

A
National
Health Service.

Ministry of Health
Dept. of Health for Scotland.
1944



MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND

A
NATIONAL
HEALTH SERVICE

*Presented by the Minister of Health and the Secretary of State for Scotland
to Parliament by Command of His Majesty
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INTRODUCTORY.

The Government have announced that they intend to establish a comprehensive health service for everybody in this country. They want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens.

The idea of a full health and medical service for the whole population is not a completely new one, arising only as part of post-war reconstruction. In the long and continuous process by which this country has been steadily evolving its health services the stage has been reached, in the Government's view, at which the single comprehensive service for all should be regarded as the natural next development. The end of the war will present the opportunity, and plans for post-war reconstruction provide a setting, but the proposal to set up a comprehensive service has to be seen against the past as well as the future and to be recognised as part of a general evolution of improved health services which has been going on in this country for generations. The case for it stands on its own merits, irrespective of the war or of other proposals for post-war reorganisation, although it must form an essential part of any wider proposals for social insurance which may be put into operation. Nor is it a question of a wholly new service, but of one with many roots already well established. The methods of organising it must be closely related to history and to past and present experience.

The decision to establish the new service applies, of course, to Scotland as well as to England and Wales and the present Paper is concerned with both countries. The differing circumstances of Scotland are bound to involve certain differences of method and of organisation, although not of scope or of object. To draw distinctions throughout the Paper in regard to the detailed application of the new proposals in each country would unduly complicate the text. For this reason the principal differences which arise in applying the proposals to Scotland are reviewed all together, in chapter VII. Similarly most of the Paper has, for convenience, to be expressed in terms (e.g. in its references to local authorities) which are not equally appropriate to both countries. Subject to the review of the main differences in chapter VII these terms should normally be taken as covering whatever is their counterpart in Scotland. Throughout the Paper references to the Minister should normally be construed as references to the Minister of Health in the case of England and Wales and the Secretary of State for Scotland in the case of Scotland.

The purpose of the Paper is to examine the subject generally, to show what is meant by a comprehensive service and how it fits with what has been done in the past or is being done in the present, and so to help people to look at the matter for themselves. The proposals made in the Paper (and summarised at the end) represent what the Government believe to be the best means of bringing the service into effective operation. The Government want these proposals to be freely examined and discussed. They will welcome constructive criticism of them, in the hope that the legislative proposals which they will be submitting to Parliament may follow quickly and may be largely agreed.

I.

THE PRESENT SITUATION.

The record of this country in its health and medical services is a good one. The resistance of people to the wear and tear of four years of a second world war bears testimony to it. Achievements before the war—in lower mortality rates, in the gradual decline of many of the more serious diseases, in safer motherhood and healthier childhood, and generally in the prospect of a longer and healthier life—all substantiate it. There is no question of having to abandon bad services and to start afresh. Reform in this field is not a matter of making good what is bad, but of making better what is good already.

The present system has its origins deep in the history of the country's social services. Broadly, it is the product of the last hundred years, though some of its elements go much farther back. But most of the impetus has been gathered in the last generation or two, and it was left to the present century to develop most of the personal health services as they are now known.

This historical process, and the health services so far emerging from it, must be looked at in some detail if the present situation is to be understood and if new proposals are to take proper account of it. There is, therefore, appended to this Paper (in Appendix A) a general survey of the medical and health services as they exist now, and of the way in which they came into being. Some features of the present services will also be discussed as they arise in later parts of this Paper, when the different branches of medical care—general, specialist, hospital and others—are considered in more detail. The immediate question is how far the present arrangements are inadequate and what are the reasons for altering or adding to them.

The main reason for change is that the Government believe that, at this stage of social development, the care of personal health should be put on a new footing and be made available to everybody as a publicly sponsored service. Just as people are accustomed to look to public organisation for essential facilities like a clean and safe water supply or good highways, accepting these as things which the community combines to provide for the benefit of the individual without distinction of section or group, so they should now be able to look for proper facilities for the care of their personal health to a publicly organised service available to all who want to use it—a service for which all would be paying as taxpayers and ratepayers and contributors to some national scheme of social insurance.

In spite of the substantial progress of many years and the many good services built up under public authority and by voluntary and private effort, it is still not true to say that everyone can get all the kinds of medical and hospital service which he or she may require. Whether people can do so still depends too much upon circumstance, upon where they happen to live or work, to what group (e.g. of age, or vocation) they happen to belong, or what happens to be the matter with them. Nor is the care of health yet wholly divorced from ability to pay for it, although great progress has already been made in eliminating the financial barrier to obtaining most of the essential services. There is not yet, in short, a comprehensive cover for health provided for all people alike. That is what it is now the Government's intention to provide.

To take one very important example, the first-line care of health for everyone requires a personal doctor or a family doctor, a general medical practitioner available for consultation on all problems of health and sickness. At present, the National Health Insurance scheme makes this provision for a

large number of people; but it does not give it to the wives and the children and the dependants. For extreme need, the older Poor Law still exists. For some particular groups there are other facilities. But for something like half the population, the first-line health service of a personal medical adviser depends on what private arrangements any particular person can manage to make.

Even if a person has a regular doctor—and this is not now assured to all—there is no guaranteed link between that doctor and the rest of necessary medical help. The doctor, both in private practice and in National Health Insurance practice, has to rely on his own resources to introduce his patient to the right kinds of special treatment or clinic or hospital—a great responsibility in these days of specialised medicine and surgery—or the patient has to make his own way to whatever local authority or other organisation happens to cater for his particular need.

When a hospital's services are needed, it is far from true that everyone can get all that is required. Here it is not so much a question of people not being eligible to get the services which they need, as a matter of the practical distribution of those services. The hospital and specialist services have grown up without a national or even an area plan. In one area there may be already established a variety of hospitals. Another area, although the need is there, may be sparsely served. One hospital may have a long waiting list and be refusing admission to cases which another hospital not far away could suitably accommodate and treat at once. There is undue pressure in some areas on the hospital out-patient departments—in spite of certain experiments which some of the hospitals have tried (and which should be encouraged) in arranging a system of timed appointments to obviate long waiting. Moreover, even though most people have access to a hospital of some kind, it is not necessarily access to the right hospital. The tendency in the modern development of medicine and surgery is towards specialist centres—for radiotherapy and neurosis, for example—and no one hospital can be equally equipped and developed to suit all needs, or to specialise equally in all subjects.* The time has come when the hospital services have to be thought of, and planned, as a wider whole, and the object has to be that each case should be referred not to one single hospital which happens to be "local" but to whatever hospital concentrates specially on that kind of case and can offer it the most up-to-date technique.

Many services are also rendered by local authorities and others in special clinics and similar organisations, designed for particular groups of the population or for particular kinds of ailment or medical care. These are, for the most part, thoroughly good in themselves, and they are used with advantage by a great many people in a great many districts. But, owing to the way in which they have grown up piecemeal at different stages of history and under different statutory powers, they are usually conducted as quite separate and independent services. There is no sufficient link either between these services themselves or between them and general medical practice and the hospitals.

In short, general medical practice, consultant and specialist opinion, hospital treatment, clinic services for particular purposes, home nursing,

* Fracture treatment is a single example. It is now a highly specialised service, coupled with the modern aim of total rehabilitation and re-employment. A fracture may be mended in a local hospital, and all the associations of habit and local interest may foster recourse to the local hospital in such cases. But the plain fact may be that ten or twenty miles away is a highly developed fracture centre, specialising in total rehabilitation of this kind of case, which the local people ought to be able regularly to use in preference to their "own" hospital. The difference between the facilities which the two hospitals can offer may determine whether or not the patient ultimately makes a full recovery from the effects of his injury.

midwifery and all other branches of health care need to be related to one another and treated as many aspects of the care of one person's health. That means that there has to be somewhere a new responsibility to relate them, if a service for health is to be given in future which will be not only comprehensive and reliable but also easy to obtain.

Last, but not least, personal health still tends to be regarded as something to be treated when at fault, or perhaps to be preserved from getting at fault, but seldom as something to be positively improved and promoted and made full and robust. Much of present custom and habit still centres on the idea that the doctor and the hospital and the clinic are the means of mending ill-health rather than of increasing good health and the sense of well-being. While the health standards of the people have enormously improved, and while there are gratifying reductions in the ravages of preventable disease, the plain fact remains that there are many men and women and children who could be and ought to be enjoying a sense of health and physical well-being which they do not in fact enjoy. There is much sub-normal health still, which need not be, with a corresponding cost in efficiency and personal happiness.

These are some of the chief deficiencies in the present arrangements which, in the view of the Government, a comprehensive health service should seek to make good.

II.

THE NEXT STAGE:

A COMPREHENSIVE SERVICE FOR ALL.

The idea of moving on to the next stage has been developing for some time. There is much agreement on what the aim should be, if not on the method of achieving it. The general idea of a fuller and better co-ordinated service has been supported in most knowledgeable quarters—professional and lay—by official Commissions and Committees, by interested public or voluntary organisations and persons, in reports, in articles and in books, before the war and during it. Some reference to these is included in Appendix B, where a summary is also given of the preliminary discussions and events which have preceded the issue of this Paper.

The method of approach.

There are two possible ways of approaching the task. One, with all the attraction of simplicity, would be to disregard the past and the present entirely and to invent *ad hoc* a completely new organisation for all health requirements. The other is to use and absorb the experience of the past and the present, building it into the wider service. The Government have adopted the latter method, as more in accord with native preference in this country.

There is a certain danger in making personal health the subject of a national service at all. It is the danger of over-organisation, of letting the machine designed to ensure a better service itself stifle the chances of getting one. Yet medical resources must be better marshalled for the full and equal service of the public, and this must involve organisation—with public responsibility behind it. It is feasible to combine public responsibility and a full service with the essential elements of personal and professional freedom for the patient and the doctor; and that is the starting point of this Paper's proposals. Throughout, the service must be based on the personal relationship of patient and doctor. Organisation is needed to ensure that the service is there, that it is there for all, and that it is a good service; but organisation must be seen as the means, and never for one moment as the end.

Nor should there be any compulsion into the service, either for the patient or for the doctor. The basis must be that the new service will be there for everyone who wants it—and indeed will be so designed that it can be looked upon as the normal method by which people get all the advice and help which they want; but if anyone prefers not to use it, or likes to make private arrangements outside the service, he must be at liberty to do so. Similarly, if any medical practitioner prefers not to take part in the new service and to rely wholly on private work outside it, he also must be at liberty to do so.

The scope of a “comprehensive” service.

The proposed service must be “comprehensive” in two senses—first, that it is available to all people and, second, that it covers all necessary forms of health care. The general aim has been stated at the beginning of this Paper. The service designed to achieve it must cover the whole field of medical advice and attention, at home, in the consulting room, in the hospital or the sanatorium, or wherever else is appropriate—from the personal or family doctor to the specialists and consultants of all kinds, from the care of minor ailments to the care of major diseases and disabilities. It must include ancillary services of nursing, of midwifery and of the other things which ought to go with medical care. It must secure first that everyone can be sure of a general medical adviser to consult as and when the need arises, and then that everyone can get access—beyond the general medical adviser—to more specialised branches of medicine or surgery. This cannot all be perfected at a stroke of the pen, on an appointed day; but nothing less than this must be the object in view, and the framing of the service from the outset must be such as to make it possible.

Temporary exceptions to “comprehensiveness.”

For a time some aspects of the new service will be less complete than could be wished. A full dental service for the whole population, for instance, including regular conservative treatment, is unquestionably a proper aim in any whole health service, and must be so regarded. But there are not at present, and will not be for some years, enough dentists in the country to provide it. Until the supply can be increased, attention will have to be concentrated on priority needs. These must include the needs of children and young people and of expectant and nursing mothers. The whole dental problem is a peculiarly difficult one, and a Committee under the chairmanship of Lord Teviot has been set up by the two Health Ministers to consider and report on it.

There may be similar (though perhaps less acute) difficulties in getting a full service in ophthalmology. But these, like the difficulties in dentistry, must be treated rather as practical problems arising in the operation of a new service than as matters of doubt in planning the service's scope and objectives.

Mental health.

The inclusion of the mental services also presents some difficulty, until a full re-statement of the law of lunacy and mental deficiency can be undertaken. Yet, despite the difficulty, the mental health services should be included. The aim must be to reduce the distinctions drawn between mental ill-health and physical ill-health, and to accept the principle declared by the Royal Commission on Mental Disorder that “the treatment of mental disorder should approximate as nearly to the treatment of physical ailments as is consistent with the special safeguards which are indispensable when the liberty of the subject is infringed.”

Some misconceptions about the meaning of "comprehensive."

There is one common misconception about the meaning of a "comprehensive" health service. Such a service emphatically has to comprehend all kinds of personal health treatment and medical advice. But that does not mean that there should be no other Government or private activity involving the use of the medical expert, or having any bearing upon health. There are many specialised and separate forms of undertaking—such as the supervision of industrial conditions—which may affect health and which may require the medical expert as much as they require the engineering or the legal or any other expert, but which cannot, simply for that reason, be regarded as necessarily part of the personal health service.

The present system of factory medical inspection and the arrangements made for the employment by industry of "works doctors" (described in Appendix A) are cases in point. From the point of view of industrial organisation, of working conditions in factory, mine and field, there is a continuing and specialised need for enlisting medical skill in ensuring a proper working environment, a proper allocation of types of work to the individual worker's capacity, a proper standard of working hygiene and a general protection of the worker's welfare. The enlistment of medical help for these purposes is part of the complex machinery of industrial organisation and welfare, and it belongs to that sphere more than to the sphere of the personal doctor and the care of personal health—which centres on the individual and his family and his home. What matters is that such specialised services, where they exist, should not impair the unity of personal health service on which he will rely; that, where there arises—perhaps first detected in workplace or factory—a question of personal medical treatment or consultation (beyond recognised incidental services of the kind described in Appendix A) this should be regarded as a matter for the personal health service.

Another example is that of the school medical service. Very similar considerations apply. It should be the part of any school medical arrangements to refer the school child for any and every form of personal doctoring to the general health service—the family doctor and other resources which that service will provide. But that does not mean that as an integral part of the educational organisation the education authorities should not have their own arrangements for looking after medical and welfare conditions in the schools, for maintaining inspection and supervision of the child in the school group, and indeed for providing, until the new health service is fully developed, such forms of treatment as may be needed by the children and may not otherwise be available for them.

The proper continuance of environmental and preventive services in school and industry may well be coupled with the habit of using for those services doctors who are also engaged in the personal health service—so that there is a continuous blending of experience in both kinds of work. With the bulk of the profession engaged, part-time or whole-time, in the new service, this process can be more readily accelerated and arrangements more readily made for proper post-graduate training of general practitioners who are going to engage in industrial or other specialties appropriate to general practice. Similarly, while matters like industrial organisation require medical as well as other experts in the central departments of Government which deal with them, there is room for a better linking of the expert staffs so engaged with the expert staffs whose time is wholly or mainly given to the personal health and treatment services.

There is also another point on which it is necessary to be clear. The subject of health, in its broadest sense, involves not only medical services

but all those environmental factors—good housing, sanitation, conditions in school and at work, diet and nutrition, economic security, and so on—which create the conditions of health and prepare the ground for it. All these are fundamental; all of them must receive their proper place in the wider pattern of Government policy and of post-war reconstruction. But they are not the subject of this particular Paper, which is concerned exclusively with the direct services of personal health care and advice and treatment. No matter how successful the indirect influence of the environmental services may become in promoting good health and reducing sickness, there will remain a need for medical and nursing and hospital services.

General nature of the Government's proposals

The rest of this Paper is concerned with the Government's proposals for bringing the new comprehensive service into being. First, the administrative structure, central and local, will be considered. Then each of the main branches—the hospital and consultant services, the general practitioner service, and the local clinic and other services—will be discussed in some detail. After that, the special circumstances of the service in Scotland will be reviewed, and the Paper will end with a general summary of what is proposed.

At this stage, therefore, before the more detailed part of the Paper begins, it may make subsequent reading easier if the broad shape of the proposals is indicated.

It is proposed that the new responsibility for providing the comprehensive service shall be put upon an organisation in which both central and local authority take part, and which both centrally and locally is answerable to the public in the ordinary democratic manner. Central responsibility will lie with the Minister, local responsibility will lie with the major local government authorities (the county and county borough councils) operating for some purposes severally over their existing areas and for other purposes jointly over larger areas formed by combination. Both at the centre and locally, special new consultative bodies are proposed, for ensuring professional guidance and the enlistment of the expert view. At the centre, in addition, a new and mainly professional body is to be created, to perform important executive functions in regard to general medical practice in the new service.

The new joint authorities, i.e. the counties and county boroughs in combination, will be responsible (over suitable areas determined by the Minister after consulting the local interests) for assessing the needs of those areas in all branches of the new service and for planning generally how those needs should best be met. They will do this in consultation with the local professional bodies referred to, and they will submit their proposed arrangements to the Minister for final settlement in each case.

Then, when each area plan is settled, the joint authority will have the duty of securing all the hospital and consultant services covered by it, by their own provision and by arrangements with the voluntary hospitals in the area, and they will for this purpose be responsible in future for the existing local authority hospitals of all kinds. The individual county and county borough councils making up the joint authority will usually be responsible for local clinic and other services within the general framework of the plan, but there will be special provision for the child welfare services—to ensure a close relation between them and child education. General medical practice in the new scheme will be specially organised, largely as a national and centralised service, but with proper links with the local organisation to

relate it to the hospitals and to other branches of the service as a whole. There will be certain variations of these proposals for Scotland, to suit the differing circumstances there.

The new service will be free to all apart from possible charges where certain appliances are provided. (The payment of disability benefits during sickness—and related questions as to the adjustment of benefit during periods of free maintenance in hospital—are matters which belong to the Government's proposals on social insurance, to be published in a later Paper). The costs of the new health service will be borne partly from central funds, partly from local rates and partly from the contributions of the public under any scheme of social insurance which may be brought into operation.

III.

THE GENERAL ADMINISTRATIVE STRUCTURE OF THE SERVICE.

If people are to have a right to look to a public service for all their medical needs, it must be somebody's duty to see that they do not look in vain. The right to the service involves the corresponding duty to see that the service is provided. Some organisation has to carry that duty, and as the service is to be publicly provided this involves responsible public authority in some form.

CENTRAL AND LOCAL RESPONSIBILITY.

With the exception of medical benefit under the National Health Insurance scheme the public health services of this country have from the outset been administered by some form of local government organisation. In the case of medical benefit the administrative body—the Insurance Committee—though operating over a local area, the county or county borough, is not answerable to a local electorate but consists in the main of persons representing Approved Societies which are non-territorial units. Apart from this exception, in a long series of Public Health Acts and similar measures Parliament has placed the prime responsibility for providing the health services—hospitals, institutions, clinics, domiciliary visiting, and others—on local, rather than central, authority. This system recognises that, in intimate and personal services of this kind, local factors such as distribution of population, transport facilities, the nature of local employment and vocation (and generally local tradition and habit) have a profound influence on detailed planning.

