to a

³⁶ Major Broun-Lindsay, East Lothian; R. A. Ure, Lanark; Captain R. J. Thomson, Peebles; G. J. Sheriff, County Clerk for Stirling and G. H. Shilton, County Treasurer for Lanark.

³⁷ Lord Provost Sir Robert Nimmo, Perth; Provost James Wilson, Kirkcaldy; Provost Hugh Mackenzie C.B.E., Inverness; John P. Morrison, Town Clerk of Paisley and Eric Maxwell, Town Chamberlain of Kirkcaldy.

³⁸ Councillor John Cunningham, Edinburgh; Bailie Edward Hunter, Glasgow; Bailie R. A. Watt, Dundee; Councillor Dixon-Swinney, Aberdeen; and J. D. Imrie, City Chamberlain of Edinburgh.

³⁹ Mr J. Gibson Kerr for the Convention of Royal Burghs, J. Storrar for the Scottish Counties of Cities Association and George Davie for the Association of County Councils.

⁴⁰ All five members were G. H. Henderson, Dr. A. Davidson, T. D. Haddow, J. Stirling and H. V. De Lorey.

considerable extent on the binding together of the several parts of the present service and that, in its turn, will depend on securing the goodwill of the various agencies administering the present service. It is to that end that discussions have been taking place with the three interests mainly involved, namely, the local authorities, the voluntary hospitals and the medical profession.⁴¹

This statement not only lays out the goal of the Government to achieve a comprehensive health service, but also demonstrates that local authorities were one of the three main players within the policy network.

Furthermore, policy network theory emphasizes the relationship between central and local government, whether it be a partnership or hierarchical, as crucial in the policy negotiations which take place. Thomas Johnston, the Secretary of State for Scotland, was central in setting the group dynamics by which discussions with local authorities took place. In putting forward a number of suggestions for the operation of the health services within Scotland, Johnston set the tone in which local authority views would be considered. In opening the first meeting on the 8th March 1943 he stated:

it is proposed to put the burden of the administration of the new service largely on the shoulders of the local authorities. The desire of the Government was to seek the minimum of new administrative devices and to depend on the well-tried system of democratic local government which had served us so well in the past.⁴²

The statement immediately suggests that local authorities would be given administrative control of the new health services. Johnston created an environment in which local authorities felt at ease in thinking that the new health service was an opportunity for local authorities to further their administrative control. As was argued above, the political costs to central government, in this case the Scottish Office, of imposing NHS policy on local authorities would have outweighed the return, as local authorities were, at that point, heavily involved in the administration of the health services. It is, however, well known that Thomas Johnston wanted administration of the hospital services to be undertaken by the Department of Health for Scotland, in order to keep control of the emergency hospital service, set up during World War II to provide medical treatment for war casualties. Ian Levitt argues that although the Hetherington Committee did not consider any type of state involvement in hospital provision, Johnston proposed to the Secretary of State's Council on Post-War Problems that the EHS should continue to be administered centrally and the

⁴¹ NAS, HH101/4, NHS Notes for meeting with the Associations of Local Authorities, 12th July 1943.

⁴² NAS, HH101/4, NHS (S) LA 1, Dept of Health, National Health Service Consultation with Local Authorities, 8th March 1943.

Hetherington Report be given very little consideration.⁴³ This shows that Johnston was in favour of centralisation of the hospital services which he had nurtured throughout the war and was willing to be persistent in his campaign for this centralisation. In his closing statement, at the first meeting of the local authority liaison committee, Johnston created ambiguity over who would receive administrative control over the health service:

if it were a question of taking away from local government the tasks it was already performing well or of making it responsible for a wider and better health organisation, there could be no doubt as to the answer.⁴⁴

Through clever wording, Johnston implied in the first statement that the local authorities were to receive more administrative duties with the NHS. Although this statement could be interpreted as a statement in favour of local authority administration within the NHS, conversely it could be seen as an early warning that Johnston was considering the ways in which administrative control could be removed from local authorities. One thing Johnston managed to put in place was the image that local authorities were in partnership with central government. The negotiations which took place between the local authorities, the Secretary of State for Scotland and the Department of Health for Scotland left the impression that the partnership established between the agencies was equal and that local authorities were considered a central component of any health service. Consequently, all three associations were under the impression that the local authorities' place in administrative control of the health services was safe and therefore they could agree certain changes which were to come about as a result of the establishment of the NHS. The Secretary of State for Scotland and the Department of Health for Scotland were not in a position to impose a hierarchical relationship with the local authorities as the resources held by local authorities, such as the hospitals, were required to establish the NHS. Consequently, the returns on imposing policy outcomes on the local authorities would not have, at this stage, been lower than the costs of entering into a political stand-off with local authorities.

The first few meetings in March 1943 confirmed the tone and dynamics in which the discussions over health service policy took place. Throughout the discussions on the 8th and 18th March 1943, all three local authority associations agreed with the principles of a

⁴³ I. Levitt, *Poverty and Welfare in Scotland 1890-1948*, (Edinburgh, 1988), pp. 171-2.

⁴⁴ NAS, HH101/4, NHS (S) LA 1, Dept of Health, National Health Service Consultation with Local Authorities, 8th March 1943.

comprehensive medical service administered by the local authorities.⁴⁵ Their acceptance was based on two qualifications: first, that the Joint Boards must remain in the hands of the local authorities and that the constitution of the Board made this clear; second, that one authority should not be given a majority over any other on any of the Boards.⁴⁶ All three associations were under the impression that the local authorities' place in administrative control of the health services was safe, and therefore they could agree certain changes which were to come about as a result of the establishment of a national health service. Although the discussions in 1943 suggest that the local authorities were willing to go along with the provisions in the National Health Service White Paper, which was still to be published, there was a clear undercurrent that they would fight for their powers of administration.

This is demonstrated in discussions on the 12th July 1943 when Councillor Murray, representing Edinburgh, expressed the view that the British Medical Association dominated the provisions of the new health services.⁴⁷ Bailie Hunter, the representative from Glasgow, also raised the experiences in New Zealand in which a national health service was vehemently opposed by the medical association and consequently not established.⁴⁸ Although this concern was not unfounded, it was almost dismissed by the representative for the Department of Health, G. H. Henderson, who pointed out that the Local Medical Advisory Committee would represent all branches of the medical profession, such as dentists, and not just the BMA. Hunter, furthermore, thought that the existence of two medical services being established side by side would defeat the principle of comprehensive medical care. It is clear from this exchange that there were issues that the local authority associations were willing to raise in defence of their position within the NHS.

It did not appear that the local authorities should be too concerned. The way in which the Department of Health and Secretary of State worded provisions during discussions suggested that most, if not nearly all, of the health services would be placed under local authority control. It is for this reason that local authorities in Scotland were not considered

⁴⁵ NAS, HH101/4, Dept of Health, National Health Service Consultation with Local Authorities, NHS (S) LA 1, 8th March 1943. and NHS (S) LA 2, 18th March 1943.

⁴⁶ NAS, HH101/4, NHS (S) 1, Dept of Health, National Health Service Consultation with Local Authorities, 8th March 1943.

⁴⁷ NAS, HH101/4, NHS (S) LA 6, Dept of Health, National Health Service Consultation with Local Authorities, 12th July 1943, p. 1.

⁴⁸ *Ibid*, p. 2.

as vocal as their English counterparts.⁴⁹ The Scottish local authorities had worries and fears surrounding the new health services, but the Secretary of State and Department of Health worded statements in such a way as to alleviate their concerns by implying that local authorities would receive the majority of administrative functions within the NHS.

During the early discussions with local authorities, the Department of Health for Scotland was in constant contact with the Ministry of Health about developments during the discussions. A memorandum from Henderson, at the Department of Health for Scotland, to Herbertson, in the Ministry of Health, reveals the reports to the Westminster Department about the situation within the Scottish negotiations. Henderson wrote:

Would you please pass this message on to Sir John Maude at once.

At the meeting yesterday, the representatives of the Scottish Association of Local Authorities, while indicating that they were not in a position to commit their constituents, approved the Secretary of State's proposals for the lay out of the new National Health Service.

The meeting was unanimous on the advisability of Joint Boards for hospitals.

As to the clinic services, a small minority favoured the handing over of the services to the Joint Boards but the majority strongly favoured retention on the hands of the existing health authorities, that is, in Scotland, County Councils and Large Burghs.

On the General Practitioner service, the general view was that the local authorities did not wish to have the responsibility of administering this service and they agreed with the Secretary of State's proposal to run the service centrally with some local advisory and co-ordinating machinery.

The Secretary of State proposes to put in a paper to the P.R. Committee explaining his scheme. He will say that he has the general support of the Scottish local authorities and in regard to Joint Boards for hospitals, of the Hetherington Committee.

I shall let you have a draft of the paper.⁵⁰

Therefore, although the discussions, within the policy network, were primarily between the local authorities and the Department of Health for Scotland, the Department did not have full autonomy from central government. The Department presented the developments

⁴⁹ C. Webster, *The National Health Service, Vol II*, (London, 1996), p. 90.

⁵⁰ NAS, HH101/4, Memorandum from Henderson, Department of Health for Scotland, to Herbertson, Ministry of Health, 31st August 1943.

within Scotland as it merged the main goals of Westminster with the particularly Scottish aspects required in the health service administration.

In return, the Department received information on the negotiations with the English local authority associations. In a departmental memorandum, dated July 1944, the Department of Health for Scotland was advised of the Ministry of Health's negotiations with London County Council, the County Councils Association and the Association of Municipal Corporations.⁵¹ The issues which arose in the memorandum included whether the Joint Authorities for the hospital service would be planning and supervising authorities only, with the local authorities dealing with the management of the hospitals; whether grants to voluntary hospitals would be through the local authorities; whether local authorities would be represented on the voluntary hospital boards, and whether professional or non-elected members, with or without voting rights, would be represented on authorities or committees.⁵² The Department of Health for Scotland had the agreement of local authorities to a much larger extent than their London counterparts. The success of the Department of Health for Scotland would have put them in a strong position to continue undertaking the Scottish negotiations on Westminster's behalf. Consequently, the Department's relationship with Westminster not only required them to report the state of negotiations within Scotland but also influenced the extent to which Westminster was willing to allow them to remain autonomous in their negotiations with the Scottish organisations. The Scottish Office, through the Department of Health for Scotland, was playing a dual role as the agent of Westminster as well as promoting particularly Scottish problems within policy formation and retaining its autonomy in the policy negotiations.

The early negotiations show that local authorities were not considered equal partners by the Scottish Office or the Department of Health for Scotland. The relationship with local authorities could, however, be beneficial to both the Scottish Office and the Department of Health for Scotland in a number of ways. First, a good relationship with local authorities, who agreed with the health service proposals, demonstrated to Westminster that the Scottish Office and its departments were able to work autonomously for a favourable outcome for the health service policy formation. Second, in bargaining with the medical profession, the Department of Health for Scotland could use local authorities to support their bargaining position by guaranteeing that most medical professionals, apart from those

⁵¹ NAS, HH101/4, NHS (S) LA 26 A, English Local Authority Reactions to the White Paper, 6th July 1944.

⁵² Ibid.

in public health, would not be under the authority of local authorities. Finally, by assuring local authorities that the proposals were temporary and that administrative authority would be passed to them at a later date, the proposals could be pushed through Parliament relatively unchanged and begin the centralisation process of the health services. The negotiations signalled the beginning of the removal of local authorities from the health services.

The publication of the White Paper in February 1944 signalled the beginning of formal discussions with the local authorities, voluntary hospitals and medical professions. The policy network established in 1943 was formalised and the negotiations proceeded under the assumption that local authorities were in a partnership with the Department of Health for Scotland. During a meeting in March 1944, the Secretary of State, Thomas Johnston, announced that within Scotland the administrative structure would be disturbed as little as possible and Scottish Committees would only be concerned with the administration of the GP and hospital services.⁵³ The statement made by Johnston immediately changed the relationship established within the policy network between the Secretary of State for Scotland, the Department of Health for Scotland and local authorities. The statement shows that the local authorities were not in a partnership with the Department of Health for Scotland but were in a subordinate position to the Department and their vision for the NHS. Consequently, using the terms of policy network theory, local authorities were becoming agents of central government and the relationship was becoming hierarchical.

Cole and John argue that the way in which actors of local government react to each other also affects the policy network and the organisations around them.⁵⁴ Furthermore, they argue that local government actors are dependent upon each other and benefits can come out of co-operation between the actors. Within the policy network, the relationships between the local authority associations were just as crucial as those with the Secretary of State and Department of Health for Scotland. The response to Johnston's statement and the provisions within the White Paper, which were in essence the same proposals discussed in 1943, were mixed. The Counties of Cities Association was not in agreement with the provisions, as they would remove certain functions from their health authorities, most notably control of hospitals in the area. It was at this time that it became clear that the

⁵³ NAS, HH101/4, NHS (S) LA10, Meeting between the Secretary of State and Local Authority Associations, 6th March 1944.

⁵⁴ A.Cole & P. John, 'Local policy networks in France and Britain: policy co-ordination in fragmented political sub-systems', in *West European Politics*, 18 (4), (October 1995), p. 90.

local authorities would be losing the main components of their health services. The Association of County Councils and the Convention of Royal Burghs held different views, however, from those of the Cities, as they were in favour of the general provisions within the White Paper. Thus, the formal negotiations began with disagreement amongst the Associations. As a result, the Secretary of State and the Department of Health held a much stronger position in the following negotiations.

The views of the local authorities demonstrate that their consensus only extended to the general principle of a national health service. The way in which this would be established and administered was contested. The local authorities were losing the main element of their health services, so the concerns they raised over the proposals were not unfounded. The concerns presented by the local authority associations, on behalf of their members, served to highlight the disagreement amongst them. Consequently, the Secretary of State and the Department of Health held a stronger position during the negotiations as disagreements among the local authority associations were evident and could be utilised against them. Furthermore, the Secretary of State and Department of Health implied that local authorities would retain many administrative functions within the NHS. Although the position of local authorities seemed protected, the move towards central administration of the NHS was evident in the White Paper.

The formal negotiations over the White Paper's proposals took place between April and October 1944, with the first meeting at St Andrew's House, Edinburgh on the 29th April 1944. One of the representatives from the Department of Health, G. H. Henderson, opened the meeting by stating that the provisions within the White Paper were what the Government believed to be the best way in which to operate an effective National Health Service. This statement reveals that the policy advocated within Scotland was combining the goals of central government with particular Scottish needs, supported by the Scottish Office and Department of Health for Scotland. Nevertheless, he also stated that the provisions were not final, and the Department was open to constructive criticism during the discussions that were to take place.⁵⁵ Thus, the Department of Health was apparently willing to consider any concerns and suggestions the local authorities had with the provisions which were proposed in the White Paper. Yet the extent to which they would implement changes requested by the local authorities is open to question.

⁵⁵ NAS, CO1/4/167, NHS (S) LA 13, Local Authority Associations Liaison Committee Meeting, 29th April 1944.

The Department of Health set the agenda during the first meeting. It covered some of the concerns raised in the discussions of 1943. Over the course of the meetings seven main areas were discussed:

Agenda I: To cover generally the whole field of the proposals.

Agenda II: Constitution and functions of Joint Hospital Boards.

Agenda III: Constitution and functions of Regional Hospitals Advisory Councils.

Agenda IV: Functions of the major health authorities.

Agenda V: Co-ordination of the hospital, clinic and general practitioner branches of the service – Local Medical Services Committee.

Agenda VI: Mental health services.

Agenda VII: Financial arrangements.⁵⁶

The relationships formed within the intergovernmental network can be analysed through considering the different discussion points in the agenda. This shows how the relationship worked practically throughout the negotiations and the way in which the outcome of the negotiations was achieved. Initially the proposals were considered generally. The Liaison Committee discussed the division between the central and local administrative functions. The Secretary of State was responsible to Parliament for the administration of the health service in Scotland and executed his responsibilities through the Department of Health. In addition, a Central Health Services Council and a Central Medical Board were proposed to assist the Secretary of State.

The first area of contention under Agenda I was the remit of the Central Health Services Council. The Council was to be an advisory body which could advise the Secretary of State on technical medical matters affecting the running of the health services. The Cities and Counties representatives were concerned that the Council might encroach on the administrative sphere of the health services.⁵⁷ Henderson noted that the advice of the Council would have some bearing on health policies; however, it would have no executive

⁵⁶ NAS, CO1/4/167, NHS (S) LA 11, National Health Service – Scotland. Negotiations with Local Authority Associations' Liaison Committee, 7th April 1944.

⁵⁷ NAS, CO1/4/167, NHS (S) LA 17, Local Authority Associations Liaison Committee, 15th May 1944.

functions and therefore would not intrude on the administrative sphere. Furthermore, he reassured them that the Secretary of State would consult with the local authorities prior to undertaking any recommendations made by the Council.⁵⁸ This initial issue brought up by the local authorities indicates their concern that the proposals in the White Paper threatened their administrative authority. Assurances given by the Department of Health, however, were enough to alleviate these fears. The group dynamic instigated by Johnston in the initial meetings of 1943 continued to dominate the way in which the local authority associations approached the discussions and the assurances which they were willing to accept. Despite the relationship slowly becoming hierarchical it did not provoke local authority withdrawal from the process. Thomas Johnston was clearly able to manage the discussion process in a manner which benefited the Department of Health during the negotiations, allowing them the manoeuvrability to push through, with relative ease, the proposals they advocated.

The introduction of Joint Hospital Boards also created opposition from the local authorities. Ian Levitt notes the lack of hospital beds had been highlighted in the inter-war period and in 1926 the McKenzie Report argued that the development in hospital provision should be through the voluntary hospital sector.⁵⁹ Although the McKenzie Committee accepted in principle the development of local authority general hospitals, they had not advocated this in their report. The Board of Health had further opposition from the voluntary hospitals that refused to be involved in any scheme which had State involvement.⁶⁰ The Local Government Act (1929) made provision for local authorities to provide hospital accommodation but the transition was not an easy one. By the time the Cathcart Committee gathered evidence many of the representations to the Committee, such as the BMA's, were advocating greater State involvement.⁶¹ The Report of the Cathcart Committee, as we saw above, recommended the development of the hospital service through the local authorities. However, it had been recognised during World War II that local authorities were too small and numerous to increase effectively hospital provision for war casualties, whilst the voluntary hospitals were facing financial problems.⁶² The EMS was established to answer these problems and provided an example of the way in which centralisation of the health services could be successful. As local authorities owned and

⁵⁸ Ibid.

⁵⁹ Levitt, *Poverty and Welfare in Scotland*, p. 155.

⁶⁰ Ibid, pp. 154-5.

⁶¹ Ibid, pp. 162-9.

⁶² Ibid, p. 170.

administered hospitals at the time of the negotiations in 1944, they should have been able to utilise their resources to gain a position of strength within the policy network and influence the Department of Health to obtain a favourable outcome for the local authorities. The relationship already established with the Department of Health since 1943, combined with the lack of unity amongst the local authority associations did not allow them to capitalise on their vast resource base.

The answer, to the problem of small area hospital cover by local authorities, by the Department of Health was the introduction of Joint Hospital Boards. The Joint Hospital Boards were to take ownership and administer hospital provision in their area along with specialist clinic services such as tuberculosis clinics. The Boards were to be comprised of representatives from neighbouring local health authorities. There was opposition to the establishment of such boards, despite general acceptance that the health boards, currently running the health services, were too small to administer a hospital service effectively. Opposition to such boards was not universal across all three Associations however. The Cities, for example, were far more vehement in their opposition to this proposal than the Royal Burghs or Counties. The Association of County Councils only indicated general agreement that the Boards were necessary for the administration of effective hospital provision.

The Cities' representatives protested against these changes arguing that they could administer a health service including hospital provision without delegating functions to separate administrative authorities.⁶³ Henderson doubted that Dundee and Aberdeen were large enough to provide adequate hospital provision.⁶⁴ Therefore, the status of Aberdeen and Dundee was under threat from the proposals for hospital provision more so than that of Edinburgh and Glasgow. J. D. Imrie, the representative for Edinburgh, thought an alternative was to place all hospitals with the Joint Boards unless an exceptional circumstance arose in which it would be expedient to leave the hospital with a particular local authority.⁶⁵ As Imrie was a Cities representative, it can be assumed the exceptional circumstances would be that the Cities were capable of administering an effective and efficient hospital service. The Cities protested strongly about this matter, during the discussions on the White Paper, as this removed a large part of their health service

⁶³ NAS, CO1/4/167, NHS (S) LA 13, Local Authority Associations Liaison Committee, 29th April 1944.

⁶⁴ NAS, CO1/4/167, NHS (S) LA 17, Local Authority Associations Liaison Committee, 15th May 1944.

⁶⁵ Ibid.

provision. As the Cities constituted large health authorities, they had the most to lose if the proposals for the health service went ahead. They would lose both ownership and administrative control of their hospitals.

The debate over hospital ownership was not exclusive to the discussions over the White Paper, as the local authorities had been asked to submit their views to the Hetherington Committee on post war hospital policy. The Cities, in their memorandum of evidence, saw not only an opportunity for the expansion of health services as a whole but also the opportunity for local authorities to expand their administrative authority over the hospital service.⁶⁶ The Cities were

unanimously of the view that these new hospitals should be transferred to the local authorities. It is assumed that they will be required to meet the needs in hospital provision.⁶⁷

Therefore local authorities were aware of the regionalisation of hospital provision but were consistent in their view that hospital ownership and administration should have been placed within their authority. Ownership of hospitals was an issue which the Convention of Royal Burghs took up in the White Paper discussions. Lord Provost Sir Robert Nimmo, from Perth, advised that the Convention was willing to accept the principle of Joint Hospital Boards on the basis that no authority could outvote another.⁶⁸ He suggested that ownership of the hospitals should be a decision taken between the Joint Hospital Board and the local authority as to who would own individual hospitals.⁶⁹ The Royal Burghs saw the prospect of being attached to larger, more dominant local authorities as a loss of administrative control. Although the Royal Burghs understood Joint Hospital Boards were necessary, some assurances over this proposal were required for them to enter fully into it.

Henderson accepted neither suggestion as he thought this would only provide a bad start for the Joint Boards. He argued the Joint Boards would provide a less complicated financial structure and more flexible staffing arrangements.⁷⁰ He furthermore suggested that the board could be given authority over the hospitals but delegate the day-to-day

⁶⁶ DCA, Box 21 TC/SF/H49, Counties of Cities Association Memo of Evidence by the Association for submission to the Hetherington Committee on Post War Hospital Policy, p. 1.

⁶⁷ Ibid, p.1.

⁶⁸ NAS, CO1/4/167, NHS (S) LA 17, Local Authority Associations Liaison Committee, 15th May 1944, p. 2.

⁶⁹ Ibid, p.2.

⁷⁰ Ibid, p.2.

administrative functions to the local authorities.⁷¹ In rejecting Nimmo's suggestions Henderson, on behalf of the Department of Health, was not willing to consider alternatives to the proposals within the White Paper. The assurance of delegation to local authorities by the Department of Health was a way of silencing the concerns raised by local authorities over the issue of hospital administration. Nevertheless, this was one of the few times in the discussions that two associations worked together to gain a solution to a problem which might be acceptable to all parties.

Within the dynamic of the network, such solidarity could have put the local authorities in a far stronger position, as they held the resources necessary for the smooth establishment of the NHS. A Department of Health for Scotland memorandum demonstrates that the local authorities could have bargained to a greater extent against proposals within the White Paper if they had managed to work together when delegation of functions to existing health authorities was considered. The Memorandum stated that

the most obvious item is the day-to-day administration of hospitals and clinics. Delegation under this head would often be useful where the hospitals etc. had formerly been run by the constituent authority. It might almost be essential for a transitional period. Experience would show whether local knowledge justified the continuance of the delegation indefinitely. Undoubtedly local knowledge could be of service in connection with child welfare and other schemes where environmental conditions were important (housing, etc.).

The value of the local knowledge held by local authorities is acknowledged in this memorandum. Nevertheless, solutions to the problems raised by local authorities over the administration of the hospital service were not found at this stage of discussions and were not brought up again in discussions until 1946.

The Cities' representatives indicated that they were still not in favour of any form of regional planning or Joint Hospital Board.⁷² Glasgow Corporation went so far as to request in November 1944 that the phrase 'administered locally entirely by the Local Authorities' be included in the White Paper as assurance of their administrative functions within the health services.⁷³ They further objected to the inclusion of the medical and medical-

⁷¹ Ibid, p.2.

⁷² NAS, CO1/4/167, NHS (S) LA 30, Local Authority Liaison Committee, 23rd of October 1944.

⁷³ GCA, C1/3/110, Meeting of the Corporation of the City and Royal Burgh of Glasgow, 2nd November 1944.

educational representatives on the Regional Hospitals Advisory Committee (RHAC).⁷⁴ The Committee's remit was to advise the Secretary of State on the best way in which to secure hospital planning within the regions. Each region had its own advisory Committee and any plans put forward by the Joint Hospital Boards would be put to the Committee before the Secretary of State would approve or reject them. The Committee would consist of, in equal numbers, members of the Joint Hospitals, members from the Voluntary Hospitals, medical and medical-educational representatives.

It was made clear that the Cities' representatives felt the balance of the Committee would be tipped in favour of the voluntary hospitals, thereby removing the ability of the local authorities to exercise an influential voice within the health services.⁷⁵ Nimmo from Perth and Broun-Lindsay from East Lothian indicated that they had no objections to voting powers for the medical faction and welcomed this as an opportunity for them to participate fully in the planning of the new hospital service.⁷⁶ The Department also assured them that the addition of these members would not necessarily swing the balance of power to the voluntary hospitals.⁷⁷ The local authorities were conscious of BMA domination throughout the proposals. They perceived the BMA as the single biggest threat not only to a comprehensive health service but also to the administrative structure of the NHS. McCrae argues that in Scotland the NHS Act was drawn up to make the GP the centre of the service and to guarantee that local authorities would not have the authority to influence the GP service.⁷⁸ Furthermore, the medical profession, especially GPs, saw the NHS proposals offered them security, within the NHS and as the medical profession had a good relationship with the Department of Health, they could make arrangements specific to Scotland more openly.⁷⁹ The BMA and medical profession played a crucial part in the formation of NHS policy, and local authority concern over this was not unfounded. Rhodes' criteria for recognising the existence of a policy network suggests that the dominant coalition can employ strategies to regulate the process of exchange. As is demonstrated in the next chapter, the coalition of the Department of Health for Scotland

⁷⁴ NAS, CO1/4/167, NHS (S) LA 27, Draft Report of Discussions between Local Authority Associations Liaison Committee and Department of Health, July 1944.

⁷⁵ NAS, CO1/4/167, NHS (S) LA 30, Local Authority Liaison Committee, 23rd of October 1944.

⁷⁶ NAS, CO1/4/167, NHS (S) LA 21, Local Authority Liaison Committee Meeting, 5th June 1944.

⁷⁷ Ibid.

⁷⁸ M. McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950*, (East Linton, 2003), p. 227.

⁷⁹ Ibid, pp. 232-3.

and the medical profession was influential in the implementation process, and the local authorities' concerns were valid.

Local authorities, however, failed to exert influence on the rules which governed the network, because they demonstrated a lack of solidarity throughout the discussions over the NHS and an inability to utilise their resources and knowledge in the bargaining process. The dynamics of the group discussion, set up by Johnston, and the lack of local authority co-operation, brought about the weakened position of the liaison committee, even though they held resources which were crucial in the establishment of the NHS.

The Department argued that the Secretary of State did not want to remove any functions from the local authority and implied throughout the discussions that many functions would be delegated to them. Simultaneously the Department was not willing to reach agreements that would satisfy all of the local authority associations. The lack of coherence between the arguments put forward by the local authority associations is clear throughout the discussions surrounding the Regional Hospital Advisory Councils. This allowed the Department of Health and the Secretary of State some flexibility during the discussions. The dual nature of discussions suggests that the Department and Secretary of State were only going through the motions of negotiation and were willing to imply local authority dominance to gain accord.

The White Paper proposals stripped local health authorities of most of their administrative functions, such as the provision of hospital services, all poor law medical services and some clinic services. During the White Paper discussions, local authorities disputed the functions which remained with major health authorities.⁸⁰ The provisions stated that clinics provided by the school health service would remain with the education authorities, whilst clinics for maternity and child welfare, venereal disease and scabies would remain with the existing major health authorities.⁸¹ The Joint Hospital Boards would administer other clinics, such as tuberculosis and cancer clinics. The Cities were strongly against the split in the clinic services. Councillor Swinney from Aberdeen argued that tuberculosis services should not be removed from the jurisdiction of the Medical Officer of Health, as they were not solely a hospital matter.⁸² The transfer of clinics was not necessary in the

⁸⁰ Major health authority was the title given to the local health authorities in the 1944 White Paper proposals.

⁸¹ Department of Health for Scotland, *A National Health Service*, (1944, London), Cmd.6502, p. 44.

⁸² NAS, CO1/4/167, NHS (S) LA 13, Local Authority Associations Liaison Committee, 29th April 1944, p. 3.

case of the Cities, where the existing health authorities were capable of undertaking the administration of a comprehensive health service for their area.

The dispute not only centred on the issue of splitting administrative control of the clinics, but also addressed a larger concern over the lack of co-ordination between preventive and curative health services. Captain Thomson, from Peebles, raised the concern that removing such services from the Medical Officer of Health could result in a patient who refused to go to hospital falling between the two services, going untreated and without notification to the Medical Officer of Health.⁸³ Furthermore, Councillor Swinney, from Aberdeen, and Baillie Watt, from Dundee, argued that Aberdeen and Dundee could provide specialist medical facilities as they were major health authorities and ‘saw no need to transfer the dispensary clinic’.⁸⁴ Although Thomson was speaking on behalf of the Association of County Councils, both the Association of County Councils and the Convention of Royal Burghs were later in favour of the transfer of some clinic services, such as the tuberculosis dispensary service, to the Joint Hospital Boards.⁸⁵ This is a further example where the three local authority associations presented similar concerns but failed to create a united defence against specific proposals as the views of individual local authorities were in direct contrast to the views of their association.

In response to these concerns, Dr A. Davidson, for the Department of Health, argued that tuberculosis was now seen as a disease which was in the sphere of the chest specialists and orthopaedic surgeons, which explained why this service was placed with the hospital board.⁸⁶ Specialisation was central to the new hospital service which would be based round specialist consultants and departments. Also at the Department of Health, Henderson felt that liaison could be made between the hospital board and the Medical Officer of Health, thus alleviating any problems which may occur from the division in the services provided.⁸⁷ The Convention of Royal Burghs and the Association of County Councils accepted the White Paper proposals at this point, even though they had concerns over the manageability of such disjointed services.

⁸³ NAS, CO1/4/167, NHS (S) LA 17, Local Authority Associations Liaison Committee, 15th May 1944, p. 3.

⁸⁴ *Ibid*, p. 3.

⁸⁵ *Ibid*, p. 3.

⁸⁶ NAS, CO1/4/167, NHS (S) LA 13, Local Authority Associations Liaison Committee Meeting, 29th April 1944, p. 3.

⁸⁷ *Ibid*.

As we have seen above, lack of cohesion among the three local authority associations characterised the discussions which took place in 1944. The three associations did not provide a unified front against the changes put forward by the Secretary of State and the Department of Health. This, combined with the way in which the Secretary of State and Department of Health portrayed the influence the local authorities would have after the NHS was established, provided an easier passage for the Scottish section of the White Paper than its English equivalent. Charles Webster argues that

in Scotland the Secretary of State faced fewer pressures to modify the White Paper scheme than his colleague in England. Many of the features of the Scottish scheme were justified on relatively non-controversial geographical grounds. Also Johnston had avoided conflict by accepting separate organisation for the three major components of the health service.⁸⁸

The acceptance of the separation of the hospitals, GP services and local authority health services by the Department of Health combined with the dynamic within the network shaped the way in which the local authority associations reacted to the proposals. Although local authorities were in a strong position with the resources that they held, the network had created a more hierarchical structure in which local authorities lost their previous advantage.

GP services provide a further example in which the Secretary of State and Department of Health assured local authorities that the health services would be passed to them at a later date. The White Paper proposed that the GP service and health centres would be a responsibility of the Department of Health.⁸⁹ A Local Medical Services Committee would be constituted of local medical, dental, pharmaceutical and nursing professionals along with local authority representatives.⁹⁰ The Committee would be advisory and would report to the Secretary of State on questions relating to the administration of the GP service and its relationship with the other health services. The Secretary of State, however, would have the discretion to delegate the administration of health centres to local authorities.⁹¹ The placement of GP services with the Department of Health was mentioned in a memorandum on the functions of major health authorities as not diminishing the existing duties of local authorities.⁹² Furthermore, Henderson suggested that, a few years after the

⁸⁸ C. Webster, *The Health Services Since the War*, Vol 1, (London, 1988), p. 65.

⁸⁹ Department of Health for Scotland, *A National Health Service*, (London, 1944), Cmd.6502, p. 45.

⁹⁰ *Ibid*, p. 44.

⁹¹ *Ibid*, p.44.

⁹² *Ibid*, p. 1.

establishment of the NHS, when doctors and local authorities had experience of working together, the administration of health centres and the GP service would be passed to the local authorities.⁹³ The transfer would depend on a change in the attitude of the medical profession who were, at that stage, unwilling to come under local authority control.

On one hand this could be seen as the Department showing acquiescence to the BMA, whilst on the other demonstrating a middle ground by which GPs and local authorities could become accustomed to working in close association prior to the administrative changeover to local health authorities. The Local Authority Liaison Committee indicated that they 'took no exception to the proposals' whereby for an undefined period the Secretary of State would provide health centres and the GP service, with power to delegate these functions to the local authorities at a later date.⁹⁴ Indications that the services would be passed to the local authorities are prevalent throughout the discussions and may have appeased the local authority associations to such an extent that they saw no reason to object to the proposals during the discussions. The dynamic of the network, and the relationships built within it, was such that the local authorities were put at ease over the proposals by the assurances of the Department of Health. The negotiations were also controlled by the strong personalities of the Secretary of State for Scotland and high ranking civil servants, giving the impression that local authorities were partners in forming the NHS policy. Simultaneously the local authorities were unable to assert influence by providing a united front against any proposals they opposed. The dynamic created an environment in which a split in the administrative structure did not seem to threaten local authorities.

Nevertheless, the associations still made their views known about the representatives who would constitute the Local Medical Services Committee. BMA dominance of the health services and discussions over these proposals was a major concern of local authorities. It was only on advisory bodies such as the Local Medical Services Committee that the local authorities were willing to allow members of the medical profession. During discussions of the membership of the Committee, the Liaison Committee made two statements indicating that all three associations were unanimously against medical representation

⁹³ NAS, CO1/4/167, NHS (S) LA 17, Local Authority Liaison Committee Meeting, 15th May 1944, p. 3.

⁹⁴ *Ibid*, p. 4.

within local authorities, Public Health Committees or Joint Hospital Boards.⁹⁵ The minutes of the meeting recorded two decisions:

- (a) the meeting was unanimous against co-option of the medical profession or any other organisation to local authorities, Public Health Committees or Joint Hospital Boards;
- (b) the meeting, noting that it was the practice of local authority committees to receive deputations from organisations wishing to be heard, was opposed to any proposal that the medical profession as such should have the express right to send representatives to local authority committees, even without the right to vote.⁹⁶

Although the local authority associations seemed to be in favour of many proposals in the White Paper, their concern over the dominance of the medical profession was evident. Nevertheless, the promise of administrative control, fuelled by the Secretary of State and the Department of Health during the discussions, led the local authorities to demonstrate willingness to undertake some of the proposed changes.

The concern over the administrative separation of the health service was particularly evident within the issue of mental health services. Early on, it was agreed that mental health services would be part of the NHS, although fundamental changes in the Mental Health and Lunacy Acts were required. While it was acknowledged that the majority of mental health services were domiciliary, it was suggested that administrative control of the services should be with the Joint Hospital Boards rather than the local authorities as was the current position.⁹⁷ The associations were not in favour of giving the Joint Hospital Boards administrative control, because local authorities would have better information regarding boarding-out conditions than a psychiatric social worker aligned to the hospital service.⁹⁸ It was agreed by all three associations that, if the Joint Hospital Boards were responsible for mental health, they should be given flexibility in the way in which they administered the services and not forced to set up a special mental health committee.⁹⁹ (It was proposed in the White Paper that the establishment of mental health committees would

⁹⁵ NAS, CO1/4/167, NHS (S) LA 21, Local Authority Liaison Committee Meeting, 5th June 1944, p. 3.

⁹⁶ Ibid, p. 3.

⁹⁷ NAS, CO1/4/167, NHS (S) LA 25, The Place of Mental Health.

⁹⁸ NAS, HH101/4, NHS (S) LA 26, Local Authority Liaison Committee Meeting, 10th July 1944, p. 2

⁹⁹ Ibid, p. 3.

be by statute, so every Joint Hospital Board would be compelled to have such a committee.)

All three associations agreed that ‘the question was one of administration, which should be left to the Boards to decide; in practice they might well have a mental health committee, among others, but it should not be singled out in the statute for special attention’.¹⁰⁰ The views of the local authorities had less to do with support for the administrative freedom of the Joint Hospital Boards and more to do with opposition to the compulsion to establish committees. If Joint Hospital Boards were to have compulsory committees then this would have set a precedent which could be applied to the administrative structure of the local health authorities. Consequently, local authorities can be seen to have been protecting their own ability to administer their health services without compulsion from central government by their support for the administrative freedom of Joint Hospital Boards. This issue illustrates the multitude of services that were interwoven between hospital and domiciliary care. The separation of the two sections of the health service was not necessarily in the best interest of the patient. Within the field of mental health services, local authorities were especially experienced as they provided hospital care and provisions for boarded-out patients. The experience of local authorities, however, did not come into consideration when the final proposals were put forward. No resolution of the issue of mental health services was reached during the 1944 negotiations, though eventually the separation of hospital and domiciliary care was applied to the mental health services.

The discussions of the provisions of the White Paper culminated in a report which summarised the outcomes of the meetings, but did not commit any of the associations to the decisions.¹⁰¹ The discussions revealed the way in which the associations were persuaded by the explanations of the proposals by the Secretary of State and the Department of Health. Throughout the report it is evident that, although these explanations went some way to appease the associations, there were still many issues that were yet to be resolved. The network proved beneficial to the Department in that local authorities were appeased to an extent which allowed the proposals to be accepted in an unchanged form. The network highlighted the weakness of the local authorities, that they were unable to show solidarity with one another, thus providing the Department the opportunity to utilise the lack of uniformity in the local authority suggestions for changes to the proposals to

¹⁰⁰ Ibid, p. 3.

¹⁰¹ NAS, HH101/4, 144a, NHS Report of Discussions between the Local Authority Associations Liaison Committee and the Department of Health for Scotland.

keep the proposals in their original format. Despite the resources and knowledge with which the local authorities could bargain, they were unable to unite and utilise this to their advantage. The Department was also able to give the impression that the local authorities were partners in the policy formation process and any assurances given by the Department would come to fruition in time. The suggestion that administrative power would be given to local authorities eventually continued to prove a successful strategy in gaining the agreement necessary to provide a clear path for the White Paper proposals to proceed to incorporation into a draft Bill.

Reaction to the Bill

Between the end of discussions of the White Paper in October 1944 and the presentation of the NHS (Scotland) Bill to Parliament in December 1946, a new government had been elected. The Labour party won the general election of 1945 and ensured the NHS would be established under its welfare policies. The NHS Act for England and Wales, given Royal Assent in 1946, gave the assurance of a comprehensive health service within Scotland. Prior to the publication of the Scottish Bill and its presentation to Parliament, a draft was sent in memorandum form to the local authority associations. The Secretary of State held meetings with the three associations answering any questions or concerns they had over the Bill. The procedure of consultation over the draft Bill was the same as in 1944 during the consultations over the White Paper. The relationships created within the policy network, established in 1943, continued to dominate the discussions over the Bill. The culmination of these meetings was the introduction of the Bill to Parliament and the passing of the NHS (Scotland) Act in 1947.

The proposals in the Bill were, in essence, the same as the White Paper. The machinery, by which the health services would be administered, however, was simplified. The Secretary of State would be responsible for overseeing all health services within Scotland through a tripartite system. Centrally, a Scottish Health Services Council and Standing Advisory Committees would advise the Secretary of State. Ownership of hospitals, both local authority and voluntary, would be transferred to the Secretary of State. A Regional Hospitals Board¹⁰² would be established for each of the five regions¹⁰³ and would undertake all administrative duties regarding hospital provision and some specialist clinics. The

¹⁰² Regional Hospital Boards were previously referred to as Joint Hospital Boards in the 1944 White Paper.

¹⁰³ The five regions: Glasgow, Edinburgh, Aberdeen, Dundee and Inverness.

Regional Hospitals Board would appoint a local Hospital Management Committee to undertake the day-to-day running of individual hospitals. Local health authorities would undertake all domiciliary and local clinic provision. A Local Executive Committee would administer the provision of GPs, dentists and hear complaints between doctors and patients. The health centres, in which GP services and local authority clinics would be housed, would be administered by the Secretary of State in the first instance, or could be delegated to local authorities.

In their responses to the memorandum the local authorities also took into account the arrangements proposed for England and Wales through consideration of their NHS Bill. The English Bill was similar to the proposals in Scotland but did not include teaching hospitals within regional boards, ambulance services were placed under the administration of local health authorities and local health authorities would be involved in providing health centres.¹⁰⁴ In doing so the local authorities were ensuring that the Scottish Bill would not incorporate the elements of the English Bill which were not agreeable to them. Edinburgh Corporation's Public Health Committee criticised the English Bill on three main points. First, the administrative separation of the teaching hospitals from all other hospitals was not in the best interest of the patient, as all hospitals should be available for teaching purposes. Second, the three branches of the health service would not be co-ordinated under one regional body. Finally, local authorities should be represented to a greater degree on the Regional Hospital Boards to 'facilitate a complete co-ordination of the Hospital, Clinic and other services in each Region'.¹⁰⁵ The Association of County Councils also criticised the English Bill along the same lines of Edinburgh Corporation, but noted that clarification, within Scotland, was required regarding which authority would provide health centres, which authority would provide ambulance services, and the way in which grants were distributed to local health authorities.¹⁰⁶ The concern of the Counties and Edinburgh Corporation was that the provisions within the English Bill, which were criticised, would be incorporated into the Scottish Bill. The Counties noted that they had received a letter from the Private Secretary to the Secretary of State for Scotland, Joseph Westwood, which responded to their concerns.

¹⁰⁴ Webster, *The Health Services Since the War*, Vol I, pp. 80-6.

¹⁰⁵ ECA, SL26/2/31, Edinburgh Corporation Public Health Committee Meeting, 27th May 1946, pp. 325-7.

¹⁰⁶ ECA, SL169/1/8, Association of County Councils in Scotland, Minutes of Meeting of the Public Health and Social Welfare Committee, 16th May 1946, pp. 394-5.

It was stated in the communication that Mr Westwood notes the points which the Association made in regard to the English Bill, and will bear these in mind in the further consideration he will be giving to the corresponding Scottish measure to be introduced later in the present session; that he will also have the advantage of making decisions on the terms of that measure of knowing the views expressed in Parliament on the principles of the English Bill; and that in all the circumstances Mr Westwood feels that a discussion might more usefully take place when the Scottish Bill has been prepared rather than at the present time.¹⁰⁷

The minutes of both the Counties Association and Edinburgh Corporation record that the elements which were not acceptable in the English Bill had not been incorporated into the Scottish Bill. Morrice McCrae argues that the Scottish Bill had been ready for submission to Parliament in early 1946 and that the English Bill was ‘identical with that already drawn up for Scotland’ apart from the clauses which excluded the teaching hospitals from the regional hospital scheme and the concessions made to local authorities.¹⁰⁸ Nevertheless, it is interesting to note that local authorities kept a close watch over the English Bill and its potential influence on its Scottish counterpart. Edinburgh Corporation felt the Scottish Bill was ‘complicated and cumbersome, and fail[ed] to achieve a co-ordinated service’.¹⁰⁹ Moreover, Webster argues that the English Bill incorporated the Scottish tri-partite administrative structure as a means of placating GPs and local health authorities to some extent ‘by the prospect of the status quo in their sectors’.¹¹⁰ Discussion had not ended over the Scottish Bill; however, the influence of English proposals within Scotland had been avoided.

In a meeting with the three local authority associations in February 1946, the Secretary of State, Joseph Westwood¹¹¹ invited views on the proposals which would be put forward to Parliament in the NHS (Scotland) Bill.¹¹² Each association spoke in turn with regards to the proposals in the memorandum ‘Proposals for a National Health Service in Scotland’. Bailie Reid, the Glasgow representative, spoke on behalf of the Counties of Cities Association assuring the Secretary of State that the Association was eager to make a success of the new health services and would co-operate wholeheartedly. However, the

¹⁰⁷ Ibid, p. 394.

¹⁰⁸ McCrae, *The National Health Service in Scotland*, pp. 224-9.

¹⁰⁹ ECA, SL26/2/32, Edinburgh Corporation Public Health Committee, 26th November 1946, p. 22.

¹¹⁰ Webster, *The Health Services Since the War*, Vol I, p. 83.

¹¹¹ Joseph Westwood took over from Thomas Johnston in August 1945 as Secretary of State for Scotland and took over negotiations for the NHS at this time.

¹¹² NAS HH101/4, NHS (S) LA (46) 2, Note of Meeting between Secretary of State and Local Authority Associations, 8th February 1946.

assurance given by Bailie Reid was on the basis that certain questions were answered. The questions covered areas such as the right of the Secretary of State to appoint local authority members to councils and boards; what hospitals were to be taken over; what were the terms of transfer; what would the process of co-ordination be and clarification of the functions being left with local authorities.¹¹³ In concluding, the Cities stated that

our chief anxiety, in the interests of the Public for whom the Services are to be provided, is how best to secure complete Co-ordination between the Local Authority functions and those of the Hospital and Medical Services to be set up.¹¹⁴

Similarly, assurances and concerns were voiced by Provost Pirie from Coatbridge, on behalf of the Convention of Royal Burghs. The assurances were subject to certain questions being answered. The Burghs submitted questions about the representation of local authorities on boards and committees; whether the division of infectious diseases work was necessary; what the proportions of membership on Regional Hospital Boards and Local Management Committees would be; whether the school medical service would be included and who would finance health centres.¹¹⁵ It is evident from these questions and the questions of the Cities that they and the Royal Burghs had similar concerns over the proposals within the Bill. It was evident to them at this stage that they were excluded from some of the main health services and were running out of time to influence the administrative structure of the NHS.

The Association of County Councils, on the other hand, did not give any assurances during the meeting. Major Broun-Lindsay, from East Lothian, stated that the association had already submitted its questions and assumed they would be answered in writing. The questions from the Counties covered issues such as why administration of the health services could not be delegated to local authorities; whether there would be power to compel local authorities to combine for administration of the health services; whether infectious diseases hospitals would be included in the transfer; whether the local authority members to boards and committees would be nominated by local authorities and if the overall scheme could be simplified.¹¹⁶ Again, the questions are similar to those of the other

¹¹³ NAS, HH101/4, Questions submitted by Association of Counties of Cities, 8th February 1946, p. 1-3.

¹¹⁴ Ibid, p.3.

