COMMENTARY

Royal commissions

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Royal commissions have, on balance, tended to attract more brickbats than compliments. It is therefore not surprising that the Prime Minister's decision to appoint one to inquire into the National Health Service has been received with some cynicism. "A Royal Commission is generally appointed not so much for digging up the truth, as for digging it in," A P Herbert once remarked, "and a Government department appointing a royal commission is like a dog burying a bone, except that a dog does eventually return to the bone." More sweepingly still, Winston Churchill dismissed committees of inquiries of all types: "They are to governments what the ink is to the cuttle fish: they serve to conceal, not to reveal."

Historically these views are a libel on a powerful instrument of social reform. In the 19th century royal commissions were as catching as a 'flu epidemic: between 1851 and 1860 alone 74 were set up,¹ compared to the seven appointed between 1964 and 1970 by Harold Wilson—who, even so, was widely criticised for political prevarication. Moreover, the 19th century commissions were extremely influential in shaping public policy. They played a crucial part—organised and orchestrated by such reformers as Sir Edwin Chadwick and Sir John Simon—in bringing about the revolution in public health measures which transformed Victorian society. They collected facts, they proposed remedies, and they aroused public opinion; they were, at one and the same time, research teams, policy makers, and pressure groups.

Increased specialisation

In the 20th century royal commissions have not only become less frequent. They have also become more specialised in their roles. Like their virtually identical first cousins, committees of inquiry, they may be appointed by governments for a variety of reasons and carry out a variety of different functions. For example, the 1956 Guillebaud Committee² seems primarily to have been a political placebo, designed to head off alarm about the seemingly inexhaustible financial demands of the NHS. In contrast, the 1960 Royal Commission on Doctors' and Dentists' Remuneration³ was primarily an arbitrator in an industrial dispute: the medical profession and the Conservative Government of the day were at daggers drawn over pay, plans were being made for a "phased withdrawal" from the NHS, and there was clearly a need for a formula which would allow both parties to extricate themselves from their embattled positions. Even so, the commission did not get off the ground without trouble: there was a bitter argument about the terms of reference and at one stage the medical profession threatened to boycott its proceedings.⁴ Finally, the 1968 Royal Commission on Medical Education⁵ had yet another sort of part to play: that of technical consultant, charged with providing policy advice about how many doctors were required by the NHS and how and where they should be trained.

This does not exhaust the list of roles which may be carried out by royal commissions or committees of inquiry. They may be appointed to give advice in areas of controversy where governments prefer not to be embroiled, particularly in those areas where politics and morals overlap (capital punishment, drugs legislation, abortion, and so on) and where the issues cut across the normal party political alignment. They may be set up, most obviously, to buy time: which is, less obviously, not necessarily a disreputable motive, since if a government does not know what to do it may be better to do nothing than to plunge in recklessly at the deep end. At a time when governments are

increasingly under pressure to legislate for everything it may not be a bad thing to have a set of independent men and women point out that it is pretty futile for Parliament to try to outlaw sin. They may be appointed to neutralise opposition, a sort of exercise in consensus engineering, by co-opting potential critics among their membership: for example, the Royal Commission on Trade Unions carefully balanced two trade unionists against two businessmen. They may, lastly, be set up in order to persuade the public at large of the desirability of policies which governments wish to pursue and to document the case for change: the Robbins report on higher education was perhaps the outstanding example of an inquiry whose persuasiveness rested very largely on a foundation of well-researched facts.

More research conscious

Indeed there has in recent years been an interesting reversion to 19th century patterns as committees of inquiry and royal commissions have become increasingly research conscious. This is reflected in their budgets. The Guillebaud Committee spent £1987; the Royal Commission on Doctors' and Dentists' Remuneration—which carried out a number of surveys of earnings in other professions—cost £37 000; that on medical education more than doubled that figure and ran up a bill for over £79 000. Compared with other inquiries, outside the NHS, all these are modest figures, however. The Royal Commission on Trade Unions spent £113 500; the Royal Commission on Local Government cost £379 000; and the Royal Commission on the Constitution hardly left any change out of half a million.

Arguably, the research carried out by royal commissions is often more interesting than their reports—which may, after all, merely reflect the lowest common denominator of agreement among their members. But quality of research cannot be equated with effectiveness. Much more important than good research is good timing: for example, the Royal Commission on Trade Unions was appointed by Ray Gunter but reported to Barbara Castle—who promptly ignored its recommendations and embarked on a collision course with the trade unions.⁶ In any case, the new-found enthusiasm for finding out the facts—instead of simply relying on the evidence submitted by interested parties—has its own dangers. Facts are not neutral. No royal commission can ever find out all the facts (and if it did, no one would be able to digest them). Everything, therefore, depends on who decides on what facts ought to be sought out and for what reasons. In other words, the research strategy of any royal commission is bound to reflect its view about what really matters: tell me what its research programme is, one is tempted to conclude, and I will tell you what its conclusions will be. This means that any royal commission has to decide on what the crucial questions are at the beginning of its life (since research takes time) rather than coming to this decision in the light of the evidence submitted.

