

# (Dis)integrated care systems: lessons from the 1974 NHS reorganisation in Morecambe Bay

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## ABSTRACT

The Health and Care Act 2022 affirmed the ‘primacy of place’ in the National Health Service (NHS) through major structural reforms replacing General Practitioner (GP) led Clinical Commissioning Groups (CCGs) with 42 Integrated Care Boards (ICBs). The intention behind the Act was to strengthen engagement between the NHS, local authorities, and other stakeholders in place-based systems providing collaborative, integrated health and social care services across organisational and financial boundaries. This reversed longstanding political commitment to competition. However, identical intentions – about facilitating consensus, cooperation and cost-effectiveness between health and social services – underpinned the first major reorganisation of the NHS in 1974. Drawing upon a unique central government file dedicated to the problems the reorganisation raised for South Westmorland, this paper explores the gap between neat structural reforms imagined by the centre and their messy realisation in the periphery, highlighting similar tensions in the present.

## INTRODUCTION

The Health and Care Act 2022<sup>1</sup> affirmed the ‘primacy of place’ in the National Health Service (NHS) suggested by the 2021 White Paper *Integration and Innovation* through structural reforms replacing General Practitioner (GP) led Clinical Commissioning Groups (CCGs) with 42 Integrated Care Boards (ICBs). For Lancashire and South Cumbria ICB this meant the absorption of the five remaining of the original eight CCGs within its territorial footprint, notwithstanding the acquisition of part of Cumbria with the creation of Morecambe Bay from Lancashire North in 2017. The intention behind the Act was to strengthen relationships between the NHS, local authorities, and stakeholders through new place-based systems, although the five CCGs – Morecambe Bay, Fylde Coast, and West, Central, and Pennine Lancashire respectively – retain identities as place-based partnerships within the ICB.<sup>2</sup> These aim to provide integrated health and social care services on a collaborative basis across organisational and financial boundaries. This reversed decades of political commitment to competition as the core ideal of the ‘new’ NHS. The ‘permanent revolution’ it unleashed from the 1980s sought to overturn the ‘old’ command-and-control approach.<sup>3</sup>

However, identical intentions – about facilitating consensus, cooperation and cost-effectiveness between health and social services – underpinned the first major reorganisation of the NHS in 1974. The reform was a technocratic solution for the problems of the ‘old’ tripartite NHS created in 1948 as a pragmatic compromise, dividing health services between community, primary, and hospital care. These divisions ran deep within the ‘classic’ NHS from 1948 to 1974. The official historian of the NHS, Charles Webster, sees this as the ‘continuation of the existing fragmented system’ which ‘perpetuated the failings of lack of integration that had afflicted the pre-war market system’.<sup>4</sup> The 1974 plan for unification sounds remarkably familiar to 2022.<sup>5</sup> This included neat coterminous territorial configurations between health authorities and local government, joint finance

budgets to encourage collaboration, recognition of population health and service needs, and local representation on health authorities. Yet the reorganisation was widely regarded by contemporaries and historians as a failure with the new structure only surviving until 1982.<sup>6,7</sup> Indeed, such was the scale of problems unleashed that, combined with widespread industrial unrest among NHS workers, a Royal Commission was formed within two years to take stock of the fallout and kick the issue into the long grass.<sup>8</sup>

Whilst there were myriad reasons for the national failures of the reorganisation, the blueprint for unification imposed on health and social care services in Morecambe Bay in 1974 achieved little more than exacerbating existing inequalities, unravelling preceding planning assumptions, and compounding problems in the health system for a generation. This assessment is formed by contextualising a unique central government file dedicated to the problems that the reorganisation raised specifically for South Westmorland. Indeed, it is the *only* named file within abundant records from the reorganisation archived by central government. The paper explores the reasons for the gap between neat structural reforms imagined by the centre and their messy realisation in the periphery, highlighting similar and enduring tensions in the present.

