Interim report of the Committee on Hospital Supplies.

J. Brett

MINISTRY OF HEALTH
CENTRAL HEALTH SERVICES COUNCIL

Interim Report of the Committee on HOSPITAL SUPPLIES

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* Sir Arthur Howard was a member of the Council until March 1956.

CENTRAL HEALTH SERVICES COUNCIL

COMMITTEE ON HOSPITAL SUPPLIES

INTERIM REPORT

I. INTRODUCTION

Terms of Reference

1. We were appointed by the Central Health Services Council on 14th December, 1954, with the following terms of reference

> "To investigate and report on the organisation of all forms of hospital supplies, including their purchase, storage and issue throughout the National Health Service".

2. Our appointment followed a recommendation made to the Council by the Committee on the Internal Administration of Hospitals that a detailed investigation into hospital supplies organisation should be arranged: the Committee felt that a special study was necessary owing to the complexity of the subject and the absence of conclusive evidence in favour of any particular system.

3. The relevant part of the report* of that Committee (paragraphs 205–221) may conveniently be summarised as posing three main questions:

(*a*) At what level should supplies be bought? i.e., under contracts placed by the Ministry, by a combination of hospital groups, by individual hospital groups or by individual hospitals;

(*b*) Where should primary responsibility for buying supplies rest? i.e., with a supplies or other lay officer or with departmental heads;

(*c*) At what point should delivery of supplies be taken and what arrangements should be made for their storage and issue? i.e., whether contracts should provide for delivery into central stores for subsequent re-issue to user hospitals or for direct delivery to those hospitals.

4. We have regarded the above questions as implicit in our terms of reference.

5. We have interpreted our terms of reference as enabling us, where we think it advisable for purposes of comparison, to consider the organisation of supplies in other fields i.e., elsewhere in the public service, in nationalised industry or in private industry.

6. For the reason which we give later in paragraph 22 of this report we have felt it advisable, although our inquiries are not yet complete, to inform the Council of the preliminary conclusions which we have so far been able to reach; these deal mainly with the first of the above questions. We propose to give our final conclusions on this and on other questions within our terms of reference in a later report.

The Committee's Procedure

7. We held our first meeting on 25th January, 1955, and have in all so far met 10 times.

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* Published by H.M.S.O. in 1954.

8. As a first step we prepared and issued a questionnaire to Boards of Governors and to Regional Hospital Boards, of which a copy will be provided in our final report. Regional Hospital Boards were asked (*a*) to arrange for completion of the questionnaire by such of their Hospital Management Committees as would provide a representative cross-section of practice and opinion within their regions and (*b*) to provide themselves such general information on the supplies organisation within their regions as they considered might be helpful to us and to comment generally on matters within our terms of reference.

9. We also issued an open invitation to those interested in the Committee's work to submit written evidence and, in addition, asked particular bodies connected with the Hospital Service to do the same. A good response was received. We have since obtained further evidence both from within and outside the Hospital Service and in a number of cases the written evidence we have received has been supplemented by oral evidence. Some of the evidence we have received may require further consideration. A list of bodies and individuals who have given evidence to us will be provided in our final report.

10. The replies to our questionnaire and the evidence received in the early months of our enquiries indicated very clearly that there was a wide variety in many respects in hospital supply arrangements and we decided in August, 1955, to form three Sub-Committees to consider arrangements for particular categories of supplies: these Sub-Committees have taken evidence on our behalf on the supply of (*a*) provisions, (*b*) drugs and dressings, and (*c*) textiles and other common user items.

II. THE BACKGROUND TO THE PROBLEM OF THE ORGANISATION OF HOSPITAL SUPPLIES

Origin and Tradition

11. The historical background to our hospitals and the way in which their varying origins and traditions have affected administrative arrangements have been fully dealt with in the report of the Committee on Internal Administration and we need only say that a similar situation is reflected in the supplies field. So far as it is possible to detect a common pattern in the various types of organisation this is seen in teaching groups (where greater responsibility is usually given to departmental heads) and in mental groups (mainly inherited from local authorities). It is in general groups with their mixture of ex-local authority and ex-voluntary hospitals that the greatest variety seems to exist: in some the local authority tradition of central control remains, with close control at the group level and group purchasing and central storage : in others the individuality of the ex-voluntary hospital is preserved in a wider degree of delegation. The geographical situation of the component hospitals within the group, road and rail communications, the personal views of Committee members and senior officers, the personality and experience of the senior officers and the general administrative structure of the group are all factors which have tended to shape the form of the supplies organisation and to contribute to the present diversity.