The absorption of the existing services into a comprehensive service does not materially alter this situation. To uproot the present system and to put into the hands of some central authority the direct administration of the new service, transferring to it every institution and every piece of present organisation, would run counter to the whole historical development of the health services; and from a practical point of view a step of this kind would certainly not contribute to the successful and early introduction of the new service. Changes, some of a drastic kind, in the present organisation of local areas and administrative bodies will be necessary. For reasons discussed later the organisation of the services of general practitioners will call for a higher degree of central control than other parts of the service. But there is no case for departing generally from the principle of local responsibility, coupled with enough central direction to obtain a coherent and consistent national service.

CENTRAL ORGANISATION.

Central responsibility must rest with a Minister of the Crown, answerable directly to Parliament and through Parliament to the people. The suggestion

has been made that, while this principle should be accepted, there is a case for replacing the normal departmental machinery by some specially constituted corporation or similar body (perhaps largely made up of members of the medical profession) which would, under the general auspices of a Minister, direct and supervise the service. The exact relation of this proposed body to its Minister has never been defined, and it is here that the crux lies. If in matters both of principle and detail decision normally rested in the last resort with the Minister, the body would in effect be a new department of Government—no less than (say) the National Health Insurance Commission, which was later replaced by the Ministry of Health, or the present Board of Control or Prison Commission. If, on the other hand, certain decisions were removed from the jurisdiction of the Minister (and consequently from direct Parliamentary control) there would be need to define with the utmost precision what those decisions were. Clearly they could not include major questions of finance. Nor could any local government authorities responsible for local planning or administration reasonably be asked to submit to being over-ruled by a body not answerable to Parliament.

Nevertheless, the Government recognise that the provision of a health service involves technical issues of the highest importance and that in its administration, both centrally and locally, there is room for special devices to secure that the guidance of the expert is available and does not go unheeded. Otherwise the quality of the service is bound to suffer. They also recognise that, in a service which will affect the professional life of almost every doctor, there is need within the administrative structure for some largely professional body which can concern itself with the professional welfare of doctors who take part in the service. The proposals which follow are designed to meet this situation.

Central responsibility of the Minister

There will be direct responsibility to Parliament, therefore, resting on the Minister of Health and the Secretary of State for Scotland, respectively.

A Central Health Services Council.

At the side of the Minister, but independent of him, there will be created a special professional and expert body. It might be called the Central Health Services Council, and it will be a statutory body.

Its function will be to express the expert view on any general technical aspect of the service. There cannot be dual responsibility for the service and so it will be consultative and advisory, and not executive. It will be entitled to advise, not only on matters referred to it by the Minister, but on any matters within its province on which it feels it right to express its expert opinion, and the Minister—quite apart from any other publication of the Council's views and proceedings which he may from time to time make—will be required to submit to Parliament annually a report on the Council's work during the year. The Minister, in addition to the regular and general consultation which he will obviously want to maintain with such a body, will refer to it in draft form any general regulations which he proposes to make in the new service on subjects within its expert field.

The constitution of such a body, given statutory recognition as the mouth-piece of expert opinion in the central administration, will obviously need to be considered carefully and in detail with the professional and other organisations concerned. At this stage only the general kind of constitution which might suit its purpose and function can be suggested.

It will, it is assumed, be primarily medical in its make-up, because the main technical aspects of the health service in all its branches will be

medical. But it will not be wholly medical; it will need to be able to provide an expert view on many questions—e.g. of hospital administration, nursing, midwifery, dentistry, pharmacy and auxiliary services—which will involve other experts than the physician or surgeon. Yet, to be effective, it must not be too large and unwieldy; nor could much of its varied work be regularly done by the single full Council. The Council itself might consist of about thirty or forty members, representing the main medical organisations (specialist and general), the voluntary and municipal hospitals (with both medical and other representation), medical teaching and professions like dentistry, pharmacy and nursing and midwifery. For any of its special purposes the Council could establish small groups or sub-committees, on each of which it would be possible to introduce additional experts in the particular subject referred—the Council itself, however, retaining an ultimate single responsibility for all views or advice expressed in its name.

The members will be appointed by the Minister in consultation with the professional and other organisations concerned, and the Council will select its own chairman and regulate its own procedure. The Minister will be prepared to provide a secretariat, and the expenses of the Council will be met from public funds.

Central Medical Board.

There will also be set up, for certain specific purposes, a Central Medical Board. This will be in a different category from the Central Health Services Council, inasmuch as it will perform executive functions in the day-to-day working of the general practitioner service, rather than voice opinion on general matters of medical policy

It is mentioned here only to complete the picture of the central organisation. Its duties and its constitution will need to be referred to in chapter V, when the participation of doctors in the service and the terms and conditions of that participation are considered.

LOCAL ORGANISATION.

Local organisation is inevitably more complex. The new service has to include hospitals and institutional services for the sick in general, for mental cases, for infectious diseases and tuberculosis, for maternity and for every general and special hospital subject. It has to include the many kinds of service usually provided in local clinics, a family doctor service and many ancillary services—nursing, health visiting, midwifery and others. It ranges from the one extreme of highly specialised services, requiring relatively few centres for the country as a whole, to the other extreme of services involving a large number of local clinics and arrangements for care in the individual home.

Suggestions have been made for a completely new kind of local or "regional" authority—sometimes proposed as a vocational or technical body (like the special kind of central organisation already mentioned). In so far as those suggestions would conflict with the principle of public responsibility, they need not be considered here. Both the principles applied to central organisation—that of democratic responsibility and that of full professional guidance—must be equally applied to local organisation

Service to be based on local government.

The present local government system amply embodies the former of these principles—that of democratic responsibility—and the existing local authorities are already responsible for many kinds of personal health service which will need to be incorporated in the new and wider service in future. It is certainly no part of the Government's intention to supersede and to waste these good

existing resources, or needlessly to interfere with the well-tested machinery of local government as it is already known; nor would the record and experience of the existing local authorities in the personal health services justify such a course. On the contrary the Government propose to take as the basis of the local administration of the new service the county and county borough councils. But there are some requirements of the new service which the county and county borough councils cannot fulfil if they continue to act separately, each for its independent area; and changes will be necessary. In particular, for the future hospital service, it will be essential to obtain larger local areas than at present, both for planning and administration. The special needs of this service can be considered first.

Need for larger administrative areas for the hospital service.

Broadly speaking the hospital services, so far as they are publicly provided now, are in the hands of the county and county borough councils, with the exception of isolation hospitals for infectious disease in the counties. The size of counties and county boroughs varies enormously—ranging (without counting London) from Rutland and Canterbury, with populations of some 18,000 and 26,000 respectively, to Middlesex and Birmingham with populations of over 2,000,000 and 1,000,000.

It would be theoretically possible to put upon the council of each county and county borough the duty to provide, or to arrange with other agencies for, the whole range of hospital services. This would impose responsibility for the services on authorities many of which lack the size and resources and administrative organisation to plan and conduct and pay for the service. What is more important, it would leave untouched the demarcation between town and country which is reflected in the system of administrative counties and county boroughs, but which has no meaning in relation to hospital services. The towns largely serve the country in the matter of hospitals. If for purposes of hospital administration they are kept apart by continuing the separate county and county borough basis, the result will be a complicated criss-cross pattern of "customer" arrangements, since in most areas (particularly those of counties) it will be out of the question to secure the whole range of service—or even the bulk of it—inside the area boundary. These "customer" arrangements will in turn involve complicated administrative arrangements and a mass of financial adjustments between different areas. Alternatively, if the provision of a complete service within each area were attempted, the resulting system would run counter to the whole conception of an ordered pattern of hospital accommodation and could only lead to wasteful competition in hospital building.

The need for larger areas has long been recognised by local authorities in many branches of hospital administration. The many combinations already in existence make this clear; indeed, the very existence of these combinations would in itself give rise to administrative difficulties if it were decided that the new hospital service as a whole was to be in the hands only of the individual county and county borough councils in future.

The essential needs of a reorganised hospital service, based on a new public duty to provide it in all its branches, are these—

(a) The organising area needs to cover a population and financial resources sufficient for an adequate service to be secured on an efficient and economical basis.

(b) The area needs to be normally of a kind where town and country requirements can be regarded as blended parts of a single problem, and catered for accordingly.

(c) The area needs to be so defined as to allow of most of the varied hospital and specialist services being organised within its boundaries (leaving for inter-area arrangement only a few specialised services).

In the majority of the areas of existing authorities none of the three conditions would be met.

It is therefore necessary to decide what the form of authority for these larger hospital areas should be. On this, various alternatives are examined in Appendix C to this Paper. The course most convenient—and indeed, in the Government's view, the only course possible at the present time—will be to create the larger area authorities by combining for this purpose the existing county and county borough councils, in joint boards operating over areas to be settled by the Minister after consultation with local interests at the outset of the scheme. There will be some exceptional cases (the county of London is the most obvious) where no combination is necessary at all; in such cases an existing authority will fulfil both its own functions and those of the new form of authority—but this will be unusual. Where the new form of joint authority is referred to in the rest of this Paper it should be taken as including any individual council which, in such exceptional circumstances may be acting in the two capacities.

While both planning and administration will usually need to be based on larger areas, this does not mean that a standard-sized area need be, or can be, prescribed for the hospital services. Local conditions—distribution of population, natural trends to various main centres of treatment, geography, transport and accessibility—must determine the size and shape of the optimum area. Sometimes simple combination of a county with the county boroughs within its boundary (i.e. the geographical county as a unit) will be sufficient; sometimes the linking of two or three small counties will be needed, sometimes other variations.

Special mention should be made of the isolation hospitals for infectious diseases, because in the counties these hospitals are with few exceptions owned and administered by the minor authorities and not by the county councils, and therefore a decision to transfer them to the new joint authority will not only remove them from their present owners (as with the hospitals of the counties and county boroughs) but will prevent their present owners from retaining even the part interest in them which membership of the new joint authority will afford in the case of the counties and county boroughs. (It is, of course, not practicable to give direct representation on the joint authority to these minor authorities, without at once duplicating the representation of all local government electors who happen to live in a county and not in a county borough.) The case for this absolute transfer of the isolation hospitals has nothing to do with the past record of the minor authorities, nor is it in any way a reflection upon the quality of the work which they have hitherto done. The whole trend of medical opinion has for some time been in favour of treating these hospitals, not primarily as places for the reception of patients to prevent the spread of infection, but as hospitals where severe and complicated cases of infectious disease can receive expert treatment and nursing. The small isolation hospital of the past century is not only uneconomic in days of rapid transport but cannot reasonably be expected to keep abreast of modern methods. One result of the new outlook will be the development, in addition to the larger isolation hospital serving the densely populated area, of accommodation for infectious diseases in blocks forming part of the general hospitals. These considerations all indicate that the infectious disease hospitals must in future form part of the general hospital system.

It may be, as time goes on, that for certain specialised hospital functions there is room for the development of a few particular centres which would serve national rather than local needs. In this field there may be a case for direct provision or arrangement by the Government centrally. But such provision or arrangement would be special and exceptional and need not be considered here as part of the normal organisation of the new service.

As will be seen, when the hospital services are fully considered in chapter IV, the function of the new joint authorities will be to secure a complete hospital and consultant service of all kinds for each of the new and larger areas—partly by their own direct provision and partly by arrangement with voluntary hospitals, and all on the basis of an area hospital plan which they will formulate in consultation with the hospitals and others concerned, and which will require the Minister's final settlement and approval. The existing powers and duties of the present local authorities in regard to hospital services—including tuberculosis, infectious diseases and mental health—will pass to the joint authorities, together with the existing hospitals and other institutions concerned.

The place of the joint authority outside the hospital service.

Outside the hospital and consultant services—that is, in the kinds of service appropriately given in local clinics and similar premises, or by domiciliary visiting (like midwifery or home-nursing)—the case for centralising all administration in the one authority over the larger area is not the same, and it is the Government's view that there should be as little upsetting of the existing organisation for these services as is compatible with achieving a unified health service for all. It will not be enough, however, simply to leave all these separate services exactly as they are now. What is essential is that, although still locally conducted with all the advantages of local knowledge and enthusiasm, they should be regarded in future as the related parts of a wider whole and should fit in with all the other branches of a comprehensive service in their planning and their distribution. For this purpose it must be the single responsibility of some authority to plan the whole, although not necessarily to provide the parts, and the obvious authority to do this—from the point of view both of its area of operation and of its constitution—will be the new joint authority.

The new joint authority will therefore be charged to examine the general needs of the area from the point of view of the health service as a whole—not only in the hospital services for which it will itself be responsible but also in these more local services. It will have the duty of producing, in consultation with the local authorities and others concerned, an area arrangement or plan for a related service of all kinds—and this will need the approval of the Minister. But, within the general framework of the approved plan, the provision and administration of most of the local services—including some new kinds of service—will normally rest with the individual county and county borough councils, and the joint authority will be concerned only to watch that the general area arrangement proves to be the right one when put into actual operation, that in fact it works out as intended, and that any subsequent additions to it, or amendments of it, which seems to be required are put in hand and submitted to the Minister.

There are, however, some forms of local clinic service which—although provided in separate premises so as to make their facilities more accessible—are in essence out-patient activities of the hospital and consultant services; of which, in fact, the essential feature needs to be treatment and advice at the consultant and specialist level, provided by the same consultants and specialists as serve the hospitals or sanatoria and are based on them. Obvious examples are the tuberculosis dispensaries, mental clinics and cancer diagnostic centres. This kind of service must usually be the responsibility of the same authority as is responsible for the hospitals and consultants over the larger area—the "outpost" service going with the parent service of which it ought to be part. They differ in this respect from the other local services which belong more to the general practitioner sphere—the maternity and child welfare clinics,

school medical services, clinics for general dental or ophthalmic treatment and advice, arrangements for midwifery or home nursing or health visiting, and similar activities. These certainly need to be linked with the consultants and the hospitals for difficult cases (as the area plan will provide), but they do not have to be directly administered with the hospitals, and the counties and county boroughs are normally appropriate areas for their operation.

One case requires special mention. The Local Government Act of 1929 initiated the policy of securing that local child welfare and education responsibilities should be brought closer together, and that the local education authority in each area should as often as possible be the welfare authority. In the view of the Government the time has come to carry that policy to its full conclusion. The destination of the present welfare functions (now exercised partly by county and county borough councils, partly by other local authorities within the counties) will therefore depend upon the decisions taken by Parliament upon the educational functions of these various authorities under the current Education Bill. When the relationship between the county and county borough councils and the minor authorities in regard to education has been settled, something on broadly similar lines can be adopted as the arrangement between these authorities in regard to child welfare. This does not mean, however, that this service will be excluded from the general area planning of the health services by the new joint authority. It affects only the local operation of the service.

In dealing with the clinic and other local services generally it will not be wise to prescribe an absolutely hard-and-fast rule to be applied in all circumstances. It may be that in a particular county or county borough of exceptionally small area or resources a case for transferring local functions to the larger joint authority will be overwhelming, in the interests of an efficient service. In another area, for some particular local reason, even some of the dispensary or out-patient functions just described as belonging properly to the hospital and consultant sphere may be found more suitable for discharge by an individual county or county borough. A rigid and universal rule about the allocation of the various services would preclude a good common-sense arrangement on which all were agreed in a particular case. For reasonable flexibility, the detailed allocation of services will be left to be finally settled as best suits each case, but observing the general demarcation described in the absence of any exceptional reason to do otherwise.

This can be achieved in the following way. The new joint authority, in preparing its arrangement or plan for the whole health service of its area and submitting it to the Minister, will include proposals as to the exact allocation of responsibility for providing the various local services covered—i.e., proposals as to which services should be provided by the county and county borough councils severally and which in combination through the joint authority itself. In all cases the hospital and consultant services will be required to be the joint authority's responsibility; in all cases the child welfare service will be required to lie with the same authorities as carry responsibility for education under the new Education Bill; in between these two fixed points the allocation of clinic and other local services can vary to suit exceptional needs, but with the normal rule as stated above—those services which belong essentially to the consultant sphere, like tuberculosis dispensaries, going to the joint authority, while those which do not will rest with the several counties and county boroughs making up that joint authority. The decision, as in other proposals of the area plan, will rest finally with the Minister in each case.

Special considerations will apply to the "family doctor" or general practitioner branch of the new service, which is reviewed in detail in chapter V. The organisation there suggested will be one which is largely

central and national and only partly local. Those main aspects of the service which affect the individual practitioner—including the terms of his participation in the service, the protection of his professional interests and the general personal relationship of the doctor to the new public service—will be governed by central arrangements applicable to the country as a whole. On the other hand it is not proposed that there shall be any question of excluding this branch of the health service from the concern of the new joint authorities to plan, with the Minister, for the requirements of their areas, and the locally planned arrangement of the new service will in each case have regard to resources and needs in the sphere of general practice as well as in hospital and other facilities.

Apart from these local functions in the general practitioner service, there will also be the provision and maintenance of special Health Centres for the grouped medical practice of some of the doctors in the new service, in areas where it is decided to try this form of practice. This, as a function not belonging to the hospital and consultant sphere, will be appropriate to the individual county and county borough councils.

General.

An important task, therefore, of the new joint authorities will be to unify and to co-ordinate the service. They will be the instrument through which, with the Minister, a rational and effective plan for all branches of the health service in their respective areas is secured. It will be their responsibility to see that their proposals provide for all that the inhabitants of their areas will require, to submit the proposals to the Minister as an area plan for final settlement, and subsequently to keep the plan up to date as requirements develop and to bring before the Minister any necessary changes if the plan is found not to be working out in the manner designed. They will not themselves provide and operate all the services for which the approved area plan provides; nor is there any need for them to do so. They will usually administer themselves only those branches of the service which demand direct administration over the larger area as a whole, and not those which can suitably be administered (when once a unified plan is settled) on a more localised basis. In short, the existing major local authorities will combine to secure, with the Minister, a unified general plan of the whole service for their grouped areas; they will then combine to carry out those parts of this plan which demand a single administration over all their areas together; but they will be charged individually to carry out those parts which can be separately and locally administered.

Professional guidance in local organisation.

In order to secure good professional guidance in the local administration of the new service a special local professional organisation will be established to advise and guide and, if necessary, to initiate new suggestions.

Local Health Services Councils.

The need to ensure technical guidance—by creating special professional and expert bodies for the purpose—offers scope for innovation in local government method and justifies it. What is wanted is that there should be, in each area, some new provision for the organised expression of the views of the expert and for ensuring that the local administration can get the fullest advantage from it. The simplest way will be to apply to local administration the kind of consultative machinery suggested for central administration; i.e. to have in each case a local expert technical body, which might be known as the Local Health Services Council.

The purpose of these bodies will be to provide locally the same kind of medium for expressing the expert point of view on technical aspects of the service as has been proposed at the centre. The appropriate area for each will be the larger areas of the new joint authorities already discussed. Their functions will be not only to advise on matters referred to them by the joint authorities or other local authorities in the area, but also to initiate advice on any matters within their expert province on which they think it right to do so and if they wish, to submit their views and advice not only to the joint authority or other local authorities concerned with the matters in question, but to the Minister. Apart from its ordinary consultation, the joint authority will be required to consult them on the area plan for the local health service which it submits to the Minister, and on subsequent material alterations or additions to that plan.