¹¹⁵ NAS, HH101/4, Questions put to the Secretary of State by the Convention of Royal Burghs, p. 1-7.

¹¹⁶ NAS, HH101/4, Association of County Councils in Scotland, Notes on Memorandum of Proposals for a NHS in Scotland, 31st January 1946, p.1-5.

local authority associations. Their lack of unity, however, was evident when the procedure of how the questions would be submitted became of greater importance than their ability to provide a united front in the negotiations. The misunderstanding over the procedure for raising concerns at the meeting underlines the lack of co-ordination among the three local authority associations. They made no attempt to discuss the way in which they would put their concerns to the Secretary of State. As has been mentioned above in the discussion of policy networks, the way in which local authorities' actors interact with each other does have an effect on the relationships with other network members and the negotiation process. The same lack of co-ordination highlighted by this meeting was evident throughout the negotiations since 1944.

The Secretary of State responded to the local authorities by indicating that the questions would receive detailed consideration with written replies. He then asked the local authority associations to abandon their view that local authorities should choose their own representatives for the advisory committees in the new health care administration. The Secretary of State explained that if he gave this right to local authorities, he would also have to give it to the other professional bodies participating in the committees. He assured the local authorities that they would be consulted prior to any appointments being made. Even though Westwood had replaced Johnston in the discussions, he used the same method of persuasion by assuring local authorities they would be consulted even without having direct administrative control. The removal of local authorities from the health services was gaining pace. Nevertheless, the costs of removing local authorities from the health services still outweighed its return, as they still had some leverage through their knowledge of the operation of health services.

Although the dynamics of discussions do not seem to have changed over the period, the meeting in February 1946 signalled a change in the views of the Counties of Cities Association. Previously, the Cities had not agreed with the proposals put forward for the health service but were eager to be seen as ready to help in ensuring the success of the NHS. In a memorandum prior to the meeting, the Counties of Cities Association concluded that if local authorities were to be effective units within the NHS, an adequate field was needed for local administration or all services should be removed from local authorities and managed centrally.¹¹⁷ The four large cities had the most to lose in the new administrative structure of the health service. Suggesting that services should be removed

¹¹⁷ NAS, HH101/4, Counties of Cities Association Memorandum on NHS following Meeting of Four Cities, 1st February 1946.

entirely from local authorities shows the despondency the Cities felt after the discussions in 1944. The change of view expressed in 1946 may however have been damage limitation. By suggesting all services be administered centrally, perhaps more services would remain with the local authorities by either direct or indirect control. The reasons behind such a change in attitude, however, are unclear from the archives.

The Association of County Councils took the opposite view to the Cities, who felt the scheme was still workable, as they felt the scheme was unworkable. The change of view was expressed in a letter to Henderson from Broun-Lindsay, after the meeting. Broun-Lindsay told Henderson that three or four members wanted it recorded that they felt the whole scheme was unworkable.¹¹⁸ The local authorities realised at this point that the majority of health functions were to be removed from their administrative sphere. It was then that the Counties began to protest on a greater scale. Nevertheless, they still could not find a way to work with the other associations. In the same letter to Henderson, Broun-Lindsay commented that the Association of County Councils was unhappy with the way in which the other associations behaved in the meeting and as a result, the Secretary of State had been unable to give detailed reactions to their questions at that time. The behaviour referred to was the way in which the Cities and Royal Burghs put forward their assurances and questions in detail during the meeting, not in advance as the Counties had done. As the Counties had sent their questions in advance, they were expecting answers and discussion of the questions during the meeting. Again, the comments made to the Department of Health demonstrate that the associations could not work together even though they disagreed with similar issues in the Bill.

The questions put forward by the three associations covered all aspects of the proposals for the new health services and replies were received in late March 1946. Many of the issues raised at this stage were similar to those discussed in the previous meetings in 1944. For example, the way in which representatives would be appointed to the Health Services Council, the Standing Advisory Committee, the Regional Hospital Boards and the Local Hospital Management Committees was one of the issues raised. The co-ordination between hospital, GP and local authority health services was still a concern. Hospital ownership was also an issue which had not yet been resolved. Consequently, the previous discussions which were intended to smooth out any concerns had only delayed the debate to this later stage.

¹¹⁸ NAS, HH101/4, Letter to Mr Henderson from Major Broun-Lindsay, 12th February 1946.

In his written reply to these concerns, the Secretary of State argued that as he would be responsible for the health services, he should be able to choose his advisers at his own discretion.¹¹⁹ He went on to indicate that only representatives with the relevant experience would be appointed, after consultation with the relevant body such as local authorities, ‘to serve in their personal capacities and not as delegates of particular organisations’.¹²⁰ Furthermore, the proportion of representatives from each body on boards such as the Regional Hospital Boards would not be determined by the legislation and might fluctuate between different boards.¹²¹ The issue of the selection of representatives and the proportion of representatives on the boards and committees demonstrates the local authority associations’ fear that the medical profession would have greater influence on these boards. Their concern over the issue also indicates their realisation that the functions, which they had undertaken for some time, would be removed. The local authority associations’ desire to choose representatives for the boards and committees was an attempt to preserve what little authority they would have left.

In response to the concern over the co-ordination among hospital, GP and local authority services, the Secretary of State advised that this would be secured through the planning of the services.¹²² In the case of maternity services, the Secretary of State indicated that he would encourage close administrative contacts between the various elements of the services and the family practitioner to advise expectant mothers on what facilities and services would be available and to make use of these.¹²³ It was also intended that the local authorities would be responsible for all epidemiological aspects of infectious diseases, while hospital treatment of patients with infectious diseases would be the responsibility of the Regional Hospital Boards.¹²⁴ The co-ordination of local authorities and Regional Hospital Boards would be overseen centrally in the same way as maternity services, while

¹¹⁹ ECA, Accession 12, Questions put to the Secretary of State by Counties of Cities Association, Questions 1, 2 & 3.

¹²⁰ ECA, Accession 12, Notes by the County Council Association on the Confidential Memorandum “Proposals for a National Health Service in Scotland” and the Secretary of State Replies, Para. 8.

¹²¹ ECA, Accession 12, Questions put to the Secretary of State by Convention of Royal Burghs, Para 8.

¹²² ECA, Accession 12, Notes by the County Council Association on the Confidential Memorandum “Proposals for a National Health Service in Scotland” and the Secretary of State Replies, Para. 16, 17 & 18.

¹²³ Ibid.

¹²⁴ ECA, Accession 12, Questions put to the Secretary of State by Counties of Cities Association, Questions 15 & 17.

the day-to-day planning would be worked out locally.¹²⁵ Therefore, the Secretary of State saw no problems with co-ordination of the hospital, GP and local authority services, as both central and local planning would create the effective tripartite service envisioned.

With regards to hospital ownership, the Secretary of State confirmed in his replies to the associations that all property related to hospital provision would be transferred to Regional Hospital Boards, whilst any properties used partly for hospital services would be divided between the Board and the local health authority.¹²⁶ The Secretary of State would also be able to stop the transfer of any hospital facility not required for the NHS.¹²⁷ Furthermore, outstanding debts would also be transferred from the local authority to the Regional Hospital Boards,¹²⁸ while any plans for developments which would incur capital expenditure would be considered on a case-by-case basis.¹²⁹ Therefore, although the ownership of the main bulk of hospital facilities would be transferred to the Regional Hospital Boards, there was still some scope for the local authorities to put their case to the Secretary of State about why any particular hospital should not be transferred.

With the points on membership of committees and boards, co-ordination of the services and hospital ownership clarified, the attention of the local authority associations turned to what their functions would be within the NHS. It was confirmed by the Secretary of State that the local health authorities would be responsible for maternity and child welfare clinics, domiciliary midwifery, home nursing, health visiting, the school health service and immunisation.¹³⁰ The local health authorities would also be responsible for environmental services such as epidemiology, supervision of food and milk supplies, port health services,

¹²⁵ ECA, Accession 12, Questions put to the Secretary of State by Convention of Royal Burghs, Para 5.

¹²⁶ ECA, Accession 12, Notes by the County Council Association on the Confidential Memorandum "Proposals for a National Health Service in Scotland" and the Secretary of State Replies, Para. 6.

¹²⁷ ECA, Accession 12, Questions put to the Secretary of State by Counties of Cities Association, Questions 6 – 11.

¹²⁸ Ibid.

¹²⁹ ECA, Accession 12, Notes by the County Council Association on the Confidential Memorandum "Proposals for a National Health Service in Scotland" and the Secretary of State Replies, Para. 6.

¹³⁰ ECA, Accession 12, Questions put to the Secretary of State by Counties of Cities Association, Question 20.

health aspects of housing, water supply and drainage.¹³¹ The Counties responded, saying that

the Committee regret the extent to which the local health authorities are being shorn of their functions and the meagre extent to which they will participate in the scheme in the future.¹³²

The Royal Burghs were also disappointed with the proposals which, compared with the health functions they had been administering until the NHS, were ‘unfavourable’.¹³³ The worst fears of the local authority associations were realised through the Bill and the answers they received from the Secretary of State. The network had proved successful for the Department of Health which, by continual assurance that local authorities would not lose out within the new system, gained agreement to the extent needed to send the Bill through Parliament.

Local authorities, however, did not relinquish control quite so easily, and in December 1946 the Association of County Councils made an attempt to gain support from Scottish MPs. At this late stage local authorities felt it was necessary to go outwith the policy network to gain support for their views on the Bill. They sent a letter setting out the problems they had with the proposals within the Bill to each Scottish MP. The letter highlighted issues such as the lack of delegation of administrative functions of the NHS to the local authorities, the need for administration of health centres by local authorities and why at least 50 percent of members on committees and boards should be appointed by the local authorities.¹³⁴ Such action was too late for the local authorities within Scotland. They had relied upon the promise of delegation of administrative functions and agreed many changes which removed functions from their control. The lack of co-ordination among the three local authority associations and their willingness to accept promises of delegation of functions to the local authorities had played into the hands of the Department of Health and Secretary of State. The tripartite health system would be established.

¹³¹ Ibid.

¹³² ECA, Accession 12, Notes by the County Council Association on the Confidential Memorandum “Proposals for a National Health Service in Scotland” and the Secretary of State Replies, General Observations.

¹³³ ECA, Accession 12, Questions put to the Secretary of State by Convention of Royal Burghs, Para 16-19.

¹³⁴ NAS, HH101/4, Letter from George Davie, Association of County Councils to all MPs of Scottish Constituencies, 14th December 1946.

Glasgow Corporation also embarked upon a series of letters to the Secretary of State and the Department in protest at several sections of the Bill. The protest included demands for increased representation on the Scottish Health Services Council, continued administrative control of the treatment of infectious diseases and continued unity of maternity services.¹³⁵ In response the Department reminded the Corporation that the Scottish Health Services Council would receive increased local authority representation due to the discussions with the local authority associations. Furthermore, the facilities for the treatment of infectious diseases was required as part of the hospital provision but would necessitate close liaison between the local authorities and the Regional Hospitals Board as would maternity services.¹³⁶ Furthermore, Glasgow Corporation sent these observations to the Parliamentary Bills Committee in an attempt to highlight their disagreements with the NHS (Scotland) Bill.¹³⁷ Glasgow Corporation did not welcome the new, modern health service, but envisioned deterioration not only in their administrative control but also patient care.

The Bill passed through Parliament with only some debate over proposals such as the separation of teaching hospitals from municipal hospitals and access to pay beds within hospitals being available for all doctors.¹³⁸ These amendments were not accepted and the NHS (Scotland) Act 1947 was passed intact. The Act of 1947 incorporated the elements which the Department of Health and Secretary of State advocated from the first discussions of the NHS, a tripartite system in which the Department and Secretary of State had a high degree of central control. The Act followed closely the proposals put forward in the memorandum 'Proposals for a National Health Service in Scotland' using the same administrative machinery. Although some of the names of the boards and committees had been changed, through the publication of the Bill, the tripartite health service was established under the provisions in the NHS Act 1947. It removed most of the functions previously undertaken by local authorities leaving them with a small auxiliary role within the new scheme.

The NHS (Scotland) Act was given Royal Assent on the 21st of May 1947. It was on the appointed day, 5th of July 1948, that local authorities lost the majority of their health services to new bodies, established through the Act. By 1947 the Department of Health

¹³⁵ NAS, HH101/13, Letter to Joseph Westwood from Glasgow Corporation, 24th of January 1947 & Letter to Department of Health from Glasgow Corporation, 24th of February 1947.

¹³⁶ NAS, HH101/13, Letter from G.H. Henderson, Department of Health to the Corporation of Glasgow, 11th of February 1947.

¹³⁷ GCA, C1/3/115, Glasgow Corporation Health Committee Minutes, 19th December 1946.

¹³⁸ *Ibid.*

had turned its attention to requesting administrative schemes from the local authorities and advising, through DHS Circular No 64/1947, the elements of local authority health services within the Act.¹³⁹ The Act reorganised the Scottish health services into what the Department of Health for Scotland and Westminster considered to be a new comprehensive twentieth-century approach to health care. The reactions from local authorities, however, was not one of acclaim for a new and exciting health service, but one of doubt over the viability of such a disjointed service.

Conclusions

The creation of the NHS within Scotland was not one of universal consensus. The philosophy behind a comprehensive health scheme was not in question, but the way in which the scheme was created and administered was contentious. Scottish local authorities were at the centre of the discussions over the creation of the NHS. Local authorities were very much in favour of the concept of a comprehensive health service but had many concerns over the tripartite system which was proposed. As the providers of an extensive array of health services at the time, local authorities should have been in a particularly strong position to defend their administrative authority. In analysing the creation of the NHS, policy network theory has highlighted the existence of an intergovernmental network. This network operated alongside the professional network encompassing the BMA most commonly discussed by historians and political scientists alike.

The intergovernmental network created a forum in which the Secretary of State for Scotland, the Department of Health for Scotland and Scottish local authorities could negotiate the terms of the new health services. The dynamic created within the network was set by Thomas Johnston and created an environment which affected the way local authorities could express their concerns. The dynamic Johnston created had a duality. It was hierarchical, while at the same time attempting to portray local authorities as equal partners with the DHS. Furthermore, Johnston suggested that, although the proposals seemed to remove administrative control from local authorities, subsequent changes would return the health services to them. By giving these assurances, Johnston and the DHS created a network which demonstrated hierarchical dominance by the Scottish Office over local authorities, making the latter's non-compliance with the NHS proposals very difficult. The Secretary of State and DHS were not overtly imposing their will on the local

¹³⁹ NAS, HH61/154, Letters to Local Authorities Requesting Draft of Schemes & DHS Circular No 64/1947.

authorities but through their assurances, this was the outcome. The environment created by the Secretary of State and the DHS had a large impact on the ability of local authorities to utilise their resource base in the bargaining process.

Even so, local authorities did not give up their administrative authority without attempting to influence the proposals. Their concerns over the administrative structure, ownership of hospitals, the disjointed nature of the service and the lack of attention paid to preventive medicine were all voiced, and alternative solutions offered. Particular concern was also voiced by the local authorities over the dominance of the BMA in the proposals and discussions over the White Paper and Bill. Within the network, the three local authority associations were unable to work together to create a united front against proposals which were detrimental to their administrative authority. Partly this was due to the dynamic of the network, but also it was a result of smaller local authorities' fear of being outvoted by large authorities in the Cities Association. The inability to work together provided a further strengthening of the position of the DHS as they were able to provide assurances which were accepted by the Counties and Royal Burghs.

Such disagreements among the local authority associations did not prevent the associations from trying to gain support outwith the network. The Counties wrote to Scottish MPs to gain support for their opposition to some of the proposals of the NHS (Scotland) Bill. Furthermore, individual local authorities such as Glasgow Corporation attempted direct contact with the DHS to influence changes to the proposals. Ultimately these were unsuccessful but nevertheless demonstrate that local authorities were not part of the consensus and smooth transition to the NHS which many historians offer as the story of Scottish health services.

In the end, the NHS (Scotland) Act, 1947, left local authorities with what seemed an auxiliary role within the health services, a role mainly concerned with preventive medicine. Within the policy network, local authorities were unable to assert any authority during discussions despite their particular position of strength as owners and administrators of the health services. The negotiation over the NHS (Scotland) Act, 1947, reveals the beginning of the removal of local authorities from the health services. The Secretary of State and the Department of Health for Scotland favoured centralisation of the health services and the way in which they negotiated with local authorities was the first step towards their goal. Full removal of local authorities from the NHS, at this stage, was not feasible as the returns would not have outweighed the political costs to do this. Local authorities still owned the

resources needed for the health services, for example the hospitals, and had a lot of knowledge in providing health services. The Department of Health for Scotland, however, also had to bring the medical profession on board and local authorities were one of the bargaining chips they could use as the medical profession did not want to be under their authority. Local authorities were consequently not included in the NHS to any great extent which appeased the medical profession and took a step towards centralisation. With assurances local authorities were not mobilised to enter a confrontation with the Department of Health for Scotland over the establishment of the NHS, which could have ended with a very different administrative structure for the health services. On the appointed day, local authorities became subsidiary in the administration of the health services, losing the majority of their functions to more centralised bodies.

Policy formation, however, does not end when an Act receives Royal Assent. Implementation of the Act must also be considered as interpretation of an Act can influence the way the health services were administered in practice. The division between direct and indirect influence can also be analysed through examination of the implementation of an Act. In the case of local authorities and the implementation of the NHS (Scotland) Act, the influence which the local authorities exerted following the Act needs to be examined to assess the effect of local authorities in this policy arena. The following chapter will consider the implementation process in relation to local authorities as a means of analysing their reaction and remaining influence.

Chapter 3

Implementation of the Act, 1948-1960.

Introduction

The year 1948 brought with it a new comprehensive NHS to Scotland. After years of discussion and negotiation the Act had been given Royal Assent in 1947. Local authorities, however, had not received the proportion of the service that they had envisioned because they were unable to assert sufficiently their influence during the negotiations for the NHS. Within the Act they were only given administrative authority over what were considered to be auxiliary health services. Nevertheless, the new health service was due to begin on the Appointed Day, 5th July 1948. The Appointed Day ended the discussions between the Secretary of State, the Department of Health and the local authority associations as they all embarked upon implementation of the Act, although planning for the service began in 1947.

The outcome of the decisions made within the policy network in which local authorities were involved was the loss of the majority of their health services and the limitation of their administrative authority to an auxiliary role within the service mainly concerned with preventive medicine. The health services administered by local health authorities were fairly low in the hierarchy of the services provided. The lack of finances available to local authorities and the lack of provision for preventive medicine within the NHS (Scotland) Act, 1947 are clear indicators of their low status. Charles Webster argues that the introduction of the NHS significantly reduced their role and that the 'change was traumatic for local authorities because it represented a sudden and unexpected reversal of policies followed since the beginning of the century'.¹ However, as will be demonstrated within this chapter, within the official organisation, they were on an equal footing with the other two sections of the health services and the Department of Health for Scotland made attempts to highlight the centrality of the local health authority services. Webster argues that local authorities became the 'junior partner' in a range of health services such as maternity and child welfare, tuberculosis, mental health and mental deficiency.² Nevertheless, the role of local authorities was crucial to patients who attended local authority clinics and required assistance from nurses, home helps and other health care professionals. Even if it was not what local authorities envisioned, the new health service had arrived and the years 1948 to 1960 saw its implementation.

¹ C. Webster, *The Health Services Since the War*, Vol. I, (London, 1988), p. 373.

² Ibid, p. 373.

The chapter demonstrates that the conflict over the details of how the NHS would be run continued during the implementation of the NHS (Scotland) Act, 1947. The relationship between the Department of Health for Scotland and local authorities, which was established through the policy network, continued to place local authorities in a subordinate position to the Department. Local authorities could still assert some official and unofficial influence over the implementation of the legislation. Through their membership on boards and committees, including the Scottish Health Services Council, the Scottish Advisory Committee of the Whitley Council for the Health Services and the Council for National Health Service Negotiating Machinery, as well as through their own section of the health service, local authorities had the opportunity to establish a new role within the Scottish NHS.

Their role within the NHS, however, was determined by the Department of Health for Scotland. Due to the hierarchical nature of the local authorities' relationship with the Department, they were unable to assert influence over the direction of the NHS generally and their influence over the direction their own health services took was limited. The Department of Health underestimated the effect a negative outlook by local authorities could have on the implementation of the NHS. The three administrations of the NHS were unable to co-ordinate services or decide on who was responsible for certain services. The relationships among the three administrations of the NHS caused a range of problems and conflicts over the implementation of the Act. The problems, and solutions, do show that local authorities were service providers for a small section of the NHS and had no means of increasing their influence outside their own remit. The period 1948 to 1960, therefore, continued the marginalisation of local authorities in the NHS.

Throughout this chapter, the reaction of local authorities to the new legislation will be explored in relation to the way in which the health services developed. Furthermore, the co-operation and co-ordination of the local authority services with the hospital and GP services will be analysed, as will the problems over division of responsibility which were encountered in the implementation of the NHS. The chapter will consider the reaction of local authorities to the initial implementation up until 1950; the implementation of the Act until 1960; financial arrangements; the division of responsibility and its effect on patient care; and, the condition of the health services by 1960.

Reaction by Local Authorities to Initial Implementation up to 1950

On the appointed day, 5th July 1948, the Act came in to operation. Hamilton argues that ‘administratively the NHS started smoothly’ and had features, such as free spectacles and dental care, which ‘caught the public imagination’.³ The NHS (Scotland) Act 1947 incorporated the elements which the DHS and Secretary of State advocated from the first discussions of the NHS i.e. a tripartite system in which the Department and Secretary had a high degree of central control. Although some of the names of the boards and committees had been changed, the new health service removed most of the functions previously undertaken by local authorities, leaving them with a small auxiliary role. The Scottish Health Services Council was established to advise the Secretary of State on any matters relating to the health services. Joint hospital boards were renamed Regional Hospital Boards, while hospital Boards of Management were established to run individual hospitals.⁴ Executive Councils were established in each region to provide GP, dental and pharmaceutical services.⁵ The Act furthermore stated that it was the duty of local authorities to combine, if necessary, into larger local health authorities and provide a range of preventive, care and after-care services.⁶ The Act brought in the new health service which would completely transform the way in which health care was provided in Scotland.

The NHS was a tri-partite structure managed centrally by the Department of Health for Scotland. The Health Services Division of the Department of Health had five divisions which were: the Regional Hospital Boards; the Local Health Authorities; Executive Councils; Standing Advisory Committees; and, the Scottish Health Services Council.⁷ Figure 3.1, shows the structure of the NHS from the Secretary of State, who had overall authority over the NHS, to the separate divisions within them.

The chart indicates that each of the constituent parts of the NHS, the hospital, GP and local health authorities, were on an equal footing within the organisation. Nevertheless, the type of services provided by the local health authorities, preventive medicine and public health were seen as being low within the hierarchy of services provided. The hierarchy of services is most clearly revealed when the finance of the three types of health services

³ D. Hamilton, *The Healers*, (Edinburgh, 2003), p. 263

⁴ Department of Health for Scotland, *National Health Service (Scotland) Act, 1947*, pp. 1-13

⁵ *Ibid*, p. 26.

⁶ *Ibid*, pp. 19-24.

⁷ LHSA, HB16/39/4, National Health Service Administration Diagram.

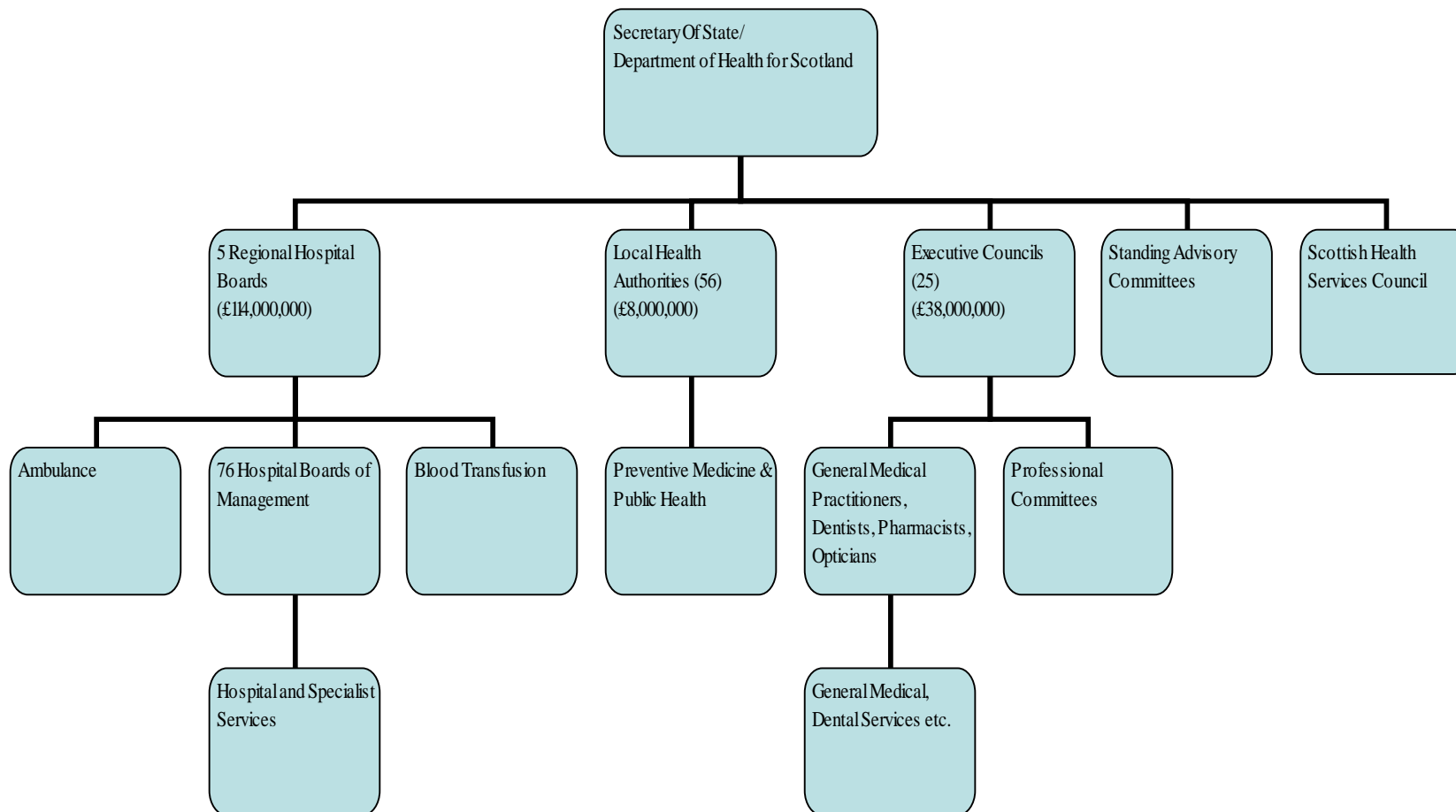
provided is considered. The five Regional Hospital Boards were allocated £114,000,000 to run hospital, ambulance and blood transfusion services, while the 25 Executive Councils were allocated £38,000,000 to run the GP and general medical services and the 56 Local Health Authorities were allocated £8,000,000 to run the preventive medicine and public health services. Therefore, while the organisation chart suggests that administratively local health authorities were on an equal footing with their counterparts in the new health services, financially they were at the lower end of the health services. Although they provided a service which was indispensable to patients, the local authorities felt that they had been pushed to the periphery of the NHS.

Division E of the Department of Health for Scotland was concerned with the local health authorities and the services they provided. Local health authorities were responsible for a range of services, from the Appointed Day, which were mainly of a preventive and auxiliary nature. They were responsible for providing maternity and child health services, domiciliary midwives, health visitors, home nursing, vaccination and immunisation, domestic helps, care and after-care generally including those for mental defectives and persons of unsound mind, and the school health service. They also provided many other health education and preventive services in their area. From this list of services, it is clear that, although the local authorities had lost what was considered the most important of the health services, hospital provision, they were still involved in a range of localised services which were important to patients.

The negotiation of an Act, however, is not the end of the policy formation process. In assessing the Rhodes typology as a framework for policy-making analysis, Smith notes that it can be used in the wider discussion surrounding the nature of the state.⁸ Smith develops the typology by acknowledging that the groups involved in the policy process can then assist in implementation of the policy thus achieving the goals of the state.⁹ Smith recognises the link between policy and implementation which he argues should be explored to distinguish between what is agreed through policy and what is actually implemented in practice. By exploring these issues, those organisations which are not dominant in the network may emerge as having greater informal influence through the implementation process.

⁸ M. J. Smith, *Pressure, Power and Policy*, (Hemel Hempstead, 1993), p 233

⁹ Ibid, p. 53

Figure 3.1: National Health Service Administrative Diagram

(Source: HB16/39/4, Lothian Health Service Archives)

Jordan and Richardson also recognise that implementation of policy is an important area, as it is often the case that intended outcomes are not always realised in the implementation process.¹⁰ Implementation is seen as a further bargaining process in which policy outcomes are not an end to discussions over a policy area but the beginning of discussions over how policy will be achieved in practice. Jordan and Richardson note that the interaction between interest groups and government from the initial discussions over a policy to implementation of the policy is a central feature of British policy formation.¹¹ Therefore, the groups which are included in policy networks are those who implement policy. The relationships which are developed are important in considering the progression in any policy area. The descriptive nature of this process, however, does not allow for generalisations to be made about power dynamics within the state, as interpersonal relationships vary between each policy arena.

Within the health arena, extending policy network theory to include implementation gives a basis for analysing the development of the Scottish NHS from initial policy negotiations and legislation into an active service for the Scottish people. Explaining the link between the interest groups, the negotiations over policy and the implementation of such policy can highlight the full policy process. Some of the organisations involved in the Scottish health policy network, such as the Department of Health, the medical profession and local authorities were all involved in the implementation of the Act which ensued from the negotiations. Other organisations, such as the voluntary hospitals, were brought under the control of the Regional Hospital Boards and no longer existed as a separate entity. The policy network not only negotiated the NHS (Scotland) Act, 1947, but by doing so, also changed the range of organisations which were involved in the health policy network. The range of organisations involved in the network is not the only area which can change as the policy process continues. The interpretation of policy also affects the way in which the outcome of negotiations is implemented. The changes which can occur between what is written in the Act and what is implemented in practice can affect not only the services provided for patients but also the dynamics among the interest groups within the health network. The extension of policy network theory will, therefore, be utilised to consider the development of the Scottish NHS, through its services and relationships among the different agencies, in the aftermath of the passing of the NHS (Scotland) Act, 1947.

¹⁰ A. G. Jordan and J. J. Richardson, *British politics and the policy process: an arena approach*, (London, 1987), p. 234.

¹¹ *Ibid*, p. 238.

In preparation for implementation of the health services, the local authorities were required to submit the proposals for each of their administrative responsibilities to the Department of Health for approval. The proposals covered all health services which were to be administered by the local authorities, as well as the setting up of local health authorities. A DHS Circular in June 1947 emphasized that provisions had been made in the Act for the voluntary and compulsory combination of local authorities into local health authorities with the approval of the Secretary of State.¹² The Secretary of State therefore had a large degree of central control over the local authorities and their ability to form health authorities.

The Department of Health also encouraged local authorities at this stage to set up a local co-ordinating committee which would include the regional hospital boards and the executive councils.¹³ Co-ordination of the three parts of the NHS was considered by the local authorities at this point. During a meeting of Edinburgh Corporation Health Committee in November 1948, the Medical Officer of Health suggested that immediate steps be taken to set up a Liaison Committee comprising of the Local Authority, the South-Eastern Hospital Regional Board and the Executive Committee for Edinburgh.¹⁴ The issue of co-ordination and co-operation was constantly referred to throughout the period immediately after the Act, as it was lacking in many local authority areas, and it will be explored in more detail later in the chapter.

On behalf of the Secretary of State, the Department of Health requested local authorities to submit their proposals in a particular form covering a range of headings. Proposals for vaccination and immunisation were due by the 31st December 1947; proposals for care of mothers and young children, domiciliary midwifery, health visiting and home nursing were due by 31st January 1948; and proposals for prevention, care and after-care in relation to tuberculosis and duties relating to defectives and persons of unsound mind were due by 28th February 1948.¹⁵ In the case of midwifery, for example, the proposals were to include details of staffing employed by the local authority, hospitals and voluntary organisations; special housing arrangements, special transport arrangements and an estimated cost of the

¹² GCA, DHE1,1,(4), DHS Circular No 64/1947, National Health Service (Scotland) Act, 26th June 1947, p. 2.

¹³ Ibid, p. 4.

¹⁴ ECA, SL26/2/33, Edinburgh Corporation Health Committee, General Health Services Sub-Committee, 9th November 1948, p.61.

¹⁵ GCA, DHE 1,1,(4), DHS Circular 85/1947, National Health Service (Scotland) Act, 1947, Proposals for the Discharge of Local Health Authority Functions, p. 3.

service provided.¹⁶ The proposals were sent to the DHS who then negotiated with each authority individually on the wording and terms within the proposals.

When considering the Edinburgh Administrative Scheme, for example, the DHS noted that the proposals did not set out the functions of the Health Committee, and felt it would be beneficial for the members of the committee if these were described in detail.¹⁷ In correspondence with Dundee Corporation, T.A. Grieg of the DHS, suggested rewording of the health visiting proposals along with requirements for record maintenance by nurses.¹⁸ Such negotiations over wording and terms of the proposals sent to the DHS were extensive and detailed. Other bodies also had the opportunity to make suggestions regarding the proposals put forward by the local authorities. The Regional Hospital Boards and Executive Committees were consulted in this process as was the Scottish Home Department. For example, in the case of the Administrative Scheme for Glasgow Corporation, the Scottish Home Department sent a memorandum to Mr Hughes of the DHS with their observations about the scheme. In their response to the Glasgow Corporation the DHS accepted some observations and rejected others. One of the suggestions taken up by the DHS, for example, was that the Scottish Home Department felt that Glasgow Corporation should have defined their health service functions more clearly, as the proposals appeared to cover every function with the Council.¹⁹ The DHS, along with input from other bodies, shaped the proposals put forward by the local authorities, thus reinforcing the hierarchical nature of the relationship between the DHS and local authorities.

The detail within each of the proposals demonstrates the way in which the four major Scottish cities reacted to the changes in the health services. For example, Table 3.1 highlights the differences among the four cities in the proposals for health visiting. This example draws attention to the way in which some Cities were precise in what they intended to provide, while others were vague and only indicated that they would stay within the remit of the Act. In the proposals from Aberdeen there was a general and

¹⁶ NAS, HH61/813, Notes for the guidance of Local Health Authorities, National Health Service (Scotland) Act, 1947 – Section 23, 1st August 1947, pp. 2-3.

¹⁷ NAS, HH61/196, Note to Mr Greig from A A Hughes, 1/9/1947.

¹⁸ NAS, HH61/334, Letter from T.A. Greig to Miss Bisset, Town Clerk Depute, 28th June 1948.

¹⁹ NAS, HH61/198, Memorandum from Scottish Home Department to Mr Hughes, DHS on Glasgow's Administrative Scheme, 22nd October 1947.

specific element to describe the services which they would provide.²⁰ Glasgow went over the history of the health visiting service within the city prior to describing in detail the future plans it had for the service. The Glasgow proposals discuss future plans for an extension in clinic services with new temporary buildings and the extension of home visitations.²¹ The Glasgow proposals furthermore highlight the close co-operation necessary among the local health authority, the hospital and specialist services and the executive council, especially in the ante-natal clinics.²² In general, Glasgow considered the way in which they could improve the health services they were responsible for, while others, such as Edinburgh were vague at best over what they would provide. The Edinburgh health visiting proposals indicated they would ‘perform the duties specified in Section 24 (1) of the Act, and may undertake other duties...as may be determined from time to time’.²³ Vague proposals however could be due to the Medical Officer of Health considering the submission of proposals as an administrative exercise which did not require much time or depth of thought. Diversity in proposals also demonstrates the different attitudes of local authorities, and their Medical officers of Health, to their role within the NHS, which will be explored later in the chapter.

The local authorities, generally, were unhappy with their diminished role within the NHS. Morrice McCrae argues that substantial evidence of any opposition to the NHS in Scotland is difficult to locate.²⁴

The NHS for Scotland had come after years of preparation. There had been no entrenched opposition to overcome and the service had been planned, introduced intact and consolidated in a spirit of co-operation and organisation. From the start, the NHS was welcomed wholeheartedly in Scotland, by the public, the civil service and the medical profession.²⁵

When considering the Scottish local authorities in the establishment and implementation of the NHS, resistance came in the form of a lack of enthusiasm for the new NHS, while co-operation was not easily, if at all, achieved. Most of the local authorities saw the changes in their remit as a loss of power and not in the first instance an opportunity to extend local

²⁰ NHBA, B/66, Corporation of the City of Aberdeen, National Health Service (Scotland) Act 1947, Proposals for the Discharge of Functions.

²¹ NAS, HH61/339, Proposals for the Discharge of Functions, Health Visiting, Glasgow, p.5.

²² Ibid.

²³ NAS, HH61/338, Proposals for the Discharge of Functions, Health Visiting, Edinburgh, p.2.

²⁴ M. McCrae, *The National Health Service in Scotland*, (East Linton, 2003), p. 233.

²⁵ Ibid, p. 247.

services. The 1950 *Annual Report* of the DHS noted that the Department did not think that local authorities appreciated their powers and duties, and the scope provided for them in preventive care.²⁶ Yet, press coverage of any developments in local authority services demonstrates that they were crucial to patients. In November 1955 the *Edinburgh Evening Dispatch* reported the increase in the number of Home Helps employed by Edinburgh Corporation and that the developments would enhance the care of the elderly and chronically ill.²⁷

²⁶ Department of Health for Scotland, *Health and Welfare Services in Scotland Report for 1950*, (1951), Cmd 8184, p. 27.

²⁷ NAS, HH61/387, *Edinburgh Evening Dispatch*, *More 'Home Help' Nurses*, 22nd November 1955.

Table 3.1: Health Visiting Schemes for Aberdeen, Dundee, Edinburgh and Glasgow

Health Visiting Schemes	Aberdeen	Dundee
Supervision of Health Visitors	Medical Officer for Maternity and Child Welfare, Superintendent Nursing Officer.	Medical Officer of Health, Superintendent Health Visitor and two deputies.
Appointment of Health Visitors	Requires and additional 18 health visitors.	Undecided.
Health Visiting Districts	Not mentioned	24 districts increasing to 30 when available numbers of staff.
Conditions of Service	Not mentioned	Not mentioned.
Numbers of Staff	27 health visitors	18 whole-time health visitors (made up of 26 part-time health visitors)
Functions of Health Visitors	Advice as to the care of young children, persons suffering from illness and expectant or nursing mothers.	As is stated in Section 24 (1) of the Act.
	To promote health and prevent the spread of infection.	Care of mothers and children will be given priority.
	School Health Service.	Visitation of homes where infectious diseases exist (including tb) will be given priority.
	Attend ante-natal and post-natal clinics and child welfare centres.	Assistance will be given to RHB and Executive Council when needed.
	Encourage parents to have children protected against smallpox and diphtheria.	A health visitor will be stationed at the Tuberculosis Dispensary to
	Duties in connection with Section 27 of the Act (Prevention of Illness, Care and After-care)	co-ordinate work of RHB with work of LHA.
	Co-ordinated services with RHB and Executive Council.	Contact will be established with the Venereal Diseases Treatment Centres.
		School Health Service.
Housing	No special housing arrangements made.	No special housing arrangements made.
Transport	By public transport	Will provide motor transport.
Records	Maintained by health visitors and open to those who require them eg MOH, GP etc.	Not mentioned.
Costs	Not mentioned	£6168
	Edinburgh	Glasgow
Supervision of Health Visitors	Supervisor of Health Visitors	Senior Child Welfare Medical Officer, Senior Superintendent and Assistant.
Appointment of Health Visitors	Requires an additional 16 health visitors.	Requires an additional 75 health visitors.
Health Visiting Districts	Not mentioned.	5 public health divisions.
Conditions of Service	Not mentioned.	In accordance with the recommendations of the Scottish Nurses' Salaries Committee.
Numbers of Staff	63 health visitors	114 health visitors
Functions of Health Visitors	As is stated in Section 24 (1) of the Act.	Supervision of children under school age: nutrition and development.
	Maternity and Child Welfare Clinics.	Maternity & Child Welfare Clinics: ante-natal, infant welfare, toddler, dental, UVR.
	Shall consider any patient reported to the Corporation by a medical practitioner or hospital.	(with close co-operation between the local authority and hospital)
		Advising mothers as to their health and welfare.
		Teaching of mothercraft and education in health.
		Immunisation sessions: Special Clinics and Child Welfare Centres.
		Visitation and supervision of cases of ophthalmic neonatorum.
		Home visitation and supervision: families rehoused in Corporation housing schemes.
		Supervision of cases of trachoma.
		Visitation of cases of scabies, pneumonia and gastro-enteritis.
		Care of persons suffering from illness including those suffering from lunacy and mental illness.
Housing	Not mentioned.	No special housing arrangements made.
Transport	By public transport or provided by the Corporation.	Public transport.
Records	Maintained by health visitors and open to those who require them eg MOH, GP etc.	Not mentioned
Costs	Not mentioned.	Not mentioned

(Source: NAS, Proposals for the Discharge of Functions, Health Visiting, HH61/338: Edinburgh; HH61/339: Glasgow, HH61/334: Dundee and NHBA, B/66, Aberdeen Corporation, Proposals for the Discharge of Functions, Health Visiting.)

The local authorities attempted to find ways to reassert their position within the NHS. As Smith noted in his consideration of policy implementation, those who are involved in the policy formation process also implement it. Furthermore, less influential members of the policy network have the opportunity to increase their influence within the implementation process. From this standpoint, local authorities could have had some influence during implementation of the NHS, for example, through different committees and boards. Within the discussions over NHS policy the local authorities continually attempted to increase their representation on a range of boards and committees. This stemmed from a feeling that local authorities were being outweighed in the boards and committees by the medical profession and consequently their voice would be drowned out in discussions over the administration of the health service. This attempt to increase representation which, as we have seen above, began before the passing of the NHS (Scotland) Act, 1947, continued afterwards. The implementation process of the Act gave local authorities a further opportunity to request increased representation on the boards and committees which they felt would provide increased influence within the health sphere. By the mid-1950s, the local authorities were represented on a range of boards and committees listed below:

Scottish Health Services Council

Standing Advisory Committee on Local Authority Services

Scottish Council for Health Education

Scottish Association for Mental Health – Executive Council

National Health Service Negotiating Machinery

Scottish Advisory Committee of the Whitley Council for the Health Services

Control of Medical Manpower – Area Committee for Public Health Medical Officers

Joint Committee for Domiciliary Nursing Service

Scottish Council of Queen's Institute of District Nursing

National Advisory Council on Nurses and Midwives

Advisory Committee under Ice Cream (Scotland) Regulations

Scottish Epilepsy Association – Executive Council²⁸

Despite this extensive list of committees and councils, their representation was deemed inadequate by local authorities.

²⁸ GCA, Box D-TC 8/16B/ 23 4 – 23 7 and Box D-TC 16B/ 23 8 – 24, Representatives on Outside Bodies.

In December 1952, Edinburgh Corporation attempted to tackle the issue of representation on NHS Boards and Committees. Edinburgh Corporation asked the Scottish County of Cities Association to take up the issue of increased local authority representation on the Scottish Health Services Council.²⁹ The Scottish Health Services Council consisted of 35 members appointed by the Secretary of State, only five of whom were non-medical professionals with local authority experience. In their letter to the other local authorities, Edinburgh urged the other local authorities to take up the issue of increasing their representation on the Council, which required agreement from the Secretary of State.³⁰ The Cities contacted the Burghs and Counties asking for their support over this issue.³¹ The three associations attempted to work together on issues such as this, in contrast to their lack of collaboration during the negotiations for the formation of NHS policy. The local authorities were attempting to increase their influence within the policy network, and NHS, through increased representation on the most influential council. Since the local authorities were in a subordinate relationship with the Department of Health, they no longer had the resources to reinstate the influence within the policy network they lost during the negotiations over the NHS.

The Department of Health considered the case made by the associations that local authority representation should be increased on the Scottish Health Services Council, and T D Haddow, later Sir Douglas Haddow, replied on behalf of the Secretary of State,

The present constitution of the Council, whose essential function is to provide the Secretary of State with expert advice on the NHS and related services, was devised to give a balanced representation of all relevant kinds of experience. It was not designed to represent the general public, and the members with local government experience are expected to make their primary contribution under the head of local authority administration. The influence of the public on matters of policy is already brought to bear on the Secretary of State through Parliament; and it would not in any event be desirable to confuse the work of an advisory council by asking it to consider questions both from the point of view of special knowledge and experience and from that of the public as potential patients.³²

Haddow's letter is revealing about the relationship between local authorities and the DHS. The DHS saw the relationship as hierarchical. The letter clearly sets out the place of local

²⁹ GCA, Box D-TC 8/16B/23 7, Letter from Storrar to Town Clerk of Glasgow, 1st December 1952.

³⁰ Ibid.

³¹ Abbreviated terms for the Scottish Counties of Cities Association (Cities), the Association of County Councils (Counties) and the Convention of Royal Burghs (Burghs).

³² GCA, Box D-TC 8/16B/23 7, Letter from T.D Haddow to Storrar, 7th April 1953.

authorities at the bottom of the political chain with Westminster at the top. The Secretary of State took public influence through the top of the chain, parliament, and not through local authorities. It was only the place of local authorities to advise the Secretary of State on administrative matters relating to local authority health services. Consequently, local authorities were seen as service providers within the NHS and not an equal partner with its own source of authority based on its electorate, who could influence the running of the service. Any advantage they had within the policy network during the negotiations over NHS policy was lost when local authorities lost their bargaining resources, the hospitals and specialist clinics. Haddow goes on to state in the letter that

the Secretary of State does not think that the working of the Council since it was set up in 1948 has shown that the interests of any section of the health service are inadequately covered by the present constitution. The work of local authorities in particular has been dealt with in a number of valuable reports including “What Local Authorities can do to Promote Health and Prevent Disease”, and on the Preventive Dental Services, whilst a further report on child health services including those provided by local authorities is in course of publication.³³

The letter firmly places local authorities within the NHS. Not only does it affirm that local authorities were influential only in their own area but also maintained that they were adequately represented in the main advisory committee. The Department of Health justified its view that the local authorities were adequately represented through the Department’s reports and publications on their health service activities. By stating that local authorities were adequately represented, the Department of Health excluded them from influencing larger NHS issues in any credible way, and kept local authorities in an auxiliary role. Furthermore, the letter from Haddow notes

The membership of the Standing Advisory Committee on Local Authority Services has, in practice, always been heavily weighted with persons who are members or officers of local authorities. In the present Committee, for example, 14 out of 20 members are either members or professional officers of local authorities. While theoretically the Committee could be differently constituted, it is very unlikely that such a situation would arise.

The Secretary of State appreciates fully the great value of the contribution made by the local authorities to the health services, but in the circumstances does not think that a case for varying the present composition of the advisory bodies has been made out.³⁴

³³ Ibid.

³⁴ Ibid.

The letter implied that the membership of the ‘heavily weighted’ Standing Advisory Committee on Local Authority Services could be altered. Because the influence which local authorities had within the NHS was not extensive, any alteration in this could have had a detrimental effect on their administrative authority within their own sphere. Although not specifically a threat to local authorities, it appears to be a way of silencing local authorities through fear of the committee structure being changed, possibly by increasing membership of the medical profession. The influence of the medical profession on public health committees and local health authorities was something which the local authorities had fought against in the negotiations over the NHS policy in the 1940s.

