The National Health Service celebrates its 50th birthday

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The National Health Service (NHS) was born on 5 July 1948, after a prolonged and difficult labour, and in 1949 it cost the Treasury all of £433 million, or 3.5% of Britain's gross domestic product. In 1997/98 it cost the Treasury £44 203 million, 5.6% of gross domestic product, and on 5 July this year it celebrates its 50th anniversary with parades, speeches, television programmes, symposia, much nostalgia and a service of thanksgiving in Westminster Abbey.

From its earliest days the NHS was prized by the British public and soon became a cherished national institution. Its central aim of providing health care for everyone, from the cradle to the grave, free, or almost so, at the point of delivery and with resources allocated in response to clinical need rather than ability to pay was unashamedly socialist, and a vital component of the 'welfare state'; yet this credo and the public's loyalty to it has survived half a century of political and economic upheaval, massive changes in the scope and organisation of health care and steadily escalating costs. The British Medical Association, whose top brass had originally fiercely opposed the creation of the NHS and had vilified Aneurin Bevan, its chief architect, became within a decade one of its most staunch supporters. Even Margaret Thatcher, to whom socialism and monolithic public services were anathema, never dared in her 17 years in power to threaten the principle of a comprehensive health service, funded by the exchequer and largely free at the point of delivery. For all its shortcomings and the inevitable uncertainties about its long-term future, the NHS can still claim to be at least as cost-effective, at least as equitable, and at least as popular with its clientele as any other system of health care in the world.

This summer the origins and history of the NHS, its past achievements and its uncertain future, will be discussed and described in many different settings, and from many different perspectives. The purpose of this editorial is to try to assess what the NHS has done for the mentally ill and for psychiatry.

THE MENTAL HOSPITALS

The county asylums had not been included in the hospital surveys of 1942 and 1944, and until 1946 no one expected mental hospitals to be included in the new NHS. As a result, little planning was done and they were incorporated into the NHS "with difficulty, as an unwilling and inferior partner" (Rivett, 1998). Isolated and poorly regarded, their problems were massive, for most of them were old, badly equipped, overcrowded and far too large, some with over 2000 beds. Yet they benefited from being brought into the same administrative structure as the old municipal hospitals, now to be known as general hospitals. The stigma of mental illness was reduced a little by this symbolic incorporation and psychiatrists and psychiatric nurses automatically received the same salaries as other hospital doctors and nurses. Indeed, their more favourable pension arrangements were maintained. For the first 15 or 20 years of the NHS British psychiatry flourished and its achievements were widely admired and copied. British psychiatrists' experience in the Second World War of treating servicemen with florid, incapacitating neurotic disorders and seeing them recover had given them an unprecedented confidence in their therapeutic powers, and also an understanding of the importance of the social milieu of an institution. Charismatic men like T. P. Rees at Warlingham Park and Duncan Macmillan in Nottingham unlocked the doors of their wards, developed comprehensive rehabilitation programmes and began to discharge many of their chronic patients into humble but real jobs in the outside world. The introduction of chlorpromazine in 1953 and imipramine a few years later created a new therapeutic optimism, as well as transforming the behaviour of many patients and the atmosphere of long-stay wards. The 1954 Royal Commission on the Law relating to Mental Illness and Mental Deficiency proposed that all distinctions – legal, administrative and social – between mental and physical illness should be abolished or minimised and that, wherever possible, psychiatric patients should be treated as out-patients rather than as in-patients. The 1959 Mental Health Act to which these proposals gave rise was, by the standards of its day, a revolutionary and enlightened piece of legislation and for a few years optimism prevailed. The stigma of mental illness had been reduced, the gulf between mental and physical illness (and between psychiatrists and other doctors) had been narrowed, exciting new drugs were being introduced, university departments of psychiatry were being created, the number of patients in the old mental hospitals was falling steadily and other countries and their psychiatrists were impressed.

At the same time it was becoming increasingly clear that psychiatric patients were not receiving their share of the NHS's slowly growing resources. Weekly expenditure on patients in mental hospitals was only £4 6s 7d at a time when it was £13 10s 10d for general hospital patients and £22 9s 3d for teaching hospital patients (Rivett, 1998). Standards of food and hygiene and the amenities available for long-stay patients were often lamentable, and the Ministry of Health's planners were appalled by the potential cost of renovating or rebuilding the crumbling 19th-century mental institutions.

