Doctors in Whitehall: medical advisers at the 60th anniversary of the NHS

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Executive summary

- The government's requirement for expert medical advice from the 1850s led to the development of a medical Civil Service, which reached its peak in size and authority in the 1970s.

- The successive Whitehall efficiency reviews from 1979 onwards culminated in 1994 in the merger of the parallel reporting hierarchies, effectively reducing the Chief Medical Officer's ability to call upon the support of medical civil servants, at a time of increasing new health threats such as AIDS and MRSA.

- In the last ten years, the government has become more imaginative in its use of temporary specialist medical advisers ('tsars') brought in from the NHS, in relaxing formal Civil Service hierarchies, and in quietly abandoning the statutory Standing Medical Advisory Committee (SMAC).

- Historical examples show that when the government has failed to give adequate support to its Chief Medical Officers, the medical Civil Service has suffered from poor morale, experienced recruitment difficulties, and the ability to respond to health crises has been compromised.

- Virtually none of the Whitehall and NHS reviews have considered their historical context. The current NHS review has been crudely timetabled to produce a politically-favourable report in time for the 60th anniversary in July 2008. As with earlier reviews, it does not appear to be addressing more deep-seated issues such as the location and management of medical expertise.

- The government needs to acknowledge that some of its tasks, such as protecting the public's health, do not easily fit into fashionable Public Service Agreements or the ethos of New Public Management.

Introduction

When Margaret Thatcher became Prime Minister in 1979 she is reported to have known the exact number of doctors working in the Department of Health and Social Security (DHSS) in Whitehall, and to have told Patrick Jenkin, her new Secretary of State for Health, that one of his first objectives should be to send many of them 'back to the NHS to do proper medical jobs'. In the subsequent eighteen-year Conservative administration, the number of medical Civil Service posts was radically reduced, in face of opposition from its head, the Chief Medical Officer (CMO), and despite the development of new health crises, such as AIDS, BSE, and MRSA.

The reduction in the size of the medical Civil Service was part of the incessant Whitehall efficiency reviews. It was accomplished through a series of 'objective' reports, none of which explored the historical context for the development of expert medical advice for governments. The permanent medical Civil Service has gradually been replaced with a smaller core staff, who no longer report to the CMO, but are integrated with administrative teams, along with a number of new 'health tzar' posts that do not fit easily within the traditional Whitehall system. Expert medical advice is increasingly outsourced. This paper suggests that the use of internal and external expertise has historically been fluid. However, the desire to prune the number of permanent medical civil servants to the bare bone has significant implications, and requires more careful consideration of such issues as the relationship between the Department of Health and the National Health Service (NHS).

The development of the medical Civil Service

From the mid-nineteenth century, the government has solicited expert advice from medical professionals in a variety of ways, initially as a reactive strategy in the face of outbreaks of infectious epidemic diseases such as cholera and smallpox. From the appointment of John Simon in 1855 to a new Civil Service position of Chief Medical Officer (CMO), the government had access to a permanent internal source of medical expertise. The CMOs have subsequently been supported in their role by a team of medically-qualified civil servants, engaged to develop health policy and determine public-health requirements. They were located within the Local Government Board from its creation in 1871, until the formation of a dedicated Ministry of Health in 1919.

Between Simon's appointment in 1855 and the formation of the Ministry of Health, the CMOs engaged in an almost continuous battle to gain and maintain sufficient medical staff to carry out their duties. Part of the enduring difficulty was in getting the administrative secretariat to understand and acknowledge the medical (technical) justification for specific policies and tasks. The sixth CMO, Arthur Newsholme, said of his time in office (1908-1919) that there was: '... an honest belief, common to many government departments, that technical advice is advice not to be given until called for by the secretariat who, it is assumed, are entirely competent to decide whether such advice is needed. Second, when such advice is on record, it is assumed that it can

be safely reapplied in what are regarded by the secretariat as analogous circumstances'.

The new Ministry of Health formalised the inherited system of parallel hierarchies for the professional medical and administrative staff, reporting to the CMO and the Permanent Secretary respectively. Long-standing grievances over the relative pay and status of the medical staff continued, and the new CMO, George Newman, had to fight to secure his own position as a civil servant with equal status to the Permanent Secretary, and his right of access to the Minister of Health. Yet by the 1930s in certain areas of government work the complexity of issues meant that the employment of 'technical experts' had become essential. The Royal Commission on the Civil Service calculated that there were some 10,000 engineers, scientists, doctors and other specialists employed in the Civil Service in 1931. However, their status fluctuated, and had a major impact on the ability to attract high-calibre staff. Wilson Jameson, perhaps the most influential person in the establishment of the NHS, rejected the initial offer to move from an academic post to become the Chief Medical Officer, claiming that the atmosphere at the Ministry of Health in the 1930s was like a 'poorly-run girl's school'.