The Department of Health successfully rebuffed the local authorities’ initiative. A Scottish Counties of Cities Association meeting in April 1953 resolved to let the matter lie, even though the Counties were willing to support further action.³⁵ The policy network did not open up the implementation process as a means of increasing formal and informal influence through these committees. The DHS kept the local authorities in their position at the lower end of the hierarchical political chain within the health services, performing an auxiliary role within the health services.

The Implementation of the NHS Act until 1960

In considering the administrative structure of the NHS in England and Wales, Rodney Lowe argues that

it failed, however, to resolve two fundamental administrative and political challenges which were critical to its future success. In the absence of a suitable system of local government, hospitals had to be nationalized; and nationalization required the development of both an organizational structure to integrate hospitals with the other health services and new administrative skills within Whitehall. In the inevitable absence of sufficient resources to satisfy all medical demands, clear criteria had also to be developed to determine priorities and to ensure the efficient allocation of scarce resources. The NHS, as originally designed by Bevan, was unable to rise to these challenges.³⁶

The split administrative structure and financial constraints which the NHS worked within were stumbling blocks in both Scotland and England. Webster notes that from the establishment of the NHS, Local Health Authorities had a ‘sense of impending doom’.³⁷

³⁵ GCA, Box D-TC, 8/16B/23 7, Minute of Counties of Cities Association Meeting, 24th April 1953.

³⁶ R. Lowe, *The Welfare State in Britain Since 1945*, (Houndmills, 2005), p. 201.

³⁷ Webster, *The Health Services Since the War*, p. 374.

The Department of Health for Scotland recognised that the Scottish local authorities were seeing their diminished role in a negative light. They tried to encourage local authorities in their role by publishing the report 'What Local Authorities can do to Promote Health and Prevent Disease', by the Standing Advisory Committee on Local Authority Services. A memorandum between two DHS civil servants acknowledged that

the Report contains a good deal of useful persuasion and encouragement to local authorities, who were inclined, at the time of the transfer and after, to repine over the loss of their hospitals and consider that they had been left with the small change of health functions. Now that the financial limitations of both hospital and general practitioner service are becoming increasingly obvious, the importance of local authority services and prevention becomes clearer.³⁸

The encouragement of local authorities to fulfil their role within the NHS was important to the preventive health services and the local services which patients received. The DHS realised, by 1950, that the removal of hospital service had left local authorities disheartened with their auxiliary role. To combat this would not only bolster local authority health services but also encourage co-operation among the three administrative structures of the NHS. The report covered a range of aspects of Local Authority health services. In the introductory section the report stated that

it is of fundamental importance to the nation that disease be prevented and health be promoted. Yet, even local health authorities sometimes fail to appreciate fully the significance and amplitude of the contribution they can make to this objective of the National Health Service.³⁹

The Report was designed to explore the ways in which local authorities could fulfil their preventive role within the health service. As seen above in the previous chapter, local authorities brought up the issue of prevention of illness within the discussions over problems within the NHS Act, as they felt prevention had been put in the periphery of the health service in favour of curative care. At the time of the discussions, however, this was not accepted by the DHS. The priority then for the DHS was to establish a hierarchical relationship in which the local authorities agreed to the White Paper which the DHS wanted to become the NHS (Scotland) Act, 1947. The DHS underestimated the disillusionment of local authorities and the impact this would have on the services which they provided within the NHS.

³⁸ NAS, HH61/857, Note to Mr Forrest from L.C. Watson, 19th June 1951.

³⁹ NAS, HH61/857, Report of the Standing Advisory Committee on Local Authority Services, *Report of the Standing Advisory Committee on Local Authority Services*, 1952, p. 3.

Many themes were highlighted in the Report as it considered six main areas of local government responsibility: reducing deaths in the first 45 years of life; reducing illness in the first 45 years of life; reducing illness and deaths in the second 45 years of life; mental health work; health education and increasing statistical research. The Report recommended that local authorities: continue to expand their mother and child services, such as the promotion of breast feeding and education of mothers; develop after care services and care for the elderly; increase preventive work against mental diseases; increase health education; and increase co-operation with the other parts of the health services.⁴⁰ In essence the Report encouraged local authorities to take up and expand the duties which were laid upon them by the NHS (Scotland) Act, 1947. The DHS, however, was pragmatic in its approach to such expansion. Prior to the publication of the Report, the DHS recognised that financial constraints were hindering local authorities and the development of their health services. Such recognition was not only a means of acknowledging the constraints on local authorities, but was also a public relations exercise. The DHS realised that publishing the Report without acknowledging the financial constraints ‘might appear that the Government was merely paying lip service’ to the policy of expanding local health authority services.⁴¹ Such attitudes were evident when the Report was published along with a circular letter advising local authorities only to implement changes which could be covered by existing arrangements and staff. The Medical Officer of Health for Fife County Council commented that

it is, however, rather surprising to find the Department of Health in the circular letter which accompanied the issue of the Report emphasising that activities should be restricted in the interests of economy. “It is far cheaper to keep a man well than to treat him when sick”, states the Report. It is difficult to correlate the two attitudes. Thousands of pounds are today being spent in the quest for health, lost through disease, accident or abuse. The comparatively small sum which local authorities would be called upon to spend if they carried into force all the recommendations of the Report would be an excellent investment and would save future generations from a considerable part of the financial burden which the nation bears today in the treatment and cure of disease.⁴²

The implementation of expanding services within local authorities largely depended on the existing services. Staffing problems were rife throughout the NHS and many services could not be extended as a result.

⁴⁰ Ibid, pp. 3-11.

⁴¹ NAS, HH61/857, Note to Mr Haddow from R G Forrest, 17th November 1951.

⁴² NAS, HH61/857, Letter to R G Forrest from G Matthew Fyfe, Medical Officer of Health for Fife County Council, 27th December 1951.

The DHS asked the local authorities to compile a review of their health services. The annual reports of the DHS indicate that the work load for local authority health services was increasing in the 1950s and progress was lacking in some areas. The *Annual Report* of 1953 pointed out that there were still inconsistencies among areas in the services provided, such as those for mothers and children, noting that many clinics were held within hired halls or unsuitable properties.⁴³ Mental health care provides a further example of inconsistencies within the local health authority services, as the 1954 *Annual Report* sums up the lack of progress by local authorities.

Generally speaking, local health authorities have not, since 1948, been able to develop their powers in respect of the care and after-care of persons suffering from mental illness. Restrictions on expenditure, shortages of qualified social workers, and lack of premises suitable for occupational centres have prevented any general expansion of the mental health services.⁴⁴

Local authorities themselves acknowledged some of the failings of their services. The Medical Officer of Inverness Town Council admitted that their clean handling of food campaign was unsuccessful because many food handlers did not turn up to the lectures.⁴⁵

Yet many of the health services provided by local authorities produced successful results. In Ayr immunisation schemes, child welfare clinics and ante-natal clinics expanded together with an increasing uptake of the services.⁴⁶ In Dumfries immunisation schemes produced satisfying results and some increases in nursing staff were achieved.⁴⁷ Although many of the local authority health services were not expanding rapidly enough, or at all in some cases, the *Report* gave local authorities some examples of ways to provide patients with a comprehensive preventive service. This did not, however, remove the perception that local authorities had an auxiliary role or the co-ordination and implementation problems.

The problems of the transition to the new health service were not only problems of attitudes within local authorities and lack of resources, but also involved the practicalities

⁴³ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1953*, (1954), Cmd 9107, p.41.

⁴⁴ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1954*, (1955), Cmd 9417, p. 45.

⁴⁵ NAS, HH61/857, Letter from Town Clerk, Inverness Town Council, enclosing Report from the Medical Officer of Health, 15th August 1953.

⁴⁶ NAS, HH61/857, Letter from R L Leask, Medical Officer of Health, Ayr, to the DHS, 26th February 1953.

⁴⁷ NAS, HH61/857, Letter from Medical Officer of Health Dumfries, 19th December 1952.

of co-ordinating a tripartite administrative system. The issues of co-ordination and division of responsibility were important in both the running of the NHS and the standard of service for patients. The transition to the new NHS was not as smooth as some historians, such as McCrae and Hamilton have argued.⁴⁸ Many of the problems which arose during the implementation of policy were created, and in some cases solved, by those who were involved in the policy formation. Local authorities tried to assert some influence in a more informal way by tackling particular cases, especially those involving the division of responsibility.

First, before considering how local authorities attempted to assert informal influence through the division of responsibility, co-ordination of the service should be considered. A tripartite service comprising three administrations, each trying to run a service to their own agenda, was difficult to co-ordinate and run efficiently. GPs grudgingly worked with local authorities, while local authorities saw the Regional Hospital Boards as removing their authority in the hospital services. Formal co-ordination was seldom exercised even with constant encouragement from the Department of Health for Scotland. The Executive Council for Glasgow noted, in 1948, that the Senior Child Welfare Medical Officer for Glasgow had drawn attention to two instances in which a doctor refused to visit pregnant patients because they attended a local authority ante-natal clinic.⁴⁹ The issue came down to who was responsible for the care and whether this came under the GPs' remit. This type of issue was not uncommon.

Problems of co-ordination were evident in the field of infectious diseases. During the NHS policy negotiations, local authorities pointed out that the split in infectious disease services created a problem of co-ordination as patients could either be treated in hospital without notification to the Medical Officer of Health, or could be notified to the Medical Officer of Health without receiving appropriate treatment. Such lack of co-ordination arose during a smallpox outbreak in the West of Scotland, in the late 1940s, and resulted in clarification of the co-ordination necessary to effectively administer health services for infectious diseases. The DHS issued a draft memorandum, to the Regional Hospital Boards, and sent it to the local authority associations for comments. With regard to the co-ordination of services, the memorandum stated that in order for a Medical Officer of Health to fulfil his

⁴⁸ McCrae, *The National Health Service in Scotland*, p. 247 & D. Hamilton, *The Healers*, (Edinburgh, 2003), p. 263.

⁴⁹ GCA, Box D-TC 8/16B/1 8-3 1, Executive Council for the City of Glasgow, Meeting held on the 6th October 1948, p.94.

or her role of protecting the general public against infectious diseases, the Medical Officer of Health must receive information from the hospitals at the earliest possible opportunity. Furthermore, the DHS required the Regional Hospital Boards to review their arrangements with the Medical Officers of Health and 'ensure that they are comprehensive, fully worked out and generally understood'.⁵⁰ The arrangements included the prompt transfer of information regarding infectious diseases from the hospital to the MOH and an invitation to the MOH to advise on preventive measures against the spread of infection within hospitals. The co-ordination within the health services was critical to its success and, this was especially true in the control of infectious disease.

The reactions to the memorandum by the local authority associations were mixed. The Cities felt that they could leave the matter to the Scottish Branch of the Society of Medical Officers of Health.⁵¹ The reaction of the individual members of the Cities was very different. Stuart Laidlaw, the Medical Officer of Health for Glasgow, felt that the DHS had not solved the problem of co-ordination satisfactorily. He argued that the hospitals for infectious diseases should be regrouped together and administrative authority given to the MOH, who held the necessary experience for the control of infectious diseases.⁵² Edinburgh Corporation agreed with the views of the Glasgow MOH and made direct representation to the DHS accordingly, arguing that the memorandum did not 'give sufficient scope for utilising the services of the medical officers who with their experience and qualifications were eminently able to contribute to this branch of medicine'.⁵³ This view was also upheld by the Association of County Councils. The Association of County Councils was advised by the DHS that the memo was centred on the function of the MOH in the wider community, and they did not want to divert attention to include wider issues of disease and infection.⁵⁴ Co-ordination was to be localised and not only include infectious diseases but also the implementation of the health service generally. By 1951, the DHS issued a further circular on co-ordination to the local authorities, after a meeting held between the Local Authority Associations, the RHBS and the Executive Councils,

⁵⁰ GCA, Box D-TC 8/16B/23 4 – 23 7, Letter from Storrar to Town Clerk, Glasgow, enclosing DHS draft memorandum to Regional Hospital Boards.

⁵¹ GCA, Box D-TC 8/16B/23 4 – 23 7, Minute 23 of Counties of Cities Association meeting, 2/6/1950.

⁵² GCA, Box D-TC 8/16B/23 4 – 23 7, Letter from Stuart Laidlaw, Medical Officer of Health, Glasgow, to Town Clerk, Glasgow, 1st June 1950.

⁵³ GCA, Box D-TC 8/16B/23 4 – 23 7, Minute 31 of the Counties of Cities Association meeting, 15/9/50.

⁵⁴ GCA, Box D-TC 8/16B/23 4 – 23 7, Letter to Inglis from Haddow, 20th June 1950.

encouraging local co-ordination among the three.⁵⁵ Co-ordination and co-operation was continually an issue for the NHS during this period. Formal co-ordination was not achieved easily if at all, as the numerous memos, issued to encourage the three administrative areas of the health services to work together, indicate.

Co-ordination was not only based on the requirements of the services which straddled the separate bodies within the NHS, but was also based on the personalities involved in administering the services. If the actors involved were not willing to enter into formal co-ordination among the three administrative spheres, then co-ordination did not occur. Co-ordination problems were highlighted in a review of the Aberdeen health services in 1952, when the Medical Officer of Health noted that formal co-ordination among the three spheres of the NHS was difficult.⁵⁶ Although a Co-ordinating Committee among the three administrative areas of the health services in Aberdeen existed, it had not met that year and 'served no useful purpose'.⁵⁷ The Medical Officer of Health was also involved in the Mental Health, Tuberculosis and Child Health Advisory Sub-Committees of the Regional Hospital Board; while the Senior Medical Officer was a member of the Local Medical Committee. The Medical Officer of Health saw the arrangements which were in place as fulfilling their remit, but they did not go far enough to co-ordinate a comprehensive health service. The MOH noted that an informal and individual approach proved much more fruitful regardless of whether the agreement made was confirmed or not by the statutory body.⁵⁸ In other words, the relationships between the actors involved in the three administrations were central to the effective co-ordination of the NHS.

Co-ordination and agreement were possible at times on specific issues, but in many cases only with the intervention of the Department of Health for Scotland. Edinburgh Corporation and the South-eastern RHB came to an understanding that the RHB would reimburse part of the cost of doctors' and specialist staff salaries who were working in local authority ante-natal clinics when pregnant women had arranged for a hospital confinement instead of a home birth.⁵⁹ This was based on the assumption that normally the pregnant women would be attending the ante-natal clinic provided by the hospital. This

⁵⁵ GCA, Box D-TC 8/16B/23 4 – 23 7, DHS Circular No 30/1951, Co-ordination of the Health Services.

⁵⁶ ACA, PD26/1/16, County of Aberdeen Medical Officer of Health Report, 1952, p.2.

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ ECA, SL26/2/35, Edinburgh Corporation Health Committee, Medical Health Services Sub-Committee Meeting, 20th June 1950, p. 17.

agreement was not easily reached. Within Edinburgh the problems began in 1950 with the staffing of ante-natal clinics. Edinburgh Corporation provided 12 ante-natal clinics during 1950, which 1,329 women attended. By December 1950, however, the Corporation had closed five clinics, as confinement in hospital became more popular and the hospitals' midwifery services developed.⁶⁰ The responsibility for staffing the ante-natal clinics was seen as a problem and was discussed between the Department of Health, the Regional Hospital Board and Edinburgh Corporation. In a letter to the Regional Hospital Board the Department of Health made it clear that

It is of course, the Department's policy that the Regional Board should make available its specialist staff for work in the local health authority's clinics which requires the services of specialists and that no charge should be made to the local health authority in this respect. The Department would not agree, however, to any proposals that the Regional Hospital Board should assume responsibility, administrative or financial, for the services, other than specialist services, which are provided by the doctors in these clinics.⁶¹

In this case Edinburgh was attempting to follow a route taken by Dundee, where the Regional Hospital Board provided all the staff for the maternal health services. The response from the Department of Health indicates their opposition to the Dundee solution. The Department of Health suggested to the Regional Hospital Board that they offer to compensate the local authority with a percentage of the cost of the medical officers' salaries which were pegged to the percentage of women attending the clinic who would be confined in hospital.⁶² The proposed solution would allow the women to continue to attend the clinics while the local authority would be carrying out its duty under the NHS Act of providing and staffing such clinics.

The solution was not initially accepted by the Health Committee of Edinburgh Corporation as they felt the medical staff of the ante-natal clinics should be specialist and therefore provided by the Regional Hospital Board. As no suitable arrangement had been made the Regional Hospital Board again requested the help of the Department of Health on this issue. It was the Regional Hospital Board's view that 'if the Board were to undertake responsibility for the ante-natal clinics in this way, the Corporation would be relieving

⁶⁰ ECA, SL27/2/20, Annual Report of the City and Royal Burgh of Edinburgh Maternity and Child Welfare Scheme for the Year 1950, p.4.

⁶¹ NAS, HH61/237, Letter from Norman W graham to Ewen Campbell, South Eastern Regional Hospital Board, 19th may 1950, p.1.

⁶² Ibid, p. 2.

themselves of all responsibility for the medical staffing of their clinics'.⁶³ Edinburgh was not undertaking its duties in respect to the provision of maternal services. The division of responsibility in this case should have been clear, but Edinburgh was arguing for specialist medical staff in the ante-natal clinics it provided. The DHS did not find Corporation's argument convincing and replied to the Corporation with a lengthy letter. The Department was concerned

at the seeming implication that there is no scope for doctors to play an active part in the "education of mothers in pre-natal and post-natal hygiene" which is to be carried out at the Corporation's clinics. All this is clearly part of the care of mothers and young children which it is the statutory duty of the Corporation to provide, and all the other Scottish cities are continuing to employ their own doctors on this work.⁶⁴

The Department of Health agreed with the Regional Hospital Board that Edinburgh was not undertaking its duties as set out in the NHS (Scotland) Act, 1947.

The issue of the co-ordination and co-operation with GPs and hospitals was also a problem involved in this issue, as the Department of Health was concerned that the Corporation did not see any place for the inclusion of GPs within the provision of ante-natal clinics. The letter points out that the other cities were employing doctors for such clinics, as they saw the provision of a range of medical staff as essential for providing the range of services they were responsible for in their areas. Edinburgh Corporation was out of line with the other local authorities within Scotland. The letter goes on to state that

to us this is not primarily either a financial or a legal problem. It is a problem of finding the technical organisation which will best contribute to the health and wellbeing of the mothers and children for whose care the Corporation are responsible. The Regional Hospital Board will make available their resources, but this cannot relieve the Corporation of their own obligations. Like other Scottish local authorities, they are being asked to do much less than their English counterparts, who have to pay for the specialists' services, and you will have observed that the favourable position of the Scottish authorities in another field, the ambulance service, has already come under fire from the Select Committee on Estimates.⁶⁵

The Department argued that the co-operation of the Regional Hospital Board would be forthcoming, but Edinburgh Corporation must also contribute to the services for mothers

⁶³ NAS, HH61/237, Letter to Mr Storrar from T D Hadow, 1st September 1950.

⁶⁴ Ibid.

⁶⁵ Ibid.

and young children. The Department pointed out that Scottish local authorities were in a more favourable position than their English counterparts, as they did not have to pay for the specialist services of the hospital service as in England. This, however, did not remove their obligation to provide other staff for the clinics. The Department made it clear that it was responsible for this favourable position and were having to defend it.

The language of the letter reveals the Department of Health's exasperation with Edinburgh Corporation for having to revisit this issue. The use of phrasing such as 'we have been over this ground already with your people' demonstrates the hierarchical relationship between the Department of Health and the local authorities.⁶⁶ The wording suggests there was no scope for discussion; the local authority should have taken the decision of the Department of Health to be final. The final phrase of the letter, however, suggests that while Edinburgh could disagree with the Department, it would 'be very sorry to see the Corporation take up a position which was indefensible in itself', as this was likely to put Edinburgh in a worse position.⁶⁷

In the end Edinburgh acquiesced to the decision of the Department of Health. In a letter to the Department in October 1950 Edinburgh Corporation asked the Department to approve proposals for the local authority to set up new clinic facilities in Corstorphine, Gilmerton, Duddingston, Lochinvar and Craightinny.⁶⁸ Arrangements were also made for the Regional Hospital Board to contribute to part of the costs of the salaries of doctors who were working in the clinics and dealing with women who had organised a hospital confinement. The Department had once again compelled a local authority to accept the Department's interpretation of the local authorities' duties under the NHS (Scotland) Act, 1947.

The general lack of co-ordination was not only due to each administrative body attempting to protect its particular field, but also to the blurred lines of division of responsibility both within the NHS and between the health and welfare services. Many problems occurred during the initial implementation of the services and the lack of clear dividing lines in responsibility only caused further confusion and lack of co-ordination. Local authorities raised a range of issues with the DHS throughout this period which cannot all be covered

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ NAS, HH61/237, Letter from Mr Williamson to Department of Health for Scotland, 26th October 1950.

in detail. Table 3.2 indicates the topics raised by the Association of County Councils and the replies from the DHS. Many of the topics highlighted by this Association were also taken up by the Cities and Royal Burghs. The problems ranged from their lack of representation on boards and lack of finance to the provision of milk for tuberculosis cases. The DHS organised a meeting in July 1952 with the Counties to discuss the topics they brought up. Sir George Henderson, representing the DHS, opened the meeting with two general points:

In the first place, the Secretary of State had been pleased to note the progress which local authorities generally had made in the development of their service under Part III of the National Health Service (Scotland) Act, and the part which County Councils had played in this general effort. In the second place, he thought it was desirable to emphasise again that the services provided by local health authorities under Part II were essentially an integral part of the whole National Health Service. References were sometimes made to provision by the National Health Service, as though it were something apart from the service provided by the local health authorities, and he thought it desirable therefore to emphasise this point at this stage.⁶⁹

The detachment felt by local authorities from the main health service compounded the problems which arose along with the co-operation and development of their services. The detachment was especially noticed in the wording of complaints over the provision of milk and medical equipment where the Counties specifically argued that they should be provided by the NHS and not local authorities. The replies given by the DHS, shown in Table 3.2, demonstrate that the DHS was willing to view some issues in terms favourable to local authorities. For example, the DHS saw hospital boards as responsible for arranging the transportation of hospital patients, but the DHS was unwilling to concede ground on larger issues such as increased grants and local authority power to appoint members to the RHBs and hospital Boards of Management. The willingness of the DHS to concede on small issues and remain resolute on issues with a greater affect on the NHS is evident in the DHS' attitude toward many issues raised by local authorities. The remainder of this chapter will consider three key areas in which local authorities raised issues: finance; patient care; and the division of responsibility.

Finance

The cost of implementing the NHS (Scotland) Act, 1947 far exceeded what was initially estimated by the DHS. Webster points out that 'the financing of the health service made

⁶⁹ NAS, HH61/919, Association of County Councils in Scotland, Meeting with Officers of the Department of Health on 4th July 1952.

little allowance for correction of inherited problems, such as maldistribution and general deficiency in standards'.⁷⁰ Furthermore, Webster argues that after an initial expansion, spending on the NHS was kept to a level which put Britain at a disadvantage compared to other western nations.⁷¹ Financial restrictions by the Government hampered the development of services throughout the NHS. Local authority services were included in the wider financial restrictions of the period and, as with all services, this had an impact on their health services. As noted above, the DHS recognised the need for economy when publishing the report of the Standing Advisory Committee on Local Authority Services in 1952. DHS acknowledgment of this was also noted in 1954 in an internal memorandum by R G Forrest on the control of local authority capital expenditure. In his memorandum Forrest pointed out that local authorities received a 50 per cent Exchequer Grant on all health authority capital expenditure and were required to have DHS approval for any projects over £2000.⁷² Forrest found that this did have a slight deterrent effect for local authorities, as they thought twice before approaching the DHS. He thought that if such regulations were altered, then local authorities might be encouraged towards more capital expenditure.

Regarding the issue of increased local authority capital expenditure, Forrest stated that

there is no evidence to suggest, however, that very much extra expenditure would be likely in those circumstances. It would be quite unrealistic to suppose that local health authorities were straining at the leash to undertake capital expenditure and are being restrained by the Department. The financial climate for them is very much the same as for us.⁷³

Financial problems for local authorities continued. With regards to the Exchequer Grant to local health authorities, it was not until 1951 that the regulations were amended to allow local authorities to use Exchequer Grants for the actual expenditure required for local health authority administration. Previously local authorities were only permitted to apply for a grant on administrative costs which were incurred as a direct result of the NHS legislation.⁷⁴ Consequently local authorities were beginning to receive greater freedom

⁷⁰ Webster, *The Health Services Since the War*, p. 398.

⁷¹ Ibid, p. 398.

⁷² NAS, HH61/148, Note to Mr MacLehose (Copy to Mr Haddow) from R.G. Forrest, 20th November 1954.

⁷³ Ibid.

⁷⁴ GCA, Box D-TC 8/16b/23 4 – 23 7, Letter from J Storrar to Town Clerk of Glasgow, Enclosing letter from J.D Haddow to J Storrar, 13th April 1951.

over expenditure by increasing the range of administrative services for which they could receive an Exchequer Grant.

Restrictions on other financial areas, however, still applied. With regards to the Exchequer Grants for local authority school health and dental services, the Counties advocated an increase in such grants, as they were being asked by the DHS to go far beyond their obligations under the Education and NHS Acts.⁷⁵ In his meeting with the Counties, Sir George Henderson said that the DHS had some sympathy with local authorities but could not 'hold out any prospect of an increase in the reasonably foreseeable future'.⁷⁶ The financial restraints affected all areas of the NHS and local authorities were no exception. Although some concessions were made with the Exchequer Grant for the administrative side of local health authority expenditure, the finance for other areas was not forthcoming.

⁷⁵ NAS, HH61/919, Letter from Secretary of the Association of County Councils to the DHS, 22nd May 1952, p. 3.

⁷⁶ NAS, HH61/919, Association of County Councils in Scotland, Meeting with Officers of the Department of Health, 4th July 1952, p.3.

Table 3.2: Division of Responsibility Issues Raised by the Association of County Councils

Issue	Details	Response by DHS
Supply of Maternity Outfits	Should be supplied through GP by Prescription or should be refunded to local authority by Executive Council.	This is part of the local health authority's remit under the maternity and child welfare scheme.
Appointment of Members to Regional Boards and Boards of Management	Local authorities should have power of appointment of members to RHBs and Boards of Management.	Direct appointment by local authorities would undermine the Boards as agents of the Secretary of State.
Aged chronic sick; "Open" respiratory tb; Mental Defectives	Due to a shortage of hospital beds, hospital boards are not taking responsibility for patients who should be admitted to hospital with the burden being placed on local authorities.	RHBs had done what they could to increase accommodation, the RHB and local authority should co-operate when developing services in their area.
Domiciliary tb cases - provision of milk	Domiciliary cases should be supplied milk through the local authority but those who require hospitalisation and do not receive this due to lack of beds should be provided milk through NHS.	Seem to be a specialised case under the previous heading but milk is seen as part of after-care and therefore to be provided by the local authority.
Medical and dental treatment	Request higher grant for local authorities to provide medical and dental through the school medical service and the priority dental service.	No prospect of an increase in the foreseeable future.
Special items of equipment, appliances etc.	Items required for treatment of an illness should be provided under the NHS and not by local health authorities.	In general if an item of equipment was advised for use for a long time this would be for the RHB to provide. The local authority however should have a small store of equipment.
District nurses etc acting as ambulance attendants.	If a patient is being removed to hospital by ambulance it should be the responsibility of the hospital board whether to provide an ambulance attendant or pay the cost of the local health authority providing one.	If the journey is particularly long then the RHB should be asked to make alternative arrangements and if a nurse must return quickly to duty the RHB should arrange this with no cost to the nurse of local authority.

(Source: NAS, HH61/919, Letter from Association of County Councils to the DHS, 22nd May 1952; Minutes of a Meeting with DHS, 4th July 1952 and Letter from G H Henderson to the Association, 3rd July 1953.)

Restrictions on charges for supplies and services were one area that local authorities were eager to clarify. Initially, local authorities had no powers under the NHS Act to charge for services and supplies. Powers to charge for services and supplies had to be agreed under regulatory powers which the DHS drew up for Section 22 of the Act, the care of mothers and children, and for Section 27, the prevention of illness, care and after-care. At the beginning of the NHS in July 1948 the DHS sent a draft circular to the local authority associations listing the items, under each section, that local authorities could charge for. Under Section 22 local authorities could make charges for layettes or clothing, beds, cots⁷⁷ or bedding, fuel, and meals or foodstuffs; but local authorities could not charge for welfare foods supplied by the Ministry of Food. Section 27 allowed local authorities to make charges for clothing; beds or bedding; invalid chairs or carriages; meals or foodstuffs; fuel and accommodation such as that for patients recovering from tuberculosis.⁷⁸ Local authorities were not authorised to charge for services or supplies, including maternity packs, which were not specified within the regulations. For local authorities this was not acceptable. Stuart Laidlaw, the Medical Officer of Health for Glasgow, commented:

I am much concerned to read that in paragraph 5 of the letter from the Department it is stated that authorities are not empowered to charge for anything that is not mentioned in the regulations e.g. the supply of nursing appliances and requisites, and that a payment can only be asked from the person if any damage is sustained by the article while in his possession, apart from fair wear and tear, or for its loss... We feel very strongly that we should be allowed to adhere to our proposal that we should charge 3d a week to each person for the articles supplied to him. If this regular payment is not asked the opinion is that there will be a certain amount of abuse of the articles.⁷⁹

This view was accepted by the Cities and conveyed to the DHS. The Department, however, took the view that nursing appliances were supplied as a central part of NHS supplies and that the view expressed was not in keeping with the 'spirit of the NHS Act'.⁸⁰ Furthermore, the Department felt that they required more knowledge of the working of the NHS before they could consider the matter again. Aberdeen Corporation also wanted a period of working knowledge of the NHS before it considered the matter further, and at the time of representation to the Department, in February 1949, Aberdeen felt that it could not

⁷⁷ This did not include special cots for premature babies.

⁷⁸ GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter from Storrar to Town Clerk, Glasgow enclosing Letter from J D Haddow and draft circular, 12th July 1948.

⁷⁹ GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter from Stuart Laidlaw, MOH, to Town Clerk, Glasgow, 29th July 1948.

⁸⁰ GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter from Storrar to Town Clerk, Glasgow, enclosing Letter from R G Forrest, 10th December 1948.

agree with the views of Glasgow.⁸¹ The degree of change which came about with the transition to the NHS was immense for all bodies concerned, and raised doubts over the best action regarding regulations governing charges, not only by the DHS, but also by local authorities such as Aberdeen Corporation. By 1950 the issue over regulations governing charges had still not been resolved. But, the DHS recognised that some alterations were necessary, because of changes in 1949 in the local authority remit for the care of mothers and young children. Under the changes local authorities were to provide residential accommodation, food and any other appliances necessary for the care of this group of patients.⁸² This change in the local authorities' remit together with the local authorities' associations' request for discussion of the regulations governing charging for services and supplies led the Department of Health to instigate a review.

This issue of charges was of great importance for local authorities, as greater autonomy in charging for services and supplies would allow them to create income to supplement the Exchequer Grant. Prior to the meeting, the DHS asked local authorities to submit any suggestions they had with regards to regulations governing charging.

Their suggestions are:

- (a) The Counties of Cities want to be empowered to charge for
 - (i) food supplies, the Regulations to define "food", and
 - (ii) accommodation in day and residential nurseries;
- (b) The County Councils Association want to be able to charge for
 - (i) maternity outfits;
 - (ii) transport to take mothers and children to clinics (Kincardine County Council), and suggest that if milk for tuberculosis families could be regarded as treatment they would be relieved of any cost.⁸³

During the meeting the Department of Health and local authorities discussed these changes. The DHS told the local authorities they could not charge for maternity outfits nor could they charge for articles used within day nurseries such as cots and blankets. They were also informed that the proposal by Kincardine County Council to include transport specially provided to transfer mothers and children to centres would be included in the amendments. Other issues such as which foodstuffs and residential accommodation could

⁸¹ GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter to Town Clerk, Glasgow, from J Rennie, Town Clerk, Aberdeen, 16th February 1949.

⁸² GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter to Town Clerk, Glasgow, from Scottish Counties of Cities Association enc. matters to be discussed at meeting with local authority associations, 13th June 1951.

⁸³ Ibid.

be included in the charges were also clarified.⁸⁴ The regulations remained within the spirit of the NHS and any services or supplies which were seen as crucial to the provision of health services were not included in the charges regulations. The local authorities were therefore able to assert some authority in this area, but within the confines of what the DHS thought was reasonable and not in contrast to the free, comprehensive health service the NHS was designed to provide.

Division of Responsibility and Patient Care

Establishing if a person was ‘in need of care and attention’ was central to deciding whether it was a health or welfare matter, and hence who was responsible for that person. Prior to the NHS many local health authorities blurred these lines and the health committee took responsibility for what was administratively seen as a welfare issue. This was the case for payments to relative carers and the case of unmarried pregnant women.

The payment of relative carers was an issue which fell between the remit of the local health authorities and the local welfare authorities. Prior to the establishment of the NHS, local health authorities would ‘employ’ relatives at the home help rate when they were caring full time for relatives who were ‘in need of care and attention’. This particular issue was brought to the fore by the case of a carer in Caithness. The woman, a widow, rented a three-roomed house in Sutherland and received a widow’s pension of 10 shillings along with 28 shillings assistance. Her mother lived in the Caithness local authority catchment, 10 miles away, and due to her failing health required full time care. The woman gave up her work and moved in with her mother to provide this care. She appealed to the National Assistance Board (NAB) for help but, as the carer was living away from home, she was advised that if she wished to keep her mother in her mother’s own home she would have to use her savings. The carer knew that her mother would be unhappy moving from her own home, and even then the carer would still not be able to work. The carer applied twice unsuccessfully to Caithness Local Authority, as the local health authority, to receive payments at the Home Help rate to help with the cost of caring for her mother. The carer noted that the payment of carers as Home Helps was undertaken in Sutherland and many other local authorities.⁸⁵

⁸⁴ GCA, Box D-TC 8/16B/ 23 4 – 23 7, Letter from Storrar to Town Clerk, Glasgow, enclosing note of Meeting between the DHS and the Local Authority Associations, 13th July 1951.

⁸⁵ NAS, HH61/591, National Health Service (Scotland) Act 1947, Payment of Relative Carers.

The issue was taken up by the local MP, who thought it was imperative that some help, whether by providing a home help or financial help, should be given. The National Assistance Board was reluctant to pay rent for the woman's home in Sutherland and advised that the local authority was in agreement to it being sub-let.⁸⁶ The MP wrote to T G D Galbraith of the Department of Health asking the Department to intervene as the woman concerned was unable to work and was not being provided with home help care as she should have under the NHS. He furthermore stated that the National Assistance Board aggravated matters by consulting the local authority about sub-letting her house without first contacting the person involved.⁸⁷ The ambiguity over who was responsible was not resolved by the Department of Health. The Department took the view that this was a local matter which each local authority could decide for themselves. David Robertson, MP, in a letter to Galbraith, however, did not think this was acceptable and said,

I am left with the impression that irrespective of the wishes of Parliament which passed Acts to provide home helps where required, and no one can dispute one is required in this case, and to provide grants from public funds to people in need, as Mrs Inrig is as she has had to give up her job in Thurso to attend to her mother in the closing days of her life, nothing is being done. I know you didn't write this letter to me, you only signed it, but I am sorry you did so because it is unworthy of you.⁸⁸

The Department of Health accepted local authority autonomy on this issue and made no attempt to clarify the place of the local health authority in providing home helps or payments to relative carers. The final reply from Galbraith did not clarify the issue, nor would the DHS intervene to compel Caithness Council to provide either a home help or payments.⁸⁹ The DHS had accepted that the new health service was understaffed and therefore would inevitably fail to provide the services required in particular areas. The episode demonstrates that the DHS only intervened when a case had an impact on them or the larger NHS. It did not provide any solution for patients requiring services who were living within local authority areas or for local health authorities who were unclear where their duties ended and the National Assistance Board's began. Such divisions of responsibility created an uneven health service throughout Scotland and were typical of the implementation problems which occurred in this period.

⁸⁶ NAS, HH61/591, Letter from NAB re payment of relative carers.

⁸⁷ NAS, HH61/591, Letter from Robertson, MP to Galbraith.

⁸⁸ Ibid.

⁸⁹ NAS, HH61/591, letter from Galbraith to Robertson.

This was not the only problem which arose between the local health authorities and the National Assistance Board. The treatment of unmarried pregnant mothers⁹⁰ was also an important issue which took many years to resolve. Aberdeen Corporation first highlighted the issue in June 1949. The Corporation asked the DHS if the provision and cost of accommodation of pregnant unmarried mothers in Salvation Army Homes where they were in need of care and attention came under the National Health Service Act, 1947, or the National Assistance Act. If a person were seen to be 'in need of care and attention' then the matter should have come under the National Assistance Board, but if they were in need of medical care they would come under the NHS. The DHS replied saying that the care of pregnant unmarried mothers was also an issue in Dundee, Edinburgh and Glasgow, amongst others, and therefore required investigation. A pregnant unmarried mother would be admitted to a home for four months, two months before confinement and two months after. The women were either thrown out of their home or had no suitable home to go to. The charge for maintenance was 35 shillings per week and 45 shillings per week during the post-natal period. The National Assistance Board also provided an income of 26 shillings per week where there was a need, on the basis that the women were in residential accommodation. There were no facilities in Edinburgh for the mothers' confinement although the DHS had sponsored a building for this.⁹¹

Many civil servants within the DHS believed that provision for unmarried mothers was a matter for the National Assistance Board, although they considered a number of solutions such as leaving it to the local authority, and making it a joint responsibility between the local health authority and the NAB. It was, however, brought to the attention of the DHS that many of the women in these homes were experiencing their first pregnancies and as such were at a higher risk of complication.⁹² Consequently it would become a health service matter due to the amount of medical attention required. The initial decision was made that one month prior to and one month after confinement, it would be a local health authority matter while for the months outside of this period it would be a National Assistance matter.⁹³ The Edinburgh case, however, was different and the DHS decided that if a mother was not confined in the Salvation Army Home, then the whole period of her

⁹⁰ An unmarried pregnant mother was the term used by the local authorities and Department of Health for Scotland. The women were usually experiencing their first pregnancies, although in some cases may already have had children.

⁹¹ NAS, HH61/30, Accommodation of Expectant Mothers.

⁹² Ibid.

⁹³ Ibid.

stay in the home was a National Assistance case.⁹⁴ Local authorities, however, were not bound to this decision and they could choose to deal with the mothers as a health or welfare matter. In general though the care of pregnant unmarried mothers would be divided between the welfare and health authorities depending on what stage in the ante- and post-natal period the mother was.

Such arrangements were not smooth and discussions over the issue of pregnant unmarried mothers continued during the 1950s. The problems experienced in Glasgow highlight the way in which co-operation and the division of responsibility could affect patients or in this instance mothers and babies. As the local health authority, Glasgow made payments to the mother and baby homes. Within this arrangement the National Assistance Board paid the allowances for cases admitted to the homes. However, the National Assistance Board withheld payment until Glasgow decided whether the cases were being treated as welfare or health cases. There was no reason for this agreement to cease but the NAB was reluctant to agree to continue with the procedure.⁹⁵ This problem highlights the confusion over who was responsible for persons in need of care and attention along with the lack of uniformity in the services provided.

The National Assistance Board argued that if Glasgow Corporation had a problem with this they should speak to the DHS. In a meeting with Miss Watson of the DHS, Mr Tinto from the Glasgow Corporation noted that such a big local authority had a variety of strong political views which included some criticisms of the mother and baby homes.⁹⁶ If the Corporation were to make payments under the NHS (Scotland) Act, they would be doing so on a care basis and would become involved in the administration of the mother and baby homes. This would raise arguments within the Corporation that they should not support the mother for the full period of four months, as set out by the DHS, but for a period of six weeks prior to the confinement date as per the regulations for their own female employees.⁹⁷ Furthermore, Tinto believed that Glasgow was being deprived of its right to choose between contributions being given as a health or welfare matter by the National Assistance Board withholding payments.

⁹⁴ Ibid.

⁹⁵ NAS, HH61/30, Memorandum to Miss Watson, 12th June 1953.

⁹⁶ NAS, HH61/30, Memo to Mr Forrest from Miss Watson, 20th June 1953.

⁹⁷ Ibid.

In this case, no-one was taking responsibility for the care of the expectant mothers. The National Assistance Board thought this was a matter between the DHS and Glasgow Corporation, while the Corporation and the DHS thought this was primarily a disagreement between the Corporation and the National Assistance Board. The DHS took the stance that the local authority had the right to choose under which Act it carried out a particular service. They welcomed a solution that the mother and baby homes be considered as the women's normal homes. Therefore the mothers could be cared for under the NHS Act by the local health authorities in the same way as other pregnant women, and the National Assistance Board could continue their grants to the women who were in 'need of care and attention'.⁹⁸ This allowed the arrangements to be straightforward for the mother and baby home, the expectant mother and the local authorities. In 1954 a National Assistance Board memorandum agreed that the solution favoured by the DHS would be the way in which unmarried expectant mothers would be regarded as they were 'in need of care and attention'. In this memorandum the NAB also stated that in exceptional cases local authorities were permitted to make payments to mother and baby homes in respect of a resident for whom they had taken responsibility. Finally, when an expectant mother was confined in hospital, the assistance grant would be paid on a pocket money basis only.⁹⁹ In this case the solution was beneficial to the local health authorities and expectant mothers, as the service was no longer blurred between the different Boards. Defining the role of the local health authority and the Assistance Board provided clarity in this area which would then have passed on to relations between the local health authority and the hospital services over the confinement of mothers and their newborn.

This clarity was only reached in specific cases, such as the unmarried expectant mother, and did not stop the difficulties experienced in other areas. The examples given so far demonstrate the difficulties experienced between the DHS, local authorities and outside boards. As mentioned previously these difficulties are just as readily seen between the three administrative areas of the NHS. It was often disputed whether a patient at a particular point in his or her treatment was the responsibility of the hospitals, GPs or local authorities. To give an example of this, patients who were to be transferred to a mental institution would often be taken by ambulance with a nurse in attendance. Who provided the nurse and paid for her time was frequently disputed by local authorities and the hospital board.

⁹⁸ Ibid.

⁹⁹ NAS, HH61/30, National Assistance Board Memorandum to Area Officers, 1954.

A further example of these blurred lines of responsibility is in the provision of maternity outfits. Maternity outfits were packs which were provided to expectant mothers for home confinements. The minimum requirements for a maternity pack included 24 sterilised maternity pads, 1 sheet of tarred brown paper, 1 accouchement sheet, 4 packets of No. 3 cotton wool, 3 cord ligatures, sterilised cord powder and 6 cord dressings.¹⁰⁰ Again this was not a dispute between the DHS and all local authorities. The different local authorities employed different methods of supplying maternity outfits, while the contents of the packs varied considerably. Many women were advised to approach their GP for a prescription to obtain a pack. But many GPs were unwilling to provide this service, as they viewed it as a local health authority service. Edinburgh Corporation took the view that maternity packs should be provided via GPs' prescriptions or when a woman was admitted to hospital.¹⁰¹ Many local authorities agreed that the provision of maternity packs was not their responsibility.

Glasgow took a different approach to the supply of maternity packs. The Glasgow Medical Officer of Health, Stuart Laidlaw, found that arrangements with GPs did not work, as they did not supply everything on the patient's list and many of the items were not sterilised. Laidlaw put in place a system whereby the local health authority would have enough maternity outfits to supply to women who booked a Corporation midwife for her confinement.¹⁰² Laidlaw found this arrangement worked more satisfactorily and helped in providing a good midwifery service for expectant mothers. After correspondence with the Secretary of the Cities Association, Glasgow reaffirmed that they agreed with the DHS and would not be moved on this matter. The Association of County Councils requested the DHS allow local authorities to charge for maternity outfits.¹⁰³ The local authorities were represented by their associations at a meeting with the DHS on the issue of maternity outfits in 1951. Local authorities commented that some items from the maternity outfits could be supplied by a GP in the meeting chaired by T D Hadow of the DHS. The meeting resulted in the local authorities accepting that it was their duty to supply maternity

¹⁰⁰ GCA, Box D-TC 8/16B/23 5, Letter to Town Clerk of Glasgow from Williamson signing for the Clerk of the Counties of Cities Association, 22nd September 1950.

¹⁰¹ ECA, SL26/2/35, Edinburgh Corporation Health Committee, Minutes of Meeting, 24th October 1950, p. 114.

¹⁰² GCA, Box D-TC 8/16B/23 5, Letter to Town Clerk of Glasgow from the MOH Stuart Laidlaw, 5th October 1950.

¹⁰³ ECA, SL169/1/11, Association of County Councils in Scotland, Minutes of Meeting of the Health and Welfare Committee, 21st September 1950, p. 269.

outfits, but arguing they should be allowed to charge for these supplies.¹⁰⁴ The DHS, however, reminded the local authorities that they did not have the authority to charge for these supplies and would have to bear the cost.¹⁰⁵ The local authorities were divided and Glasgow's view, as the largest local health authority weakened the local authority associations' case. The local authorities had to accept that they were responsible in this instance for the provision of maternity outfits through their midwife service.

It is interesting to note that, with regards to the issue of maternity outfits, the DHS consulted with the BMA and the Maternity Services Sub-Committee. Within the dynamics of the health policy network, the BMA was the primary force in negotiating the NHS Act while local authorities were sidelined. In resolving the issue over maternity packs, this dynamic was again instigated to compel the local authorities to take up their duties under the Act. The influence of local authorities was lost on this issue, as they were ordered by the centralised DHS to undertake their duties in providing the packs. The hierarchical nature of the relationship between the DHS and local authorities was backed up by the strength of the BMA within the network. Local authorities were therefore unable to exercise influence, as suggested by Smith, through the implementation process. Although local authorities managed to influence some areas on a case by case basis they were unable to influence issues which were considered more central to the entire NHS.

Health Services by 1960

The first twelve years of the NHS were characterised, not by a smooth transition, but by a lack of co-ordination, co-operation and clarity. Rodney Lowe argues that by 1962, the medical profession recognised that the tripartite structure discouraged, rather than encouraged, co-operation between the administrative bodies of the NHS.¹⁰⁶ As early as 1952 the Medical Officer of Health for Aberdeen had, in his *Annual Report*, made comments on the 'faults and imperfections' of the Act. He identified ten areas that required attention and was of the opinion that 'certain sections of the Act have received undue prominence, while certain others have remained almost a dead letter'.¹⁰⁷ The areas which required attention were similar to those highlighted throughout the chapter, including the shortage of staff, a lack of research in preventive and social medicine,

¹⁰⁴ ECA, SL169/1/11, Letter to Town Clerk of Glasgow from Storrar, 13th July 1951, enclosing Minutes of Meeting with DHS on 20th June 1951.

¹⁰⁵ Ibid.

¹⁰⁶ Lowe, *The Welfare State in Britain*, p. 201.