The constitution and membership of these bodies will call for detailed consideration later. Provided that all the professional interests are fairly represented, there is no reason why the pattern should be precisely uniform throughout the country and the most convenient course will probably be to provide for the matter by way of local schemes approved by the Minister.

Direct professional representation on local authorities.

It is sometimes suggested that the best method of linking the expert point of view with the direct administration of the service would be to include in the local administrative authorities themselves, and in their committees, a proportion of professional members appointed for the purpose by the appropriate professional organisations, with or without voting powers. Arguments can be adduced both for and against a system of this kind, but on balance the Government feel that the risk of impairing the principle of public responsibility—that effective decisions on policy must lie entirely with elected representatives answerable to the people for the decisions that they take—outweighs any advantages likely to accrue.

IV.

HOSPITAL AND CONSULTANT SERVICES.

The term "hospital services" is used in this Paper to include all forms of institutional care of every kind of sickness and injury. It comprises the whole range of general and special hospitals, including infectious disease hospitals, sanatoria for tuberculosis, accommodation for maternity cases and for the chronic sick, and for rehabilitation; and it comprises also the usual ancillary hospital services for pathological examinations, X-ray, electro-therapy, ambulances and other purposes. Out-patient no less than in-patient treatment is included. It will be the aim to restore the out-patient work of the hospitals as much as possible to its proper field of specialist and consultant care, when the existence of a general "family doctor" for all has been secured.

The mental hospitals and mental deficiency institutions have also to be included in the scope of the hospital and consultant part of the new service, under the care of the new joint authorities. They will present many problems of their own, calling for some degree of special organisation to fit them. The present general review does not attempt to deal with this special subject, and the discussion which follows is directed mainly to the more general range of hospital and consultant services—although much of it can obviously be applied to the mental health services as well.

The present hospital services are described in Appendix A. They present two main problems. The first is to bring together over suitable areas the

activities of the various separate and independent hospitals, to ensure that all the different kinds of special and general hospital treatment are so linked that the individual can get the best of each. The second is to enable the two quite different hospital systems (the voluntary hospitals and the municipal hospitals) to join forces in future in a single service.

The proposed joint authority, operating over a large area, has been described. It will be that authority's responsibility, with the Minister, to see that a full hospital service of all kinds is available for people in its area. But the authority neither will, nor will need to, provide the whole service itself.

The part of the voluntary hospital.

The conception of a public authority discharging its duty by contracting with others for the provision of services has long been familiar. As early as 1875 local authorities were enabled both to provide hospitals themselves and to enter into agreements with other hospitals for the reception of people from their district. Later legislation followed similar lines; in recent Acts dealing with special services (e.g., the Midwives Act, 1936, the Cancer Act, 1939) the use of voluntary agencies has been clearly contemplated. There are already large numbers of agreements under which existing local authorities arrange for accommodation in hospitals, sanatoria, dispensaries, or clinics, sometimes belonging to other local authorities and sometimes to voluntary agencies.

The facts of the existing accommodation in voluntary and municipal hospitals (given in Appendix A) make it clear that without the collaboration of the voluntary hospitals it would be many years before the new joint authorities could build up a system adequate for the needs of the whole population; so that, from that point of view alone, the co-operation of the voluntary hospitals is a necessity. But the matter cannot be regarded from that point of view alone. The voluntary hospital movement not only represents the oldest established hospital system of the country, but it attracts the active personal interest and support of a large number of people who believe in it as a social organisation and who wish to see it maintained side by side with the hospitals which are directly provided out of public funds. It is not merely that the best of the voluntary hospitals have, in a degree so far unsurpassed, developed specialist and general hospital resources which they will be able at once to make available, while most of the rest of the voluntary hospitals have experience and an existing organisation which it will be obviously sensible to enlist. It is certainly not the wish of the Government to destroy or to diminish a system which is so well rooted in the good will of its supporters.

Yet the acceptance by the community of responsibility for a service for all might affect fundamentally the position of the voluntary hospitals. A new universal public hospital service might have the gradual effect of undermining the foundations on which the voluntary hospitals are based. If this is not to happen, a way has to be found of combining the general responsibility of the new joint authority for the service with the continued participation in that service of the voluntary movement as such; a way, in fact, of securing a whole service under one ultimate public responsibility without destroying the independence and traditions to which the voluntary hospitals attach value. The Government believe that this can be done, and in settling the details arising out of the following proposals they will welcome the help and the suggestions of the voluntary hospital representatives in securing it.

Preparation of local area plan.

The joint authority's first task will be to assess in detail the hospital needs of its area and the hospital resources available to its area.

This it will do in close consultation with the local expert body, the Local Health Services Council. It is hoped that the hospital surveys, referred to in Appendix B and now nearing completion, will be of valuable help in this.

The authority's next task, in consultation with the local expert body and other local interests (including the voluntary hospitals and, where appropriate, the medical schools) will be to work out a plan of hospital arrangements for its area, based on using, adapting and, where necessary, supplementing existing resources. The object of the plan will be to arrive at the right quantities, kinds and distribution of hospital facilities for the area; to settle where, how, and by what hospitals, each branch of hospital treatment can best be secured; to produce a balanced scheme in which all the necessary specialist facilities in medicine and surgery (including fracture and orthopaedic, gynaecological, paediatric, ophthalmic, psychiatric and others) are provided in due proportion, together with general accommodation for cases, acute or chronic, of the ordinary type. The plan must ensure that the various special treatments are concentrated in centres competent and convenient to provide them, and not dispersed haphazard in uneconomic and overlapping units; that proper linking of services is secured by relating the work of special and general hospitals; that arrangements are at hand for the transfer of patients to the hospitals best suited to their medical needs; and that the skill of the consultant staffs of the various hospitals taking part can be used to the maximum advantage of the area as a whole.

It will be the aim of the authority to make its area (which will have been determined with this in view) as self-sufficient as possible in hospital and consultant services. But where it is obviously more sensible, as in some of the rarer services, the plan will provide for certain services by agreed arrangements outside the area.

The basis of the plan will be that the joint authority will secure the necessary service for its area partly through its own hospitals and institutions, partly through contractual arrangements made with voluntary hospitals for the performance of agreed services set out in the plan, to a minor degree (where necessary) through arrangements with the joint authorities of other areas.

Central approval of local area plans.

The plan will then be submitted to the Minister for approval, and will have no validity until so approved. The Minister, able to look at the country as a whole and at the effect of the local plans one upon another, will have power to modify or supplement the plan before giving his approval. He will consider all objections or representations made to him by local organisations (including the Local Health Services Council), voluntary hospitals or others.

The plan, when approved, will be open to amendment at any time, and the Minister will be empowered to call on the joint authority to reconsider the plan and submit fresh proposals. The procedure for amending the plan will be the same as for its original preparation and will include all necessary local consultation.

No voluntary hospital will be compelled to participate. Its participation will rest on a contract between it and the joint authority to provide the services specified in the plan. Where it agrees to participate, it will—like each of the authority's own hospitals—have to observe certain general conditions, just as it will obtain certain advantages.

General conditions to be observed by hospitals.

These conditions will be settled centrally, for the country as a whole, and they will then become the conditions on which exchequer grant will be payable.

In framing the conditions the Minister will seek the advice of the Central Health Services Council; but the more important conditions will relate to subjects such as the following:—

(a) each hospital will be required to maintain the services which under the approved hospital plan it undertakes to maintain, and generally to comply with the plan;

(b) each hospital will observe certain national requirements such as the Rushcliffe or Taylor rates and conditions for its nursing and midwifery staff and the recommendations of the Hetherington Committee for its domestic staff;

(c) in appointing senior medical and surgical staff each hospital will conform with any national arrangements adopted for regulating appointments and remuneration;

(d) each hospital will be open to visiting and inspection, in respect of its part in the public service, under arrangements laid down centrally;

(e) in the voluntary hospitals conditions to secure reasonable uniformity in accounts and audit will probably be necessary so far as they take part in the new service. The presentation of accounts of municipal hospitals is already largely subject to central direction.

Financial arrangements with voluntary hospitals.

As already emphasised, it is the aim of the Government to enable the voluntary hospitals to take their important part in the service without loss of identity or autonomy. But it is essential to this conception that the hospitals should still look substantially to their own financial resources, to personal benefactions and the continuing support of those who believe in the voluntary hospital movement. So long, and so long only, can they retain their individuality. If once the situation were to arise in which the whole cost of the voluntary hospitals' part in the public service (a service designed for the whole population) was repaid from public money, or indeed in which it was recognised that public funds were to be used to guarantee those hospitals' financial security, the end of the voluntary movement would be near at hand.

On this footing, the financial relation between the joint authority and the individual voluntary hospital must be that of an agreement to pay a specified sum in return for services rendered or to be rendered, and this should not be assessed as a total reimbursement of costs incurred. Whether the sum will be calculated in terms of beds or occupied beds, or otherwise, is for the moment immaterial. In order to avoid a large number of individual bargains, and the risk of competitive bargaining leading to undesirable results, it will be convenient for standard payments, in respect of different kinds of hospital service which involve different levels of expense, to be settled centrally. These payments will be made by the joint authorities and will fall on local rates, assisted by exchequer grant.

In addition, both the municipal and the voluntary hospitals will receive a direct grant from central funds which will include the share, attributable to hospital services, of any sum allocated towards the cost of the comprehensive health service from the contributions of the public to any scheme of social insurance. So far as this sum represented contributions by potential patients of hospitals it could fairly be said that the Government would have collected money which might otherwise have been paid to the hospitals direct, and that the proposed grant would thus restore the balance. This grant could be based on the number of beds provided by each hospital, but in the case of voluntary hospitals it would be feasible, if so desired, to regard the aggregate of their share of the payments as a central pool from which payments to individual hospitals could be varied according to the needs and resources of each.

In either case it will be the Minister's responsibility to see that the conditions of the grant are fulfilled. If the idea of a variable grant to the voluntary

hospitals is adopted, the Minister will be prepared to be guided in questions of relative need by some suitable body representing the hospitals, though the final responsibility and decision must remain with him.

Particular regard will need to be given, in connection with the area plans, to the position of hospitals used for the clinical teaching of medical students, and the question of financial assistance in respect of teaching work will be reviewed when the report is available of the Committee on Medical Schools now sitting under the chairmanship of Sir William Goodenough.

Inspection of hospitals.

In a service of this magnitude, in which hundreds of hospitals under different and independent managements will be taking part, the problem of inspection is a difficult one. Apart from special inspection in cases of difficulties arising or changes in contemplation, routine inspections—at not too frequent intervals—would serve the double purpose of bringing to notice defects of organisation or management and, what is equally important, of enabling individual hospitals to be kept in touch with the latest practice and ideas. The foundation of any inspectorate must clearly be a team of highly qualified medical men, but the inspectors need not all be persons employed whole-time on this work; from many points of view there are advantages in employing on a part-time basis medical men or women of distinction in various branches of professional work or medical administration. In addition to doctors, there is scope for experts of various kinds for dealing with an organisation so varied and complex as a modern hospital. Hospital administrators, nurses, catering experts and others should find a place.

A solution would be the appointment by the Minister of a body of persons of the types mentioned, some of whom would be on a whole-time and others on a part-time basis. These appointments could be made with the advice of the Central Health Services Council and for convenience those appointed might be grouped in suitable panels operating over different areas of the country. The selection of the part-time doctors could be partly from those associated with consultant practice and voluntary hospitals and partly from those with experience of municipal hospitals, as in the case of those who are already conducting on the Minister's behalf the survey of hospital resources referred to in Appendix B. In cases of importance the inspectors could, again like the hospital surveyors, work in pairs.

The system of inspection must take account of the fact that the new joint authorities, no less than the Minister, will have a responsibility for the hospital service as a whole in their respective areas. The arrangements are intended to serve the double purpose. Inspectors' reports on any hospital will be available both to the Ministry and to the joint authority, and it will be open to the latter to ask for a special inspection if it thinks it desirable. Where in the past contractual arrangements have been made between a local authority and a voluntary hospital, special provision has not uncommonly been made for a right of entry for the authority's medical officer. There would be nothing to prevent similar arrangements being locally agreed under the system now proposed, but normally a more general system of the kind described will better serve the purpose in view.

Provision for consultant services in the local plan.

A main object of the new arrangements will be to ensure all kinds of consultant and specialist advice and treatment to all who need it. This part of the service will be best and most naturally based on the hospital services, in the wide sense in which these have been defined.

This means that it will become one of the duties of the joint authority to ensure that, through the various hospitals taking part, there will be provided an adequate consultant service available to all general practitioners in the service. It will do this, as in other branches of the hospital service, partly by its own direct arrangement and partly by contracting with the voluntary hospitals. In the latter case it will be for the authority to agree with a voluntary hospital for the provision by the latter of consultant services both at the hospital and—where necessary—by visits to a clinic or Health Centre or the patient's home. The hospital will itself enter into the necessary engagements with the consultants and specialists concerned. The local service payments to the hospitals, already mentioned, can be based on the assumption of a consultant staff properly remunerated to enable the hospital to fulfil the tasks which it has undertaken to perform.

Some principles affecting consultant services.

Before proposing in detail the form of a consultant service the Government are awaiting the report of Sir William Goodenough's Committee on Medical Schools. But it is clear that there are certain general considerations of which account must be taken in devising the new service.

The need is twofold—more consultants, and a better distribution of them. Apart from distribution, there are not yet enough men and women of real consultant status and one of the aims will be to encourage more doctors of the right type to enter this branch of medicine or surgery and to provide the means for their training. As to distribution, the need is for a more even spread. The main consultant facilities now are inevitably concentrated at the medical teaching centres. The consultant service still needs to be organised with the teaching centre as its focus, but the service must be spread over a wider area by enabling and encouraging consultants taking part in it to live and work farther afield. Apart from the main effect of greater accessibility to the public, this will also have a beneficial effect upon general medical practice over larger areas—where the habitual presence and services of consultants will serve as a means of continuous postgraduate education.

The consultant taking part in the service must be associated with his particular hospital or hospitals on a much more regular basis—and with more regular attendances and duties—than is often the case now, when he is regarded as merely "on call." It will often be desirable that the consultant's association should be with more than one major hospital, so as to enable the sharing of a common consultant staff to become an effective link between hospitals. The consultant's function will be normally one of regular and frequent visiting of these hospitals, both for in-patient and for out-patient consultation; also of properly arranged visiting of outlying "general practitioner" hospitals, which need to be linked with the major hospitals; and—for certain consultants as circumstances may require—of visiting Health Centres and clinics, and, in case of need, the patient's home, at the request of the general practitioner.

For this sort of duty the proper and regular remuneration of consultants, through the hospitals with which they are associated, will become essential. This remuneration, and the engagements entered into in respect of it, can be on either a full-time or a part-time basis (and might well include part-time engagements with more than one hospital). There will be no need to make either whole-time or part-time appointment a universal rule.

The conditions, including the financial terms, on which consultants undertake work on a whole-time or part-time basis will be a matter for arrangement by the hospitals, voluntary or municipal, which offer the appointments; but in order to avoid anomalies as between hospital and hospital and between area and area some central regulation of scales will be required.

Some degree of control of the discretion of individual hospital authorities will be required in appointments to senior clinical posts. Under existing practice a danger of "in-breeding" has been commonly recognised, and while it is important that the ultimate responsibility for an appointment should rest unmistakably with the body of persons conducting the hospital's affairs, it will be necessary to consider a system under which an expert advisory body recommends a number of suitable candidates from which the hospital authority makes the final choice. The necessary machinery could be organised in a variety of ways. It might consist of a number of advisory panels, working over regions based, broadly, on the medical teaching centres and representing both the consultant members of the profession and the medical teaching organisations. One or more representatives of the appointing hospital could join the panel dealing with the sifting of candidates for appointment.

V.

GENERAL PRACTITIONER SERVICE.

The arrangements for general medical practice in the comprehensive service—i.e. for ensuring a personal or family doctor for everybody—present the most difficult problem of all. This is partly because this will be the front-line of the service, the first source of help on which the individual will rely and one involving a close personal relation between doctor and patient. In addition, although the provision of medical benefit under National Health Insurance covers over twenty millions of persons and has afforded much experience of the working of a public general practitioner service, the widening of public responsibility to cover the whole population and the need to fit the general practitioner into a comprehensive service will create new problems and will make it necessary to reconsider, without preconception, the whole of the existing arrangements.

If the service is to be free to the people for whom it is provided, the doctors taking part in it will look to public funds for their remuneration. They must, therefore, be in some contractual relationship with public authority, which in turn must be able to attach such conditions as will ensure that the services which the people get are the services which they need (and for which they will be paying in taxation and otherwise) and that they can get them where and when they need them. The State must, therefore, take a greater part in future in regard to general medical practice.

The method of embodying general medical practice in a national service must observe two principles. The first, which mainly concerns the patient, is that people must be able to choose for themselves the doctor from whom they wish to seek their medical advice and treatment, and to change to another doctor if they so wish. Freedom of choice is not absolute now; it depends on the number and accessibility of doctors and on the fact that there is a limit to the load which any one doctor can or should take on. But the present degree of freedom must not be generally diminished, and the fact that public organisation ensures the service must not destroy the sense of choice and personal association which is at the heart of "family" doctoring. The second principle, which mainly concerns the doctor, is that the practice of medicine is an individual and personal art, impatient of regimentation. Whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best.

Methods of approach to the problem.

One method would be to abandon entirely the present system, on which National Health Insurance has been based, and to substitute for it a system under which all doctors taking part would become the direct employees of the State or of local authorities and would be remunerated by salary. As a problem of administration, there would be no insuperable difficulty in organising a scheme of this kind. But this is a highly controversial question, on which opinions are sharply divided. Many experienced and skilled doctors would be unwilling to take part in a service so conceived. They would hold that it infringed the second of the two principles just stated, and that if they became the salaried servants whether of the State or of local authorities, they would lose their professional freedom and be fettered in the exercise of their individual skill. Other doctors, with an equal right to be heard, would welcome a salaried service, believing that it would relieve them from business anxieties and enable them to devote themselves more freely to the practice of their profession. Lay opinion is similarly varied.

The Government have approached the question solely from the point of view of what is needed to make the new service efficient. Some of the proposals made in this Paper involve forms of medical practice for which present methods of payment are inappropriate, if not unworkable. Where this is so, remuneration by salary or its equivalent is suggested. A universal change to a salaried system is not however, in the Government's view, necessary to the efficiency of the service. They consider that to make, unnecessarily, so total and abrupt a change in the customary form of general medical practice would offend against the principle—earlier stated—that the new service should be achieved not by tearing up all established arrangements and starting afresh but by evolving and adapting the present to suit the future. They are averse from imposing a total salaried service merely for the sake of administrative tidiness.