Policy of the Ministry

12. It has been the Ministry's policy within the essential limits of the financial control necessary for a service financed from public funds not to discourage hospital authorities from evolving the supplies organisation best suited to their individual needs and at no time have they attempted to impose a uniform pattern. They did however originally contemplate a more general use of the method of central purchasing or central contracting by the Ministry than now exists.

13. The development of Ministry policy is best illustrated by summarising or quoting the relevant Ministry circulars relating to supplies. We have put in italics certain passages to which we attach particular importance.

(*a*) At the outset [in March, 1948—H.M.C. (48) 1]:

"*Supplies*

29. Regulation 5 (vii) confers on Management Committees the powers necessary for acquiring and maintaining the equipment, furniture and supplies of all kinds required for the hospital or group under their control, including instruments, drugs and appliances for supply to patients. It may at the outset be necessary to continue for a time to use the methods and sources of supply already existing for the service of the different hospitals and Regional Boards have already been asked to arrange with local authorities that existing centralised supply arrangements shall be maintained for an interim period. The time factor has made it necessary that the Boards should take this action on behalf of Management Committees and it will also be necessary, if the arrangements are to work smoothly, that Committees should adhere to the arrangements made by the Boards for the whole of the period for which they have been made. *It will, however, be for Management Committees themselves to decide the future methods and sources of supply, subject to any arrangements for central purchase of particular items which may from time to time be made by the Minister or by the Regional Boards with his consent.*"

(*b*) In June 1949 (R.H.B.(49)89/H.M.C.(49)72/B.G.(49)74) :—

"2. The Minister has had under consideration the need for extension of central purchasing and contracting by the Department, in the interests of economy and better efficiency, to other major equipment and common-user stores, both medical and domestic. He has decided that this shall be undertaken wherever it appears to be economically or otherwise advantageous or necessary.

* * *

7. It is the intention so far as practicable to standardise the quality and dimensions of common-user stores supplied centrally, but every endeavour will be made to provide variety in colour and design of store items which lend themselves to individual selection. In exceptional circumstances local purchases to meet special needs and temporary shortages may be made.

* * *

Provisional extension programme

10. In order to give Boards and Committees an indication of the timing of future extensions of central purchase and supply through the Department, the following provisional programme is notified for information. It should be understood that this may be varied in the light of changing circumstances.

It is anticipated that estimates of requirements will be required firstly for: theatre and ward rubber goods; cotton and linen textiles (made up articles and piece goods); woollen goods: and cleaning and chandlery.

Subsequent purchasing programmes will probably include the following types of equipment and stores: drugs; dressings; instruments, sutures and thermometers; electro-therapeutic equipment; anaesthetic apparatus; dental equipment; X-ray accessories; uniforms and overalls, domestic: uniforms and overalls, staff; patients' clothing; ward furniture and furnishings; kitchen equipment, cutlery, hardware and crockery.

Group purchasing

11. As already stated, Boards of Governors of Teaching Hospitals and Hospital Management Committees remain responsible for purchasing arrangements until notification is given that central purchase and supply by the Department is to be undertaken. The Minister does not think it desirable that Regional Hospital Boards should themselves undertake any purchasing or contracting on behalf of hospitals. *He hopes, however, that they will encourage Hospital Management Committees to consider the economic advantages of joint contracting by groups of Hospital Management Committees, particularly for food and common services, e.g., laundry, which cannot be covered centrally by the Department, and that Hospital Management Committees will press on with such arrangements.* There is no objection to these arrangements covering purchase of the equipment and stores listed in paragraph 10, provided that they are capable of early termination without liability when Hospital Management Committees are notified that these goods are to come under central supply."