¹⁰⁷ ACA, DD29/7, City of Aberdeen, Medical Officer of Health Report, 1952, p. xii.

insufficient mental health services, a lack of services for the elderly, the danger of a lack of control of infectious diseases, the declining control of tuberculosis, inadequate after-care services, inadequate training of doctors and nurses in preventive medicine, inadequate application of existing knowledge to prevention and the large numbers of consultants on committees and boards.

Despite the problems Aberdeen's Medical Officer of Health highlighted, improvements were seen in the local authority health services. The *Annual Reports* of the DHS note that although there were still inconsistencies between areas, by 1953, 73 per cent of children under the age of one year were attending child welfare clinics.¹⁰⁸ The 1961 DHS *Annual Report* illustrates the increases and decreases in the different types of visitations over the ten year period 1950-1960 (Figure 3.2). Throughout the 1950s the numbers of visits paid by health visitors, home helps and home nurses to patients increased as did the number of staff employed. The largest increases recorded were in the home help service whose staff doubled and visits increased by 61 per cent. Figure 3.2 also shows the relocation of births from the home to hospital with domiciliary births falling by 23 per cent between 1950 and 1960. This shows that some services were relocated to the specialist centres within hospitals, but there were increases in the availability of local authority health services in the first decade of the NHS.

Although many of the local authorities were increasing their services, there were certain services which were not receiving attention within this period. The mental health services, for example were pushed to the periphery by the changeover to the NHS. From the inception of the NHS in 1948 hospital provision was separated from community care which remained with local authorities. In the DHS *Annual Reports* of the later 1940s local authority provision for the mentally ill was not mentioned, suggesting the reorientation of mental health provision from their central position in local authority health services to the periphery of services under the NHS. The 1952 *Report* notes that local authorities had certain responsibilities for the after-care of mentally ill patients and could utilise voluntary organisations in the pursuit of suitable care.¹⁰⁹ In the previous year the issue of guardianship for boarded-out patients, which would come under care in the community, was commented upon in the section on hospital provision. The safeguarding of patients

¹⁰⁸ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1953*, (1954), Cmd 9107, p.41.

¹⁰⁹ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1952*, (1953), Cmd 8799, p. 40.

was of utmost concern especially for those under guardianship and ‘twice-yearly visits by a lay officer acting on behalf of the Regional Hospital Board or of the local authority’ would be carried out.¹¹⁰ This indicates some ambiguity in the administration of services for the provision of health care for mentally ill patients and indicates the reason behind the reluctance of local authorities to bring mental health provision to the core of their services after 1948.

The 1954 *Report* sums up the lack of progress by local authorities:

Generally speaking, local health authorities have not, since 1948, been able to develop their powers in respect of the care and after-care of persons suffering from mental illness. Restrictions on expenditure, shortages of qualified social workers, and lack of premises suitable for occupational centres have prevented any general expansion of the mental health services.¹¹¹

The lack of expansion of mental health services provided by local authorities continued throughout the 1950s. The 1957 *Report* concluded that local authority work in the field of mental health was complementary to the hospital service and the local authorities’ special interest lay in prevention, care and after-care of mentally ill patients.¹¹² This area will be considered in greater detail in chapter 4; however, it is relevant to note that from as early as 1952 local authorities called for a consolidation of mental health legislation. The DHS took the view that they were not in a position to consider any changes to law, and this was not an area in which local authorities had a major interest.¹¹³ Instead, the DHS advised local authorities to contact the DHS if they had difficulty in interpreting any of the Acts in relation to the services which they should be providing.¹¹⁴ It was not until 1960 that the Mental Health Act was passed. The legislation of 1960 brought about some changes within the local authority provision for mentally ill patients as the focus towards community care increased.

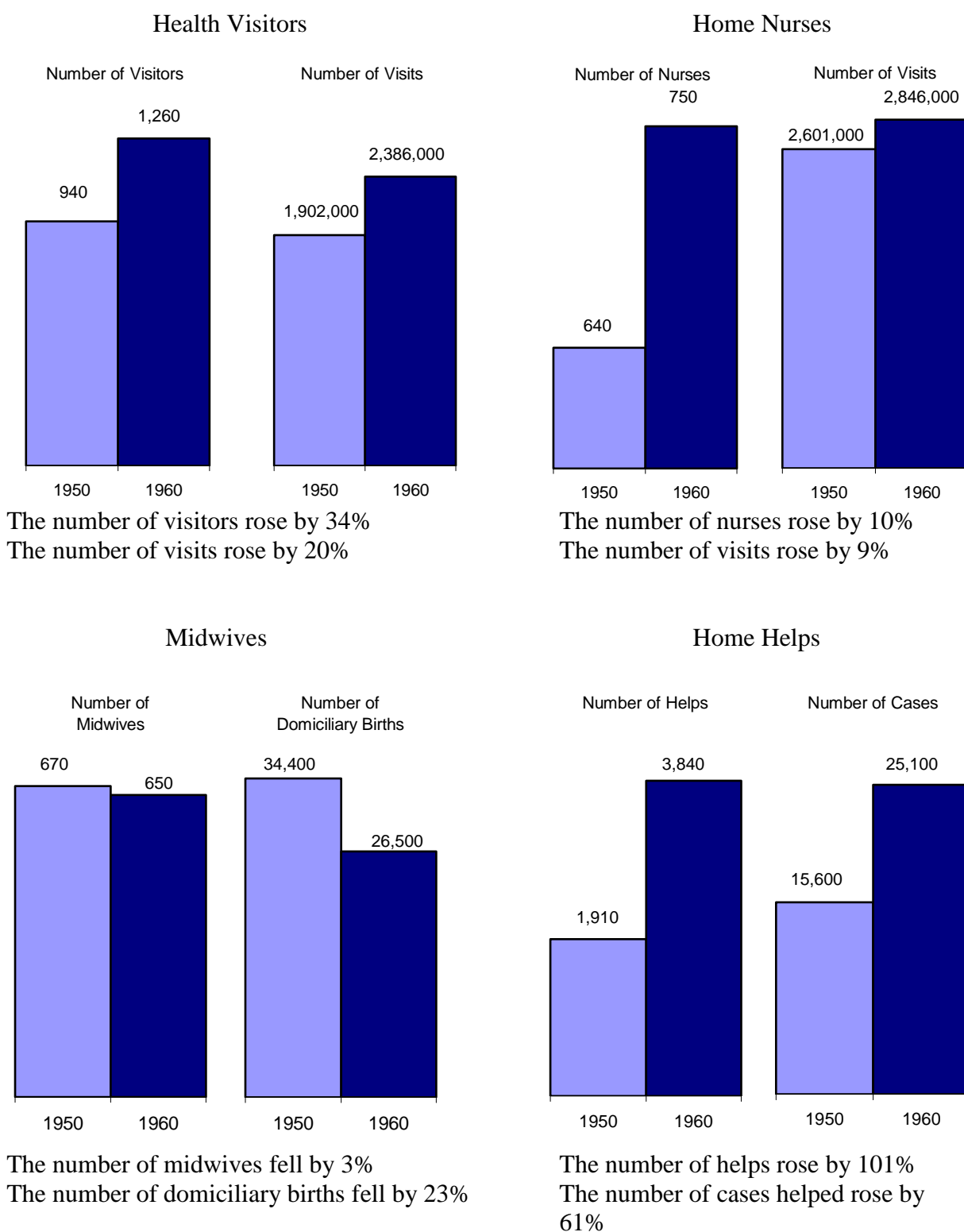
¹¹⁰ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1951, (1952)*, Cmd 8496, p. 38.

¹¹¹ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1954, (1955)*, Cmd 9417, p. 45.

¹¹² Department of Health for Scotland, *Report of the Department of Health for Scotland 1957, (1958)*, Cmd 385, p. 44.

¹¹³ ECA, SL26/2/36, Edinburgh Corporation Health Committee Minutes, 19th February 1952, p. 161.

¹¹⁴ *Ibid.*

Figure 3.2: Growth of Local Health Authority Services, 1950-1960

(Source: Department of Health for Scotland, *Report of the Department of Health for Scotland 1961 Part I Health and Welfare Services*, (1962), Cmd 1703, p. 42)

A Standing Advisory Committee on Local Authority Services, to consider and advise local authorities on mental health services, was set up in 1960 to provide some direction for future services.¹¹⁵ The Committee recommended that local authorities expand their services ‘to the point at which no person need be resident in hospital who will not benefit from or does not require hospital care’.¹¹⁶ In light of these recommendations, local authorities undertook the expansion of their services and the review of guardianship for patients in community care. Therefore the development of services, such as mental health, was not fully undertaken for more than a decade after the implementation of the NHS Act. The DHS concentrated on the areas of the health services, such as hospitals, which they considered important. This reinforced the local authorities’ perception that they had been pushed to the periphery of the NHS. The development of NHS services by 1960 was still in its early stages due to financial constraints, lack of co-ordination and co-operation and the lack of clarity over which administrative entity provided particular services.

Conclusions

The transition to the NHS in 1948 was not as smooth as some historians, such as McCrae and Hamilton, believe. The policy network established allowed the DHS to create a strong position allied to the BMA, and set in place a hierarchical relationship with Scottish local authorities. As discussed in the previous chapter, the DHS made assurances that local authorities would receive administrative authority for the NHS at a later stage, putting local authorities at their ease. The lack of unity among the three local authority associations, who were unable to capitalise on shared resources and knowledge in the bargaining process, strengthened the position that the DHS had gained. As a result, the NHS (Scotland) Act, 1947 positioned local authorities in an auxiliary role within the tri-partite health service.

Policy network theory, however, acknowledges that policy formation continues with policy implementation. The implementation process of an Act can change what is achieved in practice depending on the agenda of those implementing the policy. During the implementation process, local authorities attempted to assert greater influence and reassert their authority within the network, by requesting increased representation on boards and committees and by influencing individual issues. The network, however, firmly placed

¹¹⁵ Department of Health for Scotland, *Report of the Department of Health for Scotland 1960 Part I Health and Welfare Services*, (1961), Cmd 1320, p. 36.

¹¹⁶ Department of Health for Scotland, *Report of the Department of Health for Scotland Part I 1961 Health and Welfare Services*, (1962), Cmd 1703, p. 38.

local authorities in a subordinate relationship to the DHS, a subordinate relationship which did not allow local authorities to influence the NHS to any great extent. Only on smaller, case by case issues, generally in their own sphere of the health services, could local authorities influence the implementation process in their favour. The local authorities believed they had been pushed to the extremities of the health service with only an auxiliary role. This was evident from the proposals of some local authorities, which were vague in what they would provide for the patients in their area. Glasgow was the exception, with a Medical Officer of Health who looked not only to maintain services but develop them.

The vague nature of some of the proposals can also be attributed to the confusion over the division of responsibilities. As the examples, such as the payment of relative carers, the care of expectant mothers and the provision of maternity outfits have demonstrated, the confusion was not only between the three administrative areas of the NHS but also between the health services and welfare bodies such as the National Assistance Board. In some instances the local authorities won their case such as the use of nurses during the transportation of patients by ambulance and the provisions for unmarried expectant mothers. While in cases such as the provision of maternity outfits, they were compelled to take up their duties as laid out in the NHS Act. In all instances though, the ideal of co-operation was encouraged to provide a co-ordinated health service which did not overlap with welfare services. This was not easy to achieve and by the 1960s still required encouragement from the Department of Health for Scotland.

The Department of Health for Scotland continually used their position and the strength of the relationship with the BMA to keep local authorities in their auxiliary role. The disjointed nature of the NHS, the confusion over division of responsibility and the overlap with welfare services all contributed to the problems which were encountered in the implementation of NHS policy. In some instances these problems were not tackled until the reorganisation of 1974. No matter how much the Department of Health for Scotland attempted to co-ordinate the services, relationships among the three administrative areas and among local authorities were not at a sufficient level to sustain a co-ordinated, comprehensive service.

The period 1948 to 1960 demonstrates the continuing removal of local authorities from the health services. The costs, for the Department of Health for Scotland, of removing local authorities from the health services still outweighed the returns at this stage. With no

experience of how the NHS would run, the Department of Health for Scotland still needed local authorities to administer local services such as clinics and health visiting. The Department of Health did strengthen its hierarchical position over local authorities, ensuring local authorities were subordinate service providers in the health services. The reaction of local authorities was negative and required constant encouragement from the Department to undertake their duties. The Department of Health for Scotland had underestimated the extent to which the reaction of local authorities affected the implementation and co-ordination of the tri-partite service. Considering Scottish local authorities within the implementation of the NHS in Scotland demonstrates that the transition to the new service was filled with conflicts over implementation and disagreements over its operation.

Chapter 4

Development of health services in the aftermath of the Act, 1960-1974

Introduction

The NHS (Scotland) Act, 1947 had not created the unified service envisioned in the discussions of the 1930s and 40s. The NHS was fraught with implementation problems throughout the 1950s in areas such as finance, co-ordination and staffing. The Department of Health for Scotland had not foreseen the problems that emerged throughout the 1950s and continually attempted to encourage new levels of co-ordination between the three administrative areas of the health services. By the 1960s, it was apparent to the Department of Health for Scotland that improvements in the administration and co-ordination of the health services were slow and other action was required.

The 1960s also brought changes within the Scottish Office itself as the Department of Health for Scotland became the Scottish Home and Health Department (SHHD) in 1962. Reorganisation was the new buzzword. Major reorganisation was seen as the way to eliminate the inherent co-ordination problems in the health services and this view culminated in the NHS (Scotland) Act, 1974. Such reorganisation was not limited to the health services and changes were an element of wider governmental reform. For local authorities, the reorganisation of the health services coincided with the reorganisation of local government. The role of local authorities was changing. Throughout the period the local health authority services were consistently eroded, most notably by the removal of mental health services from their remit through legislation such as the Social Work Act 1968. The relationships established within the policy network continued to keep local health authorities in a subordinate role within the NHS. The network had not given local health authorities the opportunity to exert influence over the implementation of the NHS but had served to place them in a position whereby the erosion of their role within the NHS was easily accomplished. With experience of running the NHS for over a decade, the Department of Health for Scotland (later the Scottish Home and Health Department) no longer needed the knowledge held by local authorities. The costs of excluding local authorities from the policy network no longer outweighed the return.

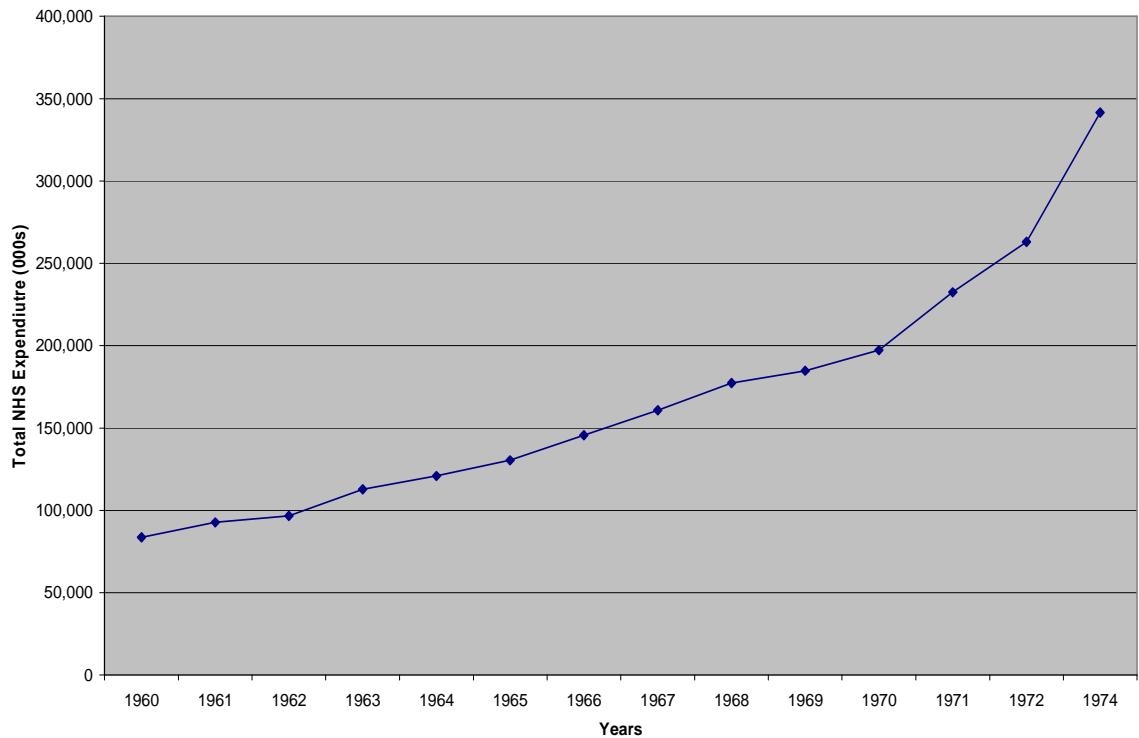
The following chapter will consider the development of the Scottish NHS between 1960 and 1974, and the way in which the relationship between the Department of Health For Scotland and local authorities developed. It will examine the development of local authority health services during the period by focusing on their attempts to overcome the problems of finance, staffing, co-ordination within the NHS, division of responsibility and

the changes in mental health services which had emerged during the first 12 years of the services and led to the 1974 reorganisation.

Finance

As indicated in the previous chapters, the changes which occurred within the local health authorities were immense. In the early 1960s the Medical Officers of Health for local authorities were asked to review the services within their areas. The income, derived from a combination of local rates and exchequer grant, and expenditure of the local health authorities determined the services they could provide. As can be seen from Figure 4.1¹, total NHS expenditure within Scotland rose throughout the 1960s and early 1970s. Although expenditure increased overall within the NHS, it cannot be assumed that the increasing funds available would be transferred equally to the main three sections of the NHS: the hospitals, GP services and local health authority services.

Figure 4.1 Total NHS Expenditure for Scotland, 1960 – 1974 (000s)



(Source: Scottish Home and Health Department Annual Reports, 1960 – 1974)

¹ The statistics provided in Figures 4.1 to 4.3 do not include capital expenditure. The Annual Report for 1973 was also unavailable to include in the statistics given.

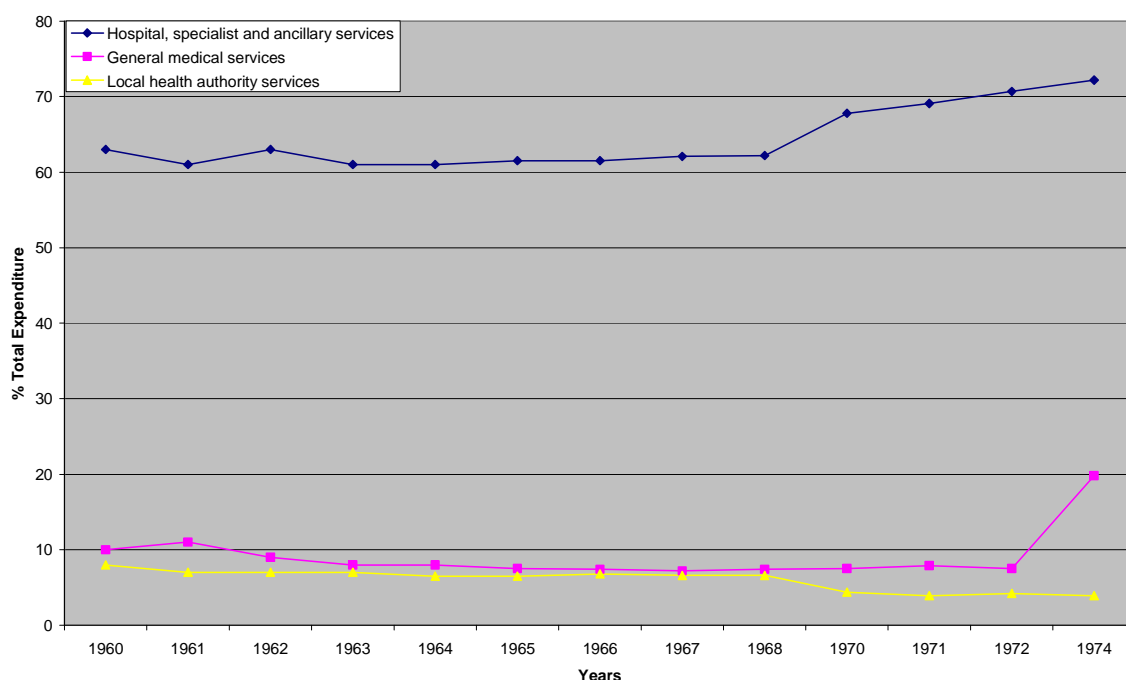
The 1962 *Annual Report of the Scottish Home and Health Department*, noted that the local authority health services grew faster than hospital and GP services.² Yet, despite this apparent relative growth of local authority health service, expenditure on local health authority services did not increase at a faster rate than expenditure on hospital and GP services according to the statistics published by the Scottish Home and Health Department or the individual experiences of local authorities during the 1960s.

Information from the Scottish Home and Health Department in Figure 4.2 shows the proportion of total expenditure of each of the three administrative divisions within the NHS from 1960 to 1974. As a proportion of total spending, local authorities, GPs and hospitals had a nearly constant level of funding throughout the 1960s. The proportion of expenditure for each service reflects their position within the NHS. Hospitals, for example, had the highest proportion of funding while local authorities received the least, contributing to the relative prestige and importance of hospitals in the NHS. When comparing the proportion of total expenditure on hospitals and GP services to local health authority expenditure, it is evident that local health authority expenditure fell relatively between 1960 and 1961, and then remained relatively constant until 1968. The expenditure on GP services in particular puts the expenditure on local authority services into perspective, as they began from a similar point. Local authority expenditure caught up with GP expenditure in the early 1960s. By the late 1960s and early 1970s expenditure on GP services rose at a higher rate while relative local authority expenditure fell.

The changes in relative proportions of expenditure among the administrative bodies in the NHS reflect three features about local health authority services. First, the local authorities' falling proportion of total expenditure in the late 1960s reflects legislation which removed services such as mental health services from their remit. Second, local health authority services were peripheral services within the NHS. As noted above, the SHHD pointed out that local health authority services grew at a faster rate than the other health services. Figure 4.2 suggests not only that the relative increase in services was not matched by a relative increase in funding, but also that the relative growth of services was sustained out of the nominal increase in funding from a rising overall NHS expenditure in Scotland (Figure 4.1). The growth of local health authority services was also due to the approach taken by the Medical Officers of Health and legislative changes, such as the Mental Health Act, 1960, which required local health authorities to invest more in particular services.

² Scottish Home and Health Department, *Health and Welfare Services in Scotland Report for 1962*, (1963), Cmd 1996, p. 37.

Figure 4.2: Expenditure on NHS Services in Scotland, 1960-74 (% of Total Expenditure)



(Source: Scottish Home and Health Department Annual Reports, 1960 – 1974)

Individual local authorities recognised the need for strict financial management in the health services. In 1968 Ian MacQueen, the Medical Officer of Health in Aberdeen, noted that ‘financial stringency’ was the feature of the preceding 20 years. In considering the future of the health services he argued that

what we have to do essentially is to cut our coat according to our cloth: to improve and re-design our services to cope as efficiently as is practicable with the needs of the people, but bearing in mind always that substantial capital expenditure and substantial staff increases are at present unlikely.³

Some local health authorities were unable to develop services to any great extent due to the financial problems and staff shortages they encountered. Up until the first reorganisation of the NHS many local health authorities had to develop in ways which did not incur costs and to utilise existing staff members. The growth of local health authority services which the Scottish Home and Health Department referred to in 1962 were an outcome of the Mental Health Act, 1960. The Act compelled local health authorities to improve their

³ Northern Health Board Archives, *Health and Welfare*, No. 39, July 1968, p. 1.

services for patients with mental illness and this required an increase in expenditure on these services. The Scottish Home and Health Department commented that

expenditure on mental health continued to increase more rapidly than in any other field of health and welfare work during 1963/64 with a rise of more than 25 per cent. over the preceding year. Even at this rate of growth the expenditure on mental health services is more than 40 per cent. below the estimated increase put forward by local authorities and accepted for general grant purposes.⁴

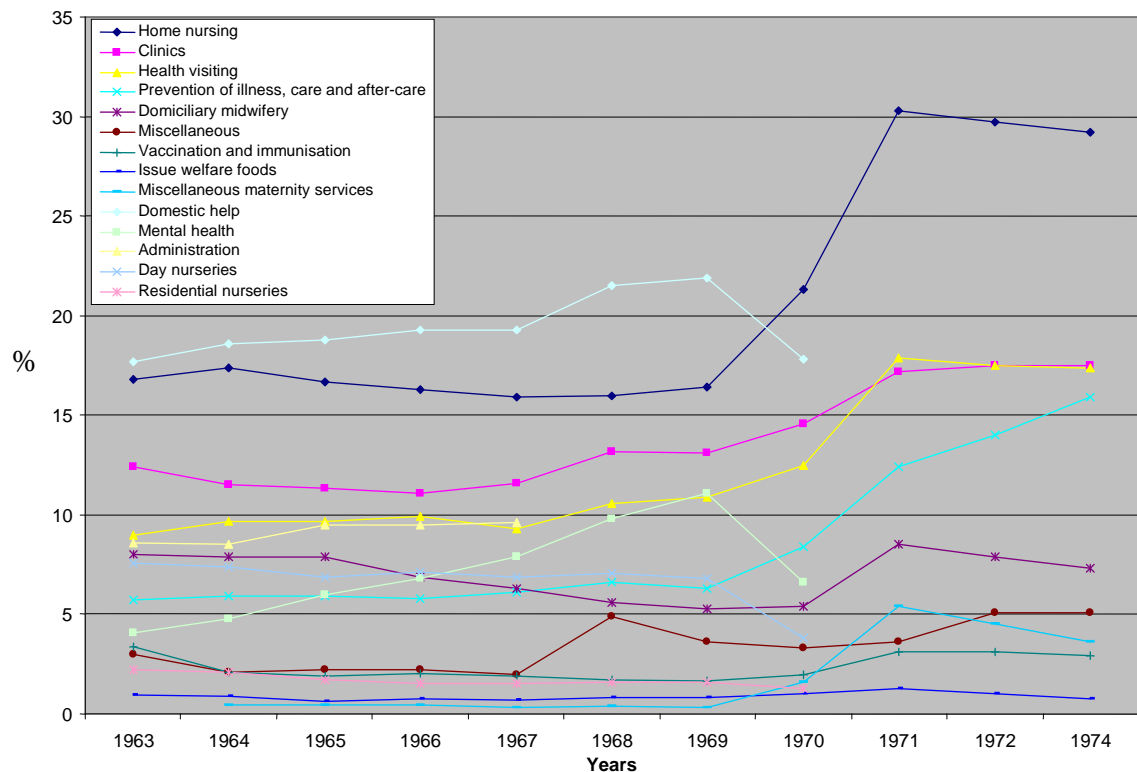
This trend of increasing local authority expenditure on mental health services continued until the late 1960s, but remained below the estimates of what was needed given by local health authorities. Mental health services, which were split between hospitals and local health authorities by the NHS (Scotland) Act, 1948, and were in competition with other areas, such as maternity and child welfare. Figure 4.3 shows that as expenditure on mental health service increased, expenditure on other services, such as domiciliary midwifery, fell. Local authorities shifted funding from one service to another, to meet the demands of the DHS, local circumstances and changing patient needs.

As will be demonstrated later in the chapter, expenditure on mental health was an area in which the Scottish Home and Health Department had to coerce local authorities to invest. As the policy network had placed local authorities in a subordinate relationship to the Scottish Home and Health Department, local authorities had to concede and increase the expenditure for their mental health services. Nevertheless, mental health services still received a relatively small proportion of the local authorities' expenditure.

By the 1960s and early 1970s expenditure concentrated on domestic help, home nursing, clinics, health visiting and domiciliary midwifery (Fig. 4.3). Due to legislation in 1968, some services moved to the welfare and social work departments of local authorities, such as mental health services, domestic help and day nurseries, so figures for these services stop by 1970. Movement of these services allowed local health authorities to concentrate on other areas. On a national basis home nursing received most funding while services which were less in demand, such as midwifery and immunisation, received level funding to keep services running as they were. The rise in home nursing expenditure reflected a shift of the age structure of patients under the care of local authorities from midwifery and children towards the elderly.

⁴ Scottish Home and Health Department, *Health and Welfare Services in Scotland Report for 1964*, (1965), Cmnd. 2700, p.46.

Figure 4.3: Expenditure on the Range of Local Authority Services in Scotland, 1960-74 (% of Total Expenditure)



(Source: Scottish Home and Health Department Annual Reports, 1963 – 1974⁵)

These are the figures for local health authority services throughout Scotland, but individual areas differed. Glasgow followed the national pattern with domestic help (also referred to as home helps) as the largest single area of expenditure in 1960 but domiciliary midwifery was the second largest area of expenditure, in contrast to the national pattern where it was only the sixth highest area of expenditure. Domiciliary midwifery was a higher than expected proportion of expenditure in Glasgow due to the lack of maternity accommodation available within the city's hospitals.⁶

The Medical Officer of Health for Aberdeen produced a bulletin called *Health and Welfare* which provided information and statistics on the health services within Aberdeen. The April 1962 issue included a comparison of health expenditure on particular services between Aberdeen, Dunfermline and Glasgow (Table 4.1). There was considerable variation. Nearly a quarter of Glasgow's expenditure was on home helps, over a third of Dunfermline's expenditure was on nurseries, while Aberdeen's expenditure was more

⁵ After 1967 administration costs are included in each of the service costs.

⁶ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, pp. 9-10.

evenly spread. It is interesting to note that for an area where the Medical Officer of Health was considered an expert in the field of mental health, Aberdeen was spending a relatively small proportion on mental health services. The *Health and Welfare Bulletin* attributes variations in expenditure to population differences, differences in the approaches of the Medical Officers of Health and the differences in focus of the Health and Welfare Committees.⁷

Table 4.1: Local Authority Expenditure for Aberdeen, Glasgow and Dunfermline, 1962 (%)

	Aberdeen	Glasgow	Dunfermline
Home Helps	18	25	12
Nurseries	18	12	38
Clinics	13	12	(included above)
Home Nursing	11	6	12
Health Visiting	9	6	15
Vaccination and Immunisation	4	3	6
Mental Health	2	12	8
Other Services	24	23	10
Total	99	99	101

(Source: Northern Health Board Archive: *Health and Welfare*, No. 14, April 1962)

It is clear that local health authorities were providing and expanding essential services for patients on a limited budget from finances which were relatively stable, in their relation to expenditure on the GP and Hospital Services, throughout the 1960s. Consequently, local authorities channelled their finances to provide the most indispensable services for their particular area, as demands on them increased through legislative changes, most notably in the provision of mental health services. Finance was not the only area in which local authorities had difficulties staffing of the services which received limited funding was also an issue in the 1960s.

Staffing Arrangements

Staffing levels from the establishment of the NHS were problematic. By the 1960s the Department of Health for Scotland recognised that the recruitment of nurses required attention. It was, however, the staffing of the hospitals which received increased attention in 1960, rather than to the local health authority staffing levels. In 1960 the Regional Hospital Boards were undertaking recruitment drives in schools and women's groups to

⁷ Northern Health Board Archives, *Health and Welfare*, No. 14, April 1962, p. 1.

increase the number of trainee nurses.⁸ Yet, the Department of Health for Scotland argued that there was no overall shortage of nurses.

While some hospitals had difficulty in obtaining sufficient nursing staff, there was no general shortage of nurses in Scotland. The numbers in all grades of nursing staffs have been increasing steadily since the inception of the National Health Service.⁹

Nevertheless, the Department of Health for Scotland felt it necessary to focus attention on ways to increase nursing staffs within hospitals through the use of part-time nurses and the greater use of all grades of trained and untrained nursing staff.¹⁰ The DHS noted that the nursing staff levels in local authorities were increasing, and reorganisation of staff workloads was the way in which local authorities could increase the productivity of their staff to cope with the new responsibilities placed upon them.¹¹ It was not until 1965 that the SHHD recognised staffing problems within local authorities. A circular was issued in 1965 advising all local authorities about ways they could increase the numbers of health visitors.¹² Furthermore by 1969 the Scottish Home and Health Department recognised that rural local authorities were experiencing difficulties in recruiting staff who could undertake combined duties of the home nurse and health visitor. A working group set up by the Scottish Advisory Committee to the Council for the Training of Health Visitors suggested training options, including a modified training course for staff in remote areas, to combat the problem.¹³

The experience of local authorities was very different to that portrayed in the *Annual Reports* of the Scottish Home and Health Department; staffing difficulties were evident in the 1960s and were not confined to rural local authorities. In 1961, for example, the Medical Officer of Health for Dundee noted that health visiting had to be continued, but there was a shortage of trained staff, and due to this a method of selective visiting was to be introduced.¹⁴ By 1967 the staffing situation had not improved and a Health Visiting

⁸ Department of Health for Scotland, *Report of the Department of Health for Scotland Part I Health and Welfare Services*, (1961), Cmnd. 1320, p. 72.

⁹ Ibid, p. 72.

¹⁰ Ibid, p. 72.

¹¹ Ibid, p. 39.

¹² Scottish Home and Health Department, *Health and Welfare Services in Scotland*, (1966), Cmnd. 2984, p. 38.

¹³ Scottish Home and Health Department, *Health Services in Scotland Reports for 1970*, (1971), Cmnd. 4667, pp. 52-3.

¹⁴ DCA, *Dundee Medical Officer of Health Report*, 1961, p. 17.

Training School was set up at the Duncan of Jordanstone College of Art in the hope that it would attract nurses, including married nurses, to take the Health Visiting Certificate.¹⁵ Local authorities had to be selective in the service they provided due to the levels of nursing staff available. In 1960, Glasgow employed 1,588 Home Help staff and found that this was still unsatisfactory especially during holiday periods such as the Glasgow Fair. During the annual Glasgow Fair in July 650 home helps were on holiday while 1000 cases required relief help.¹⁶ Furthermore, the pressure placed upon the home help service, due to the number of applications received and the lack of staff, caused Glasgow to consider each application carefully and 'ration the amount of help that [could] be given'.¹⁷ The Medical Officer of Health suggested that the high demand for the home help service was due to the lack of hospital accommodation for the elderly and chronic sick. The position was similar with regards to the number of Home Nursing staff which fell from 152 to 144 causing an acute problem throughout 1961.¹⁸ Along with financial constraints, this shortage would have put a heavy burden on the services provided and the staff providing them.

The problem did not lessen, and by 1966 Aberdeen was still suffering from a shortage of Health Visitors and could see no end to the problem. Aberdeen Corporation listed many reasons for losses of staff including marriage, pregnancy, moves to public health posts overseas and moves back to hospital work.¹⁹ The problem within Aberdeen does seem to have been more severe than in some other cities but it was a constant problem of the period throughout the country. The midwifery service within Dundee also experienced staffing difficulties in the early 1960s and began to provide furnished accommodation and car allowances to encourage more staff within the area.²⁰ Local authorities had to be inventive in the way they attracted nurses to local health authority work. The lack of nursing staff attracted to local health authority work and the relocation of nursing staff to hospital work indicate the low status local health authority work had within the NHS. The number of patients was rising while staff numbers were remaining constant or decreasing. The impact on patients was a realignment of service priorities with certain services undertaking a patient selection process.

¹⁵ DCA, *Dundee Medical Officer of Health Report*, 1967, p.15.

¹⁶ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 108.

¹⁷ *Ibid*, p. 9.

¹⁸ GGHB, HB38/1/27, *Glasgow Medical Officer of Health Report*, 1961, p. 10.

¹⁹ Northern Health Board Archives, *Health and Welfare*, No. 31, July 1966, pp. 3-4.

²⁰ DCA, *Dundee Medical Officer of Health Report*, 1962, p. 12.

Some extensions in staff, however, occurred in the 1960s. Glasgow noted that

though it has been gratifying to record that there has been a slight increase in the number of the Maternity and Child Welfare Staff, the number is not yet sufficient to overtake, really satisfactorily, the full range of activities which must be carried out under the National Health Service (Scotland) Act, 1947.²¹

Increases in the number of staff therefore, did not match the number needed for local health authorities to provide the services they were responsible for under the NHS. The Medical Officer of Health for Aberdeen pointed out that the Mental Health Act, 1960, would require an extension in the local authority health services for those with mental illness and mental disabilities. The Medical Officer further noted that in Aberdeen extensions in these services had begun prior to 1958.²² Nevertheless extensions in staff and training would be required to fulfil all the tasks to be undertaken for the mental health services.²³ In fulfilling their role in the health sphere with regards to mental health additional staff were employed by local authorities, including Dundee. In addition to a Senior Assistant Medical Officer of Health and a Mental Welfare Officer, district Health Visitors were trained in mental health services by a course of 30 lectures at Dundee Royal Mental Hospital.²⁴ Utilising the expertise of existing staff was crucial for providing specialist services such as those for mental health. As has been stated local health authorities were compelled to improve such services by the implementation of legislation. This is most clearly highlighted in the case of Edinburgh which, until the late 1950s, did not employ a Medical Officer of Health for mental health services and only in 1962 did they employ five mental health officers.²⁵ The staffing of local health authority services was crucial to the way in which they extended services over the period. In some cases innovative use of staff and employment conditions were used to attract nurses to the area. In others it took legislation to force the local health authorities to consider seriously staffing levels for particular services. The problems encountered by the local health authorities, however, were not confined to this one area and were also experienced in the hospital and GP services. It did, however, demonstrate the limited resources with which local health authorities were working and the perceived low status of their work.

²¹ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 100.

²² ACA, DD29/16, *Aberdeen Medical Officer of Health Report*, 1961, p. 82.

²³ *Ibid*, p. 83.

²⁴ DCA, *Dundee Medical Officer of Health Report*, 1962, p. 18.

²⁵ ECA, City and Royal Burgh of Edinburgh, *Review of the Activities of the Corporation*, For the Year 1962-63, p. 179.

The example of staffing, as with finance, demonstrates the attitude of the Scottish Home and Health Department which did not see any obvious problem within the local authorities. Solutions to any problems encountered came down to the way in which the local authority staff workload was organised and not to a lack of staff. This was in contrast to the hospital services, which repeatedly undertook recruitment drives to increase the number of student hospital nurses. The Regional Hospital Boards were encouraged by the SHHD to recruit student nurses, which is in contrast to the approach taken by the SHHD with local authorities. The lack of acknowledgement by the Scottish Home and Health Department of the staffing problems of local authorities contributed to the reluctant approach, by some local authorities, to the expansion of their services. It was not until the late 1960s that the SHHD made some attempt to address the staffing problem of the local authorities, through adapted training courses. As with local authority finances, the expansion and development of services were determined by the approaches taken by Medical Officers of Health who looked to new ways of utilising staff for the needs of local patients.

Co-ordination of Services and Division of Responsibility

Finance and staffing were not the only continuing problems for the administration of the NHS. The first 12 years of the NHS within Scotland revealed the reluctance of the three administrative areas to seek out co-operative measures, although the Scottish Home and Health Department circulated numerous memoranda encouraging co-operation. Ham argues that 'the theme of integration was taken up in a number of reports as the problem of securing coordination between the three different parts of the NHS gained increasing importance in the 1960s'.²⁶ Furthermore, he argues that

the need for authorities to work in collaboration had been endorsed and advocated by the Ministry [of Health] since the establishment of the NHS. The difficulty was in achieving and implementing these policy intentions at the local level. A variety of means of control were available to the Ministry, including circulars, earmarking funds for particular purposes, and setting up special agencies like the Hospital Advisory Service. At the same time, the bodies that were responsible locally for the administration of health services were not just ciphers through which national policies were implemented. They had their own aims and objectives, and, equally significant, they were responsible for providing services where professional involvement was strong.²⁷

²⁶ C. Ham, *Health Policy in Britain*, 4th Edition, (Houndmills, 1999), p. 17.

²⁷ *Ibid*, p. 18.

The co-ordination of services within the three spheres of the NHS continued to be an area of concern for the Scottish Home and Health Department in the 1960s and early 1970s. John Stewart argues that the smaller size of the Scottish Home and Health Department and the smaller number of health service bodies they were dealing with allowed tighter, centralised control than in England.²⁸ As seen in Chapter 3 the Scottish Home and Health Department made it clear in the early 1950s, that local health authorities were service providers within the NHS. The relationships established within the policy network had placed local health authorities at the bottom of the political chain and they were clearly told that it was not their duty to represent their local constituents but to provide health services on behalf of the Secretary of State. As Blom-Hansen argues 'if the relative bargaining power of the actors changes, then institutional change is to be expected'.²⁹ By the 1960s, local authorities had lost their bargaining power as the Scottish Home and Health Department gained experience in running the NHS and no longer required the knowledge of local authorities. Furthermore, the tight control the Scottish Home and Health Department exerted over local authorities removed their ability to influence the direction of the NHS to any great extent. In considering the differences between the health departments in Scotland and England, Webster argues

the health side of the department [SHHD] was well-integrated and its organisation permitted greater co-ordination of activity at senior levels than was possible within the Ministry of Health. This organisation, together with the more centralised structure of the NHS in Scotland, encouraged a more interventionist approach to health service policy than was found within the Ministry of Health.³⁰

Consequently, the aims and objectives of the implementing bodies within the NHS, which Ham highlights in his argument, were not as apparent for Scottish local authorities who were given a clear placement at the bottom of a hierarchical structure within the Scottish NHS.

By the 1960s, however, co-ordination of services was beginning to take place. The removal of the influence of local health authorities within policy formation and implementation in the NHS removed one barrier to co-ordination, but it was a slow process to join the three administrative areas of the health services. Nevertheless, co-ordination

²⁸ J. Stewart, 'The National Health Service in Scotland 1947 – 74: Scottish or British?' *Historical Research*, vol. 76, no. 193, (August, 2003), 399-400.

²⁹ J. Blom-Hansen, 'A 'New Institutional' Perspective on Policy Networks', *Public Administration*, Vol 75, Issue 4, Winter 1997, 685-6.

³⁰ C. Webster, *The Health Services Since the War*, Vol II, (London, 1996), p. 41.

was beginning to happen between local health authorities and the other facets of the NHS and can be examined by considering four areas: (1) co-operation with the hospital service, (2) co-operation with GPs, (3) co-operation with voluntary bodies and (4) the division of responsibilities.

(1) Co-operation with Hospitals

Reviewing the NHS began almost as soon as it was launched. One of the reviews, conducted by the Guillebaud Committee, published in 1956, still resonated throughout the services of the 1960s and 70s. Despite spiralling costs, the Committee found them to be acceptable for the services provided. Although set up to review the finances of the NHS, the Committee also considered the administrative arrangements and co-ordination of the health services. The Guillebaud Report emphasised that each part of the NHS, hospitals, GPs and local health authorities, had an ‘indispensable task to fulfil in their respective spheres’.³¹ Co-ordination and co-operation between these three spheres was crucial to the success of the NHS. The report argued that co-ordination could only be achieved by a change in the attitude of those administering the service, especially those within the hospital field. It is interesting to note that in contrast to circulars coming from the Department of Health for Scotland encouraging local health authorities to see themselves as part of the NHS and not a separate entity, the Guillebaud Report was saying the same thing to the hospital service.

Hospital authorities must appreciate that the hospital service is not a separate part of the Health Service, isolated from the outside world; but is part and parcel of all the services provided for the health and welfare of the patient – preventive and curative, domiciliary and institutional.³²

Therefore the hospital service was challenged to see its integration with local health authority services and GP services as a crucial part of its running. Webster argues

Pessimism concerning prospects for hospital renewal caused the SHHD to reconsider its plans, place more emphasis on health centres and primary care, and also general integration of services, which inevitably increased the argument for reorganising the health service.³³

³¹ ECA, City and Royal Burgh of Edinburgh, *Review of the Activities of the Corporation*, For the Year 1962-63, p. 62.

³² Ibid, p. 237.

³³ Webster, *The Health Services Since the War*, Vol II, p. 195.

The integration Webster highlights is evident in the last *Report* of the Medical Officer of Health for Glasgow, in 1972. The Report pointed out that co-ordination with the hospital services began in 1960 and created a two way flow of information to assist with the transfer of a patient from hospital to home.³⁴ Furthermore, the Guillebaud Report indicated that one of the main ways in which co-ordination between the hospital services and local health authorities was failing the patient was in the provision of maternity services. Although the Guillebaud Committee felt that they were not qualified to provide concrete solutions to the problems within the maternity services, they felt that they could make some observations on the problems they saw within this particular service. From the inception of the NHS, maternity services were divided among all three NHS administrative bodies. The Guillebaud Committee believed that the division of these services caused confusion and the roles of the GP, local health authorities and hospital services had to be clarified.³⁵ The problems of co-ordination among the three administrative areas of the NHS, which were inherent from its inception, were publicly recognised and required rectification.

In considering maternity services, the Report noted comments made by the Royal College of Obstetricians and Gynaecologists. The Royal College stated that the division of maternity services ‘tends to produce an atmosphere of competition not co-operation between the various components of the Service’.³⁶ Competition among the three administrative bodies of the NHS can be seen from the establishment of the policy network. The relationships within the network created an air of competition as the medical profession and local authorities competed to be the dominant, influential force behind the negotiations over the Act. Consequently, the relationships and competitive nature of the network were transferred to the administrative bodies set up during the implementation and development of the Scottish NHS.

The Committee called for an inquiry into maternity services. In preparation for an inquiry the Committee put forward three principles to be borne in mind when considering maternity services. First, it was vitally important that expectant mothers received advice on issues such as mothercraft, diet and caring for their child; second, GPs and hospitals should either provide all medical care and advice for expectant mothers or arrange for this

³⁴ GGHB, HB38/1/38, *Glasgow Medical Officer of Health Report*, 1972, p. 64.

³⁵ Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, (1956), Cmd 9663, p. 212.

³⁶ *Ibid*, p. 211.

to be done through the local health authority; and finally, local authority clinics were still vital, even with changes in their nature, and should not be set aside unless provisions were made elsewhere.³⁷

Throughout the 1960s some co-ordination occurred between the hospitals and the local health authorities with regards to maternity services. Through co-operative measures with the Western Regional Hospital Board, pupil midwives from Glasgow Royal Maternity Hospital and Cresswell Maternity Hospital, Dumfries, took on municipal cases under the supervision of the senior midwives.³⁸ Within Edinburgh, Niddrie was the only area which held a local authority ante-natal clinic staffed by health visitors working in the area alongside doctors from the Elsie Inglis Maternity Hospital.³⁹ Niddrie, however, was exceptional and by 1963 all of the Edinburgh ante- and post-natal clinics were held within maternity hospitals.⁴⁰ Co-operation between the hospitals and local authorities was evident within Edinburgh, as health visitors were attached to maternity hospitals and undertook visits within the community.⁴¹ Health visitors from Dundee were incorporated as liaison officers within hospital ante-natal clinics, children's orthopaedic clinics and one of the children's wards in the Royal Infirmary.⁴² Within Aberdeen a scheme for combined care was established which enabled GPs to take part in ante- and post-natal clinics and have access to all of the facilities provided by the joint clinics held by local authority and hospital staff.⁴³ Therefore co-operation for maternity services was evident between local authorities and the hospital services, often also incorporating the GP service. Co-operation, however, depended on the area and on the willingness of the staff involved to foster links among the three areas of the NHS.

Hospital accommodation was also a critical part of the coordination of NHS services with the other health services. Glasgow faced a different situation in 1960 when they found that in comparison with the other three Cities, they lacked maternity hospital accommodation. The Medical Officer of Health's annual report for 1960 noted that 250 additional beds were required to increase the percentage of hospital births to 75 per cent. It was also noted

³⁷ Ibid, p. 213.