## THE ROAD TO 1974

The political settlement which created the NHS in 1948 rested on preserving existing organisational distinctions, dividing the service in three between community, primary and hospital care. This remained the case until 1974. The relative stability between has led many to regard the era as the ‘classic’ NHS. Tensions lurked beneath this simple, convenient settlement. Complex territorial arrangements overlaid the tripartite division, producing a Byzantine bureaucratic web that ‘cemented inequalities of organisation, provision, and integration’ in Morecambe Bay and the surrounding area.<sup>9</sup>

Primary and community services had territorial boundaries fixed to Victorian local government frameworks dating to 1889, dividing compact county boroughs responsible for urban areas from rural county councils. The scale of suburbanisation and sprawl by 1945 left this approach outdated, with many urban districts or municipal boroughs larger in population and size than county boroughs.<sup>10</sup> To overcome this issue, and its democratic deficit, Lancashire County Council adopted a system of divisionalisation for its separate health, welfare, education and children’s services, although rarely did boundaries align. Despite this decentralisation, departments became ‘more inward-looking and somewhat less prone to cooperate’ as staff, resources, and responsibilities grew.<sup>11</sup> This was not the case in Westmorland where small departments fostered administrative cohesion.<sup>12</sup> Neither of these approaches could overcome judgments around whether needs were medical or social – especially for the elderly – with the distinction being shaped by professional and financial availability.<sup>13</sup> Although mushrooming central grants funded wholesale expansion,<sup>14</sup> and chief officers dominated their committees,<sup>15</sup> politics remained important, with Conservative councils committed to cutting rates and Labour ones tending to invest.<sup>16</sup> Whilst

exhortations for cooperation were common, they were rarely realised.

Although primary care services shared boundaries with local government, they shared little else. Professional antipathies between entrepreneurial GPs and bureaucratic local government public health doctors were entrenched, and the organisational machinery of primary care remained centralised in Morecambe Bay. Executive Councils (ECs) responsible for paying the contracts of GPs, and Local Medical Committees (LMCs) which safeguarded professional interests dated back to 1911 and the creation of National Health Insurance (NHI).<sup>17</sup> Size mattered, as some GPs in the more compact county boroughs engaged with professional reforms such as nurse and social worker practice attachments despite limited incentives.<sup>18</sup> Lancashire, with a population of over two and a half million by 1974, was a 'supremely sprawling and capriciously shaped geographical area' which could not handle policy complexity effectively through one EC, relinquishing little authority to localities.<sup>19</sup> Moreover, the location of practices in desirable suburban areas meant GPs held contracts with multiple ECs, each with different resources, expectations, and interests.<sup>17</sup> Beyond coterminous boundaries, primary and community care had limited integration until 1974.

The nationalisation of private voluntary and public municipal hospitals in 1948 meant their organisational form was created from scratch and bore no relation to community or primary care boundaries. The organisation of hospitals was rooted in the principle of 'hierarchical regionalism' with a university medical school for each of the 14 English hospital regions. This bifurcated hospitals between the Board of Governors (BoG) which ran elite teaching hospitals in Manchester, and the Regional Hospital Board (RHB) responsible for the remainder, although the University of Manchester Vice Chancellor held both chairs throughout the 'classic' NHS.<sup>20</sup> The boundaries of RHBs were determined by historic patient flows and specialist referrals, with Manchester covering most of Lancashire, half of Cheshire and Westmorland, and small pockets of Derbyshire and West Yorkshire.<sup>21</sup> Within Manchester RHB were 20 Hospital Management Committees (HMCs) which grouped hospitals by location; in Morecambe Bay these were Barrow and Furness, and Lancaster and Kendal (North Lancashire and South Westmorland from 1964). By 1974 Manchester had twice quashed regional secession. First, by reneging agreement with Preston to form a regional advisory committee in 1948.<sup>9</sup> Second, by outflanking the nascent University of Lancaster to establish a medical school as the nucleus for a separate region.<sup>22</sup> The effect was to leave Morecambe Bay's two HMCs as the farthest flung in the region, with their resources and interests subsumed in the interests of its centre: Manchester.

Spinning further threads as part of the Byzantine bureaucratic web were voluntary organisations in health and social care that formed a 'mixed economy' of welfare. The status and boundaries of these organisations varied widely, with larger ones having a district structure whilst smaller ones lacked a territorial footprint. Bilateral organisational and financial relationships were common between voluntary agencies and different parts of the tripartite NHS, being handled primarily through grants and partnerships rather than contracts and commissioning.<sup>23</sup> In many cases senior figures in voluntary organisations were members or co-opted onto the

RHB, HMCs, and local authority health committees.<sup>24</sup> The 'moving frontier' between statutory and voluntary services was fluid, not fixed.<sup>25</sup> Ultimately, health and care services in Morecambe Bay remained fragmented due to the nationalisation of pre-war market competition health economies. It was these unresolved complexities which confounded efforts towards collaboration and fuelled growing pressure for reform by 1974.