Another alternative would be to maintain the "panel" system of National Health Insurance as it is now known, while extending it to the whole population and expanding it to include consultant and specialist services. This system has had, and still has, its critics, and some of the criticism is well founded. Yet, for more than a generation it has provided a better medical service than was previously available to a large section of the population and it has enlisted the regular professional services of a great majority of the doctors of the country. There are, however, two overriding reasons why it will not be possible to meet the new need merely by extending the panel system in this way.

First, there is at present no effective means of ensuring a proper distribution of doctors. To some extent the demand in any area will, by affording opportunity for practice, itself induce the supply; but that does not work out reliably or universally. It is true even now that the need for doctors in one area may be scantily or unsuitably met, while that of another area may be over-supplied. Certainly when the much bigger public responsibility is assumed of ensuring a personal doctor service for the whole population there will have to be means of securing, through public organisation, that the resources available are so disposed as to fit the public need.

Second, there is a great deal of agreement in the profession and elsewhere that developments in the modern technique of medical practice point the way to changes which need encouragement and experiment in any future service. The recent draft Interim Report of the Medical Planning Commission

(organised by the British Medical Association) summarises these trends very well. For instance, the Report states:—

“ The days when a doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot now be all-sufficient. For efficient work he must have at his disposal modern facilities for diagnosis and treatment, and often these cannot be provided by a private individual or installed in a private surgery. He must also have easy and convenient access to consultant and specialist opinion, whether at hospital or elsewhere, and he must have opportunities of real collaboration with consultants. Facilities such as these are inadequate at the present time. There must also be close collaboration amongst local general practitioners themselves, for their different interests and experience can be of value to each other. Although this need is recognised by practitioners collaboration has not been developed as it should be.”

Or, again, in another passage—

“ At the present time the single-handed practice or partnership is usually conducted from a doctor's private residence. Certain rooms are used for professional purposes, and personal or borrowed capital is invested in equipping the practice with apparatus and in keeping it up-to-date; additional domestic staff is employed to keep the surgery and waiting rooms clean and to deal with callers; the secretarial work and record keeping are done by the doctor himself or a secretary employed for the purpose; dispensing, if done at the surgery, is undertaken either by the doctor or a dispenser employed by him. This arrangement is repeated many times over in a fairly well-populated district.”

The tendency will be away from the idea of the all-sufficient doctor working alone, and towards a bigger element of grouped practice and teamwork—in which the individual doctor retains his personal link with the patient, but has at his side the pooled ability of a group of colleagues as well as consultant and hospital services behind him. To quote the Medical Planning Commission once more:—

“ Diverse as are the views of the organization of medical services, there is general agreement that co-operation amongst individual general practitioners in a locality is essential to efficient practice under modern conditions, though views vary on the form of the co-operation. The principle of the organization of general practice on a group or co-operative basis is widely approved.”

The Government fully agree that “ grouped ” practices, to which numerous privately arranged partnerships are already pointing the way, must have a high place in the planning of the new service and they are designing the service with this constantly in view. Yet the conception of grouped practices cannot represent the whole shape of the future service. In the first place, there has not yet been enough experience of the idea translated into fact. Not enough has been found out, by trial and error, to determine the conditions under which individual doctors can best collaborate or even the extent to which in the long run the public will prefer the group system. Second, it is certain that the system could not be adopted everywhere simultaneously. The change, if experience shows that it should be complete, will take time.

The Government intend, therefore, that the new service shall be based on a combination of grouped practice and of separate practice side by side. They propose to place the group idea in the forefront of their plans in order that there may be a full trial on a large scale of the working of arrangements of this kind. Grouped practices are more likely to be found suitable in densely populated and highly built-up areas and it is there particularly (though not exclusively) that they should first be tried. It will then be possible to watch

the development, with the medical profession, and to decide in the light of experience how far and how fast a change over to the new form of practice can and should be made.

The part of central and of local organisation in the service.

All doctors in general practice who join in the new relationship with their patients, and rely largely in future on public funds for their normal livelihood, must be treated on a similar footing; the terms of their remuneration, the general conditions to be observed by them and the rights to be enjoyed by them must be nationally negotiated and settled.

In the National Health Insurance scheme successive Governments have accepted this principle, on which the medical profession itself has laid much stress. Although the local Insurance Committees play a valuable and recognised part in the administration of the scheme (and particularly in handling minor matters of discipline) the service is in fact highly centralised. Terms are laid down in great detail in the Medical Benefit Regulations, and all major questions have either been matters for negotiation between the Government and representatives of the profession or—as in the case of enquiries involving the removal of a doctor from the service—have been dealt with by central tribunals appointed by, and answerable to, the Minister.

The Government are convinced that, broadly, this system is still the right one and that it would be a mistake to apply to the new general practitioner service the normal canons of local government administration. On the other hand, it is essential that general medical practice in the new health service should not be divorced from the other branches of that service; that would perpetuate what is recognised to be the outstanding defect of the present system. Therefore what is proposed, in outline, is as follows:—

(1) The present practice of settling centrally all major terms and conditions of service, including remuneration, will stand. The local Insurance Committees will be abolished and in future doctors, in so far as they take part in the new general practitioner service, will be in contractual relation with a Central Medical Board, to which they will look for their remuneration.

(2) In general, the other functions of the Insurance Committees will also fall to the Board, but to avoid over-centralisation in detail the Board will discharge many of the minor day-to-day functions through a local committee or similar agency, on which there will be included members of the local authority in each area.

(3) The new joint authority will have an important part to play of a different kind. As the general planning authority for the whole health service in its area, it will include the needs of general medical practice, no less than of other services, in its area plan; it will provide for the linking of general practitioners (whether in grouped or separate practices) with the hospital and consultant and other services in the area.

(4) The county and county borough councils which make up the joint authority will normally each have the function of providing and maintaining such premises (in Health Centres and otherwise) as are approved in the area plan.

(5) The doctor himself will, in his contract with the Board, be required to observe the arrangements of the area plan and will be given all the necessary information and facilities to enable him to do this.

These are all matters for further explanation. The arrangement adopted is, first, to deal with the particular points arising on "grouped" general practice and on "separate" general practice respectively, and then to deal with features common to both kinds of practice and with the constitution and functions of the proposed Central Medical Board.

GROUPED GENERAL PRACTICE.

The conception of grouped practice finds its most usual expression in the idea, advocated by the Medical Planning Commission and others, of conducting practice in specially designed and equipped premises where the group can collaborate and share up-to-date resources—the idea of the “ Health Centre ”. The Government agree that it is in this form that the advantages of the group system can be most fully realised, though it will also be desirable to encourage the idea of grouped practice without special premises. They intend, therefore, to design the new service so as to give scope to a full trial of this new method of organising medical practice, and so as to enable it to be expanded and developed as time goes on to the maximum extent which the practical experience of its working is found to justify.

General lines of Health Centre development.

Where Health Centres are set up, their types will need, particularly at first, to be varied. Scope must be given (with central and local professional guidance) to experiment and to design capable of later adaptation. Broadly, the design should provide for individual consulting-rooms, for reception and waiting-rooms, for simple laboratory work, for nursing and secretarial staff, telephone services and other accessories, as well as—in varying degree according to circumstances—recovery and rest rooms, dark rooms, facilities for minor surgery, and other ancillaries. The object will be to provide the doctors with first-class premises and equipment and assistance and so give them the best facilities for meeting their patients' needs. The doctors will thus be freed from the necessity to provide these things at their own cost. They will join in something like the partnership groups already often privately formed, and there will be new scope for the young doctor, fresh from hospital training, to take his share in the Centre as an assistant to the practitioners engaged there, and then, later on, to be eligible for full participation.

Limitation of the permitted number of patients will apply whether in the Centre or outside it, and the ordinary basis of the patient's choice of doctor will not be affected. Each Centre will need to be so planned as to be regarded by patients not as a complete break with present habit but as a new place at which they can, if they wish, continue to see their own doctor when he has joined the Centre, or can choose the doctor in the Centre whom they want to attend them. Alternatively, they must be able, if they prefer it, simply to select a Health Centre as such, rather than choose a particular doctor at the Centre; and then arrangements will be made by the Centre to ensure that they obtain all the proper advice and treatment which they need.

There has often been misconception as to the precise implications of Health Centre practice. It has been assumed that a doctor would be “ on duty ” only for stated periods and that, outside those periods, his patients would always be attended by some other doctor. That need not be so. Normally, a doctor will attend his own patients as necessary, either at the Centre or at the home. He will have his consulting hours and visit his patients as at present. But the grouping of practices at a Centre will make possible a greater fluidity of arrangements; for example, as arrangements will be made for continuous staffing, a patient will, in emergency, get immediate attention even though his own doctor does not happen to be available. The grouping of practices will, moreover, make it easier for doctors to obtain reasonable holidays and to attend refresher courses. The internal organisation of the Centre so as to facilitate reasonable absences consistent with the doctor's responsibilities will be a matter for the doctors themselves.

The Centres will be provided first in selected areas. Both central and local organisation, and local professional interests represented by the Local

Health Services Council, will all have their part to play in this provision. The wish of the local doctors to bring their work into the new Centres must obviously be a big factor in a decision to provide a Centre, but in the last resort the decision will rest on the requirements of the public interest.

Provision of Centres.

It will be essential to associate any decision to provide Centres, and their location, with the rest of the arrangements of the approved area plan. This will mean, in effect, that the decision in each case that the Health Centre system should be initiated in a particular part or parts of the area, and the consequential decisions as to the location and size and kind of Centres to be provided, will normally start in the area itself where the needs are best known and where the general health services plan is formulated, but will depend in the last resort upon the decision of the Minister in the light of his central policy on the general practitioner service and the new Health Centre experiment in the country as a whole. It will be for the joint authority in the first instance, in consultation with the local medical profession, to formulate proposals for a Centre or Centres as part of the area plan—or, later on, as an extension or alteration of that plan—and to submit them to the Minister.

The actual provision of a Centre will normally be the responsibility of the county or county borough council. This accords with the principle earlier discussed under which the clinic and other services which are not essentially part of the consultant and hospital field will be allocated to these councils and not to the joint authority.

Terms of service in Health Centres.

The terms and conditions of service will be settled centrally for all doctors taking part in the new service, whether in group practice or not, and all doctors will enter into a contract of service with the central organisation. The doctor practising in a Centre will not be debarred from private practice outside it, for those patients who do not wish to take advantage of the new public service, though there will be provision to ensure that the interests of patients within the new service do not suffer in any way as a result of this.

In certain respects the contract of the doctor in the Health Centre must differ from that of one practising outside. After the establishment of a Centre the appointment of a new doctor to the Centre will be made jointly by the Central Medical Board and the council administering the Centre, and similarly the termination of his engagement at the Centre (except where the doctor himself wishes to bring it to an end) will rest with these two bodies, or if they fail to agree, with the Minister. It will be part of the arrangement that the council provide the doctors in the Centre with the necessary premises, equipment and ancillary staff. The contract will have to be a three-party one between the doctor, the Central Medical Board and the council.

But there is one important question in regard to the method of remuneration of the doctor, when practising in co-operation with a group of colleagues in a Health Centre, which does not arise in the same way when he is in separate practice outside. That is the method of payment of the individual doctor.

It seems fundamental that inside a Centre the grouped doctors should not be in financial competition for patients. All the practical advantages of the Centre—the use of nursing and secretarial staff, record-keeping, equipment, the availability of young assistant doctors in particular—will be, under a system of a salaried team, at the disposal of the group in whatever way they like collectively to arrange; it is the whole idea that they should arrange their own affairs together in this way. But if individual remuneration is based on mutual competition for patients, complication will enter into any attempt of the group to allocate and share these services—for the more any

one individual is able to draw on the ancillary helps of the Centre (and particularly on medical assistants) the more he will gain and his fellows lose in the contest for patient lists.

There is therefore a strong case for basing future practice in a Health Centre on a salaried remuneration or on some similar alternative which will not involve mutual competition within the Centre. When the salaried or similar principle is adopted, the scales will have to be decided in consultation with the profession itself. In this respect attention is drawn to Appendix D, which suggests the method by which a basis could be arrived at for settling both salaried remuneration and the payment by capitation later proposed for "separate" practice. It may also be possible, if desired by the doctors themselves, to offer remuneration on a salaried basis or on some other basis than that of capitation fees to doctors engaged in group practice even where the practice is not conducted in a Health Centre.

SEPARATE GENERAL PRACTICE.

In "separate" practice the general framework of the National Health Insurance scheme will be retained but there will have to be important changes from the past and the scheme will have to be much extended and adapted. The nature of these changes will be evident not only from the following paragraphs which relate to "separate" practice, but also from the later paragraphs dealing with features common to both "group" and "separate" practice.

Scope of Separate Practice.

In future everyone will be entitled, as only "insured" persons are entitled at present, to receive from the doctor chosen by him all the ordinary range of general medical practice, either at the consulting room or at his home, as the case requires. He will also be entitled, normally through his doctor, to all the new range of consultant and specialist and hospital or clinic services already considered.

A doctor in separate practice will engage himself to provide ordinary medical care and treatment to all persons and families accepted by him under the new arrangements. He will work from his own consulting-room and with his own equipment, as he does now, but he will be backed by the new organised service of consultants, specialists, hospitals and clinics, which he will be expected to use for his patients in accordance with the approved area plan earlier described. He will receive his remuneration for work within the new service, not from the individual patient, but from public funds; and this remuneration will be based—as it is now in National Health Insurance—on a capitation system, depending on the number of patients whose care he undertakes. (A settlement on new lines of the basis for calculating capitation or other forms of remuneration is suggested in Appendix D already referred to.) Even in the case of separate practice there will be some circumstances in which it will be possible to remunerate the practitioner on a salaried or similar basis if he so desires. Opportunity for such an arrangement may occur, for example, in sparsely populated areas where a single doctor is in fact responsible for all the work of the area and is not therefore in competition with other doctors in the neighbourhood. But, however remunerated, the doctors in separate practice will remain entitled to engage in private practice, since it is no part of the intention of the new service to prevent persons who prefer to do so from making private arrangements for medical care or to prevent doctors from meeting their needs.

Control over entry into new practice.

There will be no interference with the right of a doctor to go on practising where he is now and to take part in the public service in that area.

But an unrestricted right to any doctor to enter any new practice and there to claim public remuneration, at his own discretion, would make it impossible to fulfil the new undertaking to assure a service for all.

Under the present National Health Insurance system every qualified doctor has a right to take up panel practice where he likes. The system enables the Minister, if satisfied that the service in any area is inadequate, to replace the panel system by some other form of arrangements, although—with minor exceptions at the outset of the scheme—this power has not been invoked. There has never been any real means of securing that the doctors of the country are reasonably distributed. This has perhaps not been a pressing necessity while the scheme covered less than half the population, but it is well-known that great disparities have existed.

If under the new scheme the whole population are to be entitled to a general practitioner service, a much heavier responsibility will be thrown on the Government to see that the needs of the whole population are met. This implies some degree of regulation of the distribution of medical resources, at least to the extent of securing that a doctor does not in future take up practice in the public service (whether by purchasing a practice or by "squatting"), in a locality which is already fully or over-manned. Such control can be left in the profession's own hands as far as possible, though it must be guided by national policy. A suitable machinery will be to vest it in the Central Medical Board, working under general guidance on policy from the Government but independently in its individual decisions. Any practitioner wishing to set up a new—or take over an existing—public service practice in a particular area will seek the consent of the Board. The Board will then have regard to the need for doctors in the public service in that area, in relation to the country as a whole, and to the general policy for the time being affecting the distribution of public medical practice. If it is considered that the area has sufficient or more than sufficient doctors in public practice while other areas need more doctors, consent will be refused. Otherwise it will usually be given without question. The Board will thus be able to help the new joint authorities which, in their general concern with the health services of their area, will turn to the Board to encourage or discourage any further increases in general practice in the area.

The part of the new joint authority.

It will be the duty of the new joint authority to consider the needs of its area in general medical practice, including "separate" practice, no less than in the other branches of the comprehensive service, and to include in the area plan for central approval the arrangements—in terms of numbers and distribution of general practitioners—which it considers to be necessary to meet these needs. In this it will have the advantage of consultation with the Local Health Services Council. The plan will need the Minister's approval, after hearing any conflicting local views. The approved plan will be made known to the Central Medical Board, to be taken into account in the subsequent exercise of their functions in the distribution of public medical practice.

It will also be the duty of the joint authority to watch that the supply of all branches of the comprehensive service is adequate to the needs of their area and in the matter of general practice, therefore, to bring to the notice of the Minister and the Central Medical Board any needs which they feel should be more adequately met. They will also be responsible for ensuring that all the other services in their area (hospital, clinic, nursing, consultant and specialist) are fully known to the general practitioners participating in the new service and that the latter are enabled (as their contract will require them) to use these services fully for their patients in accordance with the approved area plan.

GENERAL.

It remains to consider certain general questions affecting medical practice, both "grouped" and "separate", and to describe more fully the proposals for a Central Medical Board.

Permitted number of patients.

From the outset of medical benefit under National Health Insurance, provision has been made for imposing a limit on the number of insured persons for whose treatment a doctor may make himself responsible. The limit is fixed by a local scheme which is subject to the Minister's approval, but the regulations themselves provide for certain over-all maxima. An additional number of patients is permitted to a doctor who employs one or more assistants. Under this system every doctor has a right to undertake as much private practice as he desires and is able to secure, and it is usual for the doctor of an insured head of a family to look after the uninsured wife and children under private arrangements.

In the new service also there will have to be prescribed limits to the number of patients whose care any one doctor can properly undertake. But the situation will be substantially altered by a scheme which covers the whole population and which contemplates both grouped and separate practice. It is not the wish of the Government to debar anyone who prefers not to avail himself of the public service from obtaining treatment privately, nor to prohibit a doctor in the public service from carrying on any private practice, but it will be necessary to ensure that the interests of the patients in the public service do not suffer thereby.

In fixing the appropriate limits, in future, allowance will need to be made for private practice remaining after the new service is in operation. There will need to be room for flexibility. A doctor entirely free from outside activity and able to give his whole time to general practitioner work in the new service will need to be able to work to a higher permitted limit of public patients. A doctor with an unusually large amount of private work, or with appointments in other branches of the public service, will be expected to work to a lower permitted limit. The effective way to provide reasonable flexibility is to entrust the decision in such cases to a suitable professional organisation—which will naturally be the Central Medical Board working through its local committees. The details of this are for discussion with the profession's representatives at a later stage, but the object must be to see that the care of patients under public arrangements does not suffer in quality or quantity by reason of private commitments or other public engagements. Nor must anyone have reason to believe that he can obtain more skilled treatment by obtaining it privately than by seeking it within the new service.

Entry into the public service.