(*c*) After further experience [in February 1953—R.H.B.(53)13/H.M.C.(53)12/B.G.(53)13]:

"*General Policy*

1. In circular R.H.B.(49)89/H.M.C.(49)72/B.G.(49)74 of 18th June, 1949, the policy and procedure in relation to central contract and supply arrangements was explained. The Minister has now reviewed the progress of these arrangements, which at present cover the following groups of supplies:

Hearing aids and batteries Blood transfusion equipment, laboratory apparatus and glassware Paper, envelopes and paper bags	Supplied through Government Stores

X-ray apparatus Mass radiography units X-ray films Spectacles Theatre and ward rubber goods Mattresses Cleaning materials, hardware, brushware, etc. Special drugs	Supplied mainly direct by contractors to hospitals
Artificial limbs, surgical boots, surgical appliances, invalid tricycles, artificial eyes, etc.	Supplied under Ministry of Pensions contracts

In the light of the experience gained during the past three years, the Minister is satisfied that, over the range of supplies covered and taking into account the overhead expenses, these arrangements have proved to be financially or otherwise advantageous. He has accordingly decided that they should be continued, subject to such modifications as may from time to time be found necessary in consultation with hospital authorities and supply experts.

* * *

Joint Contracting

6. Paragraphs 11 and 12 of the circular invited Regional Hospital Boards to encourage Hospital Management Committees to consider the advantages of joint contracting by groups of Committees and expressed the hope that Boards of Governors would associate themselves with such arrangements. A number of schemes of this kind have already been started and others are known to be contemplated. Among the classes of goods (not covered by central supply arrangements) which appear to be suitable for joint action of this kind are textiles, patients' clothing, footwear, kitchen equipment, cutlery, hollow-ware and domestic glassware. This list is not exhaustive and the choice of suitable goods will depend upon local circumstances. Furthermore, in developing schemes of this kind it should be borne in mind that many British Standards for hospital supplies have already been published and that others are in preparation. Work in progress and future publications are notified in the Monthy information Sheet of the British Standards Institution which is sent to all hospitals and may help in timing the start of joint contracting. The Minister hopes that joint contracting will be extended wherever it seems likely to achieve economies and that Regional Hospital Boards and Board of Governors will report periodically on the progress made. *It is not the intention to centralise contracting or supply in the Department if equally good results can be obtained by joint contracting.*"

14. Since February, 1953 the scope of the Ministry supply arrangements has only been slightly widened and there has been no major departure from the policy indicated above i.e. " . . . not . . . to centralise contracting or supply in the Department if equally good results can be obtained by joint contracting ".

15. The effect of the Ministry's policy of delegation to hospital authorities and the extent to which hospital authorities do their own buying can be judged from approximate figures we have received which indicate that of the total cost of hospital supplies less than 10 per cent. is bought under central arrangements by the Ministry and the supplies obtained under the latter arrangements are largely accounted for in value by certain special medical supplies (including drugs) and apparatus.

Criticisms of Hospital Supply Arrangements

16. Hospital supply arrangements since 1948 have attracted criticisms in various quarters. The Public Accounts Committee has at different times been inclined to regard them as too lax and, more recently, the Committee of Inquiry into the Cost of the National Health Service, while making no recommendations on the question of hospital supplies in view of our appointment, criticised hospital authorities for the slow progress which seemed to have been made in applying wherever practicable the " . . . well-tried practices in supplies purchasing which are already common to all large undertakings in this country ".

17. These criticisms seem to illustrate two different conceptions of how hospital supplies should be organised under the National Health Service which, starting from different premises, seem in the end to arrive at the same conclusion. On the one hand, we see the tradition of central financial control of a public service deriving from Parliamentary, Treasury and Departmental responsibility which normally involves a set pattern, evolved over the years, of uniform procedure with close control by the responsible Minister. This would normally involve a substantial degree of central purchasing or contracting. On the other hand, we see reliance on the generally accepted methods of large-scale organisations in private industry with its faith in bulk buying in all cases where articles in common use are required for a number of consumer units. This also would normally lead to a substantial degree of central purchasing or contracting.