The ambiguous nature of research—its capacity to direct a powerful beam of light towards one problem, while leaving others in the shade—can be illustrated by the Guillebaud report. This largely reflected the findings of a study carried out by Professors Titmuss and Abel-Smith which showed that, in constant price terms, expenditure on the NHS had been falling rather than rising and indicated that, taking into account only demographic factors, spending was likely to rise by a mere 8% over the next 20 years. Although the two authors of this analysis stressed that other factors, apart from population changes, might well affect the NHS costs, this warning was disregarded.

Fortified by the finding that the alarm about rising NHS costs had been based on confusing inflation with real money, the Guillebaud Report complacently concluded that nothing basically needed changing in the NHS. By extrapolating past trends, it provided a misleading picture of the future—and failed to address itself to such crucial questions as the relationship between private and public expenditure on health. It turned out to be (as intended by the Government?) an exercise in retrospective reassurance, instead of an attempt to analyse future policy problems and options.

Choosing the members

The warning example of the Guillebaud Committee also raises a further issue: just how should the members of royal commissions or committees of inquiry be chosen? In the case of the Guillebaud Committee, the members appear to have been chosen precisely because they were not NHS specialists—and so could approach their subject without preconceived ideas. Nevertheless, their report would suggest that the risk in such a choice is that, coming fresh to a new subject, the members may be over-influenced by the views of the sponsoring department or may be too deferential to the “experts” who submit evidence. (In any case, royal commission members are unpaid part-timers: their ability to devote time to their new subject is therefore limited.) As against this, if royal commission members are picked for their knowledge and expertise in the field of inquiry—as in the case of the royal commission on medical education—then to a large extent the act of choice predetermines the outcome of the deliberations. For example, the BMA would have little difficulty in guaranteeing a report recommending a great increase in NHS expenditure if it were given complete freedom to nominate the members of a royal commission, and similarly it would not be too difficult to ensure the reverse conclusion by a different choice.

The solution, in the case of the Royal Commission on the NHS, might be to combine a membership chosen for all round intellectual competence rather than direct experience of the NHS and a research secretariat manned by those with relevant experience (but not provided by the Department of Health and Social Security). This, in any case, has been the general trend in recent years. But the weakness of this combination has been that,

in most instances, the research programme has had to be hurriedly improvised: it has been designed not in the light of what was desirable but of what was possible given the royal commission's timetable.

Permanent commission on NHS?

There would therefore seem to be a persuasive argument for making the Royal Commission on the Health Service—like that on the Distribution of Income and Wealth—a permanent one: charged with reporting regularly on the progress and problems of the NHS, which it would monitor through its ongoing programme of research and analysis.

There are two good reasons for experimenting with this kind of approach. Firstly, no royal commission can predict all the future problems of the NHS: any once-and-for-all report is therefore apt to be made obsolete by events. Secondly, while there has been much talk about auditing medical practice, no one yet has devised an instrument for auditing the NHS as a whole. Parliament has conspicuously failed to introduce an effective system of accountability or audit,⁷ and it may be that a new institution is needed to carry out this crucial task.

References

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- ⁵ Royal Commission on Medical Education, *Report*, Cmnd 3569. London, HMSO, 1968.
- ⁶ Jenkins, Peter, *The Battle of Downing Street*. London, Charles Knight, 1970.
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Independent practice and the NHS

A message to senior hospital doctors from the CCHMS chairman

Mr A H Grabham, Chairman, Central Committee for Hospital Medical Services, has prepared the following message for senior hospital doctors.

On 21 October a delegation representing the medical and dental professions met the Prime Minister, the Secretary of State for Social Services, and other members of the Government. The delegation consisted of Mr Walpole Lewin, chairman of Council of the BMA, representing its membership which encompasses all the different disciplines within the medical profession; Sir Rodney Smith, PRCS, the present chairman of the Conference of Presidents of Colleges and Deans of Faculties; Mr R B Allen, Secretary, British Dental Association; Dr N A Simmons (President) and Dr J A Rickards of the Hospital Consultants and Specialists Association; Mr O J A Gilmore, of the BMA Hospital Junior Staff Committee; and myself as chairman of the Central Committee for Hospital Medical Services.

Impressive voluntary unity

We were to discuss both the Government's Consultative Document “The Separation of Private Practice from NHS Hospitals,” and the recently announced establishment of the Royal Commission on the National Health Service. It had been agreed by the professions' representatives in advance that such a degree of unity exists throughout both professions that a single spokesman should present their combined views to the Prime Minister and his colleagues: as chairman of the committee recognised as representing consultants and senior grades in NHS hospitals this task fell upon myself. Given past differences between the various professional bodies—particularly the HCSA's bitter criticisms of the CCHMS—this complete, voluntary unity was impressive.

This powerful alliance was certainly attributable to the terms of the consultative document. This deployed a series of proposals that prompted grave and widespread alarm throughout both