There is a strong case for requiring all young doctors, leaving hospital and entering individual practice for the first time, to go through a short period of "apprenticeship" as assistants to more experienced practitioners. There is a particularly strong case for saying that this should be required by the State in medical practice remunerated from public funds. When such a rule is made the young assistant doctor will have to be assured of reasonable conditions and opportunity, and certainly must not be at risk of being precluded from a proper professional livelihood by the operation of the rule. One way will be to require a suitable period as an assistant except where the Central Medical Board dispenses from the rule (e.g. to meet cases where an assistant post is not reasonably obtainable). There will, no doubt, be many opportunities to

employ assistants in Health Centres where terms and conditions can be regulated and the Board can help new entrants to find vacancies. In "separate" practices, the Board must be empowered to satisfy itself as to the proposed arrangements and remuneration for an assistant, before consenting to his engagement by the principal seeking him—guidance on standards being given centrally in consultation with the profession. The general practitioner wishing to undertake a larger number of public patients than the ordinary maximum will inform the Board, and the Board—after satisfying itself as above—will help an intending assistant to get the post on the terms approved. The Board must also be able to require the young doctor during the early years of his career to give his full-time to the public service where the needs of the service require this.

Compensation and superannuation.

The Government recognise that the adoption of the proposals in this Paper will, in certain cases, destroy the value of existing practices. In such cases compensation will be paid. It will be necessary to discuss this in detail with the profession but there are two classes of case in which a just claim for compensation will clearly arise.

The first is that of a practice in an "over-doctored" area, to the sale of which the Board refuses consent. Here the out-going doctor or his representatives will be paid compensation.

The second is that of a doctor who gives up his "separate" public practice and takes service in a Health Centre. It will be incompatible with the conception of a Health Centre that individual practices within the Centre should be bought and sold and a doctor will therefore, by entering a Centre, exchange a practice having a realisable value for a practice which he will be debarred from selling. On the other hand an efficient superannuation system will be an essential part of the Health Centre organisation. A doctor entering a Centre will acquire superannuation rights and other facilities of considerable value. The proper course will be to strike a fair balance between what he is gaining and losing and to compensate him accordingly.

It would be more difficult to institute superannuation for doctors in "separate" practices, but the Government will discuss with the profession the possibility of an acceptable scheme to provide for retirement within specified age limits and for superannuation on a contributory basis.

Sale and purchase of public practices.

The Government have not overlooked the case which can be made for the total abolition of the sale and purchase of publicly remunerated practices. The abolition would, however, involve great practical difficulty and is not essential to the working of the new service now proposed. The Government intend, however, to discuss the whole question with the profession, to see if some workable and satisfactory solution can be reached. In particular, it would obviously be incongruous that the new public service should itself have the effect of increasing the capital value of an individual practice and thus increasing the amount of compensation which may have to be provided under the circumstances described in the preceding paragraphs; and measures to prevent this, must be included in the discussion.

The creation of Health Centres will, meanwhile, do a great deal to limit the scope of the present system. The Centres will afford a wide opportunity to young doctors to enter their profession without financial burdens. They will also, wherever they are set up, bring into being a new form of practice which

will thereafter be entirely free from any necessity of sale and purchase. Moreover, the system proposed earlier of requiring young men who join the public service normally to undergo a period as assistants will go far to avoid the danger of a doctor purchasing a practice which he has not the necessary experience to handle successfully.

Creation of a Central Medical Board.

It is intended to create from the profession itself a special executive body at the centre, which will undertake some of the administrative work of the service requiring a specially intimate link with the profession.

As the contract of the doctor will be in a public service, remunerated from public funds, the Board will clearly have to be subject to the general directions of the Minister, but subject to those general directions it will be the organisation with which the doctor will deal as the "employer" element in the service—i.e., the organisation with which he will be in contract, whether engaged in "separate" or in grouped or Health Centre practice (although in Health Centre practice the local authority will be joined in the contract).

It is not for this Paper to suggest all the details of the doctor's contract at this stage (they will be for discussion with the profession's representatives); but they will need to provide—

(a) for the doctor to give all normal professional advice and services within his proper competence to those whose care he undertakes;

(b) for him to comply with the approved area plan for obtaining consultant and specialist and hospital services;

(c) for proper machinery for the hearing of complaints by patients and for the general kind of disciplinary and appeal procedure already familiar in National Health Insurance;

(d) for the observance of reasonable conditions, centrally determined with the profession, respecting certification and other matters which must arise in any publicly organised service.

The existing doctor will enter into the new contract in respect of his existing practice; the new doctor, or doctor entering a new practice, will first obtain the Board's consent (as already suggested) and then enter into the necessary contract in respect of his new practice. Termination of the contract will ordinarily be either by the doctor, at any time after due notice, or by the Board, under conditions which will no doubt be substantially similar to those now obtaining under National Health Insurance, with such special extra provisions as may be necessary in the case of Health Centre practice.

Under these arrangements there will be no need for the continuance of the present local Insurance Committees of the National Health Insurance scheme, and these Committees will be abolished. The minor day-to-day functions now exercised by Insurance Committees (so far as these still arise under the new and wider service) can be handled by a local Committee of the Board in each area, on which local authority members will be included.

The Board will also watch over the distribution of public medical practice generally. In "separate" practice it will do this through the arrangements already described, under which its consent will be required before a vacant public practice is refilled or a new public practice established. In Health Centre practice it will be the agency through which any additional doctors required in future are introduced into any particular Centre, after suitable consultation with the doctors already working there, through the local

committees earlier proposed in place of the present Insurance Committees. It will be the agency through which young doctors obtain appointments as assistants at Health Centres and by which the terms and conditions of assistants in "separate" practice are protected in the way already proposed—and from which any dispensation from the requirement of an initial "apprenticeship" for new doctors will have to be sought.

The Board will also take on many functions on the doctor's behalf—e.g. in approaching the appropriate medical schools and hospitals with a view to the arrangement of post-graduate and refresher courses for those in general practice, in acting as the general centre of advice and help in the movement of doctors within the public service and in the various personal problems and requests for information which will doubtless arise. It will, with the Minister, provide the central organisation to which the new joint authorities will make known their area's needs in general practice, in accordance with the approved area plans for the health service as a whole.

The Board will be a small body, under a regular chairman—a few of its members being full-time and the rest part-time. It will be mainly professional, but it will also have lay members on its strength. In view of the wide scope of its executive functions and handling of public funds its membership and organisation will have to be finally settled by the Minister, although of course in consultation with the profession.

Supply of drugs and medical appliances.

The existing system under National Health Insurance, under which panels of chemists are formed in each area on lines closely corresponding to the panels of doctors, has worked on the whole with success. In detail the system is no doubt capable of improvement, and discussion with the appropriate pharmaceutical bodies will be welcomed by the Government. In particular, it will be necessary to consider the arrangements to be made in connection with the supply of drugs to patients attending Health Centres.

As regards medical and surgical appliances, the existing system entitles an insured person to the supply, free of charge, of certain appliances specified in the Medical Benefit Regulations if ordered by a doctor. These "prescribed appliances" are, in the main, the articles most commonly required in general practice. In a service which includes treatment of all kinds, whether in or out of hospital, the range of necessary appliances will have to be greatly extended; but it will be a matter for consideration whether in the case of the more expensive appliances the patient himself should not be called upon, if his financial resources permit, to contribute towards the cost—either of the appliances initially ordered, or at least of repairs and replacements. The point will be of particular importance in connection with the dental and ophthalmic services.

The need for a new attitude in patient and doctor.

The aim of the service will be to provide every person, or better still every family, with a personal or family practitioner who will be able to become familiar with the circumstances of those in his care—in the home and at work. It is to be hoped that doctor and patient will not wait always till the latter falls ill and urgently requires treatment. The doctor must try, in short, to become the general adviser in all matters concerned with health (no less than with disease) on which a doctor is so well qualified to advise. This means a changed outlook in much of present medical practice—a change that has long been wanted and advocated by most doctors themselves and for which they more than anyone have desired the opportunity. But such a change cannot be effected overnight. It will be helped if a new trend can be given to undergraduate medical education

and, fortunately, there are plenty of signs that medical schools are beginning to realise the importance of this. It will take time to develop, but it is worth stating clearly at the outset that, unless this kind of medical care is ultimately provided for every person and every family, the medical profession will not be giving the public the full service which it needs and which only the medical profession can give. To provide or to extend a service which considers only the treatment of the sick is neither in accordance with the modern conception of what a doctor should be trained to do nor in keeping with the general desire that the family practitioner should begin to undertake many of the duties at present performed by his colleagues in the public health service.

VI.

CLINIC AND OTHER SERVICES.

Apart from the hospital and consultant and family doctor services, the comprehensive health service must include arrangements for home nursing and midwifery and health visiting and the various kinds of local clinic and similar services which have either been provided in the past under special statutory powers or will have to be established in the future.

When the new service is established, these local services will not be provided as entirely separate entities, but rather as parts of the one new general duty to secure a whole provision for health. It will be the duty of the new joint authority—by means of the arrangements proposed by it and approved by the Minister in the general area plan—to ensure that all these different activities are properly related to each other, to the personal or family doctor service and to the hospitals and consultants, and that they are arranged in the right way and in the right places to meet the area's needs. This done, it will be the duty either of the joint authority or of the separate county and county borough authorities which together constitute it, as the case may be, to provide and maintain the various services on the lines of the settled area plan. The usual sharing of responsibility in this respect between the joint authority and the several counties and county boroughs—under the proposals described earlier in this Paper—will be recalled.

When these local services are arranged and regarded as parts of the one planned service of the wider area, there will be room for experiment and innovation in the way they are provided—particularly as time goes on and the full service gets into its stride. It is reasonable to look forward to the time when the general medical practitioner, the personal doctor with whom the individual and the family are regularly associated, will be able to be connected more closely with the services which are performed at special clinics—e.g. for child welfare, in which there is no doubt that in much of the general care of the young child and the handling of many of its day-to-day problems the clinics and the family doctor who has the general medical care of the child must be enabled to work in better contact for their common purpose. To make this possible on any substantial scale there will have to be much more opportunity than there is now for the family doctor to acquire special experience in the children's wards of hospitals and in general child welfare subjects and the chance of post-graduate training and refresher work in these and other special subjects. Where grouped general practice in Health Centres is tried there will be special opportunity for this kind of development.

But whatever developments there may be in the clinics or other services locally provided, or in the method of operating them in relation to other branches of the service as a whole, it is clear that the coming into operation

of the new service will certainly not involve closing down or abandoning any existing facilities—but much rather increasing and strengthening them to fit the new and wider objects in view. Therefore the effect of the proposals in this Paper on the main local services of this kind as they are known now—and on the position of the local authorities responsible for them—can be summarised.

Maternity and child welfare services.

The arrangement of lying-in accommodation in hospital or maternity home—indeed all the institutional provision for maternity, both for normal and for complicated cases—will become simply one part of the re-organised hospital and consultant services and will be the responsibility of the new joint authority. The ordinary functions of the maternity and child welfare clinics, however—concerned, as they are, not primarily with direct medical treatment but more with the convenient local provision of general advice and care in the day-to-day bringing-up of young children and in the mothers' associated problems—will not be transferred to the new joint authority but will lie wherever the related functions of child education are made by Parliament to lie under the new Education Bill. Under the proposals in that Bill, as they stand now, this will mean that the county and county borough councils will be the authorities primarily responsible, but that arrangements will be made in suitable cases for delegating much of the practical care of the service to some of the existing authorities, within the counties, which have hitherto carried the responsibility and which have accumulated good experience and local interest.

The maternity and child welfare clinics, although provided and maintained in this special way over the various parts of the joint authority's area to meet the need for the link with education, will be as much a subject as any other part of the health service for the general plan for that area which the joint authority will prepare and the Minister finally settle. The sufficiency of the clinics, their distribution, their connection with the necessary specialist services and the hospitals, and the other main arrangements concerned, will all be covered by the wider area plan.

What has been said of the clinics applies equally to those arrangements for domiciliary midwives and health visitors which need to be ancillary to the clinics' work, and responsibility for those will lie with the same authorities and be similarly affected by the general area plan.

School Medical Service.

In this service also the proposals need to be related to the proposals in the current Education Bill. The conception underlying both the Bill and the present Paper is that the education authorities will retain as part of their educational machinery the functions of inspection of children in the school group (the supervision, in fact, of the state of health in which the child attends school and of the effects of school life and activities on the child's health), together with the important function of using the influence of the school and the teacher and the whole school relationship with child and parent to encourage the recourse of the child to all desirable medical treatment. But, as from the time when the new health service is able to take over its comprehensive care of health, the child will look for its treatment to the organisation which that service provides—and the education authority, as such, will give up responsibility for medical treatment.

Tuberculosis dispensaries and other infectious disease work.

The local tuberculosis dispensaries will in future be regarded as out-patient centres of the hospital and consultant service, and responsibility

for them will normally rest directly with the joint authority dealing with the whole of this aspect of the new service over its wide area. Just as it will be the aim to enable the main sanatorium and hospital treatment of tuberculosis to be more fully related in future to other specialist aspects of the diagnosis and care of diseases of the respiratory tract generally and of orthopædic conditions, so it will also be essential to develop the local tuberculosis dispensaries as specialist out-post centres of the same service, where the physician has charge of—and direct access to—hospital and sanatorium beds and where the same consultants cover both in-patient and out-patient activity. The physician in charge needs particularly to concern himself also with the social and home conditions of his patients in tuberculosis, but it is not proposed that such activities as the securing of appropriate housing for the tuberculous shall pass with the dispensaries to the new joint authority. In such matters the physician in charge must look to the local authority normally concerned with these things.

All isolation hospital responsibilities will similarly pass, under the proposals earlier explained, to the new joint authority as part of the general hospital problem of its area. But there will remain a field of day-to-day epidemiological work—many of the measures dealing with the notification of the diseases, the local control of the spread of infection, and environmental factors affecting this, which are the subject of statutory powers under the Public Health Acts already—which can still be suitably carried out locally in the different parts of the joint authority's area, although it will probably be found that most of these activities should in future be centred in the county and county borough councils rather than distributed more widely, as they are now, over the districts of the minor authorities.

In epidemiology in its wider sense there will be some activities which must be organised on a full national basis, rather than locally, and here the valuable experience of the Emergency Public Health Laboratories will be a pointer to future development.

Cancer diagnostic centres.

Responsibility for the local centres of diagnosis and advice which were contemplated when the Cancer Act of 1939 was passed, and which have had little chance to develop substantially during the war, will pass with the other responsibilities of that Act to the new joint authorities as a part of the general hospital and consultant service.

Mental clinics.

Local mental clinics are essentially an out-patient activity of the hospital and consultant service—like the tuberculosis dispensaries—and responsibility for these clinics will therefore belong to the new joint authority in its general care of mental health.

Venereal diseases.

The allocation of the present service for venereal diseases between the county and county borough councils and the new joint authority presents peculiar difficulty. In one sense it is essentially a clinic service which can continue to be locally organised within the framework of the new area plan, and which—it is arguable—need not be regarded as essentially part of the wider hospital and consultant field. The newly developing use—started during the war—of the help of individual general practitioners to supplement the work of the clinics lends some point to this. On the other hand it is a service requiring a high degree of specialisation in future, and it is as a matter of convenience one which

is usually attached to hospital premises; these are factors which point to associating it directly with the re-organised hospital service. It is something of a "border-line" case, in fact, and will be best left to the settlement of the area plan in each case to determine.

New services likely to develop.

A full home nursing service must be one of the aims of the new re-organisation. How far it needs to be directly provided by public authority, or indirectly by public arrangements made with other bodies, or both, will be matters for discussion. Its object must be to ensure that all who need nursing attention in their own homes will be able to obtain it without charge. Responsibility for securing this will normally be exercised by the individual county and county borough councils within the general area plan.

The fact that there must be delay in reaching a stage at which general dental and ophthalmic services can be provided for all has been referred to earlier in the Paper. Nevertheless, nothing less must be the object in view and the best ways and means will need to be discussed in detail with the dentists and doctors and others concerned. For some time dental care, at least, will have to be concentrated on the present priority classes—and particularly on the children and adolescents. These are matters on which, so far as dentistry is concerned, the views of the Teviot Committee, already referred to, will have a valuable bearing and must be awaited. But it is clear that one of the main calls at first will be on the clinics and similar services for the pre-school and school child.

The new service of the Health Centre for general medical practice has already been considered, and when it comes into operation it will normally be the county or county borough council's function to provide and maintain the Centres.

Medical research.

A valuable part of the medical research carried on in this country is conducted in the hospitals, and in close association with the day-to-day work of the hospitals. It has been the policy of the Medical Research Council—the body set up under Royal Charter and under the auspices of the Committee of the Privy Council for Medical Research to guide and stimulate and co-ordinate research—to encourage this work in the hospitals themselves and to assist it financially. Generally, it is felt that this is a more fruitful method of securing valuable results than the alternative method of multiplying special State institutions for the purpose, and it is of first importance that it should continue and develop, both in the municipal and in the voluntary hospitals and institutions. It does not appear to require any new express authority, and the powers of local authorities under statute and of voluntary hospitals under charters or trust deeds or other instruments seem to be already sufficient.

The Part of Medical Officers of Health and others.

Whatever changes there may be in the scope of the health services locally provided and in the local organisation for providing them, it is clear that there will be an even more important part in the future than there has been in the past for social medicine and the medical organisation of public health. The new service will make great calls upon all those medical men and women already engaged in the work of local health authorities, and upon all those who assist in the ancillary services now; just as it will give new scope and better opportunity not only to those already engaged but to newcomers to this branch of professional life.

VII.

THE SERVICE IN SCOTLAND.

What has already been said with regard to the present state of the health and medical services, the chief deficiencies in the existing arrangements, and the general shape of a comprehensive service which would make good these deficiencies applies equally to Scotland as to England and Wales.

The general administrative structure of the service in the two countries, however, cannot for various reasons be the same. The development of the health services has not been entirely uniform up to the present time; here and there differences occur in the scope and organisation of corresponding services; and each country has services for which there is no counterpart in the other. The most important of these differences are described in Appendix A. The reason why the new service, although the same in scope and objects in both countries, cannot be organised on entirely similar lines is that account must be taken of certain differences of geography and local government structure in Scotland, as compared with England and Wales. For example about 80 per cent. of Scotland's population is concentrated in about 17 per cent. of the total area of the country, across its industrial "waist." Outside the industrial belt are large and for the most part sparsely populated areas. Of the 55 existing health authorities in Scotland only 10 have populations of more than 100,000 and 32 have a population under 50,000. Against this, the population of England and Wales is on the whole much more urbanised and the local government units are larger with correspondingly greater resources.

CENTRAL ADMINISTRATION.

There will be no substantial difference in the central machinery to be set up in Scotland as compared with England and Wales.

The Secretary of State will be directly responsible to Parliament for the administration of the new service and will exercise his functions through the Department of Health for Scotland.

A Central Health Services Council for Scotland will be set up by statute with the same kind of constitution, powers and functions as the corresponding Council in England and Wales. It will consist of representatives of the medical, dental, pharmaceutical and nursing and midwifery professions and of the voluntary and municipal hospital authorities in Scotland, appointed by the Secretary of State after consultation with the organisations represented, and the Council will select its own chairman. It will advise the Secretary of State on any technical aspect of the service, either in response to a request for advice from the Secretary of State or on its own initiative, and the Secretary of State will be required to submit to Parliament annually a report on the Council's work during each year.