18. If one accepts the Ministry's general policy of delegation of responsibility for the day to day running of the hospitals to the hospital group level which, as we have pointed out, generally results in supplies being bought at that level, the question naturally arises whether there is some method which would provide most of the advantages of central purchasing or contracting but without weakening or destroying the individual responsibility of hospital groups. The possibility of some such compromise or of the development of an individual form of organisation to fit the particular needs of hospitals we will now consider in Part III of this report.

III. THE POSSIBLE SOLUTION TO THE PROBLEM

19. It will have been noticed from the circulars quoted in paragraph 13 that in 1949 the Minister recommended hospital authorities to join forces in buying certain categories of supplies under joint contracts and that this advice was repeated in 1953 with greater emphasis and in relation to a wider range of supplies. We found, however, from the replies to our questionnaire, that comparatively little progress had been made since 1953 in developing inter-group arrangements of this kind and that contracts for supplies were still largely being placed at the group or hospital level.

20. We have, therefore, through our Sub-Committees, made a special study of several of the major joint contracting schemes which are in force and have considered also why similar schemes do not appear to have met with favour elsewhere.

21. From the reports made to us by our Sub-Committees and from the other evidence we have considered we have reached the general conclusion that joint contracting among management committees and teaching hospital groups provides the only practical method of combining the advantages of large scale buying with the existing autonomy of hospital groups, and of avoiding the Minister being placed in the position of having to impose a much greater degree of central purchasing or contracting, which would not only be unwelcome to hospital authorities but would also be inconsistent with the Minister's general policy of delegation to the group level of day-to-day hospital administration.

22. In view of the fact that over three years have elapsed since the Minister enjoined hospital authorities to extend joint contracting and the relatively limited response to this advice, we feel that this is a question which now requires the most urgent re-examination and action by hospital authorities.

23. In the following Part of our report we describe the essential features of the joint contracting schemes that we have studied, the points for and against such schemes as put to us in evidence and our own views on these points and our general conclusions and recommendations on the value of such schemes and on the part which they can play in hospital supply arrangements.

IV. DETAILED CONSIDERATION OF JOINT CONTRACTING SCHEMES

Scope of our Enquiries

24. Our enquiries have covered one scheme for the supply of the common user articles listed below,* another for the supply of bedding and linen and two schemes for the supply of drugs (one of these also includes the supply of dressings). All these schemes cover nearly all or a substantial number of the hospital authorities in the Regions concerned. The essential features of all these schemes are very much the same, the main difference being that in the case of the first two schemes the major responsibility under the hospital authorities concerned is in the hands of supplies officers acting under advice from the professional or technical heads of the consuming departments in the hospitals concerned, whereas in the second two schemes these roles are reversed as major responsibility lies with committees of hospital pharmacists with the assistance of a supplies officer or officers who deal mainly either formally or informally with matters of tendering and contract and provide the benefits of their general experience in buying.

25. We have also, through one of our Sub-Committees, consulted two other regions where joint contracting arrangements have either been started and now abandoned or have not been developed.

* Boots and shoes, cutlery, glassware and earthenware, hardware, kitchen utensils textiles, patients' clothing, uniforms and protective clothing.

The Essential Features of Joint Contracting Schemes Studied

(a) *The Will to Co-operate and to Experiment*

26. This is fundamental, as the successful development and progress of these schemes depend entirely on a high degree of common effort and a readiness to discard existing supply arrangements in favour of others which seem likely to show better results. In the schemes we have studied the following take part in what is essentially a joint operation :

(i) *The Regional Hospital Board,* who provide the initial impetus, continuous support and encouragement and any necessary central advisory or statistical services, but do not exercise any form of direct control or use any powers of direction upon Management Committees who are unwilling to join in.

(ii) *The Hospital Authorities* (i.e. Management Committees and in some cases Boards of Governors), who while retaining ultimate control delegate responsibility for supply arrangements to a joint committee appointed by them and provide the services of their officers as required.

(iii) *The Supplies Officers* (and in the case of drugs the *Pharmacists*), who bear the main burden of the joint contracting arrangements and share the executive responsibility.

(iv) *The Departmental heads,* who provide technical advice and assistance. (As already stated in the case of drugs it is the supplies officers who provide technical advice on general questions regarding purchasing supplies and take responsibility for inviting tenders and placing contracts.)