³⁸ Ibid, p. 11.

³⁹ ECA, SL27/2/32, *Edinburgh Mother and Child Welfare Scheme*, 1962, p. 32.

⁴⁰ ECA, SL27/2/33, *Edinburgh Mother and Child Welfare Scheme*, 1963, p. 28.

⁴¹ ECA, SL27/2/34, *Edinburgh Mother and Child Welfare Scheme*, 1964, p. 63.

⁴² DCA, *Dundee Medical Officer of Health Report*, 1968, p. 16.

⁴³ ACA, DD29/15, *Aberdeen Medical Officer of Health Report*, 1962, p. 37.

in this annual report that since the inception of the NHS in 1948 very little progress had been made in this area.⁴⁴ In 1960 Glasgow's Health and Welfare Committee petitioned the Scottish Office and the Regional Hospital Board to provide new accommodation but were aware that this would take some time.⁴⁵ By 1963, the Medical Officer of Health noted that

While steps have been taken by the Regional Board to provide an increased number of hospital beds for mothers the need is still pressing until the standard laid down in the Montgomery Report is reached and passed. Glasgow is still far short of the 80 per cent. of births in hospital which is possible in Edinburgh and Dundee and over 90 per cent. in Aberdeen.⁴⁶

Thus, the Glasgow local health authority was expected to provide a large midwifery service with limited funds and staff. In this instance the hospital service were unable to provide the necessary accommodation for expectant women, demonstrating the profound impact one part of the NHS had on another.

The Department of Health for Scotland developed a plan to develop hospital services to cope with the demands placed upon it. The Hospital Plan for Scotland, which was a ten year plan for hospital building, was developed from 1961.⁴⁷ The original plan was to cover a ten year period up until 1970/71. The purpose of the plan was to improve all hospital accommodation including maternity hospitals and accommodation for the mentally ill. It was the first major building scheme since the inception of the NHS, and subsequent *Annual Reports* reported on progress. The basis of the Plan was to treat the Hospital Service as part of a comprehensive NHS, including local authority and general practitioner services.

The first principle on which the plan is based is that the Hospital Service has to be treated as one part only of a comprehensive Health Service. Its operations and development must be co-ordinated both with the health and welfare services provided by local authorities and with the general practitioner services.⁴⁸

When considering the need for maternity beds and beds for the elderly, the Plan took account of the scale of local health authority and GP services. For maternity services the

⁴⁴ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 71.

⁴⁵ *Ibid*, p. 10.

⁴⁶ GGHB, HB38/1/29, *Glasgow Medical Officer of Health Report*, 1963, p. 15.

⁴⁷ Department of Health for Scotland, *Report of the Department of Health for Scotland 1961 Part I Health and Welfare Services*, (1962), Cmd 1703, p. 57

⁴⁸ Scottish Home and Health Department, *Hospital Plan for Scotland*, (1962), Cmd, 1602, p. 13.

extent of local health authority ante- and post-natal clinics, domiciliary midwifery services and nursing services affected plans for maternity hospital clinics and the preference for hospital confinement.⁴⁹ The Plan, however, did not indicate that local authorities were consulted in the process and only stated that Regional Hospital Boards were asked to submit the hospital projects they thought were important.⁵⁰ The consultation process for the plan did consider the scale of local health authority services but did not include local health authorities in this process. The Scottish Home and Health Department had created a situation in which they were not required to include local authorities in the planning process. The political costs, in terms of non-compliance by local authorities, no longer outweighed the return of a more co-ordinated, centralised form of health service planning and implementation. It was in the 1960s that local authorities were effectively excluded from the policy network established in the 1940s.

The Plan did argue, like the Guillebaud Report, that the NHS should not be seen as a tripartite service, but as one that had to be co-ordinated as a singular unit. Co-ordination was intermittent but was becoming more evident throughout the 1960s. Further co-ordination between the hospital services and local authority health services began in 1965 through training initiatives, when hospital nurses began theoretical training in public health medicine as well as undertaking practical work with trained health visitors. Throughout 1966, the first full year, 399 student nurses completed the training.⁵¹ Services were diversifying by the mid-1960s, eight Glasgow nurses were engaged in work with the geriatric hospitals and were able to integrate both statutory and voluntary services available in the community with the hospital services.⁵² The co-ordination of staff, and training in the different fields of the NHS, gave the staff of each area a greater understanding of the other and the impact it could have on their own area. Co-ordination, within Glasgow, was further extended as district nurses were seconded to geriatric hospital units as a means of improving liaisons between the hospital and local health authority, and providing follow up care for patients discharged from hospital.⁵³ This type of co-ordination was along the lines which the Scottish Home and Health Department advocated and encouraged.

⁴⁹ Ibid, p. 14.

⁵⁰ Ibid, p. 12.

⁵¹ GGHB, HB38/1/32, *Glasgow Medical Officer of Health Report*, 1966, p. 114.

⁵² Ibid, p. 205.

⁵³ GGHB, HB38/1/30, *Glasgow Medical Officer of Health Report*, 1964, p. 21.

The co-ordination and co-operation of mental health services was one of the most important influences shaping the principles on which the Hospital Plan was based. As community care became a more popular solution for patients with mental illness and mental disabilities, the services provided by local health authorities became a key factor in its success. As the *Glasgow Medical Officer of Health Report* for 1964 stated

this concept of community care can only be achieved if there is a considerable expansion outside the hospitals of facilities for occupation and group activity which will afford the patient the support he requires in the community; if he could obtain it only in hospital, he would have to remain there.⁵⁴

The Hospital Plan put co-ordination with local health authorities and GPs at its centre along with regionalisation and the distribution of clinical units. Coordination was the only basis on which the hospital service would be able to provide a comprehensive service to patients within its region.

In 1966 a major review of the Hospital Plan for Scotland reassessed the priorities of the Plan for the period from 1966 to 1971. In its review the *Report* stressed that

no new hospitals will be built without the fullest consideration of the possibility of associating with them the appropriate kinds and sizes of health centres to enable the general practitioner and community services in their areas to be functionally integrated with the hospital service.⁵⁵

The *Report* alluded to further NHS reorganisation as it emphasized the interdependence of the three parts of the health services for future growth.⁵⁶ For example, Glasgow Corporation recognised a ‘growing upsurge of awareness of the advantages of a Hospital and Community Nursing Service Liaison’.⁵⁷ The Hospital Plans both provided physical buildings for hospital and specialist care, and emphasized and promoted co-operation and co-ordination among the three spheres of the NHS. The building of new hospital facilities therefore became another way the Scottish Home and Health Department encouraged co-ordination of services and tackled some of the complaints brought to light in the Guillebaud Report of 1956.

⁵⁴ Ibid, p. 14.

⁵⁵ Scottish Home and Health Department, *Review of the Hospital Plan for Scotland*, (1966), Cmd 2877, p. 5.

⁵⁶ Ibid, p. 5.

⁵⁷ GGHB, HB38/1/38, *Glasgow Medical Officer of Health Report*, 1972, p. 64.

Glasgow provides an example of the way in which co-ordination occurred on a large scale. Although the Glasgow Corporation placed nursing staff within hospitals for the mentally ill and geriatric wards, two incidents in 1968 helped achieve co-ordination. First in January 1968 Hurricane Low Q hit Glasgow, causing a crane used in the building of multi-storey flats to collapse and hundreds of residents were displaced. Accommodation was made available in South Govan Town Hall, Shettleston Hall and the Sandy Road Clinic.⁵⁸ Meals were provided by the Education Department's School Meals Service and bedding by the Regional Hospital Board. The Divisional Medical Officers undertook medical supervision at the centres whilst voluntary organisations such as the WRVS and Salvation Army helped with the organisation and management of the centres.⁵⁹ Within his *Report* for 1968, the Medical Officer of Health for Glasgow, A. R. Miller, emphasized the cooperation that took place in this emergency.

In an emergency of this kind it is impossible to mention everyone who helped, but apart from all sections of the staff of this Department assistance was received from the Women's Royal Voluntary Services, the Salvation Army, the Military, the Regional Hospital Board, and of course from other Corporation Departments – Education, Police, Transport and the Baths Department who provided bathing facilities for the residents and facilities for laundrywork. We also obtained help from senior school girls and various other people from different vocations and organisations within the City.⁶⁰

The work of all involved created an atmosphere which was deemed 'happy' within the emergency centres. Army cinema shows were shown, television installed and a baptism in one centre was undertaken by the Salvation Army.⁶¹ The emergency demonstrated that co-ordination between the local health authority, hospitals and voluntary organisations was possible. Although this was an emergency situation such co-ordination might have been harnessed, not only in Glasgow but throughout Scotland. Co-ordination, however, largely depended on the personalities involved and co-ordination within Glasgow developed from the early 1960s due to the perseverance of the Medical Officer of Health.

In 1968, a further example of co-ordination emerged when an outbreak of salmonella typhimurium occurred in the City. This outbreak was part of a larger epidemic which occurred throughout central Scotland and Argyll. During this outbreak daily meetings were held that brought together the Director of the City Laboratory, the Veterinary

⁵⁸ GGHB, HB38/1/34, *Glasgow Medical Officer of Health Report*, 1968, p. 13.

⁵⁹ *Ibid*, pp. 13 – 14.

⁶⁰ *Ibid*, p. 14.

⁶¹ *Ibid*, p. 14.

Surgeon, the Markets Manager, the Scottish Home and Health Department, the Western Regional Hospital Board and neighbouring Medical Officers of Health.⁶² The pooling of knowledge through these meetings led to successful measures for dealing with the outbreak. Again in this instance co-ordination among the different areas of the health services was possible.

Glasgow is an exceptional case within the narrative of the relationship between the hospitals and the local health authority. In many of the reports of the 1960s the Medical Officer of Health thanked his hospital colleagues for their help throughout the years. The example of Glasgow shows that although co-ordination during the 1960s and 1970s was not easily achieved between the local authorities and the hospital service, there were, attempts at co-ordination and when successful proved to be beneficial for the patients.

The example of the co-ordination between the hospital and local authority health services shows a number of features. First, co-ordination was possible between the hospitals and local authorities. Examples of co-ordination were increasing throughout the 1960s and included the training of nursing staff in wider fields than their own remit. Furthermore, the work of staff in fields other than their own, for example, local authority staff in hospitals, demonstrates the extent to which co-ordination occurred during this period. Second, the *Hospital Plan for Scotland* shows that the Scottish Home and Health Department was planning future projects for one health service in that the hospital building programme took into account the GP and local authority services. The Plan, however, also provides an example of the Scottish Home and Health Department planning future services without the input of local authorities to the planning process. The SHHD no longer felt the need to consult local authorities on all matters which would affect their services and the co-ordination between them and the hospital services. As was mentioned in the previous section, the costs of excluding local authorities, in terms of lack of agreement for projects, no longer outweighed the returns. The Scottish Home and Health Department no longer considered local authorities as part of the policy network which was established in the 1940s.

(2) Co-operation with GPs

The Guillebaud Committee in the 1950s saw preventive health as an essential part of the NHS, which could be better co-ordinated with GPs. According to the *Report*,

⁶² Ibid, pp. 15 – 16.

the Medical Officer of Health should feel...that his place in the National Health Service remains an important one, and he should be able to look to the future with the knowledge that he still has an essential and indispensable role to play in improving the health of the people of this country.⁶³

Co-operation was increasing among the hospital, GP and health visiting service, and many health visitors were attached to clinics through GPs and hospitals. The Guillebaud Report considered a range of ways in which the work of the domiciliary health services could be developed in close co-operation with the GP service. The Committee advocated health centres as the only way to solve the co-ordination problems. Within a health centre GPs could be brought into contact directly with local authority services.⁶⁴ Audrey Leathard argues that, in England and Wales, the health centre facilitated the increased co-ordination between the local health authorities and GPs.⁶⁵ Within Scotland only one health centre was established at Sighthill in Edinburgh at the outset of the NHS in 1948, though others were planned. It was the duty of the Secretary of State to finance the building of health centres but in later years it was noted within the *Annual Reports* of the Scottish Home and Health Department that delegation of health centres to local authorities had occurred. Nevertheless, Sighthill was seen as a success, but was too expensive to repeat in the restricted financial climate of the 1950s.

Because Edinburgh Corporation staff were involved in the health centre at Sighthill, reports were compiled. It was noted in 1961 that 'the experiment of regionalisation of some of the local health authority services at the Centre has proved generally successful'.⁶⁶ Communications between staff at the Centre and the Public Health Department were, at first, difficult but the problems were overcome. The staff at the Centre provided the range of services from child welfare and dental work to an old people's club.⁶⁷ By the 1950s opinion had turned against health centres because of their expense. The Guillebaud Report predicted that the establishment of health centres would be slow and put a large financial burden on the NHS. The Committee saw a case for the establishment of health centres only in areas with severely inadequate services such as new housing developments and

⁶³ Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, (1956), Cmd 9663, p. 205.

⁶⁴ *Ibid*, p. 207.

⁶⁵ A. Leathard, *Health Care Provision Past, Present and Future*, (London, 1990), p. 42.

⁶⁶ ECA, SL27/2/31, *Edinburgh Mother and Child Welfare Scheme*, 1961, p. 37.

⁶⁷ *Ibid*, p. 38.

heavily populated industrial communities.⁶⁸ But by the late 1950s the co-ordination between GPs and local health authority services was seen by the Department of Health for Scotland as the way forward. GPs providing accommodation within their surgeries for local authority health services, or local authorities providing space for GPs within their clinic accommodation was advocated as a more economical solution to the co-ordination of these services. Economy within the health services was advocated from the 1950s and encouraging means of co-operation by economical routes was a means to providing solutions to administrative problems inherent in the NHS.

The health centre in Edinburgh continued to provide services and foster greater links between the hospital, GP and local health authority services throughout the 1960s.⁶⁹ As Scotland's first health centre the co-ordination of services was successful although some interpersonal contacts admittedly required some work. The need for co-ordination might have been rectified by the health centre and the regular contacts made through it, had health centres been built as envisioned in the NHS legislation. By 1969, 14 health centres existed throughout Scotland, five of which were provided by local health authorities under delegated powers.⁷⁰ A further eight were under construction and 74 plans were approved or under consideration.⁷¹ The health centre in Glasgow was opened in 1971 and housed 19 GPs in six groups, each with a health visitor attached to the group.⁷² The distribution of GP practices and health centres, however, caused some duplication of services. Nevertheless, by the 1970s the health centre was again gaining credibility compared with the lack of support of the previous decade. The health centre provided an economical means of overcoming the hostility between GPs and local authorities which had been evident during the discussions over the NHS Act. It also proved that local health authority services could be placed in one centre with GPs and contributed to the erosion of the autonomy of local health authorities.

With encouragement from the Guillebaud Report and from the Scottish Home and Health Department, co-ordination between GPs and the local health authorities was increasing in the 1960s. Health visitors in Edinburgh, for example, held mothercraft and relaxation

⁶⁸ Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, (1956), Cmd 9663, p. 209.

⁶⁹ ECA, SL27/2/35, *Edinburgh Mother and Child Welfare Scheme*, 1965, p. 75.

⁷⁰ Scottish Home and Health Department, *Health Services in Scotland Reports for 1969*, Cmd. 4392, p. 68.

⁷¹ *Ibid*, p. 73.

⁷² GGHB, HB38/1/37, *Glasgow Medical Officer of Health Report*, 1971, p. 59.

classes through the GP clinics, and GPs welcomed this addition to their surgeries.⁷³ This was a great improvement on the lack of co-ordination in the 1950s. In Dundee, unlike Edinburgh, health visitors were not attached to any GP practices, even by 1967.⁷⁴ Further extensions in the work of the local health authority in Dundee continued in 1969 as district nurses were attached to GP practices resulting in improvements in the co-ordination of services.⁷⁵ The difference in the coordination of services within local authorities is evident, as it took Dundee until the late 1960s to place nurses within GP practices, though other local authorities undertook this move much earlier. Dundee found that placing nurses in GP practices was a slow process but there were advantages in more open discussions over patients between nurses and GPs. The nurses could not cope with the workload and an increase in nursing staff was needed to improve the service.⁷⁶ It also took Glasgow until 1967 to integrate health visitors and district nurses with local GP practices. Glasgow found that their workforce was extended to full capacity, as the work of health visitors began to include special research projects ‘undertaken at the request of universities, hospital authorities and other bodies’.⁷⁷ Despite staff shortages and financial constraints, local health authorities attempted to develop some of their services. In the *Glasgow Medical Officer of Health Report* of 1971, the MOH noted that ‘the general policy is towards attachment of nursing services to general practitioner groups, but this is progressing slowly because of the scarcity of trained staff’.⁷⁸ Local authorities found their staffing problems to be a hindrance in the co-operation with GPs and the extension of services throughout the period.

The attachment of nurses to GP practices within Dundee, once established, continued until the reorganisation in 1974, keeping contacts between nurses, GPs and patients open. By 1972 a waiting list for nurses to be attached to these practices existed.⁷⁹ There were extensions in services made within Dundee and Glasgow during the 1960s and early 1970s as health visiting continued to be a vital service within the community. These changes were not implemented as quickly as in Edinburgh, but they continued until the reorganisation of 1974. It is clear that GPs and local health authorities could work together

⁷³ ECA, SL27/2/33, *Edinburgh Mother and Child Welfare Scheme*, 1963, p. 28.

⁷⁴ *Ibid*, p. 16.

⁷⁵ DCA, *Dundee Medical Officer of Health Report*, 1969, p. 6.

⁷⁶ DCA, *Dundee Medical Officer of Health Report*, 1970, p. 15.

⁷⁷ GGHB, HB38/1/33, *Glasgow Medical Officer of Health Report*, 1967, p. 13.

⁷⁸ GGHB, HB38/1/37, *Glasgow Medical Officer of Health Report*, 1971, p. 13 – 14.

⁷⁹ DCA, *Dundee Medical Officer of Health Report*, 1972, p. 6.

within the NHS. But, the DHS' promise, in the discussions leading up to the 1947 Act, of increased administrative power for local authorities was not fulfilled. As has been previously argued in this chapter, local authorities no longer had the bargaining power to create or maintain an influential presence within the health services. Instead the cooperation that developed indicated the subordination of the influence of local health authorities and their services, and the amalgamation of the NHS under one administrative authority. The relationships established within the policy network had not given local health authorities the opportunity to increase their influence within the NHS.

(3) Co-operation with voluntary bodies

Although the establishment of the NHS led to the disappearance of the voluntary hospitals, voluntary provision of health services did not disappear. Virginia Berridge argues that voluntarism was a 'continuing strand' of health service provision and was not 'eclipsed by the arrival of the welfare state'.⁸⁰ Furthermore Berridge points out that voluntarism, through schemes such as meals on wheels, was advocated in reports of the 1950s and 1960s, such as the Younghusband Report on social work.⁸¹ In the 1960s voluntarism was seen as a means of providing more cost-effective services and reinstating 'active' citizenship through participation in the provision of health services.⁸² Co-operation between local authorities and voluntary bodies was consequently a further way to provide health services within the community. A circular in 1963 from the Scottish Home and Health Department tried to encourage local authorities to incorporate voluntary bodies in the expansion of their services.

As you know, it is the Government's policy to encourage local authorities to expand their health and welfare services and, if this is to be done effectively, it is desirable that full advantage should be taken of the resources of voluntary agencies whose interests to some extent run parallel with those of health and welfare authorities. In some areas local authorities and voluntary agencies work well together, but the position varies from area to area and between one voluntary body to another.⁸³

The circular invited the three local authority associations to a meeting with the principal voluntary agencies and requested individual local authorities to approach their local

⁸⁰ V. Berridge, *Health and Society in Britain Since 1939*, (Cambridge, 1999), p. 38.

⁸¹ *Ibid*, p. 38.

⁸² *Ibid*, p. 38.

⁸³ ECA, Acc 12 Box 16 1st Nov 1962 – 28th Feb 1963, Letter from Scottish Home and Health Department, (1963).

voluntary agencies to co-ordinate services. The local authority associations took part in the meeting with the Scottish Home and Health Department and five voluntary organisations; the Scottish Council of Social Service, the Scottish Old People's Welfare Committee, the Scottish Association for Mental Health, the Women's Voluntary Services and the Scottish branch of the British Red Cross Society.

The Scottish Home and Health Department hosted the meeting at St Andrews House in February 1963. At the meeting the Scottish Home and Health Department and the local authority associations acknowledged that the voluntary organisations provided a good range of services. The representatives for the Counties, however, felt that local authorities found it easier to deal with smaller numbers of organisations and that overlapping should first be dealt with by voluntary organisations before they were incorporated into local authority health services.⁸⁴ Throughout the discussions all three associations noted that local authorities in the Cities, Counties and Burghs were co-operating fully with voluntary organisations. The meeting ended with Mr R E C Johnson, Scottish Home and Health Department representative in the Chair, commenting that 'the discussion had brought out that more work could be done by voluntary bodies if the local authorities invited them to do it and that there was plenty of scope for more individual volunteers to come forward if the need were shown'.⁸⁵ The Scottish Home and Health Department saw the use of voluntary organisations by local authorities as an economical way to develop the preventive and domiciliary services. The local authority associations acknowledged the advantage of utilising the voluntary sector but the use was still patchy.

The 1950s and 1960s was a flourishing period for voluntary groups, as organisations, such as Help the Aged (established in 1961), were established for specific types of patients. Local health authorities made links with voluntary associations. In Dundee, for example, contacts were made with the Dundee Association for Mental Health, the Friendship Club, the local branch of the Society for Mentally Handicapped Children and the Dundee Council of Social Service.⁸⁶ Therefore within Dundee links with voluntary organisations were valid options to fill gaps in certain services provided by the local health authority. Such overt co-ordination with voluntary groups was not evident in other areas to the same extent as in Dundee. Aberdeen, for example, repeatedly noted that none of their mental

⁸⁴ NLS, Acc 7170/15/14, Note of the Meeting in St Andrew's House on 27th February, 1963 with the three Local Authority Associations and Voluntary Bodies, p. 2.

⁸⁵ Ibid, p. 3.

⁸⁶ DCA, *Dundee Medical Officer of Health Report*, 1962, p. 28.

health services had been delegated to voluntary organisations.⁸⁷ Nevertheless, in Glasgow voluntary groups were still involved in local authority health services. Glasgow utilised voluntary organisations to a great extent as noted above in the help received from the WRVS and the Salvation Army in the hurricane crisis of 1968. Further co-operation with voluntary services was apparent in the mental health services within Glasgow whereby the Balvicar Centre for Child Development utilised voluntary workers for a range of jobs including play therapy, transport and general duties.⁸⁸ Furthermore, the Scottish Society for Mentally Handicapped Children provided services within the City such as a day care for children at the Laurieston House Centre and a short-stay in Alyth for children from the city.⁸⁹ At the request of the Marie Curie Memorial Foundation, and funded by the foundation, a night sitter service was established in Glasgow in 1962, for patients reaching the terminal stage of their illness.⁹⁰ Co-operation with voluntary organisations was patchy throughout Scotland but was found to be invaluable in the areas which utilised help from this source.

Co-ordination with voluntary groups also occurred through churches providing premises for local authority clinics, the housing of pregnant unmarried mothers in Salvation Army Homes and clubs for the elderly and mentally ill. Although local authorities may not have been directly co-ordinating with voluntary organisations, co-operation came in many forms, and the SHHD constantly encouraged it as a means of developing the domiciliary services of the local authorities, without increases in expenditure or staff levels. This was one of the few areas in which the Scottish Home and Health Department did include local authorities in the consultation process. This shows that local authorities could still have some input into the services within their remit. However, the previous examples given in this Chapter and in Chapter 3, show that the local authorities were limited by the Scottish Home and Health Department in the range of areas they could influence. These areas did not include any which would have affected the wider NHS, namely the hospital and GP services.

⁸⁷ ACA, DD29/15, *Aberdeen Medical Officer of Health Report*, 1962, p. 100.

⁸⁸ GGHB, HB38/1/33, *Glasgow Medical Officer of Health Report*, 1967, p. 81.

⁸⁹ *Ibid*, p. 237.

⁹⁰ GGHB, HB38/1/28, *Glasgow Medical Officer of Health Report*, 1962, pp.140-1.

(4) Division of Responsibility

The roles of the GP, the local health authority and the hospital were still under discussion in the 1960s despite the many problems overcome in the 1950s. The problems of division of responsibility, however, were not only evident among the three administrative areas of the NHS, but also within local authorities between the health and welfare services. Christopher Ham argues that within England and Wales the 'division of responsibility for these [welfare] services and health services became a matter of increasing concern, particularly as long-term plans for both sets of services were developed in the 1960s'.⁹¹ In response to these concerns the Ministry of Health published *Health and Welfare: The Development of Community Care* in 1963 which mapped out the development of local authority health and welfare services. The publication brought together in one document all the diverse plans of the local authorities throughout England and Wales.⁹² Ham goes on to argue that the publication demonstrated two things: first, that local authorities had far greater autonomy in the planning of their services than the Regional Hospital Boards and Hospital Management Committees; and second, that the local authorities varied considerably in their plans for which services to provide in their areas.⁹³ Furthermore, he notes that the publication hoped to highlight the diversity in local authority plans and encourage local authorities to revise plans in a more uniform way.⁹⁴ Similar problems with the division of responsibility within Scotland existed in the 1960s; however, the collective public planning of local health authority services is not as clear as in England, as the Scottish Home and Health Department had a more hierarchical relationship with the local health authorities placing them in the position of a service provider, not an elected body. The Scottish Home and Health Department was able to assert greater control over the local health authorities' service provisions, as the autonomy of local authorities within Scotland was not as strong as their English counterparts.

Nevertheless, problems within local authorities existed and they called on the Scottish Home and Health Department to provide solutions. For example, in November 1965, the Town Clerk of Paisley contacted Miss Watson of the Scottish Home and Health Department regarding some difficulties they were experiencing in Paisley over the smooth running and co-ordination of the health and welfare and child care services. The services

⁹¹ Ham, *Health Policy in Britain*, p.16.

⁹² Ibid, p. 16.

⁹³ Ibid, p. 16.

⁹⁴ Ibid, p. 16.

run from the health and welfare section of the council overlapped with those run from the Home Service Unit. The situation was further complicated as the Sanitary Inspector found relations with the Medical Officer of Health difficult.⁹⁵ Overlapping of services within local authorities was a problem because many health, welfare and sanitary committees worked separately. The Department of Health did not condone separating services which it thought should be linked, and advised the Town Clerk of Paisley accordingly.⁹⁶ The 1960s was a period of integration of health, welfare and sanitary services to avoid problems with divisions of responsibility and the overlapping of services which ensued. By the late 1960s and early 1970s, however, diversification between the departments of the local authorities began as Social Work Departments began to take on some of the duties which were placed with the local health authority. This diversification did not cause further problems of division of responsibility but removed some services such as mental health and home helps from the local health authority. In practice, as the example of Glasgow shows, the changes in responsibility between the Social Work Department and the Local Health Authority did not necessarily mean the transfer of the administration of these services.

The supply of home nursing equipment was an area which required clarification as to whose responsibility it was to provide certain pieces of equipment. The supply of nursing equipment was generally a local health authority responsibility, but problems arose when equipment was required which was tailor-made to individual needs. Local authorities thought tailor-made equipment should be a hospital responsibility. The confusion between local authorities and regional hospital boards over responsibility for the provision of these items, along with equipment which would encourage early release from hospital, became a matter which was taken up by the Department of Health for Scotland. Meetings were held between the Department of Health for Scotland, the local health authorities and the hospital boards which resulted in a circular being issued in March 1961.⁹⁷ The circular, released by the Department of Health for Scotland, stated that equipment for individual patients which allowed early release from hospital was no longer a local health authority matter and would be undertaken by the hospital authority.⁹⁸ This example is a rare case in which local health authorities gained their preferred outcome.

⁹⁵ NAS, HH61/811, National Health Service (Scotland) Act, 1947, Local Authority Disagreements, 1960.

⁹⁶ *Ibid.*

⁹⁷ ECA, SL27/2/31, *Edinburgh Mother and Child Welfare Scheme*, 1961, p. 30.

⁹⁸ *Ibid.*, p. 30.

On the whole, the division of responsibility shows that problems still existed within the administration of the NHS not only among the three administrations - hospitals, GPs and local authorities - but also within local authorities. The autonomy of Scottish local authorities was not as strong as their English counterparts as the Scottish Home and Health Department exercised tighter control of the areas which local authorities influenced; by the 1960s this was very few areas. The environment created by the Scottish Home and Health Department meant that when problems arose between local authorities and the hospital or GP services, the SHHD had to mediate between the administrations to ensure the preferred outcome for the Department. This situation was not only a feature of the 1960s but began with the implementation of the NHS in the 1940s. It was also not limited to problems with the division of responsibility, but is also demonstrated in areas such as mental health services.

Mental Health Services

The final area which highlights the changes within local authority services during the 1960s is the changes within mental health services. In the 1950s, changes to mental health services came about with the separation of hospital services and community care into two different administrative bodies through the NHS i.e. regional hospital boards and local authorities. Calls for changes within mental health legislation occurred throughout the policy formation and early implementation stages of the NHS, but changes were not forthcoming until the Mental Health (Scotland) Act, 1960. The Act replaced all existing legislation dating back to the Lunacy (Scotland) Act of 1857. It provided for voluntary patients to receive treatment in hospitals and the community without the formality of certification. Treatment would be in the nearest hospital to the patient as well as in mental hospitals. Psychiatric units in general hospitals would be utilised for short stay patients whilst the mental hospitals would be utilised for longer stay patients. The Act also expanded community care, whereby local authorities would provide care and after-care of patients who suffered from mental illness. The local authorities would furthermore provide residential care for patients who did not require hospitalisation. The Act established a Mental Welfare Commission with powers to discharge patients from compulsory detention at any time and to hear and investigate any complaints. The Commission took over from the Board of Control which ceased to exist. The Act also covered patients involved in criminal proceedings, the protection of patients against ill-

treatment, and the protection of patients' property.⁹⁹ The Act served to clarify the provision of care for mentally ill patients within the NHS and provided the basis for care from the 1960s onwards.

The 1950s had seen little change in mental health provision. The Scottish Home and Health Department recognised that this was due to lack of staff, restrictions on expenditure and lack of available premises for occupation centres.¹⁰⁰ The legislation of 1960, however, brought about changes within the local authority provision for mentally ill patients as the focus towards community care increased. A Standing Advisory Committee on Local Authority Services, to consider and advise local authorities on mental health services, was set up in 1960 to provide some direction for future services.¹⁰¹ The committee recommended that local authorities expand their services 'to the point at which no person need be resident in hospital who will not benefit from or does not require hospital care'.¹⁰² In light of these recommendations, local authorities undertook the expansion of their services and the review of guardianship for patients in community care. Throughout the mid-1960s expenditure on mental health services increased more rapidly than any other feature of the local authority health services. Nevertheless, financially it was still a small part of the total local authority health services expenditure (see Table 4.1). Furthermore, the co-operation between local health authorities and mental hospitals was not developed in the 1950s. To combat the lack of co-operation, senior medical staff from the Scottish Home and Health Department held discussions, in 1964, between the medical officers from local authorities and mental hospitals to create an understanding of what each side required from the other for a coherent system of mental health care.¹⁰³ These discussions continued throughout the mid-1960s to bring together the different parts of the services. It is notable that again the Scottish Home and Health Department had to begin discussions between the hospital and local health authorities for any co-operation to occur. The hospitals and local health authorities saw themselves as in competition with one another and not partners within the health services.

⁹⁹ Department of Health for Scotland, *Report of the Department of Health for Scotland 1960 Part I Health and Welfare Services*, (1961), Cmd 1320, pp. 34-8.

¹⁰⁰ Department of Health for Scotland, *Report of the Department of Health for Scotland and the Scottish Health Services Council 1954*, (1955), Cmd 9417, p. 45.

¹⁰¹ Department of Health for Scotland, *Report of the Department of Health for Scotland 1960 Part I Health and Welfare Services*, (1961), Cmd 1320, p. 36.

¹⁰² Department of Health for Scotland, *Report of the Department of Health for Scotland Part I 1961 Health and Welfare Services*, (1962), Cmd 1703, p. 38.

¹⁰³ Scottish Home and Health Department, *Health and Welfare Services in Scotland Reports for 1963*, (1964), Cmd 2359, p. 32.

Under the Mental Health Act of 1960 local authorities were compelled to provide services within their area. Different local authorities met their responsibilities in different ways. For example, in order to meet the obligations set by the Act, Dundee Corporation created a Mental Health Section in the Department to oversee the functions related to mentally ill patients.¹⁰⁴ In fulfilling their role in the health sphere with regards to mental health, Dundee employed additional staff. In addition to a Senior Assistant Medical Officer of Health and a Mental Welfare Officer, district Health Visitors were trained in mental health services by a course of 30 lectures at Dundee Royal Mental Hospital.¹⁰⁵ The enthusiasm of staff was noted in 1961 and this gave the impetus to implement all of the duties under the Act in the following year.¹⁰⁶ The Medical Officer of Health reported this was undertaken without ‘undue difficulty’.¹⁰⁷ However, by 1963 he noted that

this has been a year in which it has been brought home to us that “Community Care” for the mentally disordered is much more than a popular slogan and that a great deal of thought, planning, money and hard work will be necessary before we can claim that we are caring adequately for the mentally disordered in the community.¹⁰⁸

These were services which were neglected from 1948 and demonstrate the reluctance of some local authorities to embrace their role within the NHS. For Dundee, co-operation and co-ordination were crucial in providing these services and by 1966 a Joint Consultative Committee for Mental Health was established. It included representatives from the Health and Welfare Committee, the Eastern Regional Hospital Board, the Board of Management for the Dundee Northern Hospitals, the Dundee Executive Council, the Dundee Association for Mental Health and the Dundee Branch of the Scottish Society for Mentally Handicapped Children.¹⁰⁹ It was to meet twice yearly to ensure that the hospital and local authority mental health services developed together.

The Medical Officer of Health for Aberdeen, like his counterpart in Dundee, noted that the Mental Health Act, 1960, would require an extension of the local authority health services for those with mental illness and mental disabilities.¹¹⁰ Furthermore, he noted that

¹⁰⁴ DCA, *Dundee Medical Officer of Health Report*, 1961, p. 18.

¹⁰⁵ *Ibid*, p. 18.

¹⁰⁶ *Ibid*, p. 23.

¹⁰⁷ DCA, *Dundee Medical Officer of Health Report*, 1962, p. 24.

¹⁰⁸ DCA, *Dundee Medical Officer of Health Report*, 1963, pp. 17-18.

¹⁰⁹ DCA, *Dundee Medical Officer of Health Report*, 1966, p. 5.

¹¹⁰ ACA, DD29/16, *Aberdeen Medical Officer of Health Report*, 1961, p. 82.

extensions in staff and training would be required to fulfil all the tasks to be undertaken for the mental health services.¹¹¹ The Medical Officer of Health commented that

1962 and the adjacent portions of 1961 and 1963 can be regarded either as two years of passivity in mental health or as two years of prolonged consideration as a preliminary to initiation of measures aimed at improving the pre-existing mental health services.¹¹²

The Medical Officer of Health divided the short period into four: (a) submitting a formal scheme for mental health services to the Secretary of State; (b) reorganising some specialist health visitors to the post of mental after-care officers; (c) the decrease of existing mental health services due to staff shortages; and (d) submission of reports by the Medical Officer of Health to the Health and Welfare Committee and the deferral of decisions on the recommendations of the reports.¹¹³ The Medical Officer of Health, noted that many advances had been made in the period 1954-60 through education of staff, the increase in staff time devoted to the promotion of mental health and the prevention of mental illness through education, and competent staff heading the expanding mental health services.¹¹⁴ The Medical Officer of Health for Aberdeen was extremely interested in mental health services and their development. He produced many reports and recommendations for ways in which the services could be developed, but the Health and Welfare Committee for Aberdeen was unwilling to make decisions on the points he put forward. The example of Aberdeen demonstrates that although an innovative medical officer of health could have made significant improvements in services, the local authorities were slow to take up new ideas. In an issue of *Health and Welfare* in 1966 the Medical Officer of Health noted that 'Aberdeen, after having been a pioneer in mental health work, has tended to lag behind in the last few years, but developments are now coming apace'.¹¹⁵ The lack of development could be attributed to the local councillors' attitude to the position of local authorities within the NHS, the tight economies which local authorities were working under, or the staff shortages which were evident throughout the country.

¹¹¹ ACA, DD29/16, *Aberdeen Medical Officer of Health Report*, 1961, p. 83.

¹¹² ACA, DD29/16, *Aberdeen Medical Officer of Health Report*, 1962, p. 94.

¹¹³ *Ibid*, p. 94.

¹¹⁴ ACA, DD29/16, *Aberdeen Medical Officer of Health Report*, 1962, pp. 95-6.

¹¹⁵ Northern Health Board Archives, *Health and Welfare*, No.31, July 1966, p. 1.

For Edinburgh, unlike Aberdeen, mental health was an area which was neglected for many years prior to the Mental Health Act. Edinburgh Corporation did not have a Mental Health Medical Officer of Health and made no changes within the area in the 1950s. The 1960 Act compelled local authorities to make provisions for treatment and after-care within the community. Nevertheless, this was still an area of neglect for many local authorities, such as Edinburgh. By 1962 health visitors within Edinburgh had been trained at the three hospitals for the mentally ill, and according to the local authority, co-ordination between these hospitals and health visitors was very good.¹¹⁶ Information was passed between the health visitor and hospital, and case conferences were held among consultant psychiatrists, nursing staff and psychiatric social workers.¹¹⁷ Although some advances were made, the lack of information in the *Reports* regarding mental health services demonstrates that this service was not a priority for the local authority. Within reports of Edinburgh Corporation, mental health services were not mentioned at all in the last half of the 1950s, nor in the late 1960s and early 1970s. This suggests that these services were only brought to the fore as a direct result of the 1960 Act and pressure from the DHS to fulfil their duties in this area.

It is interesting to note that within Glasgow special attention was given to the mental health of the infant and child. In 1960 the Medical Officer of Health reported

In the past few years it has become increasingly apparent that it is fundamentally important to make an accurate assessment of the mental progress of the infant and young child just as much as the physical process is at present supervised.¹¹⁸

To develop the area of child mental health services within the local health authority, Glasgow undertook to train its Maternity and Child Welfare Officers. Child psychiatry was the path along which local health authority mental health services were expanding. Although child psychiatry is the path that Glasgow chose to develop, Glasgow acknowledged that the area of after-care for mentally ill patients had not been developed. In response to this lack of service provision, health visitors provided training for nurses to increase the knowledge of nurses about mental health problems and the care of patients within the community.¹¹⁹ As a result of the training nurses could be placed within hospitals for the mentally ill as liaison officers and provide care within their community where

¹¹⁶ ECA, SL27/2/32, *Edinburgh Mother and Child Welfare Scheme*, 1962, p. 34.

¹¹⁷ *Ibid*, p.34.

¹¹⁸ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 179.

¹¹⁹ GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 181.

necessary. Local authorities were attempting to incorporate mental health services into the child health services, creating a service in which they considered themselves to be specialists. Thus, local health authorities were attempting to create a specialist niche in which they would be the leading force.

The Social Work (Scotland) Act in 1968, however, brought an end to the local health authority provision of mental health services. In 1968 the *Annual Medical Officer of Health Report* for Dundee, for example, noted that ‘the effect of this Act will relieve this Department of its welfare, mental health, day nurseries and domestic help services’.¹²⁰ Prior to this being handed over to the Welfare Department, the Dudhope Gardens Centre was opened in 1969. It provided a residential hostel, training centre and education facilities for patients with mental disabilities in the area.¹²¹ The 1969 Report was the final report on mental health for the Dundee health authority. It is evident that after a slow start in the field of mental health the local health authority tried to instigate changes which would benefit patients up until the changeover in 1969. Other local health authorities do not mention the changeover in the reports of the Medical Officer of Health. Mental health services once again faded into the background along with the other services which local authorities once, but no longer, provided.

The Social Work Department in Glasgow took over the mental health services in 1969 but lack of trained psychiatric social workers resulted in aspects of the work continuing to be carried out by the local health authority and its staff, unlike other local authorities where the social workers took the workload on at an earlier stage.¹²² The volume of work across all the health services in Glasgow required flexibility, and the mental health services were no exception. Even in the last Medical Officer of Health’s *Report*, in 1972, he noted that Glasgow’s Health Department provided assessment centres for mentally disabled children, child day centres, supervision of mentally disabled patients under guardianship, and after-care of psychiatric patients. He also made passing comment within this Report about the ‘occasional co-operation with the Social Work Department, especially with regard to certification or informal admission of the mentally ill to hospital’.¹²³ Although Glasgow was an exceptional case within mental health services, it serves to indicate that even with legislation passed to remove mental health services from the local health authority and pass

¹²⁰ DCA, *Dundee Medical Officer of Health Report*, 1968, p. 5.

¹²¹ *Ibid*, p. 20.

¹²² GGHB, HB38/1/36, *Glasgow Medical Officer of Health Report*, 1970, p. 211.

¹²³ GGHB, HB38/1/38, *Glasgow Medical Officer of Health Report*, 1972, p. 231.

it to the Social Work Department, informal arrangements were made on an area by area basis. Although mental health services had been removed from the remit of the local health authority, the staff of Glasgow Corporation's local health authority continued with their work.

Even though many of the day care centres and nurseries for those with mental disabilities were aimed at children, occupational centres for adults with mental disabilities were provided by the local health authority in 1962 and in addition one was organised by the Scottish Society for Mentally Handicapped Children.¹²⁴ Co-operation with voluntary organisations was notable throughout Glasgow Corporation's health services and was utilised fruitfully within the mental health services. In the mid-1960s the development of child mental health services continued. The Balvicar Centre opened in 1962, providing an assessment clinic and day nursery; it was provided in addition to the Child Development Centre in Glenfarg Street.¹²⁵ Although Glasgow Corporation accepted that there were still many gaps in the provisions for the mentally disordered, improvements, most notably for children, were made. After-care visits for mentally ill patients also increased in the mid-1960s and health visitors carried out visits to patients from seven psychiatric units within Glasgow.¹²⁶ It was still noticeable that child psychiatry was the field which was being developed in as diverse a way as possible. The 1965 meeting of senior psychiatric consultants with the local health authority furthered co-operation between the hospital and local health authority services, although it was unclear what practical measures would, if any, come of this.¹²⁷ Meetings of this group continued through subsequent years but discussions over issues such as alcoholism and psycho-geriatric care were inconclusive so no action arose from these meetings. By 1967 the meetings of the group were discontinued as they achieved few practical measures.¹²⁸ Nevertheless it was an achievement that meetings such as this occurred, even for a short time.

Glasgow did have some success in the after-care of mentally ill patients and was able to place mental health visitors within mental hospitals. Although services with one hospital were terminated in 1965, the Medical Officer of Health noted that

¹²⁴ GGHB, HB38/1/28, *Glasgow Medical Officer of Health Report*, 1962, pp. 208-9.

¹²⁵ GGHB, HB38/1/30, *Glasgow Medical Officer of Health Report*, 1964, p. 255.

¹²⁶ *Ibid*, p. 258.

¹²⁷ GGHB, HB38/1/31, *Glasgow Medical Officer of Health Report*, 1965, p. 264.

¹²⁸ GGHB, HB38/1/33, *Glasgow Medical Officer of Health Report*, 1967, p. 235.

The success of the Glasgow service has attracted some attention outside Scotland. In England and Wales where Mental Welfare Officers are well established in the after-care field the use of health visitors arouses some controversy. In this situation Sister Brown, one of the first to do this work, was invited to address the Annual Conference of the Association of Mental Health in London.¹²⁹

The interest in the services provided in Glasgow demonstrates that it was developing some unique mental health services within the UK. But, Glasgow was not unique within Scotland, as other local authorities, such as Dundee, also utilised health visitors in the after-care services for the mentally ill. By the late 1960s the care of mentally defective children was the priority of the mental health services within Glasgow. Although visitations were made to mentally ill patients and two social clubs were set up, there was no further significant expansion of services.

The example of mental health services leads to three conclusions. First, local health authority reluctance to provide certain services required the Scottish Home and Health Department to intervene and persuade local health authorities to take up their duties under the NHS Act. Second, local health authorities attempted to develop their services in the direction of child health services, in which they became specialists. Finally, after building up mental health services, local health authorities had this removed from their remit, continuing the erosion of their services prior to reorganisation. The example of mental health services shows the development of the relationship between the Scottish Home and Health Department and local authorities, not only in the 1960s but also throughout the policy formation and implementation of the NHS from the 1940s. The relationship was hierarchical, moving from encouragement of the expansion of local authority mental health services to coercing local authorities to take up their duties and ended in the removal of health services from local authority administration.

The pattern with regard to mental health services is reflected in the overall relationship between the two groups as policy formation was undertaken in an atmosphere of partnership and encouragement for a new service from the Department of Health for Scotland. In the initial implementation stages of the 1950s and 1960s, the relationship moved to a subordinate one whereby local authorities were service providers and any influence they had over the health services was diminished. Finally, the process of

¹²⁹ GGHB, HB38/1/31, *Glasgow Medical Officer of Health Report*, 1965, p. 268.

removing local authorities from the provision of health services ended with the reorganisation of 1974, which will be discussed more fully in the next chapter.

The 1960s Health Services.

Although there were problems with financing, staffing levels and co-ordination within the NHS, the Scottish Home and Health Department thought that local health authority services improved in the 1960s, particularly maternity and child welfare services. By 1959 the Department of Health for Scotland estimated that 73 per cent of children under the age of one were taken to clinics and on average made eight attendances per child. About 30 per cent of children between the ages of one and two attended clinics, and older children attended infrequently.¹³⁰ Older children, however, were examined through the school medical service, administered by the local authority Education Department, which continued to function throughout the period. In 1960, six new clinics were opened, making a total of 125 ante-natal clinics, 100 post-natal clinics and 480 child welfare clinics.¹³¹ These clinics were the most substantial area of local authority health services accounting for a total of £1,414,000 net expenditure in 1958/59.¹³² Clinic attendances for mothers and young children continued to increase throughout the period with 516 clinics in use by 1965, seeing 247,000 mothers and children.¹³³ Nevertheless, although there was an overall increase in attendances at clinics per client, the move towards hospital care for pregnant women was evident as the numbers of clients decreased. Tables 4.2 and 4.3 highlight the general decrease in the numbers attending Aberdeen ante- and post-natal clinics in the late 1960s. As is evident in both Tables the decrease in new clients and attendances between 1965 and 1966 is significant. This decrease could be attributed to the *Hospital Plan for Scotland* which focussed on hospital maternity provision and may have increased the number of clinic services available within hospitals.

¹³⁰ Ibid, p. 56

¹³¹ Department of Health for Scotland, *Report of the Department of Health for Scotland 1960 Part I Health and Welfare Services*, (1961), Cmd 1320, p. 41

¹³² Ibid, p. 40.

¹³³ Scottish Home and Health Department, *Health and Welfare Services in Scotland Report for 1965*, (1965), Cmd 2984, pp. 38-9.