With the creation of the NHS in 1948, the Ministry of Health for the first time had direct control over a comprehensive medical service. But there was no commensurate expansion of either the professional or administrative staff. In fact, an economically-motivated review of the Ministry in 1951 resulted in the loss of Cabinet representation, a reduction in staff and a consequent decline in parliamentary prestige.

As the size and complexity of the NHS continued to grow, it provided a greater share of the workload of the Ministry of Health. Matters were further complicated in 1968, when the Ministry was amalgamated into the new Department of Health and Social Security (DHSS), perhaps tellingly known by its employees as the 'Department of Stealth and Total Obscurity'. By the early 1970s it had a medical staff of 189, reporting directly to the CMO, George Godber. He vigorously campaigned to retain his line management of these staff within a 'parallel hierarchy' alongside the administrative staff. He believed that this was the only viable mechanism for ensuring that medical expertise was acknowledged and medical policy was appropriately developed.

The political economy of government reviews

Throughout the 1970s there was a perception that the DHSS was struggling to define its role and that of its staff. Indeed, the Royal Commission on the NHS, reporting in 1979, recommended that responsibility for the delivery of health services should be transferred from the DHSS to the Regional Health Authorities. With the arrival of the Conservative government in 1979, there came a sustained focus on the efficiency of government departments, and the NHS in particular. A re-structuring exercise was carried out for the NHS in 1981-2, followed by the Prime Minister's invitation to the Chairman of Sainsbury's, Roy Griffiths, to chair an Inquiry Team (of four people) to give advice on NHS management. Their report was published just six months later in

October 1983, drawing on extensive consultations but no formal evidence. This was a new form of fast government inquiry, abandoning the traditional Committees and Royal Commissions, and rejecting the production of a consensus-style report. It recommended that 'the DHSS should rigorously prune many of its existing activities'. Senior medical posts were scrutinised no less than eight times between 1981 and 1994 to establish whether the numbers and grades of staff employed accurately matched the work requirements.

The Moseley Review of Senior Open Structure of the DHSS, published in April 1986, was the first serious attack on Donald Acheson's support network during his time as CMO (1983-91), although on this occasion he succeeded in retaining his senior medical staff. In 1988, (the same year that the DHSS was split along the natural fault line into the Department of Health and the Department of Social Security) a further review was carried out. It drew attention to long-standing recruitment problems to medical posts within the Department of Health, and the lack of adequate crisis-management planning. It demonstrated a discernible increase in the amount of work undertaken by the medical staff, and predicted that with the emergence of AIDS and ongoing reform of the NHS, this would undoubtedly increase.

In 1990 Richard Alderslade, a former medical civil servant, provided a Scrutiny of the Department of Health Medical Divisions. This stated that doctors were needed in the Department to monitor public health and contribute to policy; to provide expert advice to the department and other government departments; to discharge the CMO's statutory functions; to represent the Government to the medical profession; and to carry the medical role in international health work. Alderslade's team found 'a widespread perception among medical staff, that medical work is not being managed as well as it should be. In essence what is missing is a systematic and consistent approach to assessing organisational and group objectives for the medical divisions, identifying within that framework the work to be done, allocating responsibility for that work and holding to account'. He recommended, on the basis of a trial, that there should be integrated working at all levels.

Following the separation of the NHS Management Executive in 1989, the rest of the Department of Health had become known as the 'Wider Department', and was re-structured into a pair of social-care Divisions and three paired administrative and medical Divisions. A number of NHS administrative staff were recruited to the Wider Department. A subsequent Whitehall research project suggested that, as an exercise in re-modelling policy and management divisions, this had not worked well, partly because of the clash of NHS managerial and Civil Service cultures. The NHS staff came across as risk-taking, verbal communicators, who were outcome-orientated. The civil servants were characterised as working within a system of elaborate written channels of communication with limited scope for personal initiative, and where their primary duty was to serve Ministers, particularly through protecting them from risk.

The 1994 Banks review

The most radical Department of Health restructuring took place in April 1995, following a review of senior management in 1994 by a retired civil servant, Terri Banks. She recommended much closer alignment of policy and implementation functions; tighter allocation of work to relevant Civil Service grades to avoid 'grade skipping'; more explicit criteria for the retention of committees; and a move away from calendar-driven meetings towards issue-driven meetings.

Banks advised merging the medical and administrative 'paired' Divisions, ending the professional reporting lines that had been in place since the formation of the Ministry of Health in 1919. She judged that these were 'an expensive structure. Responsibilities between the administrative and medical parts are often unclear, the duplicate management structures are wasteful, and unnecessary tension is caused by artificial links between pay and grading.' The aim of the re-organisation was to enable the Department to operate more effectively and efficiently. The proposed 'team working' ethos was intended to encourage greater flexibility and improved job satisfaction. This also reflected a wider Whitehall sympathy for more fluid organisational structures, seen in the development of JESP scores (Job Evaluation for Senior Posts), which broke the traditionally rigid Civil Service grading system. An additional review by John Evans recommended more reliance on external expert advisers, even though this might have significant costs and the speed of the advisers' responses might be compromised by the demands of their employers.