(b) *Preliminary steps*

Agreement is reached between interested hospital authorities on the types of supplies to be included in the scheme and on the specifications to be adopted. (To avoid a multiplicity of contracts for similar items with only minor differences in size or quality, and to secure the maximum possible advantage from bulk buying, standard specifications are used as far as possible.)

(c) *Administrative arrangements*

Joint contracting committees are set up by the hospital authorities who have agreed to take part in the scheme. These may be either a single regional committee representing all the participating authorities in the Region or a number of area committees each representing several authorities in particular areas within the Region. The committees consist in the first case of supplies officers or pharmacists only, and in the second, of not more than two members of each participating authority, assisted by selected supplies officers from the authorities who act as secretaries and are responsible for the executive and clerical work. In both cases, certain supplies officers or pharmacists specialise in different supplies or groups of supplies.

(d) *Estimates of forward requirements*

Member authorities are asked to submit to the Committee firm estimates of their requirements for the coming financial year.

(e) *Invitation and acceptance of tenders*

Tenders are invited for the combined requirements of member authorities in each category of supplies. Invitation was initially by public advertisement, but with experience selected lists of suitable suppliers have been compiled which are being increasingly used as a basis for sending out invitations. Firms which have asked for an opportunity to tender are included. Public advertisement is thus tending to become an occasional means of testing the market and of seeking new sources of supply.

Selection of tenders and consideration of samples (where required) is the responsibility of the joint contracting committee.

(f) *Placing of contracts*

Contracts are placed with successful tenderers by the area committees or by one or more of the individual member authorities to cover the whole of the requirements of member authorities for particular categories of supplies.

(g) *Orders*

Orders are placed by each member authority with successful tenderers under the joint contracts for its individual requirements. Each member authority undertakes not to buy elsewhere any supplies of the type covered by joint contracts.

(h) *Delivery and payment*

Contractors are required to deliver to such hospitals and in such quantities as are specified by the ordering member authorities. Payment is made by these authorities.

(i) *Quality control*

Contracts provide for rejection by member authorities of any supplies which do not conform to specification or sample (if any). In the case of textiles, any disputes on quality can be referred to the Manchester or Bradford Chambers of Commerce for adjudication. In one textile scheme, samples are required before delivery. These samples are tested against specification by the Manchester Chamber of Commerce and, if approved, specimens are then sent to member authorities for checking against deliveries.

(j) *Marking*

In one scheme, all textiles are required, as part of the specification, to bear distinctive markings which are interwoven into the materials during manufacture and thus cannot be obliterated or removed. Suppliers are required to undertake not to dispose of any spoilt or surplus production of such materials except to hospitals. At the outset a small charge was made for marking but this is now covered by the quoted price which is shown to be less than that formerly paid by individual authorities for similar unmarked materials.

27. *Points advanced for and against joint contracting schemes and our own views*

(a) *Control*

FOR Ultimate control is retained by member authorities.

AGAINST There is a strong fear of loss of autonomy.

OUR VIEWS While we appreciate the importance of hospital authorities retaining full responsibility for the day to day management of their hospitals, we cannot see how this is diminished by voluntary participation in joint contracting schemes of this kind which are run by their own members or officers, and on which they are fully consulted before entering into any commitment.

(b) *Price*

FOR It is claimed that quality for quality supplies can be bought more cheaply under joint contracts.

AGAINST It is said that there is no material advantage in price for bigger hospital authorities which already buy large quantities; that there is an economic limit beyond which increased purchases provide little or no further price advantage; that bulk buying limits the field from which supplies can be obtained and tends to squeeze out the smaller and often more efficient manufacturer.