Table 4.2: Attendances at Aberdeen Corporation Ante-Natal Clinics

Year	Number of new clients	Total attendances	Average number of attendances per client
1964	3,737	24,148	6.4
1965	3,336	23,751	7
1966	653	5,371	8.2
1967	1,589	9,130	5.7
1968	1,113	9,459	8.5

(Source: ACA, DD29/22, Medical Officer of Health Report, 1968, p. 8)

Table 4.3: Attendances at Aberdeen Corporation Post-Natal Clinics

Year	Number of clients	Number of attendances
1964	1,892	2,449
1965	2,001	2,486
1966	633	799
1967	985	1,180
1968	982	1,384

(Source: ACA, DD29/22, Medical Officer of Health Report, 1968, p. 8)

Edinburgh Corporation also noted a decrease in attendances in the latter part of the period. In considering the decrease in numbers attending corporation clinics, the author of the Review of the Activities of the Corporation for the year 1971-1972 commented that ‘although these figures are a decrease on those of previous years they are more than compensated by the 11,489 attendances, of which 1,402 were new cases which were seen by the health visitors in general practitioners’ premises’.¹³⁴ Although ante- and post-natal services were relocated to GP surgeries and hospitals, some services were increasing and evolving to create new services previously not provided. Within Dundee it was recognised, by 1966, that the child health clinics were increasing in popularity as the number of children attending them increased. This is reflected in the increased figures for immunisation within the area.¹³⁵ The percentage increase in attendances at the clinic was 21 per cent for the period 1963-67.¹³⁶ By 1968 two more clinics had been opened in Dundee, and these not only included the child health services, but also a play area for disabled children who attended once a week.¹³⁷ The services for disabled children were further developed when, in 1969, Comprehensive Assessment Centres were established to diagnose and treat any disabilities.¹³⁸ Therefore, over the period up until the reorganisation of 1974, Dundee was extending its child health services with new clinic services and co-operation with hospitals and GPs. As the number of home confinements declined over the period, Dundee considered employing midwives on maternity nursing care of women who

¹³⁴ ECA, City and Royal Burgh of Edinburgh, *Review of the Activities of the Corporation*, For the year 1971-72, p. 161.

¹³⁵ DCA, *Dundee Medical Officer of Health Report*, 1966, p. 70.

¹³⁶ DCA, *Dundee Medical Officer of Health Report*, 1967, p. 69.

¹³⁷ DCA, *Dundee Medical Officer of Health Report*, 1968, p. 61.

¹³⁸ DCA, *Dundee Medical Officer of Health Report*, 1969, p. 55.

were discharged from hospital or to assist with the ante-natal care of women placed under the care of their GP by the hospital.¹³⁹ Further developments included 'at risk' registers, family planning clinics and cervical screening for mothers. As their influence in areas such as midwifery was eroded by the increasing prevalence of hospital births, the local authorities shifted their health services priorities to incorporate new ways of consolidating their services and provide a greater range of health services within their area.

Despite the problems of accommodation for expectant mothers, discussed earlier in the chapter, increases in other services were achieved within Glasgow on similar lines to those seen in the other three cities. Although the number of midwives employed by Glasgow decreased over the period, the number and range of clinics increased to include clinics for the assessment of infants for mental and physical disabilities in 1962.¹⁴⁰ Glasgow Corporation also held mothercraft classes, family planning clinics, an 'at risk' register, cervical cytology tests held at ante- and post-natal clinics and centres for young disabled children.

In 1965 the Medical Officer of Health for Glasgow, William Horne, noted the changes in the maternity and child welfare services provided, as did the Medical Officers of Health of the other cities. Horne recognised that child welfare especially had become a specialised area which branched out into child development, psychiatry and mental deficiency. Child Welfare Staff were given further postgraduate training in these areas, which was appreciated by the large numbers of mothers attending child welfare clinics.¹⁴¹ Although by the end of the period the number of home births had fallen from 5,718 cases in 1960 to 342 cases in 1972, the midwives were still an important part of the care of mothers and newborn babies and the training of student midwives from the hospital maternity units.¹⁴² Glasgow therefore followed the trend of the other Cities by expanding their maternity and child welfare services despite the problems of accommodation for expectant mothers, the reduction in attendances at ante- and post-natal clinics and the necessity of home births by Glasgow mothers.

¹³⁹ DCA, *Dundee Medical Officer of Health Report*, 1963, p. 8.

¹⁴⁰ GGHB, HB38/1/28, *Glasgow Medical Officer of Health Report*, 1962, p. 15.

¹⁴¹ GGHB, HB38/1/31, *Glasgow Medical Officer of Health Report*, 1965, p. 16.

¹⁴² GGHB, HB38/1/26, *Glasgow Medical Officer of Health Report*, 1960, p. 102 & HB38/1/38, *Glasgow Medical Officer of Health Report*, 1972, pp. 66-7.

By the end of the period, when health boards took over the administration of all health services, there were 610 maternity and child welfare clinics in use; clinics were also held in 74 nurses' houses, seeing 274,200 patients throughout Scotland.¹⁴³ The Scottish Home and Health Department's 1974 report commented that local authority child health services were crucial in assessing the health of children. Furthermore, as maternity services were increasingly orientated towards the hospital, child health services became more concentrated and specialised under the local health authorities.¹⁴⁴ Consequently, the role of local authorities within the maternity and child welfare sphere was crucial in providing domiciliary care for the mother and specialist care for the child. The area of maternity and child welfare services therefore provided an avenue for local authorities to regain some specialisation within the health services.

Changes and expansion also took place in the home nursing and health visiting services. Table 4.4 highlights the range of services provided by health visitors and the distribution of work throughout the different patient categories such as expectant mothers, children under 5, patients with mental health problems, and patients with infectious diseases. As is shown in Table 4.4, the health visitor's work consistently focussed on children, expectant mothers and the elderly throughout the period. The change from expectant mothers to the elderly emerges clearly.

Table 4.4: Distribution of Work by Health Visitors, 1963 – 1974: Scotland (percentage of total number of visits per year)

	Percentage of total number of visits per year									
	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972
Expectant mothers	4.76	4.60	4.60	4.20	4.29	3.67	3.65	3.65	3.49	3.22
Children under 5	75.20	75.83	75.90	76.14	76.13	75.90	74.54	72.60	71.00	68.66
School children	2.68	2.57	2.66	2.56	2.58	2.66	2.74	2.49	2.78	3.27
Persons aged 65 and over	5.00	4.87	5.29	6.36	7.01	7.93	9.61	11.88	13.28	16.07
Mental health care and after care	0.95	1.22	1.42	1.48	1.50	1.73	1.74	1.33	1.35	1.21
Other hospital after care	0.48	0.56	0.51	0.58	0.73	0.72	0.80	0.69	0.76	0.86
Tuberculosis households	5.85	4.13	4.00	3.30	2.99	2.33	1.93	1.60	1.47	1.29
Other infectious diseases	0.44	1.05	0.36	0.26	0.34	0.37	0.46	0.61	0.63	0.55
Other	4.50	5.12	5.20	5.08	4.84	4.60	4.48	5.05	5.14	1.19
Total Number of Visits	2,349,500	2,408,000	2,322,500	2,223,500	2,187,000	2,137,000	2,039,000	2,027,000	2,032,000	1,969,000

(Source: Department Scottish Home and Health Department Annual Reports, 1963 – 1972)

Despite staff shortages, developments were made in the health visiting and home nursing services. The nature of the developments, however, depended on the area, and there were differences in services across the four cities. The home help service and clinics held by

¹⁴³ Scottish Home and Health Department, *Health Services in Scotland Reports for 1972*, (1973), Cmd 5323, pp. 47-8.

¹⁴⁴ Scottish Home and Health Department, *Health Services in Scotland Reports for 1974*, (1975), Cmd 6052, p. 40.

home nurses served a large number of patients. In Edinburgh in 1961, for example, the clinics received 2,339 patients giving out 8,193 treatments, and by 1965 7,545 treatments were given to 2,604 patients.¹⁴⁵ The services also provided weekend care and night nurses to patients in the Edinburgh area. The health visitors assisted three groups of family doctors at ante-natal clinics held within their surgeries.¹⁴⁶ Within Edinburgh, Corporation staff were also involved in a health centre at Sighthill. This was a great improvement in coordination compared with the 1950s.

The Home Nursing and Domestic Help services in Glasgow were also expanding during the 1960s and, although the staff was increasing, unlike Edinburgh, this was not fast enough to cope with demand for the services. In 1961 the Home Help service within Glasgow assisted 8,069 cases, the majority of which included patients with long-term illness or incapacity; while the Home Nursing service paid 328,063 visits during the year.¹⁴⁷ Night sitter services were also available for patients with severe illness who were unable to be left alone at night.¹⁴⁸ There was some co-ordination between the local health authority in Glasgow, the hospital and voluntary services.

By 1969 the face of local health authority services changed. Due to the Social Work Act in 1968, services such as mental health after-care, the home help service and the day and residential nurseries came under the remit of the newly formed Social Work Department. Within Glasgow, however, mental health after-care was provided by the health department, as there was a lack of staff who could undertake such work.¹⁴⁹ Glasgow continued to increase the attachment of nurses to GP practices and opened its first family planning clinics, which were attached to cervical cytology clinics, within the City.¹⁵⁰ While some services moved, expanded or stayed the same, others ended. For example, 1970 saw the demise of one evening club for patients with mental illness due to lack of staff, both hospital and local health authority.¹⁵¹ The early 1970s saw Glasgow providing a range of services through health centres, district nurses attached to GP practices, a range of clinics, centres for disabled children and mental health services. The co-ordination between

¹⁴⁵ ECA, SL27/2/31, *Edinburgh Mother and Child Welfare Scheme*, 1961, p. 30 & SL27/2/35, *Edinburgh Mother and Child Welfare Scheme*, 1965, p. 72.

¹⁴⁶ *Ibid*, 1961, p. 33.

¹⁴⁷ GGHB, HB38/1/27 *Glasgow Medical Officer of Health Report*, 1961, p. 10.

¹⁴⁸ GGHB, HB38/1/28, *Glasgow Medical Officer of Health Report*, 1962, pp. 140-1.

¹⁴⁹ GGHB, HB38/1/35, *Glasgow Medical Officer of Health Report*, 1969, p. 13.

¹⁵⁰ *Ibid*, pp. 13 & 75.

¹⁵¹ GGHB, HB38/1/36, *Glasgow Medical Officer of Health Report*, 1970, p. 60.

Glasgow Corporation and the other facets of the NHS seemed extensive and effective during this period. Yet, some problems which plagued the NHS from its inception were not solved before the reorganisation of the 1970s. In light of problems such as staffing and finance, the increased provision of local health authority services was due in large part to the innovative thinking of Medical Officers of Health and the dedication of their staffs.

In the later 1960s there were further legislative measures with regards to the health services. In 1968 the Health Services and Public Health Act received Royal Assent. The Act covered England, Wales and Scotland including statutes which covered all of these areas and statutes which only covered England and Wales or Scotland. The Act made amendments to hospital, GP, and local health authority services along with other areas such as finance. With regards to local authorities, the Act provided for extensions in midwifery, health visiting and district nursing services; it made the provision of home helps a duty of the local authority; it gave local authorities power to provide family planning advice and contraception; it removed deficiencies in the Nurseries and Child Minders' Regulation Act, 1948, and it required local authorities to pay compensation to persons at work who suffer loss as a result of their compliance with a written request from a medical officer of health to stay off work to help prevent the spread of infectious disease or food poisoning.¹⁵² These extensions to the local health authority's work were in direct contrast to the centralisation and regionalisation of the 1974 reorganisation which was under discussion at the same time. The extensions to local health authority work may have given some local authorities the hope that their influence within the health services would not diminish, but the Medical Officer of Health for Dundee noted 'some unrest by local authorities who regard the proposal as a further attempt by Central Departments to weaken their influence on local public health matters'.¹⁵³ Consequently, by the late 1960s the local health authority staff were acutely aware of the reorganisation proposals and the impact they were likely to have on their place within the NHS.

By the early 1970s the number of health visits was decreasing from 2.4 million in 1963 to less than 2 million in 1972 (Table 4.4). Nevertheless, the work continued up until 1974 was for patients such as children under 5, the elderly and expectant mothers. Although local authorities lost their visitation services in the 1974 reorganisation of the NHS, the

¹⁵² *Health Services and Public Health Act Chapter 46*, pp.7-54.

¹⁵³ DCA, *Dundee Medical Officer of Health Report*, 1968, p. 5.

impact of these services across the period 1936 to 1974 was integral to local authority services and the domiciliary care they provided.

The period from 1960 until 1974 saw a development within the health services generally which focussed on the hospitals but also included GP and local health authority services. The development of local health authority services varied by local health authority and the variations depended on a number of features: the flexibility of the health and welfare committee within the local health authority; the responsiveness of the Medical Officer of Health; and the shifting environment in terms of finances and availability of staff. It is clear that even with limited finances and staff, local health authorities were inventive in their expansion of services even though enhancements came in varying degrees and time frames. Lowe argues

the conclusion drawn by government from the experiences of the 1960s was not that centralized planning was defective but rather that, in the light of the failed community care programme, greater unification and centralization was needed. Community care was the responsibility of local government, which given its independent financial and electoral base, could not easily be brought into line. Accordingly one of the principle objectives of the major reorganization of the NHS which was finally implemented in 1974 was the integration of the remaining local government health services into the NHS.¹⁵⁴

Within England and Wales the failure of the community care programme provided the stimulus for reorganisation. Charles Webster, however, argues that it was the ‘failure to resource the hospital plan at a realistic level...which led Scotland to take a lead in discussions on NHS reorganisation’.¹⁵⁵ By the reorganisation of 1974 local health authorities in England and Wales were still providing grass root services but their position within the NHS was uncertain as their independence in the health services was uncontrollable. Increased control over the NHS by Whitehall was considered the only course of action. The Scottish Home and Health Department had, however, retained considerable control over the local health authorities due to the hierarchical nature of their relationship and the treatment of local health authorities as service providers rather than an elected body. With regards to local authority health services, the 1960s, proved to be a period of mixed messages. On one hand extensions in local authority health services were promoted through legislation such as the Health Services and Public Health Act, 1968;

¹⁵⁴ Lowe, *The Welfare State in Britain*, p. 195.

¹⁵⁵ Webster, *The Health Services Since the War*, Vol II, p. 195.

while, on the other, the Social Work (Scotland) Act, 1968, removed certain functions from local authority control.

Conclusion

The period 1960 to 1974 was a time of both developing the health services and of the growing recognition that reorganisation of the administrative structure of the NHS was required. As has been explored within this chapter, developments in all areas of the health services occurred but especially within local authority mental health services. The advances in each local health authority area were dependent on: first, the willingness of the health and welfare department to support their Medical Officer of Health's developments; second, the expansionist ideas of the Medical Officer of Health; and, finally, the available finances and staff. In many cases the expansion of services was thanks to innovative approaches by the Medical Officer of Health for a particular area, for example Ian MacQueen in Aberdeen. Specialisms, such as services for maternity and child welfare, developed within the local health authority sphere. Developments came in varying degrees and time scales but at the time of the NHS reorganisation in 1974, local health authorities were still at the forefront of grass root services, including maternity and child welfare, home nursing and, in the case of Glasgow, mental health services.

Despite expansion within the local health authority sphere, the Scottish Home and Health Department remained concerned about the lack of integration among the tripartite services inherent in the Scottish NHS. The SHHD continually encouraged co-ordination through memoranda and circulars. Co-ordination was a slow process during the 1960s, but a number of examples of co-ordinated services developed as the decade progressed. Local health authorities and hospitals co-ordinated services through the secondment of health visitors to specialist hospital units such as maternity units, mental health units and geriatric units. Similarly hospitals benefited from their nursing staff's involvement in training schemes through the local health authority. Co-ordination between the hospitals and local health authorities not only benefited patients, but also created nursing staff with a rounded view of nursing health care provision in both institutional and community spheres. Further co-operation was also established with GP practices. Health visitors were seconded to GP practices to provide services, most notably for maternity and child welfare. The development of health centres was also seen, by the Scottish Home and Health Department, as an economical way of co-ordinating the GP and local authority health services. Although the administration of some health centres was delegated to local

authorities, the administration of the GP service still remained separate from the local authorities. This example shows that the SHHD reneged on the promises made to local authorities of increased administrative powers, once the medical profession became used to working in the NHS. The assurances given in the 1940s were therefore means of gaining agreement over the NHS (Scotland) Act, 1947. Nevertheless, co-ordination between GPs and local authorities was increasing throughout the 1960s and the creation of health centres furthered initiatives undertaken in this period. Furthermore, many local health authorities utilised the services of voluntary organisations, especially in the fields of mental health and services for the elderly, to provide day care centres and various home help services. Therefore, although co-operation between the health services was not to the degree envisioned within the 1947 Act, the local authorities, GPs and hospitals were coming into greater contact with each other and co-ordinated certain aspects of the services they provided to a greater extent in the 1960s than in the 1940s.

Although the co-ordination experienced from 1960 to 1974 also clarified certain divisions of responsibility, some issues still arose over the clear lines of service provision. Issues were evident within local authorities as well as between the different administrative areas of the NHS. For example, the supply of nursing equipment was an issue which arose from the inception of the NHS, and it was not resolved until the early 1960s when it was agreed that the hospital authorities would provide equipment which was specially made for a patient or which would allow the early release of a patient from hospital. Even after many years of the NHS the tripartite structure was still not seen to be working effectively and questions arose over the lines of responsibility and co-ordination. The lack of effective administration through the tripartite service, combined with the perceived failure of the Hospital Plans, led the Scottish Home and Health Department to review the administration of the NHS with the intention to reorganise.

The period 1960 to 1974 therefore saw many developments and changes within the NHS. Local health authorities, after many years of trying to consolidate and develop a niche within the preventive health services were no longer an effective force within the NHS. Legislation, such as the Social Work (Scotland) Act (1968), eroded more of the local health authorities' responsibilities as the mental health services were passed to the newly formed social work departments. Furthermore, the policy network removed any influence the local health authorities once had in policy formation for the health services as they were seen as service providers and the Scottish Home and Health Department exercised tighter control of the local health authorities than their Westminster colleagues. The

bargaining power of local authorities diminished in the 1950s and by the 1960s the Scottish Home and Health Department no longer saw the need to include local authorities in the policy network. The costs of excluding the local authorities from the network no longer outweighed the return. The hierarchical relationship which the Scottish Home and Health Department initiated during the negotiations over the NHS continued to provide a means of control of the local health authorities in their role within the NHS.

The period from 1960 to 1974 also began the process of reorganisation within the health services. For local authorities this was a period of uncertainty as proposals for reorganisation not only withdrew them from health service provision, but also redefined their role within the structure of government. Chapter 5 will therefore consider the reorganisation of the NHS, which culminated in the NHS (Scotland) Act, 1972.

Chapter 5

Reorganisation of the Scottish NHS (1974)

Introduction

The Department of Health for Scotland, in the 1960s recognised that the tripartite structure of the NHS was failing to produce the co-ordination necessary to provide a comprehensive health service. Reorganisation was the buzzword of the 1960s. The Department of Health for Scotland itself was reorganised in 1962 to become the Scottish Home and Health Department. Also the 1960s witnessed the drawing up of legislation for the reorganisation of local government which, although not implemented until 1975, influenced the reorganisation of the NHS. The reorganisation of the NHS was an opportunity for local authorities to restate their case, which they argued in the 1940s, to become the sole administrator of the health services. The reorganisation of 1974, however, effectively removed the health services from local authorities and created new regional health boards. The outcome was the culmination of many years of slow removal of local authorities from the health sphere to create more centralised power within the Scottish Home and Health Department. This fulfilled the wishes of the most dominant member of the policy network, the medical profession. This chapter will, therefore, consider: the impact of local authority reorganisation; NHS reorganisation in both England and Scotland; the Scottish Home and Health Department negotiations with Westminster; and the Scottish Home and Health Department negotiations with Local Authorities on the National Health Service (Scotland) Act, 1972.

Local Authority Reorganisation

Reorganisation was not limited to the health services. Local government reorganisation was also undertaken. Robert Leach and Janie Percy-Smith suggest that the 1960s was a time of public administration rather than public management, which came later in the period.¹ Local authorities consisted of departments, developed along functional lines, which implemented the policies of central government and the local authority. The professional values of the local authority administrative staff shaped the day-to-day running of each department and there was little room for change.² Nevertheless, there were some local authority staff who had visionary ideas and were able to implement them, with regard to the provision of healthcare, as well as other services. Rodney Lowe argues that Scottish local government reform was initiated at Whitehall by the Scottish Office due to

¹ R. Leach and J. Percy-Smith, *Local Governance in Britain*, (Houndmills, 2001), p. 156.

² Ibid, p. 157.

its frustration at the local authorities' inability 'to provide a focus for economic planning'.³ The period leading up to the 1970s was seen as one in which local authorities were financially imprudent and provided uncoordinated services which were eating away at the public purse.

Reorganisation of Scottish local authorities was considered by the Scottish Office from the early 1960s. The Scottish Development Department published *The Modernisation of Local Government in Scotland* in 1963 to set out the proposals for reform.⁴ The paper stated that

the Government have been examining the present structure of local government in Scotland in order to see how far it matches up to the needs of the expanding Scotland of to-day and tomorrow. There have been many changes in the social and economic life of the country since the present system was introduced in 1929. There will be further changes as a result of the Government's policy for strengthening and stimulating the Scottish economy. Local authorities will have a vital part to play if this policy is to succeed.⁵

The paper was published to stimulate discussion between the Scottish Office and the local authorities on the form of the reorganisation. The paper proposed a two-tier system based on enlarged county authorities, which would be responsible for major services such as education, health and welfare, fire and police.⁶ The second tier would be based on the amalgamation of burgh and rural councils, which would be responsible for local services such as allotments, coast protection, flood prevention and parks.⁷ The system, however, was dependent on discussions with the local authority associations. The Government set up at the time a Steering Committee on Local Government Re-organisation in Scotland. Its membership included the Convention of Royal Burghs, the Association of County Councils in Scotland, the Scottish Counties of Cities Association and the District Councils Association in the 1960s.⁸ The list of local authority associations had increased since the discussions over the NHS proposals in the 1940s (see Chapter 2), to include the District

³ R. Lowe, *The Welfare State in Britain Since 1945*, (Houndmills, 2005), p. 102.

⁴ Scottish Development Department, *The Modernisation of Local Government in Scotland*, (June 1963), Cmnd. 2067, p. 3.

⁵ *Ibid*, p.3.

⁶ *Ibid*, p. 8.

⁷ *Ibid*, p.8.

⁸ ECA, SL169/1/26, Association of County Councils in Scotland, *Report by Secretary on the Meeting of the Steering Committee on Local Government Re-organisation in Scotland*, (1965), p. 307.

Councils Association.⁹ The Committee was established in 1963 to consider the form local government reorganisation would take within Scotland.

The Secretary of State for Scotland, Willie Ross, attended the meeting of the Steering Committee on Local Government Re-organisation in Scotland, in 1965. In opening the meeting, the Secretary of State commented that 're-organisation of local government in Scotland was one of the most difficult and most important problems which fell to be tackled'.¹⁰ Reorganisation of local government would be difficult as the local authority associations wanted to be involved in the policy-making process. As Scotland was developing quickly in areas such as water services, planning had to be positive and not limited to 'the negative attitude arising out of the 1947 Act'.¹¹ Therefore, the reorganisation of local government would overcome any co-ordination problems remaining after the Local Government (Scotland) Act, 1947, and would create a positive environment in which local government planning could proceed in the future.

At this meeting, the local authority associations voiced their views about the way in which local government reorganisation should proceed. The Convention of Royal Burghs thought that any reorganisation of local government should be undertaken by experienced members and officials of local authorities.¹² Willie Ross reasoned that a 'comprehensive and authoritative review of the structure of local government' was required.¹³ The District Councils Association recommended that a Royal Commission be established to consider local government reorganisation.¹⁴ Furthermore, the District Councils Association argued that contrary to the opinion of the Convention of Royal Burghs, a Royal Commission did not necessarily exclude local authority representatives in the reorganisation process.¹⁵ The Association of County Councils required further information before they could comment on the reorganisation process to be undertaken. All of the Associations saw the need for change and agreed that the most pressing issue was that of local government finance. As

⁹ The District Councils' Association for Scotland did exist prior to this time; the exact date of establishment is unknown. It was not until the 1960s that the Association was mentioned within the archives for the NHS.

¹⁰ Ibid, p. 302.

¹¹ Ibid, p. 302.

¹² Ibid, p. 303.

¹³ Ibid, pp. 302-3.

¹⁴ Ibid, p. 304.

¹⁵ Ibid, pp. 304-5.

has been noted in this chapter and previous chapters, financial limitations hindered local authorities in the development of services, including their health services.

The *Royal Commission on Local Government in Scotland* was established in 1966 ‘to consider the structure of local government in Scotland in relation to its existing functions’.¹⁶ The Royal Commission had nine members including local authority representation through James McBoyle, retired Clerk for Midlothian County Council, and Hugh Turner MacCalman, Bailie for Clyde Valley.¹⁷ Far from excluding local authorities from the process of reorganisation, the Royal Commission not only received evidence from each of the local authorities (see Appendix 1) but also visited local authorities throughout Scotland, London and Scandinavia.¹⁸ The Royal Commission saw the reorganisation of local government as a means of combating the perception that local government within Scotland was weak. The Royal Commission Report stated that

local government is less significant than it ought to be. It lacks the ability to speak with a strong and united voice. Local authorities have come to accept, and even rely on, a large measure of direction and control from the central Government. The electorate are aware of this. They are increasingly sceptical whether local government really means government. The question is being asked – and it is a serious question – whether, as an institution, local government is worthwhile maintaining at all.¹⁹

The Royal Commission identified the lack of unity between the local authorities which had undermined their ability to assert authority in the policy formation and implementation of the NHS (Scotland) Act, 1947. The statement also suggests that local authorities had been subject to increased central control. The subordinate relationship between the Scottish Home and Health Department and the local authorities demonstrates the increased central control. Local authorities were seen as service providers by the Scottish Home and Health Department and, in the years leading to the reorganisation of the NHS, were slowly removed from participation in the delivery of the health services. It was this reliance on the direction of central government that the Royal Commission, in part, wanted to eliminate through the reorganisation process.

¹⁶ The Rt. Hon. Lord Wheatley (Chairman), *Royal Commission on Local Government in Scotland 1966-1969*, (September 1969), Cmnd. 4150, p. 4.

¹⁷ The full list of members are: The Rt. Hon. Lord Wheatley, Thomas Fraser (MP), Ames Lyall Imrie, James McBoyle, Margaret Harvie Anderson (MP), Henry Ballantyne, Patrick Connor, David Russell Johnston (MP) and Hugh Turner MacCalman.

¹⁸ Ibid, p. 5.

¹⁹ Ibid, p. 1.

The Local Government (Scotland) Act, 1973, was based on the *Royal Commission on Local Government in Scotland* (the *Wheatley Report*), which recommended a two-tier local government structure of regional and district authorities. The Royal Commission recommended that seven regional authorities and 37 district authorities were necessary to reorganise Scottish local government.²⁰ In preparation for the reorganisation, local authorities began to plan the way in which they would restructure to incorporate the changes. Leach and Percy-Smith note that initially the response to reorganisation, through the Recliffe-Maud Report of 1967, which was set up to consider local government reorganisation in England and Wales, was to 'try to reduce the influence of individual departments and their associated professional groups and increase efficiency largely through the mechanism of centralising and concentrating bureaucratic power'.²¹ The report of the Working Group on Scottish Local Government Management Structures, *The New Scottish Local Authorities: Organisation and Management Structures*, shows that centralisation was a feature, but the ability of local authority members to increase their power in decision-making and planning was a priority.

The local authorities appointed the Paterson Committee, in 1971, which considered the reorganisation of local government with the support of the Scottish Office. As shown in Appendix 2, the Paterson Committee's membership was largely taken from the Local Authority Associations. The Report was published when the Local Government (Scotland) Bill had gone through its third reading in the House of Commons.²² The Committee was to consider the way in which local authorities could restructure in light of the new organisation of regional and district tiers. The Report pointed out that the situation leading up to the reorganisation was one of policy formulated for individual departments with the finance committee trying to co-ordinate the local authorities' activities.²³ A new approach was deemed necessary by the committee and the Report recommended a corporate approach. The corporate approach would allow effective decision-making by elected members of the authority and provide a unified approach to meeting community needs.²⁴ Finally, the committee suggested a range of structures which could be implemented by the new local authorities but recognised that this would depend on many factors such as size of

²⁰ Ibid, pp. 15-16.

²¹ Leach and Percy-Smith, *Local Governance in Britain*, p. 157.

²² Working Group on Scottish Local Government Management Structures, *The New Scottish Local Authorities: Organisation and Management Structures*, (1973), p. xiv.

²³ Ibid, p. 10.

²⁴ Ibid, pp. 26-8.

the authority. What is clear from this Report is that the local authority associations welcomed the new reorganisation of local government and thoroughly considered measures which would enhance efficiency and draw together the different facets of the authorities.

The Local Government (Scotland) Act, 1973, created a two-tier system of nine regions with 52 districts; and the three island areas of Orkney, Shetland and the Western Isles (see Appendix 3).²⁵ The Act stated that on the 16th May 1975, all counties of cities, counties, large burghs, small burghs and districts would no longer exist.²⁶ The new regions would be responsible for a range of services such as education, housing, roads, police, fire services, water, public transport and public health. It is interesting to note that at this stage the health services were omitted, as reorganisation with the NHS was well underway. The Act states that the public health department of the new regions applied to the following enactments:

- (a) The Public Health (Scotland) Act 1897;
- (b) The Alkali, Etc., Works Regulation Act 1906;
- (c) The Public Health (Scotland) Act 1945;
- (d) Part I of the Prevention of Damage by Pests Act 1949;
- (e) The Rag, Flock and Other Filling Materials Act 1951;
- (f) The Clean Air Acts 1956 and 1968;
- (g) The Noise Abatement Act 1960;
- (h) The Health Services and Public Health Act 1968, except section 65 thereof.²⁷

After a long tradition of local health authority services, the 1973 Act officially removed local authorities from the majority of the health services they had previously provided. Through local government reorganisation, the Scottish Office completed the process of the removal of local authorities from the health services, which had begun in the 1940s.

²⁵ Scottish Office, *Local Government (Scotland) Act 1973, Chapter 65*, (1973), pp.150-1.

²⁶ Ibid, p. 2.

²⁷ Ibid, p. 82.

Consequently, the Act redeveloped the local authority into a regional structure which answered to the Scottish Office.

Within England and Wales, reorganisation of local government was also undertaken. The initial reform proposals, by the Royal Commission chaired by Redcliffe-Maud, would have seen the creation of 58 local authorities with responsibility for all the services within their area. Rodney Lowe argues that the Commission ‘fell victim to party politics’.²⁸ The Commission, set up by a Labour Government, proposed to strengthen the county borough system of local government which was a Labour stronghold. The incoming Conservative Government was not happy with such an outcome and rejected the proposals as they would have caused the demise of the county councils, which were Conservative strongholds.²⁹ The change of Government significantly affected the reorganisation of local government. The outcome was that the Local Government Act, 1972, kept in place a two-tier system, by increasing the size and reducing the number of local authorities while keeping in place the county council level. Lowe goes on to argue that ‘this perpetuated the old administrative antagonisms and the damaging divisions between interrelated services’.³⁰ The political antagonisms, to the extent in England and Wales, were not evident within the Scottish reorganisation. Within Scotland, the Scottish Office had far greater control over the local authority reorganisation and was autonomous to a large extent, as they did not get into the party political exchanges seen in England and Wales. The autonomy demonstrated in local government reorganisation, by the Scottish Office, was also evident in the reorganisation of the Scottish NHS. The aftermath of both Acts was not seen as a successful outcome by Leach and Percy-Smith, who assert that emphasis was not on integration of local government departments, but on co-ordination between relatively unrelated activities.³¹ Reorganisation for local authorities was therefore extensive and swept through the Scottish Office, including the NHS.

NHS Reorganisation

It was during the 1960s that reorganisation of local government and the NHS began. The concept of NHS reorganisation was not a new idea and had been considered in committee enquiries into the cost of the NHS. On reorganisation, the Guillebaud Report stated:

²⁸ Lowe, *The Welfare State in Britain*, p. 102.

²⁹ *Ibid*, p. 102.

³⁰ *Ibid*, p. 102.

³¹ Leach, & Percy-Smith, *Local Governance in Britain*, p. 158.

We believe therefore that unless an overwhelming case could be made out for any basic reorganisation of the Service, it would be in the best interests of the Service to leave the present administrative structure undisturbed. We might add that this view was shared by the great majority of authorities and organisations who submitted evidence to the Committee.³²

The Committee felt that any new body taking over the NHS would have to go through a process of adjustment and adaptation already gone through by the administrative bodies within the NHS. Furthermore, the Committee did not support any moves which would have separated the health and welfare functions of local authorities or create further divisions within public health duties. The Committee thought any reorganisation of the NHS which would cause further disruption would be damaging. Yet, calls for a unified health service within the UK continued throughout the period with the Porritt Report (1962), Gillie Report (1963), the Seebohm Report (1968) on *Local Authority and Allied Personal Social Services* and the Redcliffe-Maud Report (1969). Charles Webster singles out the Porritt Report as particularly important for reorganisation:

Although not widely publicized, or particularly well received even within the medical profession, the Porritt Report became the effective catalyst to furthering the case for reorganization.³³

As will be discussed below, the Porritt Report became the main vehicle for reorganisation, especially within Scotland, where its recommendations corresponded with the aims and objectives of the Scottish Home and Health Department's plan for reorganisation. The reports listed above, apart from the Porritt Report which rejected local authority administrative control of the health services, advocated unified systems under either the GP service or the local health authorities. Such moves were the very ones the Guillebaud Report in the 1950s thought to be disadvantageous.

By the 1960s, the NHS had a low political priority. Politicians were choosing to advance their careers on other issues and, as Webster argues, left the NHS in the hands of a few 'uninfluential parliamentarians'.³⁴ Other factors, such as economic constraints and small Government majorities, which hindered policy initiatives in the health sphere, as they were seen as controversial.³⁵ Nevertheless, the Ministry of Health continued to follow the

³² Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*, (1956), Cmd 9663, p. 53.

³³ C. Webster, *The National Health Service: A Political History*, (Oxford, 2002), p. 63.

³⁴ *Ibid*, pp. 67-8.

³⁵ *Ibid*, p. 68.

findings of the Guillebaud Report, arguing that although co-ordination between the health service administrators was difficult, it was not considered a valid reason for reorganisation.³⁶ Webster suggests that the Ministry of Health failed to take command of the reorganisation of the NHS in a time of consensus. Webster points out that consensus was reflected in two reports on the organisation of work within hospitals in Edinburgh and London both of which concluded that continuity of care and co-ordination were unlikely to be achieved without administrative amalgamation.³⁷ Furthermore, Webster states that because the Ministry of Health did not take the lead, NHS reorganisation was discussed in the same manner as the initial Act with the same actors.³⁸ The actors included the local authorities and medical profession who had not deviated from their original stances: local government wanted overall control of the NHS, while the medical profession did not want to be under their authority. The basic arguments of all parties involved in the reorganisation of the NHS had not moved on from the 1940s. Consequently, the strength of the BMA remained, while local authorities were increasingly devoid of a convincing argument which would see the NHS placed under their administration.

Within England, Audrey Leathard has noted, the reorganisation of 1974 closely followed the findings of the Porritt Report (1962), which advocated a system of unified area health boards.³⁹ It is important to note that the Porritt Report was undertaken by medical professionals and represented nine medical organisations.⁴⁰ The Report proposed that the NHS be unified under area health boards, which would each provide health services for a defined area; a national advisory committee would be established by representatives chosen by the medical profession rather than the Minister for Health. The new area health boards would administer all of the health services, apart from the teaching hospitals which would report directly to the Ministry of Health. Furthermore, each health board would have sub-committees to run each of the services on a day-to-day basis which again would have representation from the medical profession.⁴¹ The Porritt Report consequently provided the medical profession with the unified service they wanted, under a new separate administrative body.

³⁶ Ibid, p. 87.

³⁷ Ibid, p. 94.

³⁸ Ibid, p. 89.

³⁹ A. Leathard, *Health Care Provision: Past, Present and Future*, (London, 1990), p. 53.

⁴⁰ C. Webster, *The Health Services Since the War*, Vol. II, (London, 1996), p. 324.

⁴¹ B. Watkin, *The National Health Service: The First Phase 1948 – 1974 and After*, (London, 1978), p. 135.

In 1968 and 1970, the Labour Government produced two Green Papers incorporating completely different plans. The Minister of Health, Kenneth Robinson, was unwilling to discuss the options for reorganisation with other bodies. Robinson opted for the 1968 Green Paper, as he thought it would be acceptable to both the medical profession and local government as well as being widely accepted within Scotland.⁴² Reorganisation plans for Scotland were encouraged to conform to the national priorities placed within the Green Paper. The central planning from Westminster gave the impression that the autonomy of the Scottish Home and Health Department, which had been in place for over 20 years, was being eroded. The initial restructuring proposed through the first Green Paper for England and Wales would create 40 to 45 area health authorities responsible for hospital and GP services, along with some functions of the local health authorities, and would co-operate closely with the social work departments of local authorities.⁴³ There were criticisms of the first Green Paper's proposed removal of the regional tier of administration which was thought to be crucial to NHS development. Additionally, the area health authorities were thought to be too small for effective planning but too big for successful administration or effective accountability.⁴⁴ Consequently, the first Green Paper was not acceptable to most parties involved in health care and a rethink of the proposals ensued.

Prior to the publication of the second Green Paper, Robinson was replaced by Richard Crossman as the Secretary of State for Social Services, which combined the health and social security departments. Crossman took a different approach to the reorganisation from that of his predecessor and undertook consultation with all of the organisations involved in the NHS.⁴⁵ During a Maurice Bloch lecture at the University of Glasgow, Crossman commented,

we are being forced in our planning into a miserable middle way. The new service will neither be taking over those local government services which are essentially community services, nor will it be taken into local government. It will still be wobbling in between. I knew it had to wobble, but I tried to wobble it as near the local authorities as I could.⁴⁶

Crossman was referring to the problem of successfully combining the three parts of the NHS. Health services could either be centred on the hospitals, GPs or placed within local

⁴² Webster, *The National Health Service*, p. 95.

⁴³ Lowe, *The Welfare State in Britain*, p. 196.

⁴⁴ Webster, *The National Health Service*, p. 96.

⁴⁵ *Ibid*, p. 97.

⁴⁶ R.H.S Crossman, *A Politician's View of Health Service Planning*, (Glasgow, 1972), pp. 24-5.

authorities. In making this statement Crossman was identifying an important shift away from medical control of the health services back towards local authority control. Crossman felt the problem with the hospital orientation was that the Regional Hospital Boards were 'a little remote from public needs, and remote from public criticism'.⁴⁷ Yet, in placing the health services with local authorities, Crossman felt that local rates could not cover the cost of the NHS and such a solution would not be endorsed by the medical profession.⁴⁸ Thus, Crossman acknowledged the power of the medical profession within the development of the NHS and the difficult position the Government was in when attempting to produce proposals for reorganisation which would be suitable for all parties and create a uniform service throughout England and Wales. It is notable that at this stage the Scottish reorganisation was not included in the proposals.

The second Green Paper proposed that there would be Regional Health Councils to act as a link between the 90 area health authorities and the Department of Health and Social Security. The health authorities would be responsible for the health services and be independent from local authorities although their boundaries would match those of local government.⁴⁹ Ruth Levitt and Andrew Wall argue that the second Green Paper not only revealed Richard Crossman's ideas but also answered some of the criticisms of the first Green Paper.⁵⁰ Although this was the continuation of a Labour Government, the changes in cabinet personnel had a significant effect on the reorganisation process for the NHS in England.

Further problems occurred for the process of reorganisation when a Conservative Government was elected in 1970. The new Conservative Government was unable to dismiss the reorganisation of the NHS. According to Webster 'the Green Papers had aroused the expectation that the health service would be reorganized, and these had already created uncertainty and adversely affected morale within the NHS'.⁵¹ The expectation for reorganisation had been in place for a number of years and the Conservative Government could not shy away from the reorganisation process. The Conservative Government produced a consultative paper which proposed that local authority health services be built into the new area health authority duties along with hospitals, health centres and

⁴⁷ Ibid, p. 24.

⁴⁸ Ibid, p. 24.

⁴⁹ R. Levitt & A. Wall, *The Reorganised National Health Service*, (London, 1992), p. 16.

⁵⁰ Ibid, p. 16.

⁵¹ Webster, *The National Health Service*, p. 100.

community nursing. Furthermore, GPs would be administered separately, while no decision was made on the incorporation of the school health service within the new structure. The regional tier of administration would be much stronger than previously envisaged and have control over planning, finance and building.⁵² Consequently the scheme proposed by the Conservative Government was far more complicated than previous proposals. Webster argues that

the entire planning process was marked by discord; although resistance to the final scheme died away, this was as much indicative of inaction as positive confidence in a scheme that was to suffer the fate of being disowned almost at birth.⁵³

The outcome of the policy formation process was quite different from its original intention and the NHS Reorganisation Act, 1973, established a more complicated system than was previously envisioned. Within the new structure, the Department of Health and Social Security was responsible to Parliament for the NHS; 14 Regional Health Authorities were responsible for planning the service; 90 Area Health Authorities were established to implement policy and 200 district management teams were established to oversee the day-to-day implementation of policy.⁵⁴ The NHS was not unified under this structure as GPs, dentists and opticians were not part of the Area Health Authorities' remit and came under Family Practitioner Committees. Liaison was still required with local authorities and the managerial style of administration was not clear cut as the members of Area Health Authorities came from a variety of backgrounds in the state, local government and medical profession.⁵⁵ In practice, the reorganisation in England and Wales caused further confusion within the administration of the NHS and had not created a unified service. Audrey Leathard argues that 'far from setting off into a period of consolidation with calm and steady progress, the National Health Service eventually moved, in the view of many participants, towards crisis and chaos'.⁵⁶ The new structure did not work, and as Klein argues

essentially, therefore, the 1974 reorganisation can be seen as a political exercise in trying to satisfy everyone and to reconcile conflicting policy aims: to promote managerial efficiency but also to satisfy the professions, to create

⁵² Levitt & Wall, *The Reorganised National Health Service*, p. 17.

⁵³ Webster, *The National Health Service*, p.93.

⁵⁴ Lowe, *The Welfare State in Britain*, p. 196.

⁵⁵ *Ibid*, p. 196.

⁵⁶ Leathard, *Health Care Provision*, p. 57.

an efficient hierarchy for transmitting national policy but also to give scope to the managers at the periphery...As it turned out, the attempt to please everyone satisfied no one.⁵⁷

In essence, the reorganisation for England and Wales created a complicated administrative structure, which only brought together two parts of the tripartite administration, allowing the division between the hospital and GP services to continue. The outcome did not simplify the structure of the 1946 Act, but served to remove local authorities from the administration of the Act, an outcome the medical profession had sought in the policy formation of the 1940s.

The situation within Scotland was different. Christopher Ham notes that the lack of a regional tier of health service administration allowed the Scottish Office to deal directly with 15 health boards, which were divided into districts, whilst the GP service was integrated into the administration as a unified health service.⁵⁸ The way in which the Scottish Office developed this policy must then be examined in conjunction with the influence and reaction of Scottish local authorities. As in chapter two, local authorities were again in a position to influence the policy direction of the NHS and the power they had within its administrative structure. Charles Webster argues that

the reorganisation problem proved easier to resolve in Scotland and Wales than in England. Both the Scottish and the Welsh BMA were attracted by the Porritt scheme; in neither case was local government in a position to mount a rival bid for the control of the health service.⁵⁹

As the Royal Commission noted, local authorities were weaker within Scotland. From the 1940s through to the reorganisation of the 1970s, the bargaining power of local authorities had reduced to a point where the Scottish Home and Health Department no longer felt they had to include local authorities within the planning process of the NHS. The inability of local authorities to unite over the proposals for the NHS and its implementation also depleted their ability to exert any influence over the health services. Nevertheless, local authorities would have to be involved in the reorganisation process of the 1970s, as the health services they provided were transferred to the newly established health boards. It was within this atmosphere of reduced local authority power and uncertainty over the

⁵⁷ R. Klein, *The New Politics of the National Health Service*, (London, 1995), p. 90.

⁵⁸ C. Ham, *Health Policy in Britain*, 4th Edition, (Houndmills, 1999), p. 22.

⁵⁹ Webster, *The National Health Service*, p. 90

future of local government that local authorities attempted to secure their future within the health services.

Scottish Home and Health Department and Westminster

The Scottish Home and Health Department not only had to deal with the representative organisations within Scotland over reorganisation, but also had to liaise with the Westminster administration. As has been explored in chapter two, the territorial relations between Scotland and Westminster were undertaken by the Scottish Office, creating a special case whereby Scotland was influential not only on purely Scottish policies but also on UK wide policies which had a Scottish element. Lindsay Paterson argues that the Scottish Office ‘coordinated the pressure coming from interest groups, and bargained with the UK state for resources and an appropriate legislative framework’.⁶⁰

The relationship with Westminster was not smooth and the proposals from Scotland were questioned vigorously. Nevertheless, the autonomy of the Scottish Home and Health Department allowed it the manoeuvrability to put in place a scheme for reorganisation which suited the Scottish system. John Stewart argues that ‘the whole process of reorganization in Scotland from the late nineteen-sixties through to 1974 was marked by a much higher degree of consensus than south of the border’.⁶¹ The consensus Stewart highlights can be seen in the general aim of reorganisation and at the final stages after discussions were concluded and the Bill passed through Parliament with relative ease. However, prior to this the Scottish Home and Health Department still had the task of bringing all sides, including Westminster, together in support of its reorganisation scheme. The autonomy of the Scottish Office, according to Lindsay Paterson, came from the ability of the Scottish Office to ‘choose goals which were common throughout Britain’ and consequently retain ‘control of implementation’.⁶² Paterson goes on to point out that the networks in which policy for the Scottish health services was formed were distinctly Scottish. The Scottish Office controlled the implementation of large areas of the welfare state policies.⁶³ Therefore, policy for the Scottish reorganisation, as with the initial policy formation in the 1940s, was formulated in the policy network which included only Scottish

⁶⁰ L. Paterson, *The Autonomy of Modern Scotland*, (Edinburgh, 1994), p. 130.

⁶¹ J. Stewart, The National Health Service in Scotland, 1947-74: Scottish or British?, *Historical Research*, vol. 76, No, 193, (August 2003), 399.

⁶² Paterson, *The Autonomy of Modern Scotland*, p. 116.

⁶³ *Ibid*, p. 128.

interests, although the Scottish Home and Health Department then had to translate these to fit with the broad policy goals of Westminster.

The White Paper *Reorganisation of the Scottish Health Services* demonstrates the merging of the goals of the Government and the unique way in which Scottish health services developed. The Introduction to the White Paper stated that the proposals represented the Government's goals for reorganisation. Furthermore, the introduction merged these goals with the particular needs of the Scottish health services.