It was against this background that Tooth and Brooke, a Ministry of Health doctor and a General Register Office statistician, published their prediction, based on extrapolations from cohorts of patients admitted to English and Welsh mental hospitals in 1954, 1955 and 1956, that by 1976 the number of psychiatric beds required might have fallen from over 150 000 to a mere 80 000 (Tooth & Brooke, 1961). It was on the basis of these figures and assumptions that the Minister of Health, Enoch Powell, delivered his famous 1961 'water tower' speech which doomed these institutions to a progressively increasing neglect and eventual closure. They would be replaced, he said, by new psychiatric units in district general hospitals,

https://doi.org/10.1192/bjp.173.1.1 Published online by Cambridge University Press

and slowly these new units came into being. Powell's motives were undoubtedly humane and sincere and his revolutionary policy, which no other country had previously adopted, was, in principle, correct and far-sighted. Once enunciated it was also backed by the Treasury, which envisaged huge financial savings; by libertarians who welcomed the end of compulsory detention and treatment; and by sociologists and others who regarded mental illness as largely iatrogenic, the product of stigmatisation and incarceration in profoundly anti-therapeutic institutions.

THE ADVENT OF COMMUNITY CARE

In the early years of the NHS, policy had been determined and led by psychiatrists. It was men such as Rees, Macmillan, Carse and Freudenberg who had transformed the milieu of their hospitals and developed large and successful rehabilitation programmes. They and their like were responsible for the impressive changes on which Tooth and Brooke built their extrapolations. But after the publication of Powell's *Hospital Plan* (NHS, 1962), politicians, accountants and civil liberties lawyers were firmly in control. The slow running down of the mental hospitals continued and funding and attention were transferred to the new district general hospital units and to day hospitals. The consequences for the old hospitals, doomed and increasingly neglected, were predictable, though not in fact predicted. Between 1967 and 1976 a series of scandals came to light, all involving the abuse or maltreatment of defenceless patients in mental illness and mental handicap hospitals. Public confidence in psychiatric nurses and psychiatrists was badly damaged and both ministers and the public were more convinced than ever that the old hospitals must close. Keith Joseph produced *Better Services for the Mentally Handicapped* in 1971 (Department of Health and Social Security and Welsh Office, 1971) and his successor, Barbara Castle, published *Better Services for the Mentally Ill* in 1975 (Department of Health and Social Security, 1975), both of which reiterated the need to replace institutional care with various forms of 'community care', but without describing in any detail what community care would consist of, or how it would be funded.

As the old mental hospitals reduced their beds, from 1500–2000 patients in the 1950s to 200–500 patients in the late 1980s, their unit costs rose alarmingly, for their fixed-cost overheads remained largely unchanged and their remaining patients, being the most severely disabled, required high nurse staffing levels. Largely for this reason the Treasury, successive Conservative Secretaries of State and their new Management Executive insisted from the early 1980s onwards that firm closure plans should be drawn up and adhered to; and in the 1990s limited bridging funding was provided to facilitate the provision of adequate community facilities before the last patients were discharged. The 154 000 psychiatric beds the NHS inherited in 1948 have now been reduced to fewer than 40 000. The majority of the 130 large mental hospitals that Enoch Powell was responsible for have already closed, mostly in the past 10 years, and most of the remainder are destined for closure by 2005.

Unfortunately, the community care which has replaced the old hospitals is still deeply controversial, at least in the eyes of the public. In reality, it works fairly well in most rural and suburban areas and in many mid-sized towns, and it is certainly preferred by the patients who used to live an empty, regimented existence in the back wards of the old hospitals. But there are serious problems in big cities and above all in central London, as the King's Fund has demonstrated (Johnson *et al*, 1997). Acute admission wards are grossly overcrowded with bed occupancy rates of 100–120%, and the hospital scandals of the 1970s have been replaced by the community care scandals of the 1990s. A series of homicides by former in-patients, mostly young men with schizophrenia and most of them in or near London, has been dramatised by the media. Public confidence has been sapped and life is so stressful for the social workers, community psychiatric nurses and psychiatrists attempting with inadequate resources to care for large numbers of people with psychosis that many have retired early or moved into other fields.

THE BENEFITS OF THE NHS

It is sad that the question of whether or not the introduction of the NHS 50 years ago has benefited psychiatry and psychiatric patients has to be posed against this unhappy background. Even so, there can be little doubt about the answer. Both British psychiatry and its patients have benefited very greatly, and did so from the outset. In the late 1960s I spent several years working for the US/UK Diagnostic Project, which involved interviewing several hundred patients drawn from a random sample of mental hospitals in New York and London. At that time New York was probably the world's richest city, yet most of its public mental hospitals were dismal warehouses for unwanted, shuffling humanity. By comparison, London's mental hospitals seemed humane and enlightened. It is also easy to forget, in the face of our present difficulties and discontents, that psychiatric services have improved out of all recognition in the past 50 years. In 1948 out-patient services were few and child and adolescent psychiatry consisted only of a handful of child guidance clinics in the largest cities. There are three times as many consultant psychiatrists now as there were in the 1960s and there have been even greater increases in the numbers of trained psychiatric nurses, clinical psychologists and occupational therapists. Nor has the transition from institutional care to care in the community been trouble-free in other countries. Community care appears to work impressively well in parts of Holland, Sweden and Australia, for example, but it only works well in parts of these countries, and most have higher staffing levels than we have, more acute beds and better community facilities. The NHS and its psychiatrists also deserve credit for being the first to develop an organised range of in-patient, out-patient and day patient services for elderly people and a separate breed of old age psychiatrists; and for being almost the only health care system in the world to have mounted a comprehensive, prospective study of the human and financial consequences of closing large mental hospitals. The Team for the Assessment of Psychiatric Services set up by the old North East Thames Regional Hospital Board in the 1980s to monitor the closure of Friern and Claybury Hospitals is, so far as I am aware, unique in its scope and length of follow-up.