As a result of the 1995 reorganisation, medical and administrative staff were integrated, with reporting lines to the Permanent Secretary, and not the CMO. Although some medical staff now managed administrative staff, the reality for the survivors of the rationalisation exercise was the loss of their 'esprit de corps' and, for those working on their own in administrative-led branches and divisions, the erosion of readily-available senior medical advice. Although Kenneth Calman as CMO (1991-1998) remained as head of the medical Civil Service staff for professional matters, he lost his direct line management of over 140 staff. This had implications for the prioritisation and allocation of departmental work, and budget allocations for medical projects. Between 1995 and 1998, there was a 21 per cent reduction in staff and a 27 per cent reduction in Departmental running costs: a financial vindication of Whitehall's drive for efficiency. Although compulsory redundancies were avoided, many junior medical civil servants were moved into jobs in the NHS and non-departmental public bodies (such as the National Radiological Protection Board and the Public Health Laboratory Service). Those that remained suffered a difficult period when morale declined.

The new integrated hierarchy was deemed dangerous. Acheson was sufficiently concerned to use the 1998 BSE Inquiry to circumvent the usual retired civil servant's code of discretion, and make his views on the consequences of the 1995 re-structuring clear:

Since the subsequent integration of the Department, which I understand has left the CMO with hardly any staff for whom he is managerially accountable, it is difficult to see how this responsibility [for the quality of medical advice] can be discharged effectively or indeed how he could successfully insist, against opposition, on any

necessary changes to address any new problems or emergencies. This is, I believe, a unique penalty for a person working at this level of responsibility, whether in the public or private sector and risks compromising the independence of the CMO which is so important to the protection and improvement of health in this country.

Calman's reported comment in 1998 - that his staff now consisted of a secretary and a mobile phone - exposed the nadir of medical Civil Service morale. It echoed earlier low points in the 1880s, 1930s and 1950s, when the CMOs had struggled to fulfil their statutory duties because of medical-staff cuts. This is a significant point: as the CMO leads the professional medical Civil Service by example, his personal ability to withstand attacks upon the group's size, function and credibility are critical factors in ensuring its reputation and ability to recruit high-calibre staff.

It has been suggested that the medical Civil Service was perceived as more malleable in the 1980s because Donald Acheson was the first CMO not to have been promoted from within its ranks. He lacked that insider knowledge of how the Civil Service operates, such as the sensitive nuances of grading, and he re-interpreted the CMO post as that of a pure adviser, rather than as an initiator of health policy. Therefore, he was not as prepared as some of his predecessors (such as George Godber) would have been to fight for the traditional Civil Service structures. He relied on his own personal authority to allow him to summon medical-staff support at times of crisis, such as the emergence of the HIV/AIDS crisis in 1986 and the BSE crisis in 1988. By the time Kenneth Calman became CMO, the long-established system of succession planning for medical posts had been eroded, and he did not benefit from the sort of Whitehall initiation that departing CMOs had traditionally provided.

Internal and external expertise

The creation of the new posts of National Clinical Directors ('health tsars') in 2000 was in part inspired by a recognition that NHS medical staff might respond better to advice from 'one of their own' rather than from what was increasingly seen as a dictatorial central bureaucracy, in which medical priorities were likely to be subordinate to administrative control. The tsars have proved to be effective precisely because they are practising clinicians. They are respected by their NHS colleagues because, as an experienced medical administrator put it: 'You help professional opinion to form itself spontaneously'. Likewise, they have been effective within Whitehall because the advisory culture has changed: they have been able to exploit their direct access to the Secretary of State - a privilege traditionally reserved for the CMO and Permanent Secretary. Also, recent Secretaries of State for Health, such as Alan Milburn, have encouraged a much greater degree of informality in their Departmental working regimes. Civil Service grades have mattered less than observed ability, resulting in some junior staff enjoying unprecedented ministerial access.

But the tsars are on fixed-term secondments from their NHS careers - initially given five-year contracts (although Mike Richards, the 'cancer tsar', is now in his eighth year in post). To understand the culture of Whitehall, they depend on civil servants to educate them in the somewhat arcane procedures for management and

communication. They have been parachuted into high-level posts usually above experienced medical staff whose own career progression prospects have been subject to the varying status of the Department of Health. Most have already spent a substantial period as practising clinicians in the NHS: 're-treads' as one such senior medical civil servant described himself. The move into Whitehall has been a second stab at finding the right career, often undertaken in their thirties and forties.