Similarly, Scotland will have a separate Central Medical Board to act on behalf of the Secretary of State in the day-to-day administration of the general practitioner service. This Board will perform the same functions as the corresponding English organisation described in chapter V, and like that organisation it will be created mainly from the medical profession itself. There will clearly have to be the closest liaison between the two Boards to secure uniform administration of the general practitioner service in the two countries, and special arrangements will have to be made, by a common list of doctors and in other ways, to deal with the movement of doctors from one country to the other.

LOCAL ORGANISATION.

It is in the local organisation of the service that the arrangements proposed for England and Wales must be modified to suit the special circumstances prevailing in Scotland. In England and Wales it is proposed to define areas of suitable size and resources for the direct administration of the hospital and consultant branches of the service and for the local planning of the service as a whole, and to secure suitable authorities to carry out these tasks by the combination of existing authorities in the area. To do this in quite the same way in Scotland would usually be out of the question since the areas which would have to be defined for the purpose would be so big as to be quite unwieldy and indeed destructive of local government administration. The point can probably best be illustrated in relation to the hospital service. Successive Committees on hospital problems have emphasised the need for planning and co-ordinating the hospital service in Scotland over wider areas, and for this purpose have recommended the selection of the four natural hospital regions based on the Cities of Glasgow, Edinburgh, Aberdeen and Dundee, where the key hospitals as well as the medical schools are to be found, with a fifth based for geographical reasons on Inverness. While areas of this size are necessary for the planning and co-ordination of a comprehensive hospital service, they are clearly too large for local government purposes. This means that co-ordination of the hospital service and responsibility for its actual provision have in Scotland to be separated in a way which does not apply to England and Wales.

As will be seen, these special requirements in the hospital service must to some extent affect the local organisation of the other branches of the new service as a whole, and in particular it is proposed that the scope of the duties of the new Joint Hospitals Boards in Scotland shall not extend beyond the hospital and auxiliary services.

Administration of the hospital and consultant service.

It is intended to adopt the recommendations made by various Committees, including the Committee on Scottish Health Services and the Hetherington Committee, that a Regional Hospitals Advisory Council should be set up in each of the five hospital regions referred to. The Council will consist of members nominated in equal numbers by (i) the new Joint Hospitals Boards of combined local authorities in the region, and (ii) the voluntary hospitals, with an independent chairman to be appointed by the Secretary of State. In addition, it can include a small number of representatives of the medical and medical-educational interests of the region.

The functions of the Councils will be consultative and advisory. They will advise the Secretary of State on the measures necessary to secure the co-ordination of hospital planning within the region.

A further important function which the Councils will perform will be to advise the Secretary of State on the co-ordination of the consultant service between the hospitals and other services, and they might, through sub-committees, also advise hospital authorities on the filling of vacancies in consultant and senior hospital appointments.

Next, it is proposed to set up Joint Hospitals Boards formed by such combinations of neighbouring major health authorities as are found necessary to ensure that an adequate hospital and consultant service is provided for each combined area. In one or two areas where circumstances are suitable, and where the population is large enough and the resources adequate to support a satisfactory hospital service, the major health authority will continue to be the hospital authority without combination with any other local authority.

The Joint Hospitals Boards will be composed entirely of representatives from the county councils and the town councils of large burghs in the area concerned. They will take over the whole ownership of and responsibility for the hospitals of their constituent authorities, will be charged with the statutory duty of securing a proper hospital service for their area—by their own provision and by arrangements with other Joint Hospitals Boards or voluntary hospitals—and will in fact be, so far as executive responsibility for the hospital service is concerned, the counterpart of the new joint authorities in England and Wales.

The Joint Hospitals Board will have the duty of preparing a scheme for the hospital services of their area, after consultation with the voluntary hospitals. They will be encouraged also to consult the Regional Hospitals Advisory Council at this stage to secure the fullest measure of agreement between the scheme and the wider regional arrangements proposed by the Council. The Joint Hospitals Board will then submit their scheme to the Secretary of State who will consult the Regional Hospitals Advisory Council to obtain their final views before deciding to approve or amend the scheme.

As will be seen, these Joint Hospitals Boards will also be charged with responsibility for the administration of certain clinic services, such as the tuberculosis dispensaries, which can be regarded as essentially a part of the hospital service.

Administration of the clinic services.

The arrangements proposed for the clinic services in England and Wales will be modified in their application to Scotland. This is necessary because, unlike the new joint authorities to be set up in England and Wales, the Joint Hospitals Boards in Scotland will not have planning functions outside the hospital service. In these circumstances the following arrangements will apply.

Responsibility for the administration of the school health service with its numerous clinics will remain with the education authorities, namely, the county councils and the town councils of Edinburgh, Glasgow, Aberdeen and Dundee, but these authorities will be expected to use the treatment services provided under the new scheme.

Normally the ordinary local clinics such as those for the maternity and child welfare service, including ante-natal clinics, for the venereal disease service and for scabies will remain with the existing major health authorities, namely, the county councils and the town councils of the large burghs which correspond in Scotland to the county and county borough councils in England and Wales. These authorities will normally retain responsibility for the mid-wifery and health visitor services. On the other hand, there are certain clinic services which are more nearly allied to the hospital service than to a clinic service. The most notable examples of this category are the tuberculosis dispensaries and cancer clinics. The administration of these "out-post" clinics will be entrusted to the new Joint Hospitals Boards as being ancillary to their main function of hospital administration.

No further change of general scope will be undertaken with regard to the clinic service. As recommended by the Committee on Scottish Health Services, however, it is proposed to strengthen the powers of the Secretary of State to require major health authorities, after a public local inquiry has been held, to combine for any purpose where this is proved necessary for the efficiency of the new health service as a whole. In this way it will be possible to leave essentially local clinic services with the major health authorities while securing an adequate safeguard that, should the need arise in the public interest for a combination of local authorities in any area for any specific purpose, effective machinery will be available for the purpose.

The responsibility for any new clinic services will be determined by their particular function: if they are purely local services they will be entrusted to the existing major health authorities, while if they are allied to the hospital service they will probably be entrusted to the Joint Hospitals Boards.

Administration of the general practitioner service.

There will be a difference between the two countries so far as the provision, equipment and maintenance of Health Centres are concerned. In England and Wales this responsibility will rest normally with the county or county borough councils. In Scotland, however, the smaller size of the problem, the geography and the distribution of population suggest that the whole country can more conveniently be regarded as one area for this purpose, and the Centres—where they are decided upon—can be provided by the Department of Health itself, at least in the initial and experimental years. Having in view the nature of the local organisation of the health service generally, which is proposed for Scotland, it seems desirable that the provision, equipment and maintenance of Health Centres should be administered centrally in the general practitioner service. The Secretary of State will be empowered, however, to delegate any of his functions with regard to the provision of Health Centres to a local authority where he thinks this to be desirable.

Local Medical Services Committees.

The local organisation already described will secure effective liaison between the hospital and consultant services on the one hand and the local authority clinic services on the other. There remains the general practitioner service. For the purpose of linking that service with all the other parts of the new service as a whole, there will be set up, over the same areas as those of the Joint Hospitals Boards, new advisory bodies to be known as Local Medical Services Committees.

These will be to some extent similar to the Local Health Services Councils proposed for England and Wales, but with differences of function and of organisation to suit the different local arrangements in the two countries. They will be primarily advisory bodies, but because of the vital role which they will play in linking up the various branches of the health service in their areas they will need to include not only professional but local authority representatives.

The Local Medical Services Committees will consist of representatives of all the local health authorities in the area, of the local medical, dental, pharmaceutical and nursing professions, and of other interests closely concerned with the health services. The Committees will be able to appoint such sub-committees, professional or general, as they find desirable.

The primary function of these Committees and of their professional sub-committees will be to advise the Secretary of State on any questions affecting the local administration of the general practitioner service and its relationship to the other health services. As, for reasons given, the Joint Hospitals Boards will be concerned with hospital and consultant services only and not with the health services as a whole, the Secretary of State will look to these Committees—so far as the general practitioner service is concerned—for information and advice on the sufficiency and distribution of doctors in any area, the need for Health Centres, and other relevant matters.

The Committees will also provide a suitable means of liaison between the general practitioner service and the local clinic and hospital and consultant services being carried on in their areas by the local authorities and the Joint Hospitals Boards. For example, they will be able to advise the

Secretary of State on methods of effecting the closer liaison between the family doctor, the child welfare clinics and the hospital, as forecast by the Orr Report on Infantile Mortality. They will be there to advise all those authorities as needed, and will be able also to send representatives to sit with the larger Regional Hospitals Advisory Councils to assist—with their right of directly expressing their views to the Secretary of State at any time—in making the liaison complete.

In addition, as the new general practitioner service will no longer require the local Insurance Committees which have operated under the National Health Insurance scheme in the past, no doubt such of the functions of these bodies as do not need in future to be centrally undertaken might be usefully entrusted to the Local Medical Services Committee. But these are matters for later consideration.

VIII.

PAYMENT FOR THE SERVICE.

The cost of the comprehensive health service will mainly fall upon central and local public funds. The ways in which it might be shared between the exchequer and the local rates, and other financial aspects of the service generally, are considered in the Financial Memorandum appended (Appendix E).

So far as individual members of the public are concerned, they will be able to obtain medical advice and treatment of every kind entirely without charge except for the cost of certain appliances. They will be paying for medical care in a new way, not by private fee but partly by an insurance contribution under whatever social insurance scheme is in operation and partly by the ordinary process of central and local taxation. The position in regard to disability benefits, for those ill at home and for those in hospital, will be dealt with in the Government's later proposals on social insurance.

Hospitals in the scheme will, as explained, receive from central funds payments which will include their share of the money representing the social insurance contributions of the public, so far as this is attributable to hospital services. This share can be payable on a bed-unit basis, according to the number of beds put into the service by each hospital under each area plan—except that the share of the voluntary hospitals can, if they wish, be pooled and redistributed in the manner earlier mentioned.

The voluntary hospitals will receive in addition fixed service payments from the new joint authority in respect of all services which they render to the scheme. For the rest, they will meet the costs of their participation in the service out of their normal resources, including charitable subscriptions and donations, on which their voluntary status depends. The position of medical teaching will be specially considered.

The joint authorities will receive from central funds the bed-unit payments which include their share of the social insurance contributions attributable to hospital services. Otherwise their expenses in the service—including their service payments to voluntary hospitals—will be met partly out of rate resources and partly out of central funds. For their rate revenues the joint authorities will depend upon precept upon the counties and county boroughs included in each joint area. The county and county borough councils will receive exchequer aid towards the cost of meeting these precepts and their own expenses in the service.

IX.

GENERAL SUMMARY.

It may be convenient, at this point, to summarise the proposals of this Paper in outline:—

1. Objects in view.

(1) To ensure that everybody in the country—irrespective of means, age, sex, or occupation—shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.

(2) To provide, therefore, for all who want it, a comprehensive service covering every branch of medical and allied activity, from the care of minor ailments to major medicine and surgery; to include the care of mental as well as physical health, and all specialist services, e.g. for tuberculosis, cancer, infectious diseases, maternity, fracture and orthopaedic treatment, and others; to include all normal general services, e.g. the family doctor, midwife and nurse, the care of the teeth and of the eyes, the day-to-day care of the child; and to include all necessary drugs and medicines and a wide range of appliances.

(3) To divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge (apart from certain possible charges in respect of appliances) and to encourage a new attitude to health—the easier obtaining of advice early, the promotion of good health rather than only the treatment of bad.

2. General principles to be observed.

(1) Freedom for people to use or not to use these facilities at their own wish; no compulsion into the new service, either for patient or for doctor; no interference with the making of private arrangements at private cost, if anyone still prefers to do so.

(2) Freedom for people to choose their own medical advisers under the new arrangements as much as they do now; and to continue with their present advisers, if they wish, when the latter take part in the new arrangements.

(3) Freedom for the doctor to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference.

(4) The personal doctor-patient relationship to be preserved, and the whole service founded on the "family doctor" idea.

(5) These principles to be combined with the degree and kind of public organisation needed to see that the service is properly provided—e.g. to ensure better distribution of resources and to give scope to new methods, such as group practice in Health Centres.

3. General method of organising the service.

(1) The maximum use of good existing facilities and experience; no unnecessary uprooting of established services, but the welding together of what is there already, adapting it and adding to it and incorporating it in the larger organisation.

(2) The basis to be the creation of a new public responsibility; to make it in future somebody's clear duty to see that all medical facilities are available to all people; the placing of this duty on an organisation answerable to the public in the democratic way, while enjoying the fullest expert and professional guidance.

(3) Some temporary limitations of the full service inevitable—e.g. in dentistry (owing to insufficient dentists), in ophthalmology and perhaps elsewhere; but the design to be comprehensive from the outset, and to be fulfilled as fast as resources and man-power allow.

(4) The first step to be the making of positive plans for each area of the country, determining what is needed for all people in that area; this to be followed by measures to ensure that what is needed is then secured.

(5) A combination, for all this, of central and local responsibility, to ensure that both general national requirements and varying local requirements are equally met.

4. The administrative organisation; central and local.

(1) Central.

(i) Central responsibility to Parliament and the people to lie with the Minister.

(ii) At the side of the Minister, to be a new central and statutory organisation for voicing professional views on technical aspects of the service generally; to be known as the Central Health Services Council; to represent general and specialist medical practice, medical teaching, hospital organisation and other professional interests; to be appointed by the Minister in consultation with those interests, and to choose its own chairman; to be consultative and not executive; to advise the Minister not only on questions referred to it by the Minister but also on its own initiative; the Minister to report annually to Parliament on the work of the Council.

(iii) A special executive body to be also set up, composed in the main of members of the medical profession; to be known as the Central Medical Board, and to act under the general direction of the Minister; to be the "employer" body with which the general practitioner enters into contract in the new service, and to concern itself with the distribution and welfare of practitioners and assistants.

(2) Local.

(i) Local organisation to be based on the county and county borough councils, operating in their normal local government areas where possible, but combining as joint authorities over larger areas where necessary.

(ii) Areas of suitable size and resources for the operation of a full hospital service of all kinds, to be designated by the Minister after consultation with local interests.

(iii) For each of these new hospital areas a joint authority to be constituted, being a combination of the existing county and county borough councils in the area; in the few cases where the area may coincide with an existing county area, the authority to be the county council of that area.

(iv) The new joint authority also to be charged with preparing an area plan for the health service as a whole, not only the hospital service, in manner described below.

(v) Existing county and county borough councils, while combining for these duties of the new joint authority, to be responsible severally for local clinic and domiciliary services not belonging to the hospital and consultant sphere, within the general area plan; the responsibility for child welfare to be assigned broadly on the same lines as responsibility for child education. General medical practice to be the subject of special organisation, partly local, partly central.

(vi) In each joint authority area, to be a local consultative body for voicing professional guidance on technical aspects of the service; to be

known as the Local Health Services Council; to serve a similar purpose locally to the central professional body already described; to advise both the joint authority and the county and county borough councils, and to be free to express advice and views to the Minister.

5. The planning of the local services.

(1) Each joint authority, in consultation with the local professional body referred to and with others locally concerned, to prepare an "area plan" for securing the comprehensive health service for its area; the plan to be based on an assessment of the needs of the area in all branches of the service, to propose how each of those needs should be met, and to be submitted to the Minister.

(2) The Minister to consider each area plan, and any representations made to him by the local professional body or others affected, and to approve the plan with or without modification; the plan, as approved, to be the operative plan for that area; to be the duty of all concerned to provide and maintain their services within the general framework of the plan; the plan to be modified or replaced from time to time, according to requirements, by the same procedure.

6. Provision of the various parts of the service under the plan.

(1) Hospital and Consultant Services.

(i) To be the duty of the joint authorities themselves to secure a complete hospital and consultant service for their area—including sanatoria, isolation, mental health services, and ambulance and ancillary services—in accordance with the approved area plan.

(ii) The joint authorities to do this both by direct provision and by contractual arrangements with voluntary hospitals (or with other joint authorities) as the approved area plan may indicate.

(iii) Powers of present local authorities, in respect of these services, to pass to the joint authority, with all existing hospitals and similar institutions.

(iv) The voluntary hospital system to continue side by side with the publicly provided hospitals; voluntary hospitals to participate, if willing to do so, as autonomous and contracting agencies; if so, to observe the approved area plan and to perform the services for which they contract under that plan, and to receive various service payments.

(v) All hospitals, municipal or voluntary, taking part in the service to observe certain national conditions (e.g. as to remuneration of nurses, appointment of consultants); these conditions being centrally prescribed.

(vi) Special provision to be made for inspection of the hospital service, through selected expert personnel (some part-time) working in panels over different parts of the country.

(vii) Consultant services to be made available to all, at the hospitals, local centres or clinics, or in the home, as required; to be based on the hospital service, and arranged by the joint authority, either directly or by contract with voluntary hospitals under the approved area plan.

(viii) Measures for improving the distribution of consultants, dealing with methods of appointment and remuneration, and relating this to other branches of the new service generally, to be considered after the report of the Goodenough Committee, but general direction of changes to be:—

(a) Consultants taking part to be remunerated in future (usually by part-time or whole-time salary) by the particular hospital or hospitals with which they are associated under the area plan; standards

of remuneration to be centrally settled in consultation with the profession.

(b) New arrangements for securing proper standards for consultant appointments in the service, possibly through suitable machinery set up to advise all hospitals making appointments of senior staff.

(2) General medical practice.

(i) The Minister, with the new Central Medical Board, to undertake nationally the main arrangements for a general practitioner service for the country, through which anyone who wishes to do so can associate himself with a "family doctor" of his own choice and obtain the advice and treatment of that doctor at home or at his present consulting room or at a specially provided and equipped consulting room in a Health Centre, as the case may be.

(ii) These central and national arrangements to cover terms of service, remuneration of doctors from public funds, and other general aspects of organisation, and the individual doctor to be in contract with the Central Medical Board.

(iii) The joint authority in each area to have the duty of:—

(a) including in their area plan an assessment of the needs of their area in general medical practice;

(b) keeping these needs under review and bringing to the notice of the Minister and the Central Medical Board any general features or requirements of the general practitioner situation in the area which they consider to need attention;

(c) ensuring that general medical practitioners taking part in the service in the area are acquainted with hospital and consultant and other services available under the area plan, and that they are able (as, under their terms of service, they would be required) to use those services for their patients.

(iv) The county and county borough councils to be responsible for providing, equipping and maintaining such Health Centres for the conduct of general medical practice in the new service as may be approved from time to time by the Minister in respect of any part of their area, and in such cases to be joined in the doctor's contract with the Central Medical Board.

(v) Future development to include both new methods of "grouped" medical practice in Health Centres (and, where suitable, outside them) and familiar methods of "separate" practice; each being developed as experience proves best in each area. A high place in the scheme to be given to a full and careful trial of the Health Centre method.