### REORGANISING THE WELFARE STATE

The reorganisation finalised by 1974 was a 'leisurely exercise' beginning in 1966, constituting a 'lengthy and futile attempt to appease all the relevant interest groups' according to Webster.<sup>4</sup> It was the culmination of incremental efforts towards unification throughout the 'classic' NHS which stalled through an unwillingness to renegotiate the 1948 settlement.<sup>26</sup> Political momentum shifted from 1966 as the reforms passed through two Labour and one Conservative government – and four secretaries of state – over the course of eight years, not to mention the hands of management consultants McKinsey.<sup>27, 28</sup> Moreover, the 1974 reorganisation was part of a concerted process to reshape the architecture of the welfare state; simultaneously transforming the NHS, local government, and social services.

Within the NHS, reorganisation strengthened the position of hospitals at the expense of community and primary care. The distinction between BoGs and RHBs was abolished, with the two entities forming 14 Regional Health Authorities (RHAs). Beneath RHAs were 90 Area Health Authorities (AHAs) sharing coterminous boundaries with new local authorities, mandatory representation from interest groups, and responsibility for population planning rather than simply running hospitals. Alongside each AHA was a Family Practitioner Committee (FPC) which aligned primary care services with shared boundaries – producing some 'awkward complications'<sup>29</sup> – but remained largely unchanged from ECs as bureaucratic bodies.<sup>30</sup> Below AHAs were Health Districts (HDs) which were purely executive, run by District Management Teams (DMTs) along the lines of fashionable 'consensus management', requiring representation from each professional group and unanimity in decision-making. Despite claiming to maximise responsibility downwards and accountability upwards, the reforms left unclear lines of authority and inhibited effective action.<sup>31</sup> Medical leadership was hamstrung as public health moved from local government into the NHS, leading to widespread demoralisation and further marginalisation.<sup>18</sup> Compounding the disruption of organisational reforms were financial ones. From 1976 the Resource Allocation Working Party (RAWP) amended funding from historic hospital activity to population-based funding for each RHA, accounting for morbidity and mortality along with additional costs for medical education in teaching hospitals.<sup>32</sup> Such AHAs – former BoGs – became designated as teaching with concomitant status and resources, maintaining existing inequalities and the privileged position of hospitals.

Reform in local government centred on modernising outdated Victorian structures. Here, changes encompassed the status, size, operation, and boundaries of authorities. A new system of two-tier authorities was introduced with rural county or urban metropolitan county councils overseeing district or metropolitan boroughs. Like the NHS, this was modelled

on having comparable populations and powers for each authority.<sup>33</sup> The reforms swept away old committee governance, replacing it with a more executive political style and functional directorates under corporate management, aping the private sector.<sup>34</sup> To align authorities with populations boundaries were widely redrawn. These were 'artificial creation[s]' of administrative convenience and political gerrymandering to ensure partisan parity, often erasing historic boundaries in the interests of uniformity.<sup>35</sup> This particularly impacted smaller and older county and county boroughs councils.

Preceding reorganisation in the NHS and reform in local government, was restructuring of social and welfare services. The 1968 Seebom Report<sup>36</sup> recommended that the separate specialist social services split across health and local authority provision should be unified in a single local authority department. Calls for unification reflected the professionalisation of social work from 1945, demanding resources and respect in contrast to the 'second class rating' experienced within local government.<sup>37</sup> Mental health, psychiatric social work, educational welfare, child care, adult welfare, and social care for the elderly were all consolidated from their former local authority committees or NHS hospitals into new social service departments.<sup>38</sup> Specialist identities were lost, becoming subsumed into generic social work given the primary of place.<sup>39</sup> Crucially, because reforms were simultaneous and ongoing across the welfare state from the 1960s to the 1970s, they were marked by persistent uncertainty and disruption.

## THE WESTMORLAND PROBLEM

The neat structural reforms imagined as part of an expansive programme of welfare state modernisation did not fit easily onto Morecambe Bay; primarily because of Westmorland. It was a problem to unify each of the three divisions of the tripartite NHS; to the new model of local government; and to the delivery of social services centred on place.