INADEQUATE RESOURCES

The great failing of the NHS has been its inability to ensure that an appropriate share of its total resources is devoted to the care of the mentally ill. Time after

https://doi.org/10.1192/bjp.173.1.1 Published online by Cambridge University Press

time in the past 25 years, ministers, managers and hospital board chairmen have made sincere attempts to channel a higher proportion of NHS funds to services for the mentally ill. They recognised that the wards of their mental illness and mental handicap hospitals, particularly the long-stay wards, were shabby and neglected, that their patients were poorly fed and received little real treatment or stimulation, and that staff levels were sometimes appallingly low, and they were determined to put this right. They usually failed, however, because whenever there was a financial crisis and some planned expenditures or developments had to be cut (a recurring and characteristic feature of the NHS, particularly from 1974 onwards) it was always easiest or safest to cut expenditure on the mentally ill or the mentally handicapped. Health ministers, health authorities and hospital managers all knew, or quickly learnt, that any proposal to balance their budget by closing cottage hospitals or accident and emergency departments, or by postponing the introduction of or cutting back on glamorous treatments like bone marrow transplantation and cardiac surgery, invariably led to angry protests from the public and the media, and to major political pressures to restore these services or plans. Services for the mentally ill, on the other hand, could be reduced, or new developments delayed, without incurring these risks. As Virginia Bottomley (1998) recently observed, "mental health is often the easiest budget to raid". There is no powerful pressure group to defend the interests of the mentally ill and when scandalous situations are exposed the public is generally content to blame the doctors or nurses involved rather than to point to the underlying lack of resources.

It is important to emphasise this because the fundamental problem is likely to be even worse in the future. The pressures on NHS budgets, at all levels, are likely to be even greater in the future than they have been in the past as the gap between what the public wants and what medical technology makes available on the one hand, and what the country can afford or the government decides it can afford on the other, widens progressively. Moreover, the modestly sized and often inconspicuous hostels, clinics, group homes and out-patient facilities on which community care is based will be more vulnerable to restructuring programmes to achieve financial savings than the old hospitals of the past.

Although it is appropriate to blame ministers and managers, and the British public itself, for allowing psychiatric services to become the Cinderella of the NHS, and for allowing those with mental illness or learning disability to receive lower standards of care than patients of other kinds, psychiatrists themselves and the Royal College of Psychiatrists must accept part of the blame. Ever since the 1960s a high proportion of the most able young men and women entering psychiatry have gone into the university departments, and their energies and ambitions have been expended on undergraduate teaching, or on research designed to elucidate the causes of mental illness, to improve classifications or to establish the efficacy of new pharmaceuticals. Only one of the twenty or more university departments that were in existence by the 1980s devoted any substantial part of its time and creative energy to comparing different patterns of service delivery or to assessing the effectiveness or cost-effectiveness of the alternatives to institutional care. The College was equally neglectful. Its energies were largely devoted to improving postgraduate training and to increasing psychiatric staffing levels. Although it always responded to each new policy document emerging from the Department of Health, it was almost invariably reacting, and usually defensively, to the Department's initiatives. It never developed a blueprint of its own for the future care of people with chronic or recurrent disorders. Only in the past five or six years, as the shortcomings of governmental policies have become increasingly apparent and psychiatrists' working lives have become increasingly stressful, has service provision become a major research topic for academic departments and the central focus of the College's attention.

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(First received 12 March 1998, accepted 2 April 1998)

LESSONS FOR PSYCHIATRISTS

The lessons of the past 20 years are clear. If psychiatrists and the College want to influence government policies, and persuade future governments that it is high time the NHS had evidence-based health care policies as well as evidence-based therapies, we must get involved in the requisite research ourselves, and take a closer interest in the health care policies of our own and other countries. And if we want to secure a higher proportion of the NHS's limited resources for our discipline and our patients, as we surely do, we must form effective partnerships with the mental health charities and mount a sustained campaign to persuade the British public that mental health needs to be one of its top priorities as well as ours.

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https://doi.org/10.1192/bjp.173.1.1 Published online by Cambridge University Press