The research and development programme of the health department for England and Wales, 1961 to 1986

Background paper for a seminar on 'health research policy in England: past lessons, future directions' convened by HSR UK and held on 9 May 2018.

The history – an overview

The Ministry of Health was little engaged in research and development before 1961, being barely mentioned in a review of government R&D published that year. George Godber states that the sum available to him as Chief Medical Officer (CMO) for the discretionary funding of research was unchanged when he was appointed in 1960 from that available to the first incumbent of his office, Sir John Simon (CMO 1855 to 1876). The Ministry was an outlier among civil departments, with negligible commissioning of R&D and only one directly managed research unit. In contrast, most other civil departments ran numerous R&D units in the post-war era. The Ministry's exceptional position reflected the dominance exercised by the Medical Research Council (MRC). Under a concordat between the two organisations, agreed in 1924, medical research was assigned to the Council. This agreement, together with the freedom conferred by grant-in-aid and light-touch political oversight, allowed the MRC to expand and diversify its activities, whilst those of the Ministry remained severely constrained.

Prompted by the new possibilities arising from the NHS, the UK health departments and the MRC revisited opportunities for research in the early 1950s. The resulting report, known as the Cohen Report (1953 – named after Sir Henry Cohen), adopted a very broad definition of clinical research as encompassing not only patient-based but also population-based studies. This was consistent with the outlook of the MRC, which regarded epidemiology, medical statistics and social medicine as all falling within the scope of clinical research. Following Cohen's recommendations, local NHS research units, which were few, were either closed-down or transferred to the MRC, together with funding. The Council set up a Clinical Research Board, whose duties included oversight of a modest funding stream for locally-organised clinical research. The Ministry's initial response to the new opportunities offered by the birth of the NHS thus reinforced the dominance of the health research state by the MRC.

The settlement set out in the Cohen Report soon came under pressure. The Guillebaud Report (1956) identified that capital investment in the NHS was unsustainably low and, by 1959, a cross-party consensus emerged that a hospital renewal programme was needed. The Treasury continued to resist spending, because the Ministry lacked the evidence upon which to base new investment decisions. More specifically, the Treasury wanted to be convinced that additional investment would improve NHS productivity. The programme of research pursued by the MRC offered little in response. Both Ministry and Treasury agreed that additional 'service-oriented' research was needed to ensure that greater investment yielded a more efficient health service. It was against this background, that the Ministry first created, in 1961, a new branch dedicated to the procurement and dissemination of hospital

operational and management research. This step was supported by the Treasury and helped to clear the way for the Hospital Plan of 1962.

Other new streams of activity followed during the 1960s, including research into community-based health and personal social care services, public health, buildings, supplies and equipment. The creation of the Department of Health and Social Security (DHSS) added social security research to the programme in 1968. So too did the advent of medical computing, with an experimental computer programme launched in 1967. The Department also developed its expertise in 'service-oriented medical research', which encompassed both epidemiology and 'medical care research', i.e. studies into the organisation and delivery of clinical care. By 1971, the Department thought of its health and personal social services research programme (HPSSR) as flowing within three principal streams: operational, medical and social research. Supply-side diversification in this period, which saw the growth of new disciplines such as operational research and medical sociology, reinforced diversification in research commissioning. The Department pursued development as much as research and engaged a diverse range of research providers.

In 1963, the Second Secretary of the MRC, Dr Richard H. L. Cohen, transferred to the Ministry. Under the parallel structures in place, formal powers for research commissioning were vested in civil servants of the administrative class. These non-medical administrators led the commissioning of operational and social research. Cohen, assisted and advised by medical colleagues, provided the professional networks, expertise and authority needed to commission research delivered by medical doctors. The willingness of medical and non-medical civil servants to collaborate in an 'informal team' was critical to the success of the programme in this period. The team fostered an eclectic programme which was receptive to new research disciplines and to multidisciplinary work. Its guiding star was, to quote Cohen, research 'of a precise and practical relevance to the operations of the NHS'.

Most HPSSR activity was co-ordinated, from 1967 onwards, through a Research and Development Committee (R&DC), which was supported by a Statistics and Research Division. The R&DC formalised arrangements for research commissioning, insisting that all projects must identify a 'customer', who was expected to provide input into the definition of project requirements and into the consideration of research findings. This did not always happen in practice, and the informal team played an ongoing role in specifying research requirements, and in responding to speculative researcher proposals.

Between 1961 and 1973, these administrative arrangements enabled a rapid growth in R&D spending by the Department, which moved from outlier to significant force in civil research. The Department's share of the global civil R&D budget increased from 0.13 percent in 1961/2 to 3.8 percent in 1972/3. Nearly all of this was committed to externally commissioned research, with only one new in-house unit, the Social Sciences Research Unit, established during the 1960s. The combination of rapid funding growth, enlightened patronage and agile commissioning have led to this formative period being characterised as a 'golden age'.