The Local Government Commission North Western General Area Review<sup>40</sup> noted in 1965 that Westmorland 'is unlike any other county in England', reporting that any reforms to the status, size, operation or boundaries of the county would have to account for its unique form. This verdict was gleefully highlighted by the County Council in evidence to the subsequent Royal Commission on Local Government,<sup>41</sup> tasked with reform following the failure of the review proposals, recommending they 'maintain the status quo'.<sup>42</sup> It also reflected longstanding cooperation across social services owing to administrative compactness and personal relationships among senior officials.<sup>12</sup> Yet this neatness did not extend to health, as the county was the fault line between Manchester and Newcastle RHBs, with Kendal and Appleby serving as urban centres flowing patients and specialist referrals south and north respectively.<sup>43</sup> Amplifying this fault line was that whilst Manchester prevented Lancashire forming a regional advisory committee, Cumberland and North Westmorland succeeded in establishing one under Newcastle RHB, granting them considerable autonomy although lacking a university centre.<sup>44</sup> Indeed, such was the recognised scale of their inherited problems that West Cumberland Hospital was the first approved and built under the NHS,<sup>45</sup> whilst older hospitals in Morecambe Bay languished on the future offered by Manchester RHB's slow realisation of the 1962 Hospital Plan.<sup>46</sup>

The relative stability produced by the 'classic' welfare state deepened this territorial division and exaggerated the Westmorland problem. The 1962 Hospital Plan reflected a rationalisation and centralisation of capacity within district units. Barrow and Furness HMC's patient population was at the lower end of the planning spectrum between 100-150,000 for district general hospital (DGH) at 114,000, although this was augmented by Millom which fell within Newcastle RHB advisory committee's patch.<sup>47</sup> The clinical and political opposition to a DGH for North Lancashire and South Westmorland HMC meant that services were developed around two sites: Lancaster for the southern, and Kendal for the northern group.<sup>22</sup> Notwithstanding that this split included patients from Sedbergh, part of Leeds RHB. Yet the HMC remained a single unit in the allocation of beds and specialisms, albeit heavily weighted towards Lancaster. Moreover, for Barrow, Lancaster and Kendal alike, consultant referrals were increasingly sent to Manchester alone rather than Leeds or Liverpool from 1948 owing to the consolidation of flows within RHBs.<sup>48</sup>

These intricate and incremental arrangements could not withstand the neat logic of the 1974 reorganisation. In local government terms this abolished Westmorland, and annexed Barrow and the Furness peninsula previously in Lancashire, and Sedbergh as part of an enlarged Cumbria. Given the logic of coterminosity between local government and the NHS, this split North Lancashire and South Westmorland HMC in two between Cumbria AHA to the north, and a residualised Lancashire AHA to the south. This split also served as the new boundary between Northern RHA based in Newcastle, and North Western RHA with headquarters in Manchester. Combined with new funding arrangements allocated regionally and based on population, the new border became a significant barrier to integrating care in Morecambe Bay, despite this being the intention of the reforms.

## (DIS)INTEGRATING CARE

A joint meeting between the shadow Northern and North Western RHAs in 1973 highlighted the consequences of the reorganisation and the Westmorland problem. South Westmorland was 'dependent to a considerable degree on services provided in Lancaster' with 'substantial organisational and staffing links', which also threatened the 'future viability of junior medical staffing' in Kendal.<sup>48</sup> Clinical contracts were held regionally, and the reorganisation threatened 25 years of shared working given problems of recruitment and retention.<sup>22</sup> South Westmorland Rural District Council (RDC) wrote forcefully to their Member of Parliament (MP), Michael Jopling, about the implications of the reforms. Lord Aberdare, the Minister of State, personally reassured him that new organisational boundaries 'should not and will not be barriers to the use of health services'.<sup>48</sup> Yet a deluge of professional and personal correspondence suggested otherwise.

Here, a Department of Health and Social Security (DHSS) circular<sup>49</sup> guiding shadow authorities on boundaries offered a solution: agency arrangements. These allowed AHAs to make arrangements when the services of one HD were provided for at least 25% of a neighbouring one. This was a clear case for South Westmorland, where statistics showed that for every specialty – except mental health and obstetrics – such levels of overlap existed. It was unanimously backed by senior consultants in Lancaster and Kendal. However, the proposed solution created more problems than it solved. Barrow and

Furness HMC protested for three reasons. Firstly, that to grant agency arrangements would be to isolate them further geographically from both the rest of Cumbria and Northern RHA headquartered in Newcastle. Secondly, that it would deprive the planned HD for Barrow of a significant portion of the population, down to 108,000 through depopulation by 1974. This had financial ramifications and threatened the viability of the planned DGH to provide a full range of services. Thirdly, that it would undermine the underlying principle of the reform through coterminosity as associated social services would become fragmented. They bemoaned of the 'political' interference from Jopling and suggested that although there were few 'natural' links between Kendal and Barrow in NHS terms, these would be forged as the reorganisation was implemented.<sup>48</sup>