(vi) Existing practitioners to be able to participate in the new service in their present areas of practice, and where they do so from their own consulting rooms to be normally remunerated on a capitation basis (though other methods to be considered in certain cases if desired by the practitioners themselves). Where they participate in group practice in Health Centres, remuneration to be by salary or similar alternative.

(vii) Practice in the public service not to debar a doctor from private practice for such patients as may still request this.

(viii) Appropriate limits to be fixed to the number of persons whose care a particular doctor can undertake, taking into due account the extent of private medical practice and the calls made upon a doctor's time by other public appointments; higher limits where assistants are engaged; more regulation of the conditions of the employment of assistants in the service;

a requirement that newly qualified doctors shall normally serve a period as assistants before practising on their own in the new service, and power for the Central Medical Board to require them to give full time to the public service in their early years if necessary.

(ix) New practitioners wishing to participate in the service, and existing practitioners wishing to do so in new areas or new practices, to be required to obtain the consent of the professional Central Medical Board—to check the need for additional public practice in the area, and to ensure a reasonable distribution of resources inside the public service.

(x) Compensation for loss of selling value of practices to be payable where a doctor transfers his public practice into a Health Centre, or where a public practice falling vacant is not allowed to be refilled by the Central Medical Board.

(xi) Superannuation to be provided for doctors practising at Health Centres and, if practicable, for doctors participating in the service in other forms of practice.

(xii) The question of the sale and purchase of public medical practices in future to be discussed more fully with the profession.

(3) Clinic and other local services.

(i) To be the duty of the joint authority to deal in its area plan with all necessary clinic and other local services (e.g. child welfare, ante-natal and post-natal clinics, home nursing, health visiting, midwifery and others), and to provide for the co-ordination of these services with the other services in the plan.

(ii) Administration of these local clinic and non-hospital services, however, to be normally the responsibility of the individual county and county borough councils which collectively make up the joint authority: the administration to be in accord with the general provisions of the area plan.

(iii) The exact allocation of responsibility between the joint authority and the individual county and county borough councils to be settled in each case by the Minister in determining the area plan; but normally on the principle that services belonging to the hospital and consultant sphere fall to the joint authority, while other local and clinic services fall to the individual councils.

(iv) Child welfare duties always to fall to the authority responsible for child education under the new Education Bill, but to be as much the subject of the "area plan" as any other branch of the service.

(v) New forms of service, e.g. for general dentistry and for general care of the eyes, to be considered with the professional and other interests concerned as soon as circumstances allow. In the case of dentistry, the report of the Teviot Committee to be first awaited.

7. The service in Scotland.

(1) The scope and objects of the service to be the same in Scotland as in England and Wales, and the foregoing proposals to apply generally to both countries—but subject to the differences below.

(2) Certain differences in detailed application in Scotland, due to special circumstances and geography and existing local government structure there; differences mainly affecting the arrangement of responsibility, central and local, for planning and carrying out the service.

(3) Central responsibility to rest with the Secretary of State. A Central Health Services Council and a Central Medical Board to be set up, as in England and Wales.

(4) Local organisation to differ from that in England and Wales and to be on the following lines:—

(a) Regional Hospitals Advisory Councils to be set up for each of five big regions; to consist of equal representation of the new local authority Joint Hospitals Boards (below) and of voluntary hospitals; also representation of the Local Medical Services Committee (below) and of medical and medical-education interests; independent chairman to be appointed by Secretary of State.

Councils to be advisory to Secretary of State on the co-ordination of the hospital and consultant services in each region.

(b) Joint Hospitals Boards to be formed by combinations of neighbouring local authorities (county councils and town councils of large burghs), to ensure an adequate hospital and consultant service in their areas; these to take over all responsibility for the hospital services of the constituent authorities (including services like the tuberculosis dispensaries, which essentially belong to the hospital and consultant field) and also to arrange with voluntary hospitals.

These Joint Boards to prepare a scheme for the hospital service of their areas, to submit this to the Secretary of State, who will consult the Regional Hospitals Advisory Council before deciding to approve or amend it.

(c) Education authorities (county councils and town councils of four cities) to retain responsibility for school health service and clinics; existing major authorities (county councils and town councils of large burghs) to retain responsibility for the ordinary local clinic and similar services; the necessary co-ordination to be secured (i) through their membership of the Joint Hospitals Boards and (ii) through the Local Medical Services Committees (below).

Powers of Secretary of State to be strengthened to require local authorities to combine for any purpose proved necessary, after public local enquiry, for the efficiency of the new service as a whole.

(d) Local Medical Services Committees to be set up over the same areas as the Joint Hospitals Boards; to be advisory bodies; to include representation of all the local health authorities and of local medical, dental, pharmaceutical and nursing professions and other interests; free to appoint smaller sub-committees and groups, as found desirable.

These Committees to advise the Secretary of State on local administration of the general practitioner service; also to provide liaison between the different branches of the service.

(5) Central provision of Health Centres more suitable in Scotland owing to the smaller size of the problem and the special circumstances of geography and distribution of population—with a power to the Secretary of State to delegate his functions in this respect to a local authority, where found desirable.

8. Financial.

(i) The service to be free to all, apart from possible charges for certain appliances. Questions of disability benefits, for those ill at home and for those in hospital, to be dealt with in later proposals on social insurance.

(ii) Cost of the service to be met from both central and local public funds. These arrangements, as affecting the various local authorities and the voluntary hospitals, are fully considered in a special financial memorandum appended.

APPENDIX A.

THE EXISTING HEALTH SERVICES.

GENERAL SURVEY OF THE PRESENT SITUATION AND ITS ORIGINS.
ENGLAND AND WALES.

Before the nineteenth century there was little regular intervention by public authority in the personal health of the people, which was left to rest in the main on private arrangements and on various forms of charity and voluntary organisation for relief. The early nineteenth century brought the beginning of full-scale attempts to protect and relieve the destitute (and as a corollary to tend the destitute sick) and also a quickening of interest in the welfare of the younger generation, particularly in the supervision of child labour in industry. As the century went on, more attention began to be given to the environmental conditions of health, to sanitary services, drainage, water supply, street cleaning and the whole make-up of public hygiene, and to the idea of local government responsibility in matters of public health—while measures for the prevention of the major infectious diseases, including notification and isolation, became more and more the subject of public regulation and concern. It was not, however, until the present century that the public provision of direct services for personal health began to get into its real stride, and began to evolve the wide variety of services which are now familiar—like the services for maternity and child welfare, midwifery, tuberculosis, the health of the school child, the National Health Insurance scheme, venereal diseases, and the provision of general hospitals by public authority for others than the destitute sick.

In general terms, the result is a complicated patch-work pattern of health resources, a mass of particular and individual services evolved at intervals over a century or more—but particularly during the last thirty or forty years—and for the most part coming into being one by one to meet particular problems, to provide for particular diseases or particular aspects of health or particular sections of the community. Each, as it emerged, was shaped by the conditions of its time, by the limited purposes for which it was designed, and perhaps by the fashions of administrative and political thought current when it was designed. Most of these services, though progressively expanded and adapted as the years have gone on, are still broadly running on the lines laid down for them at the start and are administered largely or, partly, as separate and independent entities. The patch-work, however, contains some very good pieces—well established and by now rich in experience.

It is worth looking at these principal pieces in more detail—to make a survey of how the ordinary man and woman and child can at present get the various medical services which they need.

General Medical Care.

To the individual the natural first-line resource in all matters of personal health is the general practitioner—the personal medical adviser, the “family doctor.” With one important exception (and a few minor ones) the relationship of the ordinary member of the public to the general medical practitioner has been, and is now, a matter of private arrangement. He makes his own choice of doctor, from among those who happen to be accessible to him, seeks his advice and attention when he wishes to, and pays whatever private fees the doctor is accustomed to charge him. The relationship is a purely personal one between doctor and patient, and no form of public organisation is involved in it. The general medical practitioner, for his part, pursues his profession privately and individually. He decides for himself where he wishes to practise, he usually obtains the “good-will” of an existing practice by purchase from another practitioner, and he practises in the open competitive market. He may choose to combine with other practitioners in a voluntary partnership—and there is an increasing tendency to do so in recent years—but that is an individual decision and a matter of business agreement. The traditional basis of general medical practice, in fact, is one of free and private buying and selling in which the State does not intervene—apart from the provisions of the Medical Acts with regard to qualification and registration and professional conduct.

The earliest exception to this rule was the provision of a general practitioner service under the poor law. An organisation designed for the "destitute sick," and including a domiciliary service, was gradually built up throughout the nineteenth century and still gives valuable aid to those in difficulty. Although generally officered by part-time (or occasionally whole-time) District Medical Officers, it has in recent years been converted in some areas into a service of the "panel" type, in which all doctors practising in the locality can take a share. Apart from this limited service, arrangements for general practitioner treatment were, up to 1912, either of a purely private kind or were organised by Friendly Societies, medical clubs and similar organisations.

The National Health Insurance service, instituted in that year, formed part of the provision made by the National Health Insurance Act for the protection of the bulk of the working population against loss of health and for the prevention and cure of sickness. Broadly speaking, its "medical benefit" extends to the whole insured population (some 21,000,000 people) representing for the most part those employed under contracts of service whose income is less than £420 a year. These select from the local panel of doctors their personal medical attendant, who can be consulted as and when the need arises, without fee, and from whom they can obtain such advice and treatment (including visits at their homes) as are within the ordinary scope of the general practitioner. Similarly, they can obtain drugs which the doctor considers requisite and a limited class of surgical and medical appliances. Provision is also made for the issue of medical certificates free of charge. Any doctor who so wishes has the right to take part in the service. The range of medical benefit provided by the scheme does not normally cover consultants or hospital services, although certain facilities for obtaining specialist advice and diagnostic services in difficult cases are afforded. The scheme is designed in fact for a limited object, which is to enable the great bulk of the employed population to get advice and treatment and necessary medical certificates from doctors of their own choice, without the deterrent of fees. This object has, on the whole, been fulfilled.

Apart from the National Health Insurance scheme and the poor law, there is no public provision for general medical attention on any considerable scale. There are various special services for children and other limited groups, as will be seen. Also some adult members of the public are entitled to general advice and treatment under schemes for particular vocational groups (such as Post Office employees or the Police) some carried on by Government departments, others by local authorities, and others by large industrial concerns. Some members of the public—particularly in parts of the London area—obtain advice and treatment from the out-patient departments of hospitals and from dispensaries of various types without going first to a general practitioner. Others do so through co-operative arrangements made in societies or clubs—an example of which can be seen in the "Public Medical Services" set up in some areas, largely for the dependants of insured persons on the initiative of the medical profession itself. A war-time development of a somewhat similar kind has been the arrangement made by the Government, through the Local Medical War Committees of the profession, for the medical attendance of evacuated school-children.

Hospital and Consultant Services.

For those who require hospital treatment, as in-patients or as out-patients, or who require specialist advice beyond the ordinary scope of the general medical practitioner, a wide range of hospital services is available. The individual may, of course, choose to enter a private nursing home and to engage the services of a specialist to attend him there—just as he may, for consultation, make purely private arrangements with the specialist at his home or at the specialist's consulting room. In such cases the whole matter is one of personal arrangement at private cost, in which no intervention of a publicly organised service arises—although the State intervenes to a limited extent to secure reasonable standards by the registration and inspection of nursing homes. Similarly, the individual may arrange to enter a private room or ward set aside in a voluntary

hospital for those who want to make their own arrangements at their own expense. Apart from any such private arrangements as these, the public look to the ordinary hospital services both for hospital treatment and for specialist medical advice, usually arranging for either or both through their general medical practitioner in the first instance.

There are two distinct systems of hospital provision in this country, running side by side—the voluntary hospitals and the public or municipal hospitals. They have quite separate origins and histories, and are quite differently organised and financed. In earlier years the two systems had little working contact with each other and each went its own way with its own kind of service to the public. In recent years there has been an increasing tendency for the two systems to get closer together, to realise their common aims in the service of the public and the value of a greater degree of organised partnership in improving that service together. But in all questions of hospital provision and of future hospital reorganisation it has to be clearly kept in mind that there are these two quite distinct systems at the moment, and that both are strongly rooted and established, with their own traditions and experience. The way this has come about, and the extent to which each contributes in making up the present total service, are not always clearly kept in mind—and are worth summarising.

Until recent years the main burden of providing hospital treatment for acute medical and surgical conditions (though not so much for infectious diseases or mental ills) was carried by the voluntary hospitals, and rested in fact upon voluntary philanthropy rather than on publicly organised provision. The voluntary hospital is, in essence, an independent charitable organisation, deriving its money from the voluntary subscriptions or donations or endowments of benevolent individuals or associations; it is administered by its own governing body or trustees and provides its own service to the public in its own way, subject to the conditions laid down by its constitution. In origin, a few of them can trace their existence back to mediaeval ecclesiastical foundations, but the great majority have come into being during the last two hundred years. There are, at the present day, more than a thousand voluntary hospitals in England and Wales, and they vary enormously in type and size and function. Some of them are large and powerful general hospitals of the kind familiar in London and certain of the big cities, with distinguished specialists and consultants available, with first-class modern equipment and treatment facilities, sometimes associated with well-known medical schools, and drawing their patients from areas wide afield—as leading institutions in the medical world. Others are highly specialised hospitals, concentrating on particular kinds of diseases and conditions such as eye conditions, or ear, nose and throat complaints, or diseases of the nervous system. The rest cover a wide and varying range of size and function, with varying degrees of specialist and other facilities, including a large number of small "cottage" hospitals served in the main by the local general practitioners and really functioning as local nursing homes for the mutual convenience of doctor and patient. Something of the diversity of size and scope of the voluntary hospitals is evidenced by the fact that, of rather more than 900 hospitals in England and Wales of which particulars were available before the war and which provided about 77,000 beds, there were about 230 specialised hospitals dealing mainly with particular diseases, and the general all-purpose hospitals numbered about 700. Of these 700 only some 75 were hospitals of more than 200 beds (and about 25 of these were teaching hospitals); some 115 of the rest provided between 100 and 200 beds each; over 500 had less than 100 beds, and more than half of these had less than 30 beds.

The other arm of the present hospital services—the hospitals provided directly by public authority out of public funds—had its first roots partly in the early public measures for protecting the sick poor, in the first half of the last century, and partly (a little later in that century) in measures which were taken to combat the spread of epidemic infectious diseases. From these two strains there gradually emerged, in recent years, the wider conception of providing through local government machinery and out of public funds a general hospital service—no longer related only to the sick poor or to infectious diseases, but catering for the ordinary public and their ordinary hospital needs.

From the time of the earliest poor-houses it was usual to provide some sort of public accommodation for the destitute sick. Out of the first horrors of the mixed workhouse there began to emerge the notion of the separate and special sick ward, endorsed by the Poor Law Commissioners and adopted more and more by the early Boards of Guardians; from this the wholly separate infirmary or poor law hospital developed—catering still in the main for the chronic and incurable or senile cases. Standards improved, the poor law flavour diminished, and the interpretation of the “destitute” sick became elastic; the field of treatment grew and the poor law idea as a whole became outworn as the expanding public health services began to oust it. This long process of over a century culminated at last, in 1930, in the final acceptance of the principle that general hospital provision was a proper activity of the major local health authorities, rather than of the poor law machinery.

Since 1930 it has been the accepted function (though not the statutory duty) of the major local authorities—the county and county borough councils—to enter the field of general hospital provision for the ordinary hospital case, side by side with the voluntary hospitals already engaged in that field. Many of the earlier poor law hospitals have been taken right out of the poor law sphere and converted to this new and wider function, and new hospitals have been built. Some of the older poor law hospitals still form part of the poor law service (which has itself also passed into the hands of the county and county borough councils), but many even of these have lost their earlier poor law atmosphere. The result of all this new activity is that, just before the war, there were in England and Wales—quite apart from special hospitals for such conditions as maternity, tuberculosis, or infectious diseases—nearly 70,000 beds in 140 general hospitals maintained by the local health authorities under public health powers, and nearly 60,000 more in 400 hospitals and institutions still administered under the poor law. This great pool of 130,000 beds represents a varied service, at every stage of development from the sick wards of an institution for the aged or chronic sick to the most modern and up-to-date of hospitals with every kind of special department and equipment and highly skilled staff.

It has for some time been recognised that all these varying and independently provided hospital facilities, both in the voluntary system and in that of the public authorities, need a great deal more co-ordinating, and some supplementing, so as to ensure a right distribution of hospital accommodation according to local need—and so as to secure that all the types of specialised and general work which the different hospitals are best qualified to perform are arranged in some better related scheme; in a word, to make the hospitals complementary to each other in a combined and balanced service.

At present the hospital facilities to which any particular individual can get access, when in need, depend to a large extent on what kind of hospitals happen to be available in his area, on his ability—if the right hospital is not at hand—to go perhaps a long way afield and arrange for admission to one elsewhere, and on the extent to which his local doctor has been able by his own initiative to maintain personal contact with hospitals and consultants. It is not at present the duty of any public authority, central or local, to ensure that all the right kinds of hospital facilities are available and reasonably accessible to him or that every general practitioner is readily able to obtain every kind of hospital or consultant service which he is likely to need for his patients. The exercise by the major local authorities of their power to provide hospitals and the activities of voluntary hospitals do between them often have the result that the right hospital is where it is wanted and do usually have the result that hospital provision of some kind is available in every area. But these present powers and activities do not extend to any duty to review all branches of the local hospital service and to see that they are so adjusted to each other—and if necessary so supplemented—that the total service available corresponds, both in kind and in quality, with the likely demands upon it. The anomalies of large waiting lists in one hospital and suitable beds empty at another, and of two hospitals in the same area running duplicated specialist centres which could be better concentrated in one more highly equipped and staffed centre for the area, are largely the result of a situation in which hospital services are many people's business but nobody's full responsibility.

When admitted to hospital in the ordinary way, the patient is usually expected to pay what he can reasonably afford towards the cost of his treatment and accommodation there. Local authorities are required to make these charges (except in the case of infectious disease, where they have a discretion) and voluntary hospitals usually follow the same practice. Very often the patient compounds for this liability by joining one of the many contributory schemes, associated with voluntary hospitals, in which he pays a small sum weekly and in return is paid for by the scheme's fund when he is in hospital. Those schemes may apply only to a particular hospital or group of hospitals—on which he must then depend entirely or go elsewhere and pay what he can afford—or they may (and this is the growing tendency in the more up-to-date schemes) entitle him to be relieved of payment in any hospital, whether voluntary or belonging to a public authority, in a wide variety of hospitals.

On many of the existing hospitals the wartime Emergency Hospital Scheme of the Government has had a considerable effect. Seeking to use (and where necessary to improve) the services of the hospitals for various war-time purposes, this emergency service has temporarily entered the field, adding new buildings and extensions to the number of about 50,000 beds; up-grading surgical and X-ray and other medical facilities; relating the hospitals one to another for the interchange of patients according to their special needs; developing specialised treatment centres for fractures and rehabilitation, brain surgery, chest disorders, neurosis and other purposes; and providing inter-hospital transport, country branches and recovery and convalescent homes. It is a war-time organisation which would not suit the requirements of peace; but it will, in its passing, have left improved resources—even entirely new hospitals where none existed before—and above all experience of what it means to translate a collection of individual hospitals into something of a related hospital system.