The ‘Rothschild reforms’ of 1971/2 represented an unprecedented opportunity for the DHSS to build on the programme laid down in the 1960s. The Department had moved ahead of Rothschild in promoting the customer-contractor principle. It was to benefit from the transfer of a quarter of the MRC budget, to be used in commissioning biomedical research, and it had developed a good understanding of further opportunities for service-oriented medical research. Further growth in HPSSR funding, overlain with the transfer of biomedical funds, resulted in the DHSS R&D budget achieving a real-terms peak in 1976, when it came close to matching the MRC budget.

Despite this apparent success, the new research management system implemented by the Department in response to Rothschild soon proved fundamentally unfit for purpose. Rather than further integrating programme management, this was fragmented between more than twenty divisions. The role of Chief Scientist, which Rothschild envisaged as empowering customers, was reduced to an advisory role with no executive capacity. Rather than being agile, the Department created a cumbersome system, bogged down by a plethora of committees and a multitude of advisors. The evidence now available, which adds to the earlier account by Kogan and Henkel, shows that this unfortunate, and almost certainly unintended, outcome arose from two principal determinants between 1971 and 1974. The first of these was the re-organisation of the DHSS, which was undertaken in anticipation of the NHS reorganisation of 1974. Influenced by fashionable views in industry and promoted as a nostrum by management consultants, ‘planning’ was made central to the re-shaped organisation. R&D was left side-lined in an over-elaborate organisational machinery that soon proved dysfunctional.

The second determinant was medical leadership within the Department and the MRC. Senior individuals, drawn from a professional elite, closed ranks to defuse the tension introduced by Rothschild. During the 1960s, the two organisations had largely pursued separate tracks. Any boundary issues, which were mostly minor, were resolved by friendly discussion between senior leaders. This comfortable accommodation was rudely disrupted by Rothschild. The response of the medical elite was to construct arrangements that exhibited face conformity with the Rothschild reforms, whilst leaving all real decision-making for biomedical research in the hands of the MRC. This was achieved through agreements which favoured ‘broad commissions’. Such commissions could only be placed with the MRC, which was free to decline any that were not to its liking. A prominent opponent of the Rothschild reforms, Sir Douglas Black, was appointed as Chief Scientist and, by his own later admission, demonstrated that the system for commissioning biomedical research could not be made to work. Although Black was more sympathetic to HPSSR, his ability to exercise a more constructive influence in this arena was hampered by his lack of executive authority.

Most of the R&D committees set up in 1972/3 had been dismantled by 1977, in which year the Cabinet Office and the Department undertook a ‘management review’ (a proto Rayner review). This identified R&D management as an area of significant concern. In response, the Department moved to strengthen the role of Chief Scientist, underpinning it with an executive Office of the Chief Scientist (OCS). The OCS was made responsible for

HPSSR, biomedical and social security research. Some other strands of the programme, such as computing and building research, remained under the management of specialist branches. Douglas Black stood down in 1977 and his successor, Professor Arthur Buller, took up office as the first executive Chief Scientist in August 1978. In published testimony, Buller makes it clear that he was appointed by members of medical and political elites to work towards this goal within the Department. Buller was dismissive of the Department's programme and of the capacity of the new OCS. He immediately began discussions with the MRC about returning biomedical research funds and about shifting funds from DHSS to the MRC to build up a programme of health services research. By this time, the Department had committed a large part of its budget to rolling contracts with research units, mostly in the universities and medical schools, and so this strategy would require a progressive re-direction of funding. A new MRC Secretary, Sir James Gowans, was appointed in 1977 and set about lobbying for the return of biomedical funds.

Gowans' campaign was initially viewed as unlikely to succeed, and Buller received little encouragement from his colleagues. Departmental policy leads understood that without the power of the purse, the MRC would continue to shape its programme primarily according to criteria of scientific value, rather than value to the health service. Committee chairpersons and other advisors argued strongly against the proposal that the MRC might take on a growing role in health services research. The Department's position appeared secure when a review of the Rothschild system, published as a White Paper in 1979, confirmed that the system was working well. Various teething problems had been encountered across government, but Health was not identified as any exceptional case, let alone one meriting a reversal of policy. This situation changed only when first the Auditor General and then the Committee of Public Accounts became aware that the arrangements for commissioning biomedical research, as put in place in 1972/3, did not meet accountability requirements. The Treasury view was that biomedical research commissioning should be made more accountable, but the Committee of Public Accounts argued that the system should be dismantled. Buller continued to argue that the Department could never become a competent commissioner and that the future lay in greater reliance on the research councils. Against this background, the Permanent Secretary, Sir Patrick Nairne, advised Ministers that the game was not worth the candle and, on 1 April 1981, biomedical research funds were returned in full to the MRC. This strand of the Department's programme thus ended in counter-reformation.