OUR VIEWS Except in the case of one of the drugs schemes, where substantial savings can be shown, detailed evidence of the overall financial savings achieved is generally not available. In the case of textiles and common user items this is due to differences in specification and quality and changes in market conditions since the schemes were introduced. From such evidence as is provided we are satisfied that savings are being made and we accept the definite view held in the Regions concerned that supplies are being bought more cheaply than would be the case if similar supplies were purchased by individual hospital authorities. On the other side, no convincing evidence has been presented to us to show that worth-while savings to hospital authorities as a whole would not result from the introduction of similar schemes in the two Regions without joint contracting schemes which we have consulted. We acknowledge the possible existence of a law of diminishing returns with bulk buying and the dangers of losing the services of the small manufacturer. We have not, however, found any evidence to show that combining the requirements of several hospital authorities in an area, or even most of the hospital authorities in a Region, in joint contracts results in purchases of such magnitude as to create difficulties of this kind. As regards textiles and other common user articles, the requirements of all hospitals combined would represent only a relatively small part of the total demand on manufacturers so we do not consider that in that particular

field this point is of any practical importance. It is possible, however, that with certain categories of drugs difficulties of this kind might arise if contracts were placed on a larger scale than at a Regional level.

(c) *Choice and quality*

FOR In the case of textiles and common user items it is claimed that joint contracting has led to an improved range and generally better quality of supplies.

AGAINST It is feared that standardisation would lead to loss of individuality and to a drab institutional uniformity.

OUR VIEWS We see no particular merit in this criticism in so far as it relates to loss of individuality. Individual hospital authorities may have an attachment to particular sizes, types or qualities, but we see no sufficient reason why this should be maintained for supplies which in general do not affect the service to the patient. We understand that in the hotel and catering industry, for example, standardisation in order to secure the advantages of large scale buyers terms is normal practice for units providing a similar standard of service. We would accept the criticism only if joint contracting were to lead to any lowering of standards below a reasonable level. But we are assured that this has not been so and that in many cases standards have been improved.

(d) *Liaison*

FOR It is claimed that the setting up of joint contracting committees has led to an improved liaison and exchange of information between supplies officers.

AGAINST It is pointed out that adequate liaison already exists in the regular meetings which are being held between supplies officers.

OUR VIEWS We concede that regular meetings between supplies officers to discuss common problems and matters of mutual interest may already be held, and that further liaison is maintained at the regular meetings held at the Supplies Division, Ministry of Health, which are attended by representative supplies officers from each region. Such liaison is satisfactory so far as it goes but it does not appear, however, from the information we have received that meetings of this kind involve a detailed comparison of prices and quality of supplies, such as is facilitated by the existence of regional contracting schemes, and in one region by the circulation of a regional schedule showing the items bought under contracts placed by the various area committees. In this Region, the chairmen of each of the area committees meet once per year: the secretaries of each area committee meet bi-monthly: the supplies officers employed in the Region meet every 6 months. At meetings of chairmen, general policy is discussed and determined: at the meetings of secretaries

of area committees and of supplies officers, the whole field of supplies is open to discussion and problems arising are brought forward.

(e) *Stocks*

FOR It is claimed that under joint contracting schemes, the tendency has been for stocks to be reduced.

AGAINST It is feared that under joint contracting schemes there would be a tendency to over-estimate and that difficulties would be created by inadequate storage and transport difficulties.

OUR VIEWS We can see no justification for any fear that joint contracting would lead to any greater tendency to over-estimate than would arise under group or hospital purchasing. In any case the estimates are within the control of the individual hospital authority. As regards storage and transport difficulties, we think these could be overcome in most cases possibly by arranging with suppliers to make periodical deliveries to hospitals or by using storage at certain hospitals to hold stocks for others without adequate storage. We consider that the final cost (including all the elements of cost after delivery by the supplier such as storage, handling, further transport and interest on capital) should be less than if purchases were made by individual groups or hospitals.

(f) *Administrative costs*

FOR Evidence was produced to show that the cost of running joint contracting schemes was negligible.

AGAINST It was acknowledged that the direct costs of administration were small, but it was contended that allowance should be made for the time spent by the officers concerned with these schemes and other "invisible overheads."

OUR VIEWS We are not persuaded by the argument about "invisible overheads." Admittedly a good deal of time is required to be spent by supplies officers and pharmacists, but this is mainly in the early stages, and in any case should, in our view, be more than offset by the "invisible savings" in the staff time, due to the avoidance of individual tendering and contracting by H.M.Cs. for the items bought under joint contracts.