Medical-career management inside the Department of Health has not always been found to be of the highest quality. Even in the 1950s, the Civil Service Medical Officers' Joint Committee was complaining that it was difficult to attract high-calibre applicants for Whitehall posts: there were few promotion prospects, it was difficult to move back into clinical medicine after such an appointment, and the Civil Service pay scale was inferior to that for NHS medical staff. The Chief Medical Officers have personally played strategic roles in appointing medical staff and managing career progression. George Godber and Henry Yellowlees were conscious of the need to maintain a degree of clinical medical expertise within the DHSS. In contrast, Donald Acheson saw his priority as strengthening the public-health function, which undoubtedly coloured his staff selection criteria. Such personal preferences matter: the balance of clinical and non-clinical medical staff within the Department of Health is picked up on by the NHS and the medical profession as a whole as indicative of where priorities lie.

A further significant issue is the balance between internal and external expert medical advice. While the arrival of the 'health tsars' was publicly championed by the government, the abolition of the Standing Medical Advisory Committee (SMAC) happened almost without notice in May 2005. This is perhaps surprising given that its formation in 1949 had been at the insistence of the medical profession, as one of the conditions for its entry into the NHS. Enshrined in the 1946 National Health Service Act, SMAC had provided ministers with access to the very best medical advice from a broad spectrum of specialists appointed as individuals in their own right, not as official representatives for the medical royal colleges or interested organisations. It was significantly a statutory body - a vital channel of communication that government ministers could not choose to sideline. Its three recognised functions - developing advice, commenting on advice developed by others, and alerting ministers and the Department to issues that were likely to be important in the future - were not fulfilled by any other organisation in quite the same way. Yet the Quinquennial Review in 2004 of its structure and function (required by the Cabinet Office of all non-Departmental Public Bodies) found that some of the advice it gave was duplicated through more recently created channels, such as the National Institute for Clinical Excellence (NICE), the National Clinical Directors and the Academy of Medical Royal Colleges. However, these bodies do not completely represent the wide range of interests that had been found within SMAC, and the cost-saving motivation for its abolition may yet prove short-sighted.

Conclusions

Very few of the Whitehall reviews discussed here have acknowledged their historical context. Their frequency has been such that they could not all even be mentioned within the confines of this paper, and the NHS is now unable to get through a political season without some sort of analysis. This is a malaise that many modern health-care systems suffer from. Charles Webster, the NHS's official historian, suggested at its fiftieth anniversary in 1998 that Britain might be getting close to the sort of NHS Commission envisaged when the Ministry of Health was designed in 1919. Yet as we approach its sixtieth anniversary, the NHS continues to exhibit symptoms of advanced instability, with almost continual structural change, particularly since the introduction of the internal market in 1991. The Secretary of State for Health, Alan Johnson, in announcing the current NHS review in July 2007, acknowledged that 'subjectively and anecdotally, there has been confusion and frustration in the NHS ... Doctors, clinicians and nurses complain that they are fed up with too many top-down instructions and are weary of re-structuring. They want a stronger focus on outcomes and patients, and less emphasis on structures and processes.'

Yet it needs to be acknowledged that as long as the boldest re-structuring proposal is avoided - that of divorcing the NHS from the Department of Health - the Department will continue to be the main generator of medical expertise, produced and managed within the culture of the Civil Service. This provides valuable continuity in the face of short-term politicised targets, through the long-term employment of medical Civil Service staff. It requires an appropriate range of medical expertise located within Whitehall, from clinical to public health medicine, and that it is managed to ensure the effective development and implementation of policy, while maintaining the integrity and status of the medical Civil Service. In the 1920s senior Ministry of Health mandarins quipped that expert advice should be 'on tap, but not on top': in 1994 the Banks review team mantra was 'do we need a doctor in that post?'. What seems to have driven both these views is the belief that medical Civil Service staff should be kept under tight administrative control, whether for financial or cultural reasons.

The issue of whether medical civil servants require a separate management hierarchy is secondary to the personal authority of the CMO in being able to access such staff when the need arises. At times when the CMO has been perceived as either weak or narrowly focused, the broader reputation of the medical Civil Service, and its ability to recruit and maintain high-quality staff, has suffered. It is important therefore that the CMO is seen to be well-supported and influential. The strength of the CMO's personal authority, especially in ensuring the capacity for providing expert advice, has been demonstrated consistently since the 1850s. Crises such as AIDS and BSE have shown that the CMO requires unhindered access to medical Civil Service staff as well as external expertise. Furthermore, the CMO's oversight and gatekeeper function is critical in managing conflicting demands for resources, particularly between clinical and non-clinical health services in the new Whitehall culture of Next Steps agencies and health tsars. Active consideration of the historical context of current, seemingly transient structures, is essential.

Further reading

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- G. Rivett, *National Health Service History*, online at www.nhshistory.net
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