After the disruption of 1972 to 1981, the Department was left with the task of sustaining a programme of commissioned HPSSR into the 1980s. Buller's term of office ended in August 1981. His successor, Sir Desmond Pond, took up office in June 1982, bringing a more conciliatory tone. The OCS had, regardless of Buller's negative views, expanded between 1978 and 1981, taking on more staff and acquiring responsibility for nursing and social services research. Pond's tenure was largely dominated by inherited issues, not least the review of department-funded units, which had been initiated by Buller and undertaken by his Chief Scientist's Advisory Group (CSAG) independently of OCS. The CSAG report, published in March 1982, awarded unfavourable or indifferent gradings to most units. CSAG failed to fully justify these judgments; its findings were rejected, and the group dissolved.

Pond settled for a policy of gradually withdrawing funding from weaker units. By this time, OCS had developed, through systematic processes of horizon scanning and consultation, periodic assessments of future research needs. Pond sought to re-direct money to new areas of research, thus identified, but most of the budget remained tied up in rolling contracts with 34 extra-mural units. His ability to 'turn the tanker' was further constrained by public spending reductions as the DHSS R&D budget fell by 20% in real terms between 1981 and 1986.

This period also saw the growth of analytical units within DHSS but not under the management of OCS. The most notable of these were the Operational Research Unit and the Economic Advisors' Office, which were brought under common management in 1982. These units were often more agile and focused on producing policy-relevant systematic analysis, than the extra-mural units. When combined with the limited scope to commission new research in salient areas, this development slowly eroded the credibility of the commissioned programme.

Under a new concordat agreed in 1980, the MRC had made a commitment to allocate some funds towards health services research (HSR). The sums involved were small in the context of the total MRC budget, now boosted by the funds returned from DHSS. The Council moved slowly to discharge its commitment, setting up a purely advisory Health Services Research Panel (HSRP), with no grant-making powers. This slow pace reflected anxieties within the Council about the potentially disruptive influence of HSR. HSR was viewed through the lens of medical interests, with epidemiology as its core discipline. The Council believed that all HSR should be medically-led or undertaken in close co-operation with doctors. By 1984, members of HSRP were becoming increasingly frustrated about their purely advisory role. Under pressure from within, the Council eventually agreed to reconstitute HSRP as the Health Services Research Committee (HSRC). The new committee was to be given a modest budget for an 'experimental period' of three years and limited grant-making powers. A cautious pace prevailed even once this decision was made, with the start date for HSRC being set as September 1986.

A further pressure in the 1980s was the threat of privatisation, for which the DHSS offered exceptionally unpromising ground because it had never developed much by way of intra-mural R&D capacity. Nevertheless, a review process was initiated that caused further uncertainty. The programme fell into political disfavour at around this time, as some studies called government policy into question, provoking the ire of ministers.

Under Pond, the Department had finally attained a mature and reasonably competent organisation for commissioning HPSSR and allied R&D, operating under Rothschild principles. However, this achievement appeared to count for little in a changed climate and departmental R&D infrastructure was reduced in 1986. Pond's successor, Professor Francis O'Grady (the last Chief Scientist), was appointed on a part-time, advisory basis. The OCS became the Research Management Division (RMD) and its staff were reduced in number. This low point set the scene for the House of Lords Select Committee report of 1988, which was extremely critical of the department's stewardship of R&D. The history from 1961 to 1986 is thus one of meteoric rise from a near zero base, followed by turbulence ending in

partial reversal, slow decline and deliberate reduction. This history can only be understood by appreciating the challenges arising from the diversity of the programme, which never came under fully integrated management, and the very dissimilar dynamics shaping the different strands of activity.

The full history

The overview above is drawn from my PhD thesis *Organisation and Policy for Research and Development: the Health Department for England and Wales, 1961 to 1986* (University of London, 2017).

The full thesis is available on-line here http://researchonline.lshtm.ac.uk/4646130/

For discussion

These events occurred more than thirty years ago, and one must be cautious about reading too many 'lessons' into them. That said, the past, when systematically examined, prompts us to re-consider the present - revealing new patterns, continuities and discontinuities. The participants will bring their collective knowledge of current policy to the seminar. I will identify historical findings that appear likely to have enduring relevance; and some questions arising for future policy.

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