The Government accept the argument in the 1968 Green Paper in favour of a united administration of the health service, and the structure now proposed follows the broad lines set out in the Green Paper... The Government have developed certain aspects of the proposals in ways which they hope will meet some of the difficulties, and they believe that the proposals now set out in this White Paper represent a structure for a unified health service in Scotland that will be acceptable and will work, taking account of special Scottish needs and circumstances.⁶⁴

The White Paper proposed that the Secretary of State for Scotland would be responsible to Westminster for the health services in the same manner as in the 1947 Act. To advise the Secretary of State, a Scottish Health Service Planning Council and Common Services Agency would be established. The health services would be administered by 14 health boards, and they would be part of the membership on the Scottish Health Service Planning Council. Furthermore, a local health council would be established to incorporate local views about the health services from a patient perspective and would consist of, among others, local authority representatives.⁶⁵ Therefore, a single-tier structure was proposed for Scotland to create a simplified structure for the administration of the NHS. The White Paper not only dealt with the problems of co-operation between the tripartite structures of the NHS, but it also dealt with the problems encountered in the division of responsibility. In defending the proposal for a single tier structure, the White Paper states that

the original Green Paper suggested that a two-tier structure may lead to uncertainty about the division of responsibility. It is just as important for the public to know where responsibility rests as for those who are entrusted with the control of essential and expensive health resources.⁶⁶

⁶⁴ Scottish Home and Health Department, *Reorganisation of the Scottish Health Services*, Cmnd 4734, (1971), p. 5.

⁶⁵ *Ibid*, pp. 6-10.

⁶⁶ *Ibid*, p. 7.

With this statement, the Scottish Home and Health Department acknowledged the problems of the tripartite NHS, in which the clear lines of responsibility were lost on many occasions. Some examples of the uncertainty over responsibility, such as which body should provide maternity outfits, were given above in chapters three and four. Therefore, the distinctly Scottish proposals dealt with Scottish problems which had been evident from the inception of the NHS. The Scottish consensus, which is emphasized by Webster and Stewart, came from the Scottish Home and Health Department addressing these problems and aligning the proposals to the Porritt Report. Consequently, the specific Scottish proposals had the support of the most influential force within the policy network, the medical profession, which allowed the introduction of the proposals in Parliament to be seen as coming from a consensus viewpoint.

Despite the Scottish consensus, it was noted in Whitehall that there were inconsistencies between the proposals of England, Wales and Scotland. In 1971, the Scottish proposals were thought to 'have a somewhat ill-defined policy advisory body interposed between areas and headquarters, as well as a common services agency'.⁶⁷ The civil servants in Whitehall viewed the proposals which had been submitted by this point as unsatisfactory. In response to this memorandum, Meyjes, of the Lord Privy Seal's Department, replied that although he agreed with the decision not to have a regional tier within Scotland, he felt that central organisation within the Scottish Office was not satisfactory.⁶⁸ The proposed central structure was to be separated into three parts: policy and financial control; planning; and provision of central services. Meyjes argued that this would weaken the power of the central authority. Furthermore, under a unified central organisation, a defined career path for civil servants could be developed.⁶⁹ The Whitehall civil servants were comparing the Scottish proposals for reorganisation with the English and Welsh proposals in a bid to identify some uniformity in the health services throughout the country. The approach to reorganisation within Scotland, however, removed the problems witnessed in England and Wales, giving credence to the Scottish proposals. Consequently the Scottish Home and Health Department was conducting its negotiations on two fronts; one with Westminster, and the other with the organisations involved in the Scottish health services.

⁶⁷ NA, BA25/93, Memorandum to Mr Meyjes from P Mountfield, NHS Reorganisation: England, Scotland and Wales, 11th March 1971, p. 1.

⁶⁸ NA, BA25/93, Memorandum to P Mountfield from Mr Meyjes, NHS Reorganisation: England, Scotland and Wales, 17th March 1971, p. 2.

⁶⁹ *Ibid*, p. 2.

A memorandum by the Home Secretary considered the proposals put forward by the Scottish Home and Health Department in conjunction with the proposals for England and Wales. There were some concerns over the membership of the health boards in Scotland, as lack of local authority representation potentially was in conflict with the Government's plan to afford more power to local authorities through local government reorganisation. Furthermore, it was thought that the reorganisation of the health services in Scotland would have a detrimental effect on the reorganisation of local government, as local authorities would be opposed to the proposals for both Acts.⁷⁰ In reply to such criticisms, J Hogarth of the Scottish Home and Health Department wrote to J P Dodds, of the Department of Health and Social Security in Westminster to say that the SHHD saw the problems which might occur with the appointment of members in relation to local authorities. Nevertheless, the SHHD felt that giving the right of appointment to local authorities but not the medical profession would not be feasible and therefore the members should be appointed by the Secretary of State.⁷¹ In a Treasury memorandum, the Chief Secretary was urged to support the SHHD White Paper which proposed that all health board members would be appointed by the Secretary of State for Scotland. The memorandum advised the Secretary of State not to offer local authorities the right to nominate their own members to the boards, as was previously agreed.⁷² Furthermore, a written note on the memorandum gives a further insight into Whitehall's thoughts about the White Paper from the Scottish contingent, saying,

the Scots have decided on a White Paper not a consultative document (on which the debate continues in England and Wales with pleas for more local authority and medical representation). Treasury officials will welcome its publication as soon as possible.⁷³

Some Whitehall circles welcomed the way in which the Scottish Home and Health Department undertook the reorganisation of the health services. The Department had not left the discussion of reorganisation open and although some of their proposals were not acceptable to all parties within Whitehall, especially those involving local authorities, the pace and forceful nature of its proposals reorganisation was admired. Webster argues that

⁷⁰ NA, T227/3473, Reorganisation of the National Health Service, Memorandum by the Secretary of State for the Home Department, 24th March 1971, pp. 3-4.

⁷¹ NA, T227/3473, Letter to JP Dodds, Department of Health and Social Security from J Hogarth, the Scottish Home and Health Department, 15th April 1971.

⁷² NA, T227/3473, Treasury Memorandum, Reorganisation of the Scottish Health Services, 8th July 1971, p. 2.

⁷³ *Ibid*, p. 2.

the introduction of the unification of the health services went unhindered in Scotland for three reasons. Firstly, Scottish local authorities were less powerful and more fragmented, allowing the recommendations of the Porritt Report to be implemented more easily as they could not mount a defence against the medical profession or the Scottish Home and Health Department. Secondly, proposals for Scotland's social work policies were further along than in England, allowing assurances to be given to local authorities that they would retain control of the social work services. Finally, the Royal Commission on Local Government in Scotland was less favourable towards local authority control of the health services than its English equivalent.⁷⁴ Consequently, the move towards a unified NHS was contested by local authorities who had lost power within the health field.

Scottish local authorities were unhappy with the lack of time to consider possible alternatives. The relationships established within the policy network of the 1940s had changed, as the voice of local authorities was removed from the health network. Nevertheless, the Scottish Home and Health Department had kept who it considered the main voice within the health services content, the medical profession, and followed the Porritt Report's findings. The Scottish Home and Health Department had also successfully answered their critics in Westminster and gained enough agreement to continue with the reorganisation it advocated. Consequently, the Scottish Home and Health Department successfully pushed through its proposals for reorganisation with few changes and balanced the two spheres of policy formation to its own benefit.

Scottish Home and Health Department and the Local Authorities

The place of the local health authority services within Scotland was considered as early as 1964 by the Scottish Home and Health Department. A memorandum to Mr Paterson of the SHHD, from an unknown author in the Glasgow Corporation, considered the place of the health authority under the banner of local government reorganisation.⁷⁵ The memorandum argued that the place of local health authority services within the top or second tier of local government was a fundamental question. Even as late as the 1960s, the place of local health authority services within the NHS was considered a fundamental decision to be

⁷⁴ Webster, *The National Health Service*, p. 91.

⁷⁵ The memorandum is likely to have come from the Medical Officer of Health for Glasgow, as it mentions that Mr Paterson sent an initial memorandum to the County Medical Officer requesting views on the place of the health services in the reorganisation of local government. It is also assumed that Mr Paterson may be the local authority member who chaired the Working Group on Scottish Local Government Management Structures, discussed earlier in the chapter.

taken prior to local government reform.⁷⁶ Preventive medicine was still not regarded as part of the NHS, and the comment made within the Memorandum reveals the view of some local authorities that their services were separate from the NHS. In summarising the memorandum, the unknown author argues that due to volume and importance of the work undertaken by local health authorities, and their connections to the Regional Hospital Boards and Executive Councils, their remit should be placed within the top tier of the new local government structure.⁷⁷ Although some local authorities did not see themselves under the umbrella of the NHS, local authorities still considered the health services they provided to be an important part of their functions.

This early assessment of the place of the health services within local government came from Glasgow and shows the importance of the health services to this large local authority. Surprisingly, the views of Glasgow Corporation about the reorganisation of the health services do not appear in the Glasgow City Council archives. Also the annual *Medical Officer of Health Reports* for Glasgow in the 1960s barely mention the reorganisation process. In the 1971 report, the Medical Officer of Health, Thomas Wilson, noted

During the year many members of staff of the Health Department have been busily engaged on national and local working parties concerned with future developments in the National Health Service. These activities have entailed a great deal of work and effort, and in association with a staff shortage, particularly on the medical side, have meant for all concerned a most active year.⁷⁸

Undoubtedly Glasgow would have been involved in the discussion and implementation of reorganisation, however, no archival information has been found to explore in detail their views or level of involvement.

As the 1960s continued, so too did the discussion by other local authorities of the reorganisation of both local government and the NHS. In the 1967 issue of *Health and Welfare* the question of reorganisation was addressed by Ian MacQueen, the Medical Officer of Health, Aberdeen. Ian MacQueen was one of the more vocal Medical Officers of Health. He often commented on situations which arose not only in Aberdeen but also on the NHS generally. So much so that, on some occasions, he was required to clarify his views in the following month's issue of *Health and Welfare*. He acknowledged that

⁷⁶ GCA, SR3/71/1/1, Note for Mr Paterson, p. 1.

⁷⁷ Ibid, pp.1-2.

⁷⁸ GGHB, HB38/1/37, *Glasgow Medical Officer of Health Report*, 1971, p. 13.

mental after-care officers had reservations about the White Paper and that their fears might account for some losses in staff including after-care officers, health visitors and male health visiting officers.⁷⁹ The fear of staff was that if the White Paper were implemented, health visitors, after five or six years of gaining the appropriate qualifications and becoming an expert in the field, might find themselves working within a new Department under superiors who were less qualified.

MacQueen thought that this fear was needless, as there was a shortage of staff in all Health, Welfare, Children's and Social Welfare Departments and, even if departments were fragmented, the increase in patients such as the elderly would necessitate increases in the size of staff of the departments created. He also argued that any separation of departments required more staff rather than less, the White Paper had not suggested any reductions in staff; and that if staff were trained for both health and social work, they could, if not happy within their current department, find it easy to move across to the other.⁸⁰ The Medical Officer of Health noted that there could be difficulties for those in senior posts, but for all other staff the reorganisation would not cause any problems. MacQueen, thus recognised that the White Paper and subsequent reorganisation would effectively see the demise of the Medical Officer of Health.

In November 1967 Willie Ross, the Secretary of State for Scotland, announced in Parliament that he intended to review the administrative structure of the NHS. He said:

I have decided that the time has come to undertake a thorough examination of the administrative structure of the health service in Scotland in order to ensure that it is adequate to ensure the most effective development of these services in the future. In the course of the examination I shall seek the views of the associations representing local authority, professional and other interests; and I should propose in due course to publish my tentative proposals as a basis for wider public discussion.⁸¹

With this statement, Willie Ross reinstated the policy network which had been utilised during the discussions over the initial NHS policy in the 1940s. As Webster noted, however, the local authorities within Scotland were in a weaker position this time round. The basis of policy network theory, as has been explained in earlier chapters, is the

⁷⁹ Northern Health Board Archives, *Health and Welfare*, No. 35, July 1967, p. 3.

⁸⁰ *Ibid*, p. 3.

⁸¹ NAS, HH61/859, HSC (68)4, Scottish Health Services Council, Review of the Administrative Structure of the National Health Service in Scotland, Note by the Joint Secretaries, Enclosing House of Commons Speech, Tuesday 7th November 1967.

assumption that the groups within the network with the greatest assets for bargaining would be in a position of strength within the policy formation process. As was demonstrated in Chapter Two, this is not always the case as local authorities, despite their experience of providing health services and owning hospitals and clinics were placed in a subordinate relationship to the Department of Health. Local health authorities in the 1960s were no longer in a position of strength, and therefore had very little to bargain with. Nevertheless their organisations were invited to take part in discussions over the reorganisation.

The decision by the Secretary of State to consider the reorganisation of the health services was carried forward by the Scottish Health Services Council which prepared a discussion document for the actors involved in the policy process. The review by a department of the Scottish Home and Health Department was not seen in a favourable light by the Association of County Councils who thought that 'a Committee of Inquiry into the organisation of the Health Service might well have been more appropriate than a Departmental review on the Secretary of State's behalf'.⁸² The document indicated that it was 'not a statement of the Secretary of State's views on what the right pattern should be, but is intended merely to draw attention to some of the matters which must be considered in any study of a new administrative structure'.⁸³ The Council put forward the case for change, arguing that the tripartite structure did not allow effective or efficient use of resources to meet patients' needs; patients' needs could only be met through co-operation among the three administrative bodies.⁸⁴ As has been previously noted in Chapters Three and Four, co-ordination was not easily achieved and often depended on the personalities involved, for example the Medical Officer of Health for Glasgow, A. R. Miller, successfully co-ordinated his local authority services with the hospital and GP service. Furthermore, the Council felt that it was not easy to determine whether resources were arranged advantageously in each area and whether the financial arrangements, which included separate systems of budgeting and accountability, were being utilised to the

⁸² ECA, S1169/1/29, Association of County Councils in Scotland, Health and Welfare Committee Meeting Minutes, 16th May 1968, p. 269.

⁸³ NAS, HH61/859, HSC (68)4, Scottish Health Services Council, Review of the Administrative Structure of the National Health Service in Scotland, DE 75950, Structure of the Scottish Health Service in Scotland, p. 1.

⁸⁴ *Ibid*, p.1.

benefit of the different areas.⁸⁵ The criticisms highlighted by the Council were not new and had been brought up prior to the inception of the NHS (Scotland) Act of 1947.

Although the Council considered alternative arrangements, such as the combination of GP and hospital services while local health authorities continued their role, the proposed solution was the establishment of Area Health Boards. The Boards would takeover all the health functions of the three administrative areas. The Council acknowledged the view that local authorities could undertake the duties of all of the health services after reorganisation but did not see this as a likely outcome.⁸⁶ As in England, the financing of the NHS from local rates and an exchequer grant was not considered a feasible option. Furthermore, the Council recognized that, with careful consideration, the administrative areas of the reorganised NHS would have to be related to the new local government areas so as to encourage co-operation between the health services and the local authorities.⁸⁷ As the social work services and some public health responsibilities would still be placed with the local authorities, co-operation between the health services and local authorities was still necessary. Membership of the Area Health Boards was also mentioned, as the form of appointment of members was under discussion. This took the same form as discussions before the 1947 Act, in that members could be elected, a proportion of members could be elected by local authorities or they could be selected by the Secretary of State.⁸⁸ One further area of continuing interest to local authorities was that of finance, which required discussion but was still to come from the Exchequer and local authorities. The discussion paper produced by the Council may have given local authorities some hope, as they were still to be represented on the area health boards that were proposed.

In responding to the discussion paper, the Association for County Councils felt that there was a case for reorganisation to some extent. Even so, the Association argued

bearing in mind that the Guillebaud Committee had reported against a unified structure, the Baillie Committee had not considered that a change in the administrative structure was an essential pre-requisite for an improved family doctor service, and the Birsay Committee had recorded that it had received little evidence of any discontent from hospital authorities or local health authorities..., it would be necessary for a persuasive and well-argued case to be

⁸⁵ Ibid, p.1.

⁸⁶ Ibid, p. 3.

⁸⁷ Ibid, p. 3.

⁸⁸ Ibid, p. 4.

made if general acceptance were to be secured for the view that a total re-casting of the Service was now justified.⁸⁹

In saying this, the general consensus within the Counties was that area health boards were the most appropriate change, if one were to occur, and the Counties acknowledged that the area health boards were not likely to be a function of the local authorities. The counties were somewhat contradictory in their statements, as they felt the case had not been strongly argued in favour of reorganisation, but they were willing to acquiesce to the outcome proposed which removed the health services from their remit. Additionally, the Counties argued that local authorities should propose their own members for the area health boards from their elected body.⁹⁰ The local authorities therefore attempted to protect and further their position within the new health service while being realistic about the nature of the impending structural changes.

The Convention of Royal Burghs, however, was in a particularly difficult position as the reorganisation of the NHS began. Not only were the Burghs considering their role within local government reorganisation, but they were also defending their position as local health authorities. During a meeting of the Large Burghs Committee in April 1969, the Committee stated that NHS reorganisation should not take place unless within the scope of local government reorganisation.⁹¹ The view of the large Burghs was that there was scope to improve the arrangements for NHS reorganisation, but they were not against the establishment of Area Health Boards. Their agreement with the establishment of these Boards was based on two conditions: first, that adequate representation for local authorities was guaranteed; and second, that the financial arrangements for the Boards were satisfactory.⁹² The Burghs considered the changes within the framework of local authority reorganisation and concluded that 'indications were favourable to the future of the Large Burghs'.⁹³ This initial consideration of the future of the NHS corresponded with the views of the Association of County Councils. Local authorities were still attempting to extend their role within the NHS through the Area Health Boards. As in the 1940s and 1950s, representation on the main boards and committees was seen, by the local authorities, as the

⁸⁹ ECA, SI169/1/29, Association of County Councils in Scotland, Health and Welfare Committee Meeting Minutes, 16th May 1968, p. 269.

⁹⁰ Ibid, p. 271.

⁹¹ ECA, SL30/1/2/107, The Convention of Royal Burghs of Scotland, Large Burghs Committee Meeting, 24th April 1968, p. 8.

⁹² Ibid, p. 8.

⁹³ Ibid, p. 8.

way for them to increase their influence within the NHS. Again, throughout these negotiations, as with the negotiations of the 1940s and the implementation of the 1950s and 1960s, local authorities were not influential in bargaining a favourable outcome. The period from the 1940s had witnessed the slow removal of local authorities from the NHS, through their diminishing influence and the decreasing number of services they provided. Reorganisation was the opportunity for the SHHD to obtain full central control.

The Housing and Health Committee of the Convention of Royal Burghs, however, noted that the Secretary of State for Social Services, Richard Crossman, had withdrawn the tentative proposals for NHS reform put forward by his predecessor. The original proposals were withdrawn and a decision was delayed in order to allow the English Local Authority Associations time to consider the Report on Local Government in England.⁹⁴ The Royal Burghs noted the removal of the proposals with interest, as the positive implications for local government reorganisation and their continued input into the NHS were in question.⁹⁵ By December 1969, the Royal Burghs commented that

the Agent made a statement on the position of Health in Local Government Reorganisation. A new Government Green Paper was expected very soon, and it seemed likely that Local Authorities would have an opportunity of taking quite a large part in Health Services, possibly under Reorganisation.⁹⁶

Local authorities were positive about their future within the health services. The Scottish Home and Health Department had varying options for reorganisation, one of which was to place the health services under the control of local authorities. This was not a favoured option by the Scottish Home and Health Department, who were fortunate to have support for a new system of area health boards through the findings of the Porritt Report.

The Green Paper, published in 1968, caused further discussion amongst the local authorities on the reorganisation which ensued. Ian MacQueen, Medical Officer of Health for Aberdeen, wrote about the Green Paper on *Administrative Reorganisation of the Health Services* in a *Health and Welfare* issue in 1969. He noted that ‘few if any health workers are unconvinced of the need for any changes at all, but that there is little, if any enthusiasm

⁹⁴ ECA, SL30/1/2/108, The Convention of Royal Burghs of Scotland, Housing and Health Committee Meeting, 21st April 1969, p. 9.

⁹⁵ Ibid, p. 9.

⁹⁶ ECA, SL30/1/2/108, The Convention of Royal Burghs of Scotland, Housing and Health Committee Meeting, 17th December 1969, p. 30.

for the detailed proposals contained in the Green Paper'.⁹⁷ Gordon McLachlan also provides evidence of this lack of enthusiasm when he observes that the local authorities were publicly vocal through newspapers, such as the *Scotsman*, about their fear of the impact of the reorganisation on the health services.⁹⁸ Concerns over the reorganisation of the NHS had plagued local authority health workers for many years and the lack of enthusiasm for reorganisation and the vocalisation of their concerns were an eloquent response to the Green Paper.

The Association of County Councils (Counties) also produced an extensive memorandum on the Green Paper. The observations followed those previously emphasised by the Royal Burghs, although they were more severe in their criticisms of the way in which the Scottish Office was dealing with the matter. For example, the Counties pointed out that the Green paper failed to explore all options for the health services, including local health authority control, which was only mentioned as being financially difficult.⁹⁹ This was not acceptable to the Counties, as they felt that all options should be explored and the financial difficulties, which were not explained in detail, could be overcome. Moreover, the Counties felt that the Green paper moved away from the Government strategy of involving the public to a greater extent in policy implementation and accountability. They felt that accountability could only be achieved through an elected body such as local authorities.¹⁰⁰ In concluding the memorandum, the Counties argued

with as much force as possible, its complete opposition to the severance of the local health services from local democracy and from local authority social and related services. It is the Association's belief that local government is best able to provide a sound administrative basis both for serving the public and safeguarding the professional independence of the medical and allied professions.

In the light of these principles, the Association considers that as much of the National Health Services as possible, and preferably all of them, should come within the ambit of democratically elected local government which already provides the bulk of social services. Accordingly, the Association urges the Secretary of State to withdraw the Green Paper proposals and to defer for a short time the consideration of the reorganisation of the National Health

⁹⁷ Northern Health Board Archives, *Health and Welfare*, No. 42, April 1969, p. 2.

⁹⁸ G. McLachlan, *Improving the Common Weal*, (Edinburgh, 1987), p. 131.

⁹⁹ ECA, SL169/1/30, Preliminary Memorandum by Association of County Councils in Scotland on the Government's Green Paper, p. 10.

¹⁰⁰ *Ibid*, p. 11.

Service until the Association and other organisations concerned can put forward and discuss possible alternatives.¹⁰¹

The Association of County Councils felt pressured into the discussion over reorganisation and felt the time scale of events did not allow proper consultation with its organisation. Such pressure demonstrates that the Scottish Home and Health Department was, as in the 1940s, going through the motions of discussion, while creating a reorganised structure which would give it effective control of the health services under area health boards.

Edinburgh Corporation also made representations regarding the reorganisation of the health services within Scotland. The Scottish Home and Health Department wrote to the Corporation enclosing a copy of the White Paper, *Reorganisation of the Scottish Health Services*. The Corporation noted that the White Paper did not differ significantly from the Green Paper and agreed to reaffirm its previous observations.¹⁰² Its main observations covered the membership of the area health boards and financial arrangements. Edinburgh Corporation argued that the appointment of local authority members by the local authorities in the area should be developed, in direct contrast to the system proposed in the 1944 legislation, which allowed the Secretary of State to appoint members after consultation.¹⁰³ It is interesting to note that, even by 1971, when the outlook for local health authority services was bleak, Edinburgh Corporation was still actively pursuing representation on the health board, as they had pursued representation in the 1940s and 50s. Furthermore, Edinburgh Corporation was concerned that the financial arrangements for the reorganised NHS would not allow the development of community and preventive medicine and health education in conjunction with the hospital, specialist and other curative services.¹⁰⁴ It is evident from the discussions leading up to the 1974 reorganisation, that some of the concerns brought up by the local authorities were issues which concerned them in the policy formation of the 1947 Act and had not been resolved.

The actors within the Scottish Home and Health Department had moved on since the first NHS Act, 1947. T G D Galbraith, previously a civil servant within the Department of Health for Scotland, had become an MP. He still had an underlying interest in the health services within Scotland. In the House of Commons, on the 5th November 1970, Galbraith

¹⁰¹ Ibid, p. 14.

¹⁰² ECA, SL26/2/56, Edinburgh Corporation Health Committee Minutes, 14th September 1971, p. 35.

¹⁰³ Ibid, p. 35.

¹⁰⁴ Ibid, p. 36.

asked the Secretary of State for Scotland, Gordon Campbell, if he would make a statement about the reorganisation of the National Health Service.¹⁰⁵ The Secretary of State replied that the NHS within Scotland would be unified under a single health authority for each area. These new authorities would operate outside of local government but have strong links with the local authority social work and environmental health services.¹⁰⁶ In conjunction with this, a Central Planning Council and common services agency would be established for the whole of Scotland.¹⁰⁷ The White Paper also brought out the need for co-operation with local authorities in many different areas of responsibility. The health boards were required to co-operate with the environmental services, education authorities and social work services of local authorities, while also considering financial arrangements between the two.¹⁰⁸

Although the actors within the Scottish Home and Health Department had changed, the attitude towards local authorities had not. A Scottish Home and Health Department memorandum, in February 1971, concluded that

the local authority representatives expressed mixed (and personal) views; but since the local authorities are in any case losing their responsibility for personal health services the views of the medical officers of health in support of a single-tier structure are perhaps of more significance.¹⁰⁹

The memorandum went on to discuss the views of the medical profession, Executive Boards and Regional Hospital Boards on the single-tier structure proposed during the reorganisation.¹¹⁰ This shows that the relationship established between the Scottish Home and Health Department and local authorities, through the policy network in the 1940s, continued to affect the influence of local authorities in the reorganisation process. The comment within the memorandum demonstrates that although local authorities were consulted about the reorganisation, their views were not considered important. The SHHD had the agreement of the medical profession to their preferred administrative structure, and

¹⁰⁵ ECA, SL169/1/31, Association of County Councils, Health and Welfare Committee Meeting, 12th November 1970, p. 520.

¹⁰⁶ Ibid, p. 520.

¹⁰⁷ NA, T227/3473, Reorganisation of the National Health Service, Memorandum by the Secretary of state for the Home Department, 24th March 1971, p. 2.

¹⁰⁸ ECA, SL169/1/32, Association of County Councils, Health and Welfare Committee Meeting, 16th September 1961, p. 417-418.

¹⁰⁹ NA, T2227/3473, Memorandum by the Scottish Home and Health Department on NHS Structure, February 1971, p. 5.

¹¹⁰ Ibid, p. 5.

that is what counted. Again, as throughout the period from the 1940s, the SHHD utilised its relationship with the medical profession to sideline and ultimately remove local authorities from the NHS. Nevertheless, co-operation between the reorganised health services and the local authorities was necessary and working groups such as the Working Party on Relationships with Local Authorities discussed issues such as employment of social workers within the health services.¹¹¹ The demise of the local authorities within the NHS was, however, inevitable.

National Health Service (Scotland) Act, 1972

The National Health Service (Scotland) Act, 1972, followed the published Green Paper and as Webster noted was a 'filial descendent of the Porritt Scheme'.¹¹² The Porritt Scheme was also accepted by the Scottish BMA, the most influential member of the policy network, consequently making the route to the Act easier. According to Helen Dingwall,

it may be that there was more of a corporate will and consensus among Scots as to how their health services should be organised. The Scottishness factor may be defined in terms of a distinct Scottish view on management strategies and the ability to realise that some degree of centralisation and standardisation was necessary... This consensus was achieved in part, perhaps a large part, because on the whole the Scottish arm of the BMA was generally in favour of the principles involved, though not always of the precise details of their application.¹¹³

The Scottish Home and Health Department utilised the relationship with the BMA to create a dynamic within policy discussions whereby local authorities were, as in the 1940s, discounted from the policy process. The ease with which the Scottish Act came into being was not evident in England where two Green Papers and two White Papers embodied the disagreement and fundamental changes required within the scheme necessary in order for it to receive Royal Assent. Prior to the introduction of the English Bill in Parliament, however, the Department of Health and Social Security waited to see how the Scottish Bill was received. The ease with which the Scottish Bill was passed through Parliament gave

¹¹¹ NA, T227/3475, Working Party on Relationships with Local Authorities, Social Work Sub-committee, 11th January 1972, p. 1.

¹¹² Webster, *The National Health Service*, p. 91.

¹¹³ H. Dingwall, *A History of Scottish Medicine*, (Edinburgh, 2002), p. 232.

the Department of Health and Social Security confidence to introduce the Bill for England and Wales.¹¹⁴

The National Health Service (Scotland) Act, 1972 set up a system of health boards which unified all of the health services, including the GP service, under one administrative organisation. In contrast to the Act for England and Wales, the Scottish system was far simpler and did not include a regional tier between the Scottish Home and Health Department and the health boards. The new health boards included representation from local authorities, but the appointment of these members was at the discretion of the Secretary of State for Scotland. Although local authorities were still represented on the health boards, they failed to assert any power within the policy formation process that resulted in the Act and failed to gain a more favourable position within the health services. The Scottish Home and Health Department achieved their goal, which stretched back to the 1940s, of centralisation of the health services. The removal of local authorities from the health sphere was complete.

The planning for integration of the health services began before the passage of the Act. By 1971, Sir Keith Joseph had written to all County Councils in England and Wales emphasising the need for the local authorities to build up their preventive health services prior to integration of the services.¹¹⁵ Within Aberdeen, such a letter was expected from the Scottish Home and Health Department. Planning for integration had begun in Aberdeen by 1971 through the upgrading and redesignation of senior posts and the request to increase the number of Senior Medical Officers from two to three.¹¹⁶ The Medical Officer of Health thought that integration within the North-East should pose fewer problems than in some areas due to the good relationships which existed. He felt that planning for integration should have two main aims:

to improve the health and disease services for the people by making the most effective use of staff available or likely to become available; and to ensure adequate protection of the status, job satisfaction, remuneration and conditions of persons previously employed in any of the three arms of the service.¹¹⁷

¹¹⁴ Ibid, p. 107.

¹¹⁵ Northern Health Board Archives, *Health and Well-Being*, No 51, July 1971, p. 1.

¹¹⁶ Ibid, p. 1.

¹¹⁷ Ibid, p. 1.

Ian MacQueen thought these objectives were not incompatible and with considerable work they could be achieved. Regarding the development of health services, he noted that health workers would endorse the need to devote more resources to the prevention of disease and the maintenance of health.¹¹⁸ In highlighting the need for resources within preventive medicine, MacQueen quoted President Nixon who said:

In most cases our present medical system operates episodically – people come to it in moments of distress – when they require its most expensive services. Yet both the system and those it serves would be better off if less expensive services could be delivered on a more regular basis. If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures. If we gave more attention to treating illness in its early stages, then we would be less troubled by acute disease.¹¹⁹

The Medical Officer of Health, at this stage, emphasised that even within a fully integrated service, the preventive side of medicine was at the forefront of prevention and the maintenance of health. In turn, this could ease pressure on hospitals, specialist clinics and GP services. MacQueen made many comments on the work towards the reorganisation of the NHS. In the *Health and Well-Being* issue of April 1972 he had to defend his comment that the future should be prepared for without neglecting the present. In his defence comment he said that due to national, area and local work, the workload of the local authority health workers was very heavy. Therefore, there could be a tendency to look to future work while not fulfilling their duties to current patients.¹²⁰ Aberdeen had a very vocal Medical Officer of Health who looked at all health services and made comments to support the continuation of the standard of service which patients deserved. In concluding his defence he said:

If we fail in the present, old people will die where they could have survived, unwanted and fatherless children will be born, and the health workers of 1980 will be saddled with many victims of unprevented preventable disease that developed in 1972 and 1973.¹²¹

The reorganisation of the NHS increased the local authority health services' workload making it difficult to continue providing a high standard of health services while preparing them to be passed over to the new health boards. Even to the very end, Medical Officers of

¹¹⁸ Ibid, p. 5.

¹¹⁹ Ibid, p. 5.

¹²⁰ Northern Health Board Archives, *Health and Well-Being*, No. 54, April 1972, pp. 2-3.

¹²¹ Ibid, p. 4.

Health, such as MacQueen, fought to keep services running at a high standard even with lack of staff and stretched duties.

By 1972 the impending changes within the NHS caused Glasgow to begin negotiations with the Western Regional Hospital Board. It was recognised that the obstetric units of hospitals would be dealing with all maternity cases, and negotiations to place the domiciliary midwifery service within the hospital units was undertaken.¹²² The Standing Nursing and Midwifery Advisory Committee advised the SHHD that Scotland should be divided into maternity districts. Each district would be based on a specialist obstetric unit and would provide the complete range of services required.¹²³ By this time, local health authorities and the Medical Officers of Health who ran them realised that the reorganisation, which effectively removed health services from the local authority sphere, was inevitable and negotiations regarding services, such as the maternity service, were necessary to secure the jobs of staff and the continuation of the services provided.

Furthermore, Edinburgh sought to redefine the remit of its Health Committee. The personal and community health services became a function of the Area Health Boards and the responsibility of the Secretary of State for Scotland on the 1st February 1974. Redefinition, however, was considered under the acknowledgement that local government organisation might remove further public health functions from the Corporation and place them with a district council.¹²⁴ The functions which remained with the Health Committee were the environmental services which included control and prevention of disease, food inspection, sanitary inspection and pest control.¹²⁵ Edinburgh felt that the Corporation should retain a Health Committee, as the functions were regarded as important to the public.¹²⁶ In putting this to the Corporation it was noted that

in all the circumstances it appeared preferable that the Health Committee should continue after 1st April 1974 although its functions would be reduced and it would not be necessary to have a Standing Sub-Committee.¹²⁷

¹²² GGHB, HB38/1/37, *Glasgow Medical Officer of Health Report*, 1971, p. 14.

¹²³ ECA, SL169/1/34, Association of County Councils in Scotland, Health and Welfare Committee Meeting Minutes, 15th November 1973, p. 503.

¹²⁴ ECA, SL26/2/58, Edinburgh Corporation Health Committee Minutes, 5th February 1974, p. 73.

¹²⁵ *Ibid*, pp. 73-4.

¹²⁶ *Ibid*, p. 74.

¹²⁷ *Ibid*, p. 74.

Local authorities were consequently undergoing a time of uncertainty in both the organisation of their authorities and the removal of functions which they had performed for many years. A new niche for local authorities had to be found as they were no longer considered part of the health services within Scotland.

When it became inevitable that reorganisation would lead to new area health boards, which would effectively remove nearly all health services from local authorities, the Convention of Royal Burghs was willing to acquiesce. This is most clearly highlighted by a letter to the Scottish Home and Health Department regarding the financial arrangements of the NHS after reorganisation. When replying to proposals for the financial arrangements between local authorities and the NHS, the Chief Executive for Greenock commented:

with reference to the attached papers dealing with financial relationships between the new Health Service and Local Authorities, I consider that these papers are acceptable to us, in particular the proposal that there will be no attempt made to recover the cost of specified services which would involve detailed costing and accounting to one another, is sensible and in our interest.¹²⁸

It was only at this late stage that the financial arrangements of the NHS were simplified and the responsibility for services was clear. To gain this, local authorities lost their place within the health services and only provided a few public health services from the reorganisation onwards.

The outcome of the reorganisation of the National Health Service within Scotland was that local authorities lost the administration of the preventive health services. Although they argued against reorganisation of this type and quoted various governmental reports to substantiate their misgivings, the Scottish Home and Health Department opted for the single tier area health board structure. The negotiations over NHS reorganisation were clearly placed within the wider reorganisation of local government; however, local authorities were unable to convince the Scottish Home and Health Department that the local government reorganisation would allow them the opportunity to administer effectively all of the health services. Local authorities were therefore effectively removed from the health sphere after a gradual erosion of their powers in this field from the NHS (Scotland) Act, 1947. The Scottish Home and Health Department had successfully balanced the pressures from Westminster with the pressures from the BMA and local

¹²⁸ ECA, SL30/3/23, The Convention of Royal Burghs Letterbooks, Letter to J. Walker from the Convention, 13th March 1974.

authorities within Scotland. The new single tier health service was implemented on the 1st April 1974.

Conclusion

Gordon McLachlan argues that the reorganisation of the Scottish health services in 1974 caused further administrative confusion and created a consultative structure which was 'over elaborate and unwieldy, and led to unacceptable delays in decision making'.¹²⁹ The reorganisation of the NHS came at a time when reorganisation was the buzzword. The Department of Health for Scotland had undergone reorganisation in the early 1960s, transforming it into the Scottish Home and Health Department. Reorganisation of the NHS was also undertaken at a time of local government reorganisation when local authorities were uncertain about their future. Local authorities argued that local government reorganisation would create a system which would allow local authorities to administer the entire NHS.

The Scottish Home and Health Department was negotiating on two fronts, with the organisations involved in the Scottish policy network and with Whitehall. Although Whitehall and the Scottish local authority associations had misgivings about the proposed single tier, area health board structure, the Scottish Home and Health Department had the agreement of the Scottish BMA and the findings of the Porritt Report to support them. Again, as in the 1940s, the association between the Scottish Home and Health Department and the Scottish BMA was successful in achieving the desired outcome of both groups.

The discussions over the reorganisation of the NHS reinstated the policy network which was active in the formation and implementation of the NHS (Scotland) Act, 1947. Within this network, however, local authorities were at a distinct disadvantage as they no longer provided the main section of the NHS, i.e. hospitals and specialist clinics. The bargaining power of local authorities had been lost in the negotiations of the 1940s and they had not been able to recover it thereafter. As a result of the loss in bargaining power and the subordinate relationship to the SHHD, by the 1960s, local authorities were no longer a major player within the policy network.

Additionally, local government within Scotland was seen as weak. The subordinate relationship between the local authorities and the Scottish Home and Health Department

¹²⁹ McLachlan, *Improving the Common Weal*, p. 144.

indicated this. Local authorities were seen by the SHHD as service providers and as such had no voice within the health services. The relationships established among the Scottish Home and Health Department, the medical profession and local authorities, in the 1940s, continued and were reinforced during the reorganisation process to gain the outcome favoured by the SHHD.

Furthermore, although local government reorganisation was under way, the system of local government finance had not altered in a way that persuaded the Scottish Home and Health Department to allow unitary NHS reorganisation to be placed in the hands of local authorities. The medical profession also would not accept such a solution as their attitude toward local authority control had not changed since the 1940s. The attitudes of the actors within the policy network had not altered from the negotiations in the 1940s and were reinforced throughout the implementation of the NHS in the 1950s and 1960s as local authority influence weakened. Consequently, local authority involvement in the reorganisation process did not lead to their incorporation them into the decision-making process but merely created the lines of communication to facilitate the handover of their health services.

The NHS (Scotland) Act of 1972 saw the introduction of 14 area health boards, which included local authority representation, but only on appointment by the Secretary of State for Scotland. The Act secured central control of the NHS within the SHHD, and signalled the end of the local authorities as providers of health services, which throughout the twentieth century were firmly within their remit.

Conclusion

This thesis has concluded that local authorities were ‘crowded out’ of the Scottish health services between 1939 and 1974. The ‘crowding out’ of local authorities was not only by the medical profession, but also by the Department of Health for Scotland through the negotiations over NHS policy and its implementation between 1947 and 1974. This thesis has also concluded that due to the removal of the most important health services, the hospital service, from local authorities a realignment in priorities occurred most notably towards child health services. Consequently, after the reorganisation of 1974, local authorities played no further part in the Scottish NHS and passed the services they were responsible for to a regional health board which amalgamated all the health services under one administrative body.

NHS: Conflict or Consensus

Local authorities have largely been forgotten in the historiography of the development of the Scottish NHS. Most histories of the establishment of the Scottish NHS, such as that of Morrice McCrae, highlight the dominant position of the medical profession and do not consider the impact of local authorities.¹ The histories of the Scottish NHS emphasize three key features: the autonomy of the Scottish Office, a prevailing consensus over a comprehensive health service and the dominance of the medical profession.

Levitt argues that the Scottish Office was created for three reasons: first, to represent the distinctiveness of Scottish culture; second, to integrate devolutionists into the Union; and, finally, to keep Scottish interests in touch with Westminster.² Jenkinson also attributes the smooth passing of the NHS (Scotland) Act, 1947, to the autonomy of the Scottish health services in the late nineteenth and early twentieth centuries, prior to the establishment of the Scottish Board of Health in 1919.³ The establishment of the Scottish Office and its relocation to Edinburgh affected the way in which central, regional and local government interacted. Throughout the early twentieth century the Department of Health for Scotland increased its power through its attachment to the Scottish Office and the autonomy experienced in Scottish governmental spheres. The Secretaries of State for Scotland and the Department of Health for Scotland were able to develop health services which met the specific needs of the Scottish people, such as the Highlands and Islands Medical Service in

¹ M. McCrae, *The National Health Service in Scotland: origins and ideals, 1900-1950*, (East Linton, 2003).

² I. Levitt, *The Scottish Office 1919-1959*, (Edinburgh, 1992), p. 65.

³ J. Jenkinson, *Scotland's Health, 1919-1948*, (Oxford, 2002), p. 443.

1913. As a result, historians such as Jenkinson and Stewart argue that the legislation and development of the NHS in Scotland was distinctive, as it included features such as the executive power of the Secretary of State for Scotland and both teaching and non-teaching hospitals under the same administration.⁴ The autonomy of the Scottish Office and the Department of Health for Scotland is not contested in this thesis. The literature discussed in Chapter One, however, does not examine the way in which this autonomy affected the relationship among the Scottish Office, the Department of Health for Scotland and local authorities. As local authorities provided the majority of the health services prior to the NHS (Scotland) Act, 1947, it can be assumed that the autonomy of the Scottish Office would affect its relationship with local authorities.

The second feature emphasized in the historiography is the consensus over the need for a comprehensive health service. The consensus achieved among political groups, bureaucratic groups and the medical profession facilitated the easy passage of NHS legislation. Eckstein argues that consensus among these groups was evident in England over a long period prior to the establishment of the NHS.⁵ Although the consensus was evident in England, the formation of the NHS was not free from conflict over the details of how the service would run. Within Scotland, McCrae argues that there was no conflict over the NHS (Scotland) Act, 1947, as not only was it based on a widespread consensus over the need for a comprehensive health service but also on the Cathcart Report which, in 1936, had recommended a comprehensive health service as the basis for the future for the Scottish health services.⁶ Hamilton concurs with McCrae's argument, noting that opposition to the NHS was minimal within Scotland.⁷ Klein, Berridge and Lowe see the establishment of the NHS as one of conflict within consensus.⁸ Consensus was evident over the main principles of a comprehensive health service, but the NHS was established despite conflict between differing groups who were unable to agree on the details of the legislation.⁹ The histories suggest the consensus within Scotland was far stronger than that

⁴ For a fuller discussion of the distinctiveness of the Scottish NHS see Chapter One above; J. Jenkinson, *Scotland's Health*, pp. 439-41, and J. Stewart, 'The National Health Service in Scotland 1957-74: Scottish or British?' *Historical Research*, vol. 76, no. 193, (August, 2003), 390.

⁵ H. Eckstein, *The English Health Service*, (Oxford, 1958), p. 161.

⁶ McCrae, *The National Health Service in Scotland*, p. 229.

⁷ D. Hamilton, *The Healers*, (Edinburgh, 2003), p. 262.

⁸ A fuller discussion of this is given in Chapter One. See also R. Lowe, *The Welfare State in Britain Since 1945*, (Basingstoke, 2005), p. 178; and, V. Berridge, *Health and Society in Britain Since 1939*, (Cambridge, 1999), p. 13.

⁹ R. Klein, *The New Politics of the NHS*, (Harlow, 2001), p. 5.

in England. Consensus, however, was only evident over the principles of a comprehensive health service and not over the details behind it. Again, local authorities are not considered in this analysis yet in both England and Scotland local authorities voiced concerns over the impending legislation.

The final feature is the dominance of the medical profession. For Webster, the concessions given to the medical profession and the pharmaceutical companies, demonstrate that consensus was not evident in the establishment of the NHS.¹⁰ McCrae also considers the establishment of the NHS from a medical viewpoint, although he does acknowledge the negotiations which took place with local authorities.¹¹ Furthermore, Jenkinson attributes the smoothness of talks over the Scottish NHS to the experience with the HIMS, which was centrally managed and provided an element of GP salaried practice.¹² The medical profession had seen the success of a centrally managed health service in the HIMS, dispelling their fears. Levitt also argues that the Department of Health for Scotland was able to uphold the tradition of the 'eminent specialist, the university teacher and the consultant' through the centring of hospital provision on the medical schools and their teaching hospitals.¹³ In considering the health services in Glasgow, McTavish argues that dominance of the medical profession was inevitable, due to the doctors' domination of the health services prior to the NHS and their opposition to local authority control.¹⁴ The historians, however, do not consider the views of local authorities and their opposition to the dominance of the medical profession in the establishment of the NHS. They see the NHS as captured by the medical profession, which dominate both the initial policy formation and the subsequent development of the NHS.

Scottish Health Services

The move towards a comprehensive health service within Scotland began prior to the negotiations over the NHS (Scotland) Act, 1947. As was argued in Chapter One local authorities were central to municipal health service provision, the assessment of the health services within Scotland and the future planning of the health services. Particularly

¹⁰ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth-Century British History* 1, (1990), pp. 150-1.

¹¹ McCrae, *The National Health Service in Scotland*, p. 221.

¹² Jenkinson, *Scotland's Health*, p. 443.

¹³ Levitt, *The Scottish Office*, pp. 61-2.

¹⁴ D. McTavish, 'Case Studies in British Management, Public and Business Sectors, 1900-present', PhD Thesis, (PhD Thesis, University of Glasgow, 2002), p. 234.

Scottish circumstances, such as the contrast between the vast geography of the rural highlands and the highly populated central belt areas, created a plethora of problems related to the provision of health services. Health services were provided by a range of organisations including local authorities, through the poor law, voluntary hospitals and private practice. One of the first acknowledgements that the poor law, private practice and voluntary hospitals were not fulfilling the medical needs of the Scottish population was the establishment of the Highlands and Islands Medical Service in 1913. The HIMS was a centrally administered health service providing free medical care for the population of that area. It also incorporated medical professionals, notably GPs, into a grant based system of payment. The medical profession was also well represented on the Highlands and Islands Medical Board, which included six medical professionals, only one of which represented the Local Government Board for Scotland.¹⁵ As early as 1913, centralised health services were used to combat Scottish problems of health care provision. At this early stage the medical profession began to dominate centralised health services.

In 1929, the position of local authorities within the provision of health care was consolidated through the Local Government Act. The Act required local authorities to provide hospital services within their area, although many went further providing clinic services for a range of medical needs such as tuberculosis, cancer and maternity and child welfare. Ian Levitt argues that the 1929 Act emphasized to the Department of Health for Scotland three problems with local authority health services: a lack of hospital accommodation, a lack of co-operation among local authorities and a lack of co-operation from voluntary hospitals.¹⁶ Consequently, the Department of Health for Scotland found it increasingly difficult to encourage a uniform development of local authority health services throughout Scotland. Nevertheless, by the early 1930s, local authorities were playing an integral and increasing role in the health service arena. Governmental involvement in the health services did not end with the local authorities. Bringing health services under local authority control was one step towards a more centralised system of health care. Although problems occurred, local authorities had a direct relationship to central government, in this case the Scottish Office. Local authorities could be encouraged to develop their health services in accordance with the plans of the Department of Health for Scotland.

¹⁵ Highlands and Islands Medical Service Board, *The British Medical Journal*, (11th September 1915), 2(2854), 402.

¹⁶ I. Levitt, *Poverty and Welfare in Scotland 1890-1948*, (Edinburgh, 1988), pp. 162-8.