The DHSS developed an option appraisal which was also filtered through meetings between the Minister of State and senior civil service mandarins. They rejected agency arrangements, as did a lengthy report of the Cumbria Joint Liaison Committee, which acted as a forum for stakeholders in the reorganisation. This was on two counts. Firstly, the DHSS did not want agency arrangements *anywhere* as it would interfere with the coterminosity as a guiding principle of the 1974 reorganisation. Secondly, that the boundary such arrangements wished to cross was not just one of HDs – envisaged in the circular – but of AHAs and RHAs. Furthermore, 'while recognising the problem of Barrow', the appraisal noted, 'there is no justification for attempting to solve them at the expense of South Westmorland'. The appraisal was primarily concerned that 'existing hospital links with Lancaster should not be disturbed as a result of reorganisation'. Accordingly, the appraisal felt that it would be easier to introduce agency arrangements later if circumstances dictated their necessity, rather than impose them reverse them.<sup>48</sup>

There was a mounting war of words between locals, clinicians, and administrators over the 'thorny problem of future hospital facilities for South Westmorland'. Jopling was a crucial intermediary, and repeatedly petitioned the DHSS and led deputations to protest at the consequences of the reorganisation for patients in his constituency. Ultimately the decision was final: that Lancaster and Kendal would be split in the interests of the principles of reform.<sup>48</sup> Integrated care for the many meant disintegration of health services for Morecambe Bay.

Although obtaining the desired result, the outcome did not fully satisfy Barrow's claims. As with the 1962 Hospital Plan, Kendal pushed against being swept into a larger district as part of their DGH population and insisted on organisational separation. Accordingly, a key recommendation of the DHSS appraisal was that to assuage sensitivities, Kendal and Westmorland should not form part of South Cumbria HD with Barrow. Instead, it became a self-governing sector of East Cumbria HD which was centred at Carlisle. This resulted in South West Cumbria HD having a population of 107,500, West Cumbria with 134,329; and East Cumbria with 234,005 of which 59,606 formed the semi-autonomous South East Cumbria sector.<sup>50</sup> This compromise unintentionally led East Cumbria to pioneer speciality budgeting as a means to monitor costs and account for the financial consequences of patients crossing RAWP borders.<sup>51</sup> However, it was the words of the outgoing Chairman of Cumbria AHA, later MP for Carlisle, Eric A. Martlew, in 1979 which glimpsed the future for the organisation of health services in Morecambe Bay: 'Barrow,

with Kendal, would be better served by joining with Lancaster in a separate area'.<sup>48</sup>

## CONCLUSION

Identical intentions underpin the reorganisations of the NHS in 1974 and 2022: consensus, cooperation and cost-effectiveness between health and social services developed through partnerships in place. These intentions have been arrived upon by different routes: 1974 by modernising inherited fragmentation dating to historic pre-war markets; 2022 following years of austerity and decades of political commitment to competition being exposed as flawed during the pandemic. However, the lessons from 1974 speak to the gap between seemingly simple structural reforms which incentivise intentions of the centre's imagination, and their realisation in the periphery. The reorganisation for Morecambe Bay instead caused disintegration owing to the imposition of new service and organisational boundaries which did not reflect relationships as they existed. An unwillingness to compromise the principles of the reorganisation by the centre led the Westmorland problem to collapse in practice, serving to worsen inequalities, unravel planning proposals, and intensifying issues of cooperation across the health system for a generation.

Whilst the substance of the 2022 reforms and the current Lancashire and South Cumbria ICB remain to be seen, there are indicators of similar tensions. The replacement of the six district councils with two unitary ones in Cumbria for 2023 – which do not align with ICB or provider health service boundaries – erects barriers to integration rather than facilitating cooperation.<sup>52</sup> Population disparities between the place-based partnerships similarly reflect underlying contests over the organisational and physical location of services. Between Pennine Lancashire (566,000), Central Lancashire (399,000), Fylde Coast (354,000), Morecambe Bay (352,000) and West Lancashire (114,000) are a range of priorities for stakeholder and service partnerships.<sup>53</sup> Crucially – as in 1974 – changes to funding regimes with new territorial units determine the extent to which intentions are realised. The economic and financial crises of the 1970s ultimately shattered the ambitions of technocratic reformers as cuts stymied unification; will history repeat?

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