(g) *Reduction in losses of stocks*

FOR It is claimed for the bedding and linen scheme that the system of marking is a major deterrent to pilfering, which has in the past been a problem in that region.

AGAINST It is stated that marking of textiles is already practised.

OUR VIEWS Our only comment on this is to express the view that the marking of bedding and linen should be a universal practice, and to recommend the method of interweaving which can be adopted without extra charge where sufficiently large quantities are bought. We consider however that a standard pattern of marking for hospitals should be devised which can be registered and protected against reproduction.

General Conclusions and Recommendations

28. (*a*) We strongly advise that all hospital authorities (both Management Committees and Boards of Governors) should consider the adoption of joint contracting schemes, such as those we have briefly described, and not be discouraged by apparent difficulties at the outset or by any feeling of prejudice which may exist against them. Although in the schemes we have considered it has been the Regional Hospital Board who have taken the initiative, there seems no reason why such schemes should not be initiated or proposed by groups of hospital authorities or by their officers.

(*b*) We feel that it is impossible to assess the value of such schemes in a particular area or Region without not only much preliminary study but also systematic experiments in the actual invitation of competitive tenders over as wide a field as possible.

(*c*) We do not wish to express any special preference on the points of difference in the schemes we have studied. We firmly believe that for schemes of this kind no hard and fast rules can be laid down, and that it is for the hospital authorities in each Region to devise a scheme or schemes to meet their individual circumstances, learning from their own experience as well as from the experience of others.

(*d*) It has been suggested to us that in the textiles field in particular, there may be room for still better terms to be obtained if purchases were made on a national basis under Ministry contracts. We have no evidence in support of this suggestion, and we do not feel able to recommend it, at least at this stage. It seems to us that an extension of Ministry contracting into this field would carry with it possible disadvantages which are not present with regional or area schemes (for example, the loss by the H.M.C.s of individual control and responsibility and the points we have already mentioned under 27 (*b*) above), and would only be justified if substantially greater financial savings would clearly result. We do not rule out the possibility of advantage to the hospital service through Ministry contracting, but we would prefer this to be regarded as a matter for later consideration when the possibilities of joint contracting have been exhausted. As regards drugs, a comparison of prices paid under the two joint schemes we have considered with those paid under Ministry contracts for similar supplies for hospitals in Wales and Scotland do not show any marked advantage one way or the other. It seems therefore that for drug supplies of this kind hospital authorities by joint contracting can do as well as if corresponding supplies were obtained under Ministry arrangements.

(*e*) We feel that as matters stand at present it is right that central supply arrangements should remain on the present limited scale, i.e., that they should be substantially confined so far as value is concerned to those categories of drugs or equipment or other special supplies which necessitate

central supply arrangements owing to the inadequacy of available supplies or to the limited sources of supply which are available. As regards Ministry supplies under central purchase or contracting in the more general field of common user articles, we have met with a certain amount of criticism of these arrangements and, while we do not recommend that they should be discontinued, we reserve our views on them for our further report.

(*f*) We are very conscious of the fact that joint contracting schemes are so dependent on voluntary co-operation and of the difficulties which can be created by authorities who stand firm against any change in their arrangements even if a change would be clearly to the advantage both of themselves and of the hospital service as a whole. For this reason, we feel that a clear obligation should be placed on all hospital authorities to report either to the Minister or where appropriate, to the Regional Hospital Board the progress which has been made in the development of joint contracting schemes. It can be expected that if any hospital authority were to continue to behave unreasonably in this matter, that authority would soon be called upon to defend its actions.

Possible Extensions of Joint Contracting

29. We have so far confined our remarks to the supply of drugs in common use such as are not covered by Ministry contracts and to the supply of dressings, bedding and linen or other textiles and to other common user articles of the kind listed at the foot of page 9. It may well be however that in reviewing their arrangements hospital authorities may find that there is scope for including other categories of supplies under joint contracts. In this connection from our preliminary survey of the field of provisions supplies (by far the biggest item in expenditure on supplies), we feel that there may be room for joint contracting for certain categories of non-perishable foodstuffs.

Signed on behalf of the Committee,

FRED MESSER,
Chairman.
June 1956.

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