Centralised health care also developed through the Emergency Medical Service, established to cope with the anticipated large number of war casualties during the Second World War. When the number of war casualties did not materialise, the Secretary of State, Thomas Johnston, authorised the use of hospital beds to tackle the voluntary hospital waiting lists and establish experiments in social medicine, such as the Clyde Basin Experiment. The Clyde Basin Experiment provided free medical care for war workers initially in the West of Scotland. As the centralised provision of care was deemed successful, the scheme was rolled out throughout Scotland, except in the Highlands and Islands where the HMS was still running.

The consensus over a comprehensive health service had increased throughout the early 1930s as political and medical groups acknowledged the system in Scotland was failing the population. Local authorities were consistently part of the consultation process and influenced the findings of the investigations into the future of the Scottish health services. The Cathcart Committee was the main investigation into the health of the Scottish population in the 1930s. Local authorities made individual representations to the Cathcart Committee, as well as through their associations: the Scottish Counties of Cities Association, the Convention of Royal Burghs and the Association of County Councils in Scotland. The Committee concluded, in its Report in 1936, that a centralised, comprehensive health service was the natural progression for the Scottish health services to combat the varied health problems of the nation. Under the Committee's recommendations the Department of Health for Scotland would have overall administrative control, with local authorities providing the local health services for their area.¹⁷ Local authorities would be involved in the provision of all health services under these recommendations including hospital services, the most valued part of the health services. As a result, under this concept of centralisation within the Scottish health services, local authorities were integral to its success on a local level. It can therefore be reasonably assumed that the importance of local authorities in the future planning and administration of the health services would transfer to the policy formation of the Scottish NHS.

The involvement of local authorities in the future planning of the health services is also evident in their participation in the review of hospital services through the Hetherington Committee. Local authorities were again represented individually, through their associations and as part of the Nuffield Provincial Trust Committee. The Report of the

¹⁷ Department of Health for Scotland, *Committee on Scottish Health Services Report*, (1936), Cmd 5204, p. 339.

Hetherington Committee, published in 1943, concluded that a regional hospital system was required to extend Scottish hospital provision; however, it should be administered by local authorities. The impact of the establishment of the HIMS and the Cathcart and Hetherington Reports was evident in Parliamentary discussions about the need for a comprehensive health service. The Secretaries of State for Scotland referred to them as the forerunners of and blueprints for the particularly Scottish legislation necessary to provide extensions in the health services. Therefore, local authorities were not only at the forefront of municipal health service provision within Scotland, but were also heavily involved in the assessment of the future of Scottish health services.

Policy Formation and the NHS (Scotland) Act, 1947

This thesis found the establishment of the NHS to be a time of conflict within consensus. A consensus within Scotland was evident over the principles of a comprehensive health service. The establishment and implementation of the NHS, however, were not without conflict within Scotland. The lack of consideration of local authorities within the histories of the Scottish NHS eliminated one of the voices which raised concerns from an early stage over the NHS proposals.

As local authorities were so heavily involved in the health services prior to the establishment of the NHS, local authorities should have been in a strong position to influence the health policy formation of the 1940s. Policy network theory suggests that groups with information or resources to bargain with become the main force influencing policy negotiations.¹⁸ The policy network approach proved to be a useful analytical tool for analysing the relationships among the organisations involved in the health arena. The approach was effective as it provided a framework for analysing the negotiations of the 1940s which was amongst many different organisations including the local authorities. This thesis utilised Rhodes' framework for recognising policy networks and the way the bargaining power of organisations, through knowledge and resources, affects policy negotiations.¹⁹ Developing Rhodes' framework, Smith argues that policy formation does not end with an Act but develops through the policy process.²⁰ Including the analysis of the implementation process allowed the development of relationships within the network

¹⁸ For the full discussion of policy networks and the Scottish NHS policy network see the Introduction and Chapter 2.

¹⁹ R. A. W. Rhodes, *Control and Power in Central-Local Government Relations*, (Farnborough, 1981), pp. 98-9.

²⁰ M.J. Smith, *Pressure, Power and Policy*, (Hemel Hempstead, 1993), pp. 53-6.

and the effect it had on the implementation of the Scottish NHS to be examined. The extension of Rhodes' initial theory allowed the approach to provide further structure to the analysis of the initial implementation period. However, the approach did not fully allow for the changes within the power of the groups involved in the health service network and further extension to the initial theory was necessary. Consequently, the thesis incorporated the perspective of Blom-Hansen, who argues that as the bargaining power of actors within the network changes so too will the institutional arrangements established in the network.²¹ Therefore the development of the relationship between the Department of Health for Scotland and local authorities can be analysed as the bargaining power of local authorities' decreased. By combining the theories of Rhodes, Smith and Blom-Hansen a workable analytical approach was developed which proved effective in the analysis of the development of the NHS and the effect this had on local authority health services.

The policy network involved in the establishment of the Scottish NHS was complicated by the three tiers of government involved: Westminster, the Scottish Office and local government. The Scottish Office enjoyed a substantial amount of autonomy over the formation of NHS policy and within the network took the place of central government. As a result, all negotiations over the NHS (Scotland) Act, 1947 took place between the Scottish Office and Department of Health for Scotland and the relevant organisations, such as local authorities. The negotiations between the Department of Health for Scotland and local authorities can be seen as central-local relations, which in turn can be hierarchical, a partnership or a combination between the two. Rhodes argues that no matter how hierarchical the central-local relations might become, central and local government will always be reliant on each other to some extent.²² Central-local relations, within Scotland, were more local in nature as the Scottish Office linked Westminster and local authorities. Stoker argues that this allowed the actors in the Scottish Office and local authorities to develop an understanding of each others' preferences and the constraints on them in policy formation.²³ The nature of the relationship between the Department of Health for Scotland and local authorities was crucial in the formation of NHS policy and affected the local authorities' bargaining power throughout the negotiations. Policy network theory therefore pointed to the importance of examining the relationships within the network, demonstrating their effect on the policy outcome, the NHS (Scotland) Act, 1947.

²¹ J. Blom-Hansen, 'A 'New Institutional' Perspective on Policy Networks', *Public Administration*, Vol 75, Issue 4, (Winter 1997), 669.

²² Rhodes, *Control and Power in Central-Local Government Relations*, pp. 97-101.

²³ G. Stoker, *The Politics of Local Government*, (Basingstoke, 1991), p. 133.

Within the health policy arena two policy networks were evident: a professional network, including the medical profession; and an intergovernmental network, including local authorities. The intergovernmental network operated alongside the professional network and created a forum in which local authorities negotiated their terms for the new health services with the Secretary of State for Scotland and the Department of Health for Scotland. The local authorities were represented by their associations: the Scottish Counties of Cities Association, the Convention of Royal Burghs and the Association of County Councils. The intergovernmental network created the environment by which local authorities could express their views about the policies put forward for the NHS. It was noted, in 1943, by the Department of Health for Scotland that local authorities were one of the three main set of organisations to be consulted in the negotiations over the Act. The local authorities' relationship with the Scottish Office and the Department of Health for Scotland was crucial in the progression of negotiations.

As was shown in Chapter Two, the relationship between the local authorities and the Department of Health for Scotland became a central feature not only of the negotiations leading to the 1947 Act, but also in the subsequent implementation process. As mentioned above, Jenkinson argues that the strong management of the talks by Thomas Johnston, Secretary of State for Scotland, was central in the smoothness of talks over the NHS.²⁴ Johnston created the dual dynamic in which the network operated. The network was hierarchical, but also portrayed a partnership between the local authorities and the Department of Health for Scotland. The dynamic of the network had a large impact on the ability of local authorities to utilise their resources in the negotiations over NHS policy. In the 1940s the political costs of imposing NHS policies upon the local authorities outweighed the return, as local authorities were heavily involved in the administration of the health services. The knowledge and experience local authorities had, was required in the establishment of a comprehensive health service, a factor which the Department of Health for Scotland recognised. Johnston, however, was in favour of centralisation of the hospital services and developed a strategy which implied a local authority and Department of Health for Scotland partnership but in reality was a hierarchical relationship.

Nevertheless, local authorities attempted to assert influence over NHS policy through the negotiating process. They raised many concerns over the White Paper proposals. The concerns raised by local authorities are in contrast to the consensus emphasized by the

²⁴ Jenkinson, *Scotland's Health*, p. 443.

histories of Jenkinson and McCrae.²⁵ Local authorities had concerns over the tripartite administrative structure of the NHS, the lack of attention to preventive medicine, the removal of the hospital service from the local authorities' remit, the split in clinic services and the dominance of the medical profession are a few of the areas which local authorities had raised as problematic. For example, evidence presented in Chapter Two demonstrates that the local authorities voiced concern over the dominance of the medical profession several times from the earliest discussions in 1943 through to the final discussions of the Bill in 1946. The removal of specialist clinic services, such as those for infectious diseases, away from the work of the local authority was also an issue of concern throughout the discussions of the Bill in 1946. The analysis of the negotiations between local authorities and the Department of Health for Scotland shows that, as argued by Klein²⁶, the NHS in Scotland was established under an overarching consensus on the principles of a comprehensive health service but with conflict over the details of its administration. Solutions to these concerns, and many others, were not found prior to the passing of the Act in 1947.

The difficulty in finding solutions to these issues was not only due to the relationship established between the local authorities and the Department of Health for Scotland, but also due to the relationships which existed between local authorities. The local authority associations were unable to work together to create a united front against the proposals they saw as detrimental to their authority within the health services. Although they voiced many similar concerns, smaller local authorities' fear of being outvoted by large local authorities on health service issues hindered co-operation among the three associations. The Royal Burghs, for example, were the smallest of the local authorities. They saw attachment to larger, more dominant local authorities as a loss of their influence, in the same way that larger local authorities feared that their power would be eroded by the inclusion of voluntary hospital and medical profession representation on the Joint Hospital Boards. Consequently, any solutions offered by an individual association over the problematic parts of the proposals were dismissed by the Department of Health for Scotland due to the disagreement among the local authority associations themselves. The inability to work together further strengthened the position of the Secretary of State and the Department of Health for Scotland.

²⁵ Jenkinson, *Scotland's Health*, p. 443 and McCrae, *The National Health Service in Scotland*, p. 229.

²⁶ Klein, *The New Politics of the NHS*, p. 5.

From a position of strength, the Secretary of State and Department of Health for Scotland moulded the dynamic of the relationships in the network in their favour. As Chapter Two shows, they created the hierarchical relationship between themselves and the local authorities by repeatedly giving assurances to local authorities about their position in return for their agreement over the proposals. The Department of Health for Scotland benefited from the relationship in three ways. First, showing Westminster that the Department had a good relationship with local authorities demonstrated the Scottish Office's ability to conduct policy negotiations autonomously to gain a favourable outcome. Demonstrating the ability to conduct policy negotiations autonomously confirms Levitt's argument that the Scottish Office was unique in that it was not only 'an ordinary experiment of state' but was created to merge the goals of Westminster with that of specific Scottish interests.²⁷ Second, the Department of Health could use local authorities as a bargaining chip with the medical profession to gain the profession's agreement by guaranteeing it would not be under the administrative control of local authorities. As Webster argues, concessions were given to the medical profession to pacify them.²⁸ Consequently, the argument put forward by McCrae²⁹ that the Scottish NHS was established with ease due to the consensus built up by political, bureaucratic and medical profession is contested. Within Scotland, the assurance that local authorities would not be in administrative control of the health services was as concession given to the medical profession to gain agreement over the proposals. Finally, by assuring local authorities that many of the arrangements were temporary, the Department could push its proposals through Parliament relatively unchanged. The importance of local authorities in the planning and administration of the health services, as seen through their provisions and influence in the 1930s, had been significantly reduced through the NHS policy formation process. This resulted in the beginning of the centralisation of the NHS and the slow removal of local authorities from the policy formation and provision of health services.

Johnston suggested that although the proposals seemed to remove administrative control from the local authorities, changes after the initial implementation of the NHS would restore their prominent position. As was shown in Chapter Two the Department of Health for Scotland suggested that the day-to-day functions of hospital administration could be delegated to local authorities. The Department of Health for Scotland argued that once the

²⁷ Levitt, *The Scottish Office 1919-1959*, p. 65.

²⁸ Webster, 'Conflict and Consensus', 150-1.

²⁹ McCrae, *The National Health Service in Scotland*, p. 229.

medical profession had some experience of being part of a national health service, the doctors would be more willing to come under local health authority administration. This includes the GP services and the administration of health centres, which would be transferred to the local authorities if a change in the attitude of the medical profession to local authority control occurred. McCrae, however, argues that GPs already had experience of working for central government through the BMA's Scottish Emergency Committee which had authority to direct GP services, during World War II, to either civilian or armed service work.³⁰ Such assurances from Johnston, the Secretary of State, created an environment in which non-compliance with the NHS proposals by local authorities was very difficult.

As Chapter Two argues, to bolster their influence within the network, local authorities looked to engage support from external groups. The Association of County Councils, for example, approached Scottish MPs for support for its opposition to some of the proposals. This was ultimately unsuccessful but demonstrates that local authorities considered ways of gaining support for their concerns out with the policy network. Other local authorities looked to other members within the network to bolster their influence. Glasgow Corporation, for example, contacted the Department of Health for Scotland directly to try to change the proposals. Again, this approach was unsuccessful. The examples mentioned support the argument that local authorities were not part of the consensus and smooth transition to the NHS. Local authorities were concerned about the health service proposals and attempted many different ways to assert influence over the policy formation process. In the end the policy network did not open an avenue for local authorities to utilise their knowledge and resources during the bargaining process over the NHS (Scotland) Act 1947.

The outcome of negotiations was the NHS (Scotland) Act 1947. The Act created a tripartite structure of hospital, GP and local authority health services. The removal of hospitals and specialist clinics left local authorities with an auxiliary role within the health services. The role was mainly concerned with preventive medicine which was not well represented within the Act, a concern voiced by the local authorities from the early negotiations over the NHS proposals. Consequently, local authorities lost the prestigious part of their health services to regional bodies and were pushed to the periphery of the health services. Their position within the policy network hierarchy had not allowed the local authorities to assert any influence during the negotiations over the Act, despite the

³⁰ McCrae, *The National Health Service in Scotland*, p. 232.

local authorities' ownership and administration of the majority of the health services prior to the inception of the NHS.

Implementation of the Act, 1948-1974

McCrae argues that the Scottish NHS was implemented without any conflict due to the consensus built up in previous years.³¹ Analysis of local authorities' views during the implementation of the NHS (Scotland) Act, 1947, does not support this view, as many problems and points of conflict occurred in the development of the NHS. Lowe argues that the planning of the English NHS was eclipsed by a sense of crisis.³² The sense of crisis was equally apparent in the development of the Scottish NHS. It was from a position of hierarchical dominance that the Department of Health for Scotland began to implement the NHS (Scotland) Act, 1947. The Department of Health for Scotland requested local health authorities to submit proposals outlining how they would undertake their duties under the Act. As Chapter Three demonstrated, the terms of the proposals for the local health authority schemes were negotiated between the Department and local authorities. The proposals covered health services such as vaccination and immunisation, care of mothers and young children, domiciliary midwifery, health visiting, home nursing, and prevention, care and after-care of patients with tuberculosis and mental illness. Consideration of the negotiations over the proposals revealed a number of features of the position of local authorities in the NHS and the local authority reaction to their diminished role. First, the detail of the proposals submitted to the Department of Health for Scotland indicates the reaction of individual cities to the NHS legislation. The example given in Chapter Three, relating to health visitors shows the diversity in the proposals submitted. While Glasgow Corporation submitted detailed proposals, Edinburgh's proposals were vague. Vague proposals suggest that the Medical Officer of Health felt this was an administrative task which did not require much attention, but it also reflects the attitude of the local authorities to their diminished role. The attitude of local authorities to their diminished role is also shown through their attempts to increase their influence on many different committees, such as the Scottish Health Services Council.

Second, the negotiations over the proposals reinforced the local authorities' subordinate position to the Department of Health for Scotland thus, accounting for Hamilton's

³¹ Ibid, p. 241.

³² Lowe, *The Welfare State in Britain*, p. 178.

argument that opposition was ‘muted’ within Scotland to the NHS proposals.³³ Not only did the Department have influence within the negotiations over the proposals, but the Scottish Home Department, Regional Hospital Boards and Executive Committees were involved in the process. Consequently, local authorities were not in a position to influence the establishment of their NHS health services, but were under the tight control of the Department of Health. The Department utilised the views of other bodies within the NHS and Scottish Office, to create services which they wanted to be administered by local authorities. For local authorities the introduction of the NHS was a loss of power through the change in their remit and they expressed their resistance to change through a lack of enthusiasm for the new health service.

The lack of enthusiasm for the new health service was also reflected in lack of co-ordination among the three administrative bodies within the NHS. The issue of co-ordination among the infectious diseases services, for example, was a cause for concern, not only in the discussions over the NHS legislation, but also during the implementation process. A smallpox outbreak in Glasgow confirmed the fears which local authorities voiced during the negotiations over the Act, as co-ordination was not easily achieved and information about smallpox cases was not passed from the hospitals to the Medical Officer of Health for Glasgow. The Department of Health for Scotland requested the Regional Hospital Boards to pass on information regarding patients with infectious diseases to the Medical Officer of Health in a timely manner. Furthermore, the Department requested the Regional Hospital Boards to ensure that their arrangements with the Medical Officers of Health were comprehensive and understood by all parties involved. The Corporations of Glasgow and Edinburgh, along with the Association of County Councils, argued that infectious disease hospitals should be regrouped under the authority of the Medical Officer of Health who had the specialist knowledge to protect the population from infectious diseases. In this case the Department of Health for Scotland only advocated co-ordination and did not alter the implementation of the legislation to include the views of local authorities.

The passing of an Act is not, however, the end result of the policy formation. Policy network theory recognises that policy formation continues with the implementation process. The implementation process of an Act can change what is achieved in practice. Smith argues that implementation of legislation is based on merging the agenda of the

³³ Hamilton, *The Healers*, p. 262.

actors involved in the process with the goals of the state.³⁴ At this stage the groups and organisations which were not dominant within the policy negotiations can attempt to assert some influence over the way in which an Act is interpreted and implemented. It was at the implementation stage that local authorities again attempted to assert their influence within the network.

Chapter Three argues that by the implementation stage, however, the actors within the policy network had altered. The main organisations, including the Department of Health for Scotland, the medical profession and the local authorities, were still part of the health network. Organisations such as the voluntary hospitals had ceased to play a part in the network, as they were taken over by the newly formed regional hospital boards. Therefore, the decisions made within the network regarding policies and their implementation could alter the membership as the less influential groups were incorporated into the service under the newly formed administration. As has been mentioned above, it was important for local authorities to attempt to increase their influence within the health services and the network. The attempt was initially made in the early 1950s when the local authorities requested increased representation on the most influential advisory council, the Scottish Health Services Council. Increased representation on this council would have allowed direct advice to the Secretary of State and the Department of Health for Scotland. This would in turn, have enabled local authorities to pursue their agenda for a larger share of the administration of the health services. Within the policy network, however, local authorities were in a subservient relationship to the Department of Health for Scotland. The Department clearly stated in its response that the local authorities were service providers within the NHS and were not participating in the health services as an elected body representing their local constituents. As far as the Department of Health for Scotland was concerned, local authorities were well represented within the committees and boards of the NHS. The Department's attitude demonstrates that local authorities were no longer the influential force they were prior to the establishment of the NHS and were seen as service providers, not elected bodies representing their constituents. It also demonstrates, as historians such as McCrae argue, that the NHS was captured by the medical profession.³⁵ The established relationship did not allow the local authorities to influence NHS policy.

³⁴ M.J. Smith, *Pressure, Power and Policy*, (Hemel Hempstead, 1993), p. 53.

³⁵ McCrae, *The National Health Service*, p. 221.

The proposals for the implementation of their responsibilities within the NHS in 1948 and the local authorities' quest for greater representation on the most influential boards demonstrate that there existed a belief among local authorities that they were not part of the NHS and they had been pushed to the periphery of the health service. The lack of enthusiasm from local authorities for their role within the NHS was something the Department of Health for Scotland tackled through constant encouragement and acknowledgement of the central place preventive health services had, even when hospitals were seen by the Department as the main component of the NHS. As has been stated above, McCrae argues that the consensus built up over the NHS within Scotland was not disturbed by the implementation of the legislation and the Scottish consensus did not include the bitter disagreements which emerged in England and Wales.³⁶ McCrae's argument, however, does not take into account the problems encountered among the three administrative bodies of the NHS and among the groups representing the Scottish local authorities. As shown through Chapters Three and Four, co-ordination, co-operation, finance, staffing levels and the division of responsibilities with local authorities proved to be ongoing concerns for the Department of Health for Scotland up until the reorganisation of 1974.

Confusion over the division of responsibility not only existed among the three administrative bodies of the NHS, but also among the health service administrators and welfare bodies such as the National Assistance Board. Furthermore, numerous instances of co-ordination, finance and staffing problems regularly occurred within the first 12 years of the NHS. It was in these individual cases that local authorities recognised a further opportunity to influence the outcome of the NHS implementation process. On a case by case basis local authorities attempted to influence the Department of Health for Scotland's decision-making process. Local authorities were able to influence some issues that arose, but only those which affected their health services or overlapped with some welfare services. They could not influence issues which affected the other parts of the NHS. Chapter Three shows that this was the case for the payment of relative carers and for the provisions made for unmarried expectant mothers. Regarding the payment of relative carers the Department of Health for Scotland decided that local authorities had the right to choose whether they paid carers at the home help rate, did not pay relative carers, or provided a home help to the patient. Additionally, the provisions for unmarried expectant mothers were clarified, as it was agreed that the National Assistance Board would support

³⁶ Ibid, p. 241.

mothers in mother and baby homes as if it were their own home. This allowed a local health authority to provide medical treatment to the expectant mothers on the same basis as any other pregnant woman under the NHS. On these issues the local authorities were able to influence the outcome in their favour.

On issues which affected the other parts of the NHS, such as the hospital service, local authorities were not able to secure a favourable outcome. The Department of Health for Scotland utilised its position of power over the local authorities to keep them in their auxiliary role within the NHS. Chapter Three argues that this was the case when it came to the provision of maternity outfits. Many local authorities argued that maternity outfits should be provided by a GP prescription or local authorities should charge patients for them. The Department of Health for Scotland advised local authorities that it was their duty under the NHS Act to provide maternity packs to expectant mothers and that they were not authorized to charge for these packs. Interestingly, the Department of Health for Scotland also utilised their relationship with the medical profession to compel local authorities to undertake these duties which they deemed to be within their remit by requesting their opinion on who should provide the packs. The problems encountered during the implementation and development of NHS policy was a reflection of the disjointed nature of the administration of the service, the confusion over the division of responsibility and the lack of co-ordination. The problems continued into the 1960s and had, in some cases, not been fully resolved by the 1974 reorganisation.

Considering Scottish local authorities within the implementation and development process of the NHS demonstrates that the transition to the new health services was full of conflicts over implementation and disagreements over its operation. Despite continued attempts by the Department of Health for Scotland to encourage co-operation and co-ordination at all levels of the health services, relations between the three administrative bodies and between local authority areas were not advancing sufficiently to sustain a comprehensive, co-ordinated service. By the 1960s co-ordination and co-operation were still major problems for the Department of Health for Scotland reorganised into the Scottish Home and Health Department in 1962.

The Scottish Home and Health Department continually encouraged co-operation and co-ordination among the three health service administrative bodies during the 1960s. As discussed in Chapter Four, although a slow process, examples of co-ordination developed as the decade progressed. Local health authorities entered into co-ordinated services with

hospitals, GPs and voluntary groups. For example, health visitors were seconded to both specialist hospital units and GP surgeries to develop a complete system of care. Consequently, continuity of care by the GP, hospital and local health authority extended throughout the decade. Furthermore, local health authorities were utilising the services of voluntary groups to expand community health services, such as day care centres and some home help services. For example, Dundee's local health authority had links with the Dundee Association for Mental Health, the Friendship Club, the Scottish Society for Mentally Handicapped Children and the Dundee Council of Social Service. Glasgow also utilised volunteers in the Balvicar Centre for Child Development and had contacts with the WRVS and the Salvation Army. In contrast, Aberdeen repeatedly reported proudly that none of its mental health services had been assigned to voluntary organisations. Although sporadic, Chapter Four presents evidence that in areas, such as Glasgow and Dundee, the co-operation of voluntary organisations was invaluable in filling in the gaps in services provided by local authorities. Attempts to co-ordinate services with the hospital and GP services increased, and the effectiveness of local health authority services was recognised by the Scottish Home and Health Department. By the 1960s local authorities were less isolated from the NHS.

During the first 12 years of the Scottish NHS local authorities began to create specialisms within their health service remit. The expansion of local health authority services was most notable within the child health services. The Scottish Home and Health Department saw the specialised nature of the local authority child health services as central in assessing the health of children. Legislation emphasised mental health services, through the Mental Health Act (1960), as one of the main areas requiring improvement in the 1960s. The legislation required local authorities to improve their services for all patients suffering from mental health problems. Chapter Four demonstrated that although services for all patients suffering from mental health problems expanded, local authorities, such as Glasgow tended to focus on child psychiatry. In Dundee child health clinics were increasing in popularity and developments included a play area for disabled children to attend weekly and Comprehensive Assessment Centres to diagnose and treat disabilities. William Horne, the Medical Officer of Health for Glasgow, noted that by 1965 child welfare services had extended to include child development, psychiatry and mental deficiency.

The extensions in the child health services and many other local health authority services were dependent on the local health authority. The availability of finance and staff, the

willingness of the local health authority to support its Medical Officer of Health's service extensions and the expansionist ideas of the Medical Officer of Health all contributed to the way in which services expanded throughout the country. Figure 4.2 in Chapter Four, shows that the increase in services was not matched by an increase in local authority income from the NHS. The centrality of local authority services within the NHS, which was encouraged by the Scottish Home and Health Department publicity, was not evident in the financial position of local authorities within the wider NHS. Lowe argues that the Treasury opposed any redistribution of resources to local authorities, as the Treasury could not control the way in which local authorities spent their grant.³⁷ Lowe's argument is upheld when the stagnant finances of Scottish local authorities are examined. Furthermore, the financial breakdown of each local authority area of expenditure revealed the services which received the most support were home nursing, clinics and health visiting. This supports the argument of this thesis that local authorities attempted to find a niche in which to specialise and gain a more influential position within the NHS.

As with finance, staffing was also a problem which local authorities dealt with throughout the 1960s and affected the services provided. For example, in Dundee in 1961 a method of selective health visiting had to be introduced due to staff shortages. Glasgow also experienced similar problems, especially during local holiday periods such as the Glasgow Fair. Nonetheless, staffs were trained in new areas such as mental health and nursing staff were offered new incentives such as furnished accommodation to encourage them to work for the local authority health services. Local authorities and their medical officers of health attempted to find ways around problems which were out of their control in order to continue and increase health services in their areas.

The way in which services developed was also influenced by both the expansionist ideas of the Medical Officer of Health and the willingness of the local authority to support their Medical Officer of Health's proposals for the expansion of services. For example, the Medical Officer of Health for Aberdeen, Ian MacQueen, produced many reports and made many recommendations about the way in which mental health services could be improved. By 1966, however, mental health services within Aberdeen were lagging behind developments in Scotland, as the local authority was unwilling to make decisions on the recommendations he put forward. To take another example, in Dundee as the number of home births decreased, the Medical Officer of Health considered utilising midwifery staff

³⁷ Lowe, *The Welfare State in Britain*, pp. 191-2.

for maternity nursing care for women discharged from hospitals and for assisting in ante-natal care of women placed under the care of their GP by the hospital. In Glasgow a range of services were provided through health centres and district nurses were attached to GP practices, clinics, centres for disabled children and mental health services. The examples given in Chapter Four show that service developments were occurring in the local authority sphere, but this relied on the innovative ideas of the Medical Officer of Health and the local authority acceptance of these ideas. The problems encountered throughout the 1960s and early 1970s did not stop local authorities from attempting to increase services. Local authorities attempted to create specialisms which would restore their bargaining power within the health service policy network.

Legislation of the 1960s both increased the role of local health authorities and continued their slow removal from the NHS. The Mental Health Act (1960) and the Health Services and Public Health Act (1968) provided the opportunity for the local health authorities to extend the range of their health services, and extensions in local health authority services were evident throughout the decade. Nevertheless, the Social Work (Scotland) Act, 1968 reversed this trend and removed services which had been developed by local health authorities such as the mental health services, day nurseries and domestic help services. The place of local health authorities within the NHS was not guaranteed. The Social Work (Scotland) Act demonstrated that their services could be relocated to a new administrative body within the local authority at any time. The uncertainty which faced local authorities increased their concern about their lack of influence within the NHS which, from its inception, had slowly eroded. The hierarchical relationship between the Scottish Home and Health Department and the local authorities provided the Department with a means of tighter control over the local authorities than its counterpart in Whitehall had over English local authorities. Additionally, John Stewart argues that tighter control was exercised by the SHHD, due to the smaller number of health service bodies being dealt with and the smaller size of the Department itself.³⁸ By the 1974 reorganisation local authorities had lost their influence in the health service sphere. Local authorities no longer needed to be included in the policy network by the Scottish Home and Health Department. The costs of excluding local authorities from the network and from the planning of the health services, no longer outweighed the return. The Scottish Home and Health Department saw reorganisation, by the removal of local authorities from the provision of health services, as the only means to remove the tripartite administrative problems.

³⁸ Stewart, 'The National Health Service in Scotland', 399-400.

Reorganisation of the Scottish NHS, 1974

Reorganisation was not confined to the health services. The Department of Health for Scotland was reorganised in 1962 to become the Scottish Home and Health Department. Additionally, local authorities faced uncertainty over the wider reorganisation of local government. The SHHD would once more utilise the policy network and the relationships established within it to develop policy changes within the NHS. The local authorities saw this as one last opportunity to assert some influence over the future of the health services.

The policy network had changed from its original form in 1943. As was discussed in Chapter Three, the voluntary hospitals no longer existed and the network had shifted even more favourably towards the medical profession. Furthermore, in gaining the acceptance of local authorities for their diminished role within the NHS, the Scottish Home and Health Department relied on the medical profession for support over issues such as the provision of maternity packs. Although the network had altered from its original form, the dynamic between the Scottish Home and Health Department and local authorities, however, had not altered since 1945. The relationship was still hierarchical with the Scottish Home and Health Department recognising local authorities as service providers. Webster argues that local authorities within Scotland were weaker than their English counterparts.³⁹ Local authorities were at a disadvantage as they no longer had the resources to be an effective bargaining group within the network. They had lost the hospitals and specialist clinics in the initial policy formation and this loss removed any significant influence they had over health service policy development.

Local authorities, however, were not deterred, and in the run up to 1974 they attempted to increase their administrative authority within the NHS. The Convention of Royal Burghs argued, during the reorganisation negotiations, that local government reorganisation was the key to the reorganisation of the NHS. They argued that the reorganised local government system would provide the necessary administrative organization for local authorities to manage effectively the amalgamated NHS. Furthermore, the Association of County Councils argued, in a memorandum to the Scottish Home and Health Department, that as much of the NHS as possible should be placed with local authorities. The Scottish Home and Health Department did not see local authority administration as a feasible option for the NHS reorganisation for a number of reasons. First, the Scottish Home and Health Department advocated a system of centralised health care under its control.

³⁹ Webster, *The National Health Service Vol II*, p.90.

Second, local government reorganisation did not alter local authority finance in a way that convinced the Department that local authorities could finance the service. Finally, the medical profession's attitude to local authority administration had not changed and it would oppose such a solution. The local authorities' attempt to influence NHS policy developments again failed.

The Scottish Home and Health Department negotiated the terms of the reorganised NHS on two fronts: first, with Whitehall and second, with the Scottish policy network. Whitehall had concerns about the single tier area health board structure advocated by the Department and vigorously questioned the proposals. The capture of the NHS policy network by the medical profession is noted in many histories. McCrae examined the establishment of the NHS from a medical point of view, highlighting the dominance of the medical profession in NHS policy formation.⁴⁰ Webster argues that concessions were given to the medical profession to gain agreement over NHS policy.⁴¹ The policy network re-confirmed the strong links between the medical profession and the Scottish Home and Health Department through acceptance of the Porritt Report which had been undertaken by the medical profession and represented nine medical organisations. As Chapter Five argues, the Scottish Home and Health Department aligned its proposals to the Porritt Report, which was welcomed in many circles, including the medical profession, thus convincing Whitehall of the merit of the structure adopted. Consequently, local authorities were discounted in the negotiations as they had no bargaining resources. The central control of the NHS within the Scottish Home and Health Department was secured by the NHS (Scotland) Act, 1972, and local authorities were finally removed from the provision of health services within Scotland.

The 1972 Act introduced 14 area health boards which amalgamated the three administrative bodies of the NHS. Local authorities were represented on the new area health boards but only through the appointments by the Secretary of State for Scotland. The 1972 Act effectively caused the final demise of local authority health care which had been initiated by the formation and implementation of the 1947 Act. The policy network established in the 1940s did not allow local authorities to use their resources to negotiate initial health service policy, increase their influence within the health services during the implementation process, nor defend their health service provisions in the reorganisation of

⁴⁰ McCrae, *The National Health Service in Scotland*, p. 221.

⁴¹ Webster, 'Conflict and Consensus', pp. 150-1.

the NHS. The reorganisation of 1974 completed the long, slow removal of local authorities from the health services.

The analysis of the development of the NHS within Scotland has led this thesis to reach a number of conclusions. First, the development of the NHS in Scotland was characterised by conflict within consensus. Consensus was evident over the need for a comprehensive health service, whilst conflict resulted from disagreements over the way in which such a service should be administered. Second, that during the negotiations over the NHS, the DHS created a hierarchical relationship with local authorities which prevented them from influencing the Act in any significant way. Third, the local authorities' inability to work together and their acceptance of the assurances from the DHS, that the removal of the NHS from their administrative control was temporary, resulted in their auxiliary role within the NHS (Scotland) Act 1947. Fourth, the implementation of the NHS (Scotland) Act 1947 continued the slow removal of local authorities from the health services. Despite the attempts of local authorities to increase their influence within the NHS, the DHS saw them as service providers. The continuation of the subordinate relationship did not allow local authorities to influence any areas within the health services apart from those within their own field. Fifth, the implementation of the NHS continually encountered problems which the DHS, when solving the problem, tended to favour the hospitals and GPs over local authorities. This was in spite of the recognition by the DHS that some local authorities were making positive and innovative contributions to the health services most notably through their child welfare services. Sixth, by the 1960s the Scottish Home and Health Department recognised that administrative reorganisation was the only means of resolving the inherent issues within the NHS. Local authorities attempted to assert influence over the reorganisation of the NHS but had lost all their bargaining power in the previous years of the NHS. The reorganisation of the NHS in 1974 achieved the Scottish Home and Health Department's goals of centralisation and the removal of local authorities from the Scottish health services. Finally, the period 1939-74 witnessed the slow removal of local authorities from the Scottish NHS.

The conclusions expounded from this thesis have demonstrated that local authorities have largely been forgotten in the histories of the Scottish NHS. Historians such as Morrice McCrae and Jacqueline Jenkinson have paid little attention to local authorities despite their centrality and influence on the health services in the pre-NHS era. The histories provided by McCrae and Jenkinson stress consensus and the domination of the medical profession in the development of the Scottish NHS. By demonstrating that conflict was evident between

the Department of Health for Scotland and local authorities, the arguments given by McCrae and Jenkinson that the development of the Scottish NHS was smooth and free from conflict is contested. This thesis therefore has provided evidence to support the view of Charles Webster and Rudolf Klein that conflict within consensus epitomised the development of the NHS in Scotland as in the rest of the UK.

The histories of the Scottish NHS, given by Jenkinson and Stewart, also argue that the development of the health services was distinctive due to the differences in legislation to that of England and Wales. This thesis has provided further evidence that the distinctive development of the NHS was also evident through the way in which the Department of Health for Scotland dealt with negotiations over the Act of 1947 and created a dynamic within the negotiations where local authorities seemed to have, as argued by Hamilton, a 'muted voice'. However, the thesis argues that the relationships among local authorities and between local authorities and the Department of Health for Scotland created a particularly Scottish response to the negotiation process. This response, which has been detailed previously, led to the perception that local authorities had a 'muted voice' in comparison to their English counterparts and Jenkinson's argument that the management of negotiations by Thomas Johnston was central in the smoothness of talks over the NHS. Consequently, by analysing the influence and reaction of local authorities in the development of the Scottish NHS, this thesis has provided further evidence to suggest that conflict was evident at this stage.

Furthermore, this thesis contests the view of McCrae that the implementation of the Scottish NHS was undertaken without any conflict. As has been discussed throughout the thesis, conflict was evident among the three administrative bodies within the NHS. The conclusions uphold Lowe's argument that the NHS was planned under a permanent air of crisis, which was as evident in Scotland as in England. Problems continually arose in the implementation of the Scottish NHS and the alignment of the DHS' interests with the medical profession created a powerful alliance against local authorities. The thesis therefore agrees with the argument of McCrae that the NHS was captured by the medical profession. Nevertheless this thesis has demonstrated that despite the dominance of the medical profession, some local authorities provided innovative services such as the extensions in their child health services, a story which is missing from the current histories of the Scottish NHS. As John Stewart argues, the Scottish Home and Health Department were able to exercise tighter control on the development of the NHS due to the smaller size of the Department and the smaller number of bodies it had to deal with. The control

discussed by Stewart is apparent when considering the role of local authorities and their inability to exercise any influence over the development of the Scottish NHS in its first 25 years. Ultimately this thesis has expanded the current histories of the Scottish NHS by bringing the changing fortunes of local authorities within the health service sphere to light and contesting some of the arguments upheld by historians of the Scottish health services.

The period 1939 to 1974 saw the demise of local authorities from the health service arena. The policy network established to negotiate health policy, implement both Acts and develop the NHS placed local authorities in a hierarchical relationship with the Scottish Home and Health Department thus removing their ability to influence policy formation in the health services during this period. Local authorities attempted many times to reinstate their influence within the health services and realigned their priorities towards the child health services to create a specialism which would make them indispensable within the health services. Nevertheless, the Scottish Home and Health Department saw local authorities as a service provider and utilised the policy network to keep local authorities in their auxiliary role within the NHS. Consequently, by the reorganisation of 1974, local authorities had been 'crowded out' of the health services by the medical profession and the Scottish Home and Health Department and played no further part in the Scottish NHS. Although ultimately a story of loss, historians should no longer ignore the story of how the local authorities struggled to restore their influence and find new roles within the NHS in Scotland during its first quarter century.

Appendix 1: Written and Oral Evidence given to the Royal Commission on Local Government in Scotland¹

<i>Counties of Cities</i>	<i>Written Evidence</i>	<i>Oral Evidence</i>
Aberdeen	†	†
Dundee	†	†
Edinburgh	†	†
Glasgow	†	†
<i>Large Burghs</i>		
Airdrie	†	
Arbroath	†	
Ayr	†	
Clydebank	†	
East Kilbride	†	
Greenock	†	
Hamilton	†	
Kilmarnock	†	
Motherwell & Wishaw	†	
Paisley	†	
Perth	†	
Rutherglen	†	
Stirling	†	
<i>Small Burghs</i>		
Aberlour	†	
Alloa	†	†
Alva	†	
Anstruther	†	
Ardrossan	†	
Armadale	†	
Banchory	†	
Barrhead	†	
Bathgate	†	
Bearsden	†	
Bishopbriggs	†	

¹ The Rt. Hon. Lord Wheatley (Chairman), *Royal Commission on Local Government in Scotland 1966-1969*, (September 1969), Cmnd. 4150, p.

Written Evidence**Oral Evidence**

Bo'ness	†
Bonnyrigg & Lasswade	†
Brechin	†
Buckhaven & Methil	†
Carnoustie	†
Crail	†
Crieff	†
Cupar	†
Dalkeith	†
Dingwall	†
Dollar	†
Dornoch	†
Dufftown	†
Elgin	†
Elie	†
Forfar	†
Fort William	†
Fraserburgh	†
Galston	†
Girvan	†
Gourock	†
Grangemouth	†
Inverbervie	†
Jedburgh	†
Johnstone	†
Kelso	†
Kilsyth	†
Kinross	†
Kirkwall	†
Kirriemuir	†
Lanark	†
Laurencekirk	†
Lerwick	†
Leven	†
Linlithgow	†
Loanhead	†
Lossiemouth & Branderburgh	†
Maybole	†
Millport	†
Milngavie	†
Monifieth	†
Montrose	†
Musselburgh	†
Nairn	†
Newport-on-Tay	†
Peebles	†
Penicuik	†
Pittenweem	†
Prestwick	†
Queensferry	†

Written Evidence**Oral Evidence**

Renfrew	†	
St. Andrews	†	
Saltcoats	†	
Sanquhar	†	
Stevenston	†	
Stonehaven	†	
Stornoway	†	
Stranraer	†	†
Tain	†	
Tayport	†	
Thurso	†	
Tillicoultry	†	

Counties

Aberdeen	†
Argyll	†
Ayr	†
Banff	†
Berwick	†
Bute	†
Caithness	†
Clackmannan	†
Dumfries	†
Dunbarton	†
Fife	†
Inverness	†
Kincardine	†
Kinross	†
Kirkcudbright	†
Lanark	†
Midlothian	†
Moray	†
Moray & Nairn	†
Orkney	†
Peebles	†
Perth	†
Perth & Kinross	†
Renfrew	†
Ross & Cromarty	†
Roxburgh	†
Selkirk	†
Stirling	†
Sutherland	†
West Lothian	†
Wigtown	†
Zetland	†

<i>Districts of Counties</i>	<i>Written Evidence</i>	<i>Oral Evidence</i>
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Aird, Inverness-shire	†
Ardnamurchan, Argyllshire	†
Badenoch, Inverness-shire	†
Carnoustie, Angus	†
Cromdale, Morayshire	†
Cupar, Fife	†
Deeside, Aberdeenshire	†
Dornoch & Creich, Sutherland	†
Duffus & Drainie, Morayshire	†
Eastwood (First), Renfrewshire	†
Elgin, Morayshire	†
Fearn, Ross & Cromarty	†
Fochabers, Morayshire	†
Forres, Morayshire	†
Gairloch, Ross & Cromarty	†
Harris, Inverness-shire	†
Helensburgh, Dunbarton	†
Highland, Perthshire	†
Inverness, Inverness-shire	†
Jedburgh, Roxburgh	†
Kilmarnock, Ayrshire	†
Lanarkshire (Second)	†
Lanarkshire (Ninth)	†
Lewis, Ross & Cromarty	†
Montrose, Angus	†
North Lorn, Argyllshire	†
Roths & Knockando, Morayshire	†
St. Andrews, Fife	†
South West, Ross & Cromarty	†
Tain, Ross & Cromarty	†
Tongue & Farr, Sutherland	†
Vale of Leven, Dunbarton	†
West Kilbride, Ayrshire	†
Yell, Zetland	†

Local authority associations

Association of County Councils in Scotland	†	†
Convention of Royal Burghs		
Large Burghs Committee	†	†
Small Burghs Committee	†	†
District Councils' Association for Scotland	†	†
Aberdeenshire Burghs Association	†	
Banffshire Burghs Association	†	†
Border Burghs' Convention	†	†
Fife & Kinross Small Burghs Association	†	
Midlothian Small Burghs Association	†	
Northern Burghs Association	†	
Perth & Kinross Small Burghs Association	†	
West Lothian Burghs Association	†	

Appendix 2: Membership of the Working Group on Scottish Local Government Management Structures (Paterson Committee)¹

Steering Committee

Chairman: J. F. Niven (Wigtown)

Association of County Councils in Scotland: Major A. J. MacDonald (Inverness)

P. M Robertson (Ayr)

G. Sharp, OBE (Fife)

Convention of Royal Burghs: Provost J. Crawford (Dunfermline)

Lord Provost A. U. Cross, TD (Perth)

Ex-Provost E. J. Dowdalls (Coatbridge)

Bailie J. Forde, MBE (Stevenston)

Ex-Provost A. C. Smyth, OBE (Forfar)

District Councils Association for Scotland: A. Devlin (Glenrothes)

D. M. McBain (Lairg)

Scottish Counties of Cities Association: Councillor G. Foulkes (Edinburgh)

Treasurer W. S. Gray (Glasgow)

Treasurer Mrs E. McCulloch (Glasgow)

Councillor R. A. Raffan (Aberdeen)

Councillor J. Slack (Edinburgh)

Treasurer R. M. Tosh (Dundee)

Advisory Group

Chairman: I. V. Paterson, CBE (County Clerk, Lanark)

Vice-Chairman: R. G. E. Peggie (Depute City Chamberlain, Edinburgh)

Association of County Councils: E. Geddes (County Treasurer, Midlothian)

F. Inglis, CBE (Secretary and Treasurer, Association of
County Councils in Scotland)

¹ The Working Group on Scottish Local Government Management Structures, *The New Scottish Local Authorities: Organisation and Management Structures*, (1973), pp. iii-v

Association of County Councils in Scotland: G. H Spiers (Secretary and Treasurer,
 Association of County Councils in
 Scotland)

Convention of Royal Burghs: J. R. Hill, (Town Clerk, Inverness)

J. Gibson Kerr, CBE (Agent and Clerk, Convention of
 Royal Burghs)

R. Kyle, MBE (Town Clerk and Manager, Cumbernauld)

A. McIntosh, (Town Clerk, Motherwell and Wishaw)

District Councils Association for Scotland: J. S. Campbell, MBE (Hon. Secretary,

District Councils Association for Scotland)

G. S. Thomson (Clerk, First District Council,
 Renfrew)

Scottish Counties of Cities Association: Dr L. Boyle (City Chamberlain, Glasgow)

S. F. Hamilton (Depute Town Clerk, Glasgow)

Scottish Development Department: R. D. M. Bell, CB (Under Secretary)

Central Advisory Unit

Director: G. McGowan (P.A. Management Consultants Ltd)

J. H. Haddow (Edinburgh Corporation)

J. Maitland-Ward (Lanark County Council)

C. Bookless (Midlothian County Council)

Appendix 3: Local Authority Regions and Districts¹

Region	District
Highland	Caithness
	Sutherland
	Ross & Cromarty
	Skye & Lochalsh
	Lochaber
	Inverness
	Badenoch & Strathspey
	Nairn
Grampian	Moray
	Banff and Buchan
	Gordon
	Aberdeen City
	Kincardine & Deeside
Tayside	Angus
	Dundee City
	Perth & Kinross
Fife	North East Fife
	Kirkcaldy
	Dunfermline
Lothian	West Lothian
	Edinburgh City
	Midlothian
	East Lothian
Borders	Tweeddale
	Ettrick Forest
	Roxburgh
	Merse
Central	Clackmannan
	Stirling

¹ The Working Group on Scottish Local Government Management Structures, *The New Scottish Local Authorities: Organisation and Management Structures*, (1973), pp.113-115.

Region	District
Strathclyde	Falkirk
	Argyll
	Dunbarton
	Glasgow City
	Strathkelvin
	Monklands
	Motherwell
	Cadzow
	East Kilbride
	Lanark
	Renfrew
	Inverclyde
	Cunninghame
	Kilmarnock & Loudoun
Dumfries & Galloway	Kyle & Carrick
	Cumnock & Doon Valley
	Merrick
	Stewartry
	Nithsdale
Orkney	Annandale & Eskdale
Shetland	
Western Isles	

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