Rehabilitation.

What has come to be known as "rehabilitation" is more a process or a method than a separate organisation or service. But its requirements, in modern technique, have caused it to be so often specially and separately considered in recent years that it justifies special mention in this review.

So far as it belongs to the sphere of the health services (it is partly a health problem, partly an industrial and vocational one) it rests on the principle that the actual mending or curing of an injury or disease is often not sufficient unless it is accompanied by a process of completely restoring the whole of the patient's previous capacities—or doing so as completely as possible; i.e. restoring the whole of muscle tone, of full function, of general health and strength, as well as cure of what was wrong. It involves various processes supplementary to ordinary treatment, such as massage, exercise, electro-therapy and occupational therapy, and therefore it may often involve special accommodation and apparatus and staff. Thus, while in principle it has been accepted in good surgery and medicine for a long time, it has still not become as much part and parcel of hospital and medical practice as many think it ought to be, and it is legitimate criticism of the existing services that they are not yet organised on the whole (although there are brilliant exceptions in particular areas and institutions) to give the scope that ought in future to be given to the rehabilitation aspect of hospital and medical treatment.

Considerable experiment has been conducted—and considerable result achieved—in this direction by developments in particular hospitals and centres under the Emergency Hospital Scheme. An important review of the whole subject was published recently in a report of an Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons, and this report recommended greatly increased attention to the rehabilitation principle in any future arrangements of the hospital and health services. The subject is not one for any detailed review here, but it has to be mentioned if only to note what has hitherto been a deficiency in existing services and to keep in mind the necessity for developing it in any reorganisation.

Infectious Diseases and Isolation Hospitals.

Apart from sanitary and other improvements, public action in relation to infectious diseases was first taken in the Vaccination Act of 1840, providing public

facilities for vaccination against smallpox. In 1853 provision was made for penalties against parents for failure to have their children vaccinated, and a series of enactments on the vaccination question followed right up to the present century. Since 1898 it has been possible for a parent or guardian who believes that vaccination would prejudice a child's health to withdraw the child from the application of the Acts. At the present time only one-third of the children born each year are vaccinated. It is probable that the time has come to amend the law, and to substitute for compulsory vaccination a system of free vaccination for all through the family doctor, the clinic services, or otherwise. This is the method adopted during the present war in organising the immunisation of children against diphtheria. Supplies of the necessary toxoid have been provided free, and immunisation has been performed normally without charge to parents, while every method of publicity has been used to encourage them to take advantage of the facilities provided. By the end of 1942 about half the child population under 15 had been immunised.

Infectious diseases are the subject of a special service of treatment in isolation hospitals, which is provided by the councils of the boroughs and urban and rural districts, but not usually the county councils. This separately organised service was one of the earliest of the local government medical services to take shape—as far back at 1866. Before that, some of the charitable institutions had provided specially for fever or smallpox patients, and the invasions of Asiatic cholera which began in 1831 had reinforced the arguments of the Poor Law Commissioners that there should be more regular provision made for infectious diseases; but only temporary measures had been taken during epidemics under orders made by the Privy Council. The first real powers to provide public isolation hospitals began with the Sanitary Act of 1866, and from then on the local authorities of the sanitary districts—which became in time the county borough, borough and urban and rural district councils—began to develop, severally or in combination, the system of the separate treatment of infectious diseases in isolation hospitals which exists to-day. In London a special Metropolitan Asylums Board was created in 1867 for the central provision of asylums for certain of the sick poor, and it became in time the general provider of infectious diseases hospitals for the metropolis, until its services were finally transferred to the London County Council in 1930. In spite of the general tendency to attach public hospital provision to county councils and county borough councils, the county councils were not, prior to 1929, brought very directly into the infectious diseases service, though they were given certain powers by the Isolation Hospitals Acts, 1893 and 1901, which have since been repealed. In 1929, by the Local Government Act, they were given the function of drawing up a local scheme for adequate isolation accommodation in each county, in consultation with the county district authorities. The carrying out of the schemes has normally remained a function of the latter authorities, though occasionally a county council has undertaken the provision for the whole or part of a county.

In 1889 the sanitary authorities were authorised to make certain infectious diseases notifiable in their respective districts, if they so desired; before that notification applied only in a few areas where special powers had been conferred. Ten years later the notification principle was made universal throughout England and Wales for these diseases. Other diseases, such as tuberculosis, have since been made notifiable by general regulation of the Minister. Local authorities can also, with the Minister's approval, make local additions to the list.

The present situation is that there are some 1,500 local authorities with powers to provide for the hospital treatment of infectious diseases (including smallpox) in their areas. They do not all make separate and independent provision, and the obvious good sense of pooling resources so as to plan a more useful and economical service for larger areas has resulted in many of them combining into formal Joint Boards or less formal joint committees for the purpose. About 800 of them have so combined, into about 160 Joint Boards—apart from the other less formal combinations referred to—so that the principle of planning over more suitably sized areas already exists to a considerable extent in this service.

Altogether there were, just before the war, something like 38,000 beds in isolation hospitals provided under the infectious diseases and smallpox service,

and they were to be found in some 810 separate hospitals, about 630 of which contained less than 50 beds. The hospitals thus tend to be small (although there are well-known exceptions) and they vary considerably in quality. Some of the provision is very good of its kind, much of it reasonably satisfactory; but in general the small and separate hospital for infectious diseases is uneconomical, viewed as a medical and nursing organisation; and for most infectious diseases it is to be regarded as less satisfactory—in future planning from the medical point of view—than either the provision of larger units or of separate blocks inside the bigger organisation of the general hospitals.

Admission to infectious diseases hospitals is in many areas quite free of charge for any of the inhabitants of the area—as distinct from the ordinary practice of recovery of costs according to ability to pay, which applies in the general hospital services.

Tuberculosis.

Public measures for the care of the tuberculous are organised under a separate machinery, and in many cases by different authorities from those concerned with general infectious diseases. Before 1912 there existed some 5,000 or 6,000 tuberculosis beds in sanatoria or hospitals, mostly administered by voluntary organisations or private individuals, and mostly quite small. The greater part of them had been established within the previous ten years or so. A few local authorities had provided sanatoria themselves, and some were treating tuberculosis cases in smallpox hospitals or infectious diseases hospitals when accommodation was available. There were also about 50 tuberculosis dispensaries in existence. From 1912 onwards public intervention in the treatment of tuberculosis began to quicken and in that year all forms of the disease were made for the first time notifiable. Local authorities were encouraged by exchequer grants to make better provision for the treatment of tuberculous persons in their areas and sanatorium benefit under the National Health Insurance scheme was designed to secure that insured persons if they were found to be suffering from the disease should get the advantages of sanatorium and other treatment whether or not they could afford to pay for it.

The strain of the 1914-18 war was reflected in an increased incidence in the disease and there was a heavy demand for accommodation, in particular for men discharged from the Forces. This led to increased exchequer assistance which resulted in further provision of sanatoria and other accommodation. In 1921, Parliament imposed a general duty on the county and county borough councils to make arrangements for the treatment of tuberculosis, this legislation being later incorporated in the Public Health Act of 1936. From these beginnings there has emerged a strong and still developing special service dealing with all aspects of the diagnosis and treatment of the disease and providing a considerable amount of supplementary help and after-care to those suffering from it. The county and county borough councils fulfil their duties partly by their own direct provision of dispensaries, sanatoria and other institutions, partly by arrangements which they make with voluntary and other agencies. At the outbreak of the present war there were some 28,000 regular beds in tuberculosis institutions, with many more available in approved institutions for use when required. About 400 sanatoria were provided by the local authorities directly, and some 270 by other agencies. These sanatoria are not usually very large, only about 30 having more than 200 beds.

Apart from actual diagnosis and treatment, the service provides—in a degree varying from area to area, and partly through voluntary Care Committees or similar organisations—a variety of supplementary services dealing with additional comforts, extra nourishment and clothes, training for employment, help in obtaining suitable housing, dental care, and other matters. Valuable pioneer work in rehabilitation and resettlement of the tuberculous has been done by a small number of voluntary organisations, eminently in two well-known village settlements and tuberculosis colonies. Local authorities have made full use of these facilities, just as for suitable types of case they have linked up with the training and settlement resources of the Ministry of Labour and National Service. Increasing interest has recently been taken in the rehabilitation of the tuberculous patient

(although hampered at the moment by the restricted conditions of war), and also in new aids to early detection and diagnosis afforded by mass miniature radiography. Another recent advance has been the scheme for the payment of allowances to patients under observation or treatment, in order to encourage early recourse to treatment where financial responsibilities might otherwise be an obstacle tending to delay it.

For the exercise of their duties a few local authorities have combined with each other in seven Joint Boards. Some of these Boards have taken over all the tuberculosis services of their constituent authorities; some only undertake the joint management of particular institutions. A unique experiment in large-scale combination has been in operation in Wales for the last 30 years, in the King Edward VII Welsh National Memorial Association. This was established in 1910, as part of a national campaign against tuberculosis in Wales, and its special constitution (under a Charter of Incorporation) provides for the representation of all the county and county borough councils in Wales, and also includes co-opted members, members nominated by the Minister of Health and others. It provides dispensaries and visiting stations and some 2,000 beds in its own sanatoria and hospitals, and also arranges for accommodation through other agencies.

The tuberculosis service—even after allowing for the indirect effects of improved housing and food and environmental conditions generally—has very tangible results to its credit over the last twenty years reflected in improvements in the rate of mortality from the disease. It tends to be administered as a separate entity, perhaps not enough related to the diagnosis and treatment of other chest and respiratory conditions or to the work of the general hospitals, because it has come into being as a separately organised service with one particular objective.

Venereal Diseases.

A special service for the early diagnosis and treatment of venereal diseases has, since 1916, been the responsibility of the county and county borough councils. It provides some 200 out-patient clinics and centres (usually by arrangement with local hospitals, sometimes independently) for free and confidential diagnosis and treatment for all, irrespective of place of residence or circumstances. Hospital beds and hostels are usually available for in-patient treatment if required. During the war the service has been supplemented by arrangements made, particularly in rural areas, under which suitably qualified general practitioners give free treatment in their own consulting rooms. Doctors in general practice are always at liberty—and are encouraged—to use the laboratory and other resources of the service free of charge and to consult the expert medical officers of the service on any case under treatment.

Cancer.

Just before the present war the Cancer Act of 1939 put upon the county and county borough councils a new special duty, to see that facilities for the diagnosis and treatment of cancer were available to meet the needs of their areas. The Act contemplated a new and comprehensive service for detecting and treating the disease, based on a local scheme which would utilise existing resources (in voluntary hospitals and elsewhere) and would supplement them as necessary, with new diagnostic centres and with additional treatment facilities. It was expected that, in many cases, it would be necessary for county and county borough councils to combine in order to operate an effective scheme over a wider area, and provision for such combination was included in the Act. The whole service would be backed by arrangements for access to a centralised supply of radium organised by the National Radium Trust and Radium Commission.

The outbreak of war immediately after the Act was passed, however, prevented the new service from materialising—except for a few interim schemes which have been started in some areas. Some special war-time arrangements, designed to relieve some of the cancer centres in certain large towns, have been made through the Emergency Hospital Scheme, but these do not properly form part of the present review.

Mental Health Services.

Provision for the care and treatment of persons suffering from mental disorder is made by local authorities under the Lunacy and Mental Treatment Acts, 1890 to 1930. The local authorities concerned are the councils of counties and county boroughs, and of 15 non-county boroughs. Many of the functions are obligatory, particularly as regards provision for certified patients. The powers conferred on local authorities in regard to provision for voluntary patients and out-patient diagnosis and treatment are permissive; but this part of the service has in fact developed rapidly since the passing of the Mental Treatment Act of 1930. In 1941, 35 per cent. of the admissions to public mental hospitals were voluntary patients. Local authorities are required by these Acts to exercise all their powers and duties through Visiting Committees which have powers in regard to staff and finance that give them a certain measure of independence. This arrangement is a survival of an Act of 1845. Three county councils—London, Middlesex and Surrey—have by local Act modified this arrangement so as to bring the committee dealing with this service into line with the position normally occupied by statutory committees of local authorities.

In this service combination between authorities is a common feature. There are three Joint Boards established under local Acts. These provide for the combination of the county council with the county boroughs in the county in Lancashire, the West Riding of Yorkshire and Staffordshire. Joint action has been taken under the provision of the Lunacy Act by a large number of counties and county boroughs for the provision and maintenance of a mental hospital to serve the combined area. Of 101 public mental hospitals (accommodating some 130,000 patients) 42 are managed by a Joint Board or by a combination of two or more local authorities. The provision of a public mental hospital must clearly be entrusted to an authority covering a considerable area. The average number of beds required per 10,000 of population is about 32. The optimum size of a public mental hospital is between 1,000 and 1,200 beds, and it has been found that when the number of beds in such an institution is below 500 it tends to become uneconomical in management.

Under the Lunacy and Mental Treatment Acts a considerable number of patients are treated in private institutions. Some 2,500 are in registered hospitals (i.e. private institutions supported partly by voluntary contributions or charitable bequests) and rather more in licensed houses, i.e., private profit-making establishments, licensed under the Lunacy Act. There are about 12,500 persons of unsound mind in the public assistance institutions and public health hospitals.

Provision for the care of mental defectives is made under the Mental Deficiency Acts, 1913 to 1938. The local authorities concerned are the county and county borough councils. For the execution of the Acts these councils are required to appoint a committee for the care of defectives, some members of which may be co-opted. Certain of the functions are obligatory while others are permissive. The local authorities are required to make arrangements to ascertain what persons within their areas are defective and subject to be dealt with under the Mental Deficiency Acts. The service covers provision for institutional care for patients who need it and community care for defectives who are placed under guardianship or supervision. There are some 37,000 mental defectives in certified institutions, and about 5,000 under guardianship and 37,000 under statutory supervision. Some 9,500 are in public assistance institutions approved for the reception of mental defectives.

Institutional provision under the Act generally is considered to be inadequate. The operation of the principal Act of 1913 was checked at its inception by the outbreak of the last war, and further developments are essential if an adequate service is to be provided. Here again joint action is fairly common, 13 out of a total of 61 certified institutions being carried on by Joint Boards or Joint Committees. Some of the largest certified institutions have been provided by organisations other than local authorities; and there are a number of small certified houses and approved homes which are privately owned.

The central supervision of the mental health services is exercised by the Board of Control, which was reorganised under the provisions of the Mental Treatment Act, 1930. The members of the Board are appointed by the Crown, on the recommendation of the Minister of Health, with the exception of the legal

member, who is appointed on the recommendation of the Lord Chancellor. The Minister appoints the Chairman, and the appointment of the staff of the Board is also subject to his approval. He is responsible for the presentation of the Board's estimate in Parliament, and answers questions in the House of Commons relating to the mental health services. He is consulted, and his directions are taken by the Board, on all questions of major policy. The Board exercises independently of the Minister certain quasi-judicial functions conferred on them by statute in relation to the discharge of individual patients.

Maternity and Child Welfare.

The health of the expectant or nursing mother and of the child under five who is not attending school is the subject of a specially organised maternity and child welfare service. This service is mainly a development of the present century, and particularly of the years between the two great wars. There were beginnings in the latter part of the nineteenth century, when concern about the high infant death rate led to the start of a health visiting service of women workers (volunteers at first, then professional and qualified visitors) who advised mothers on infant welfare in their homes; it led also to the establishment of special depots or centres, where the mothers could attend for advice, and for milk and other special necessities. This work was made easier, and the way for a more organised service was paved, by making the notification of births compulsory—a process which began in 1907 and was extended in 1915. The real foundation of the present service was, however, the Maternity and Child Welfare Act of 1918.

The service is provided by local welfare authorities, which may be county councils or county borough councils or minor authorities according to circumstances which need not be elaborated here. The actual result is that outside London there are nearly 400 separate local welfare authorities, of which 60 are county councils, 83 county borough councils, 162 borough councils, 63 urban district councils, and 10 rural district councils. In London the Common Council of the City and the 28 metropolitan borough councils are the welfare authorities. The service is not a duty of these authorities, but a power—although in practice all of them provide it, in varying degree. It is concerned to provide medical and general advice and attention (but not treatment, except for a few minor ailments) to the young child and its mother, before the child's birth and afterwards until it is five years old or until it attends school. The service includes the provision of ante-natal and post-natal clinics and welfare centres, where attendance is for the most part free and advice and minor treatment are given, the supply of milk and special foods, and the visiting and advice of health visitors at the home.

The close connection between this service and the school medical service, which is referred to below, has always been recognised and under the Local Government Act, 1929, the Minister has power, on representations made by a council which is the education authority, to transfer the welfare functions to that council. When the two services are in the hands of the same body they are usually linked closely with each other.

For her actual confinement the expectant mother may be helped by the welfare authority—through their own provision or through arrangements made by them with other agencies—to get admission to a bed in a maternity home or hospital. She may, alternatively, be confined in accommodation provided as part of the general hospital services. Or again she may, and commonly does, have her confinement at home, and in this case there is a separately established midwifery service which has grown up under the Midwives Acts 1902-1936 in the hands of local supervising authorities. These—for historical reasons—may or may not be the same as the welfare authorities; there are in fact 188 of them and they include 62 county councils, 83 county borough councils, 39 borough councils and 4 urban district councils. Their original duties (which explain their title) were to supervise the practice of independent midwives in accordance with the professional rules of the Central Midwives Board; but since 1936 they have been charged to see that an adequate service of domiciliary midwives is available in their area for those who need it, and they do this either by arrangement with voluntary organisations or by themselves directly engaging and employing midwives. Of some 16,000 midwives in practice, nearly 2,700 are directly employed by the local authorities as domiciliary midwives and over 5,200 are in the employment of voluntary

bodies, usually county or district nursing associations. Many midwives, particularly in country areas, combine midwifery work with home nursing and health visiting.

Notwithstanding the complication of the system, the quality of the maternity and child welfare and midwifery services is in general high, although they vary in scope considerably from area to area. Results, reflected in lower maternal and infant mortality, have been striking and well reward the growing efforts of the service in its relatively short development between the two wars. The commonest ground of criticism is that it is divided up among too many separate agencies and kept too much apart from the related fields of the family doctor and the hospital and specialist services.

Home Nursing.

Home nursing forms a most important branch of the health services, and one which is almost entirely the concern of voluntary organisations. Local authorities have limited powers to employ nurses for nursing at home patients suffering from infectious diseases, or expectant or nursing mothers or children under five suffering from various conditions, but they have no general power to provide a home nursing service and the number of nurses employed directly by them is very small. Within the limits of their responsibilities local authorities have, however, used extensively the services of the voluntary organisations providing home nurses, and they have also assisted them financially under powers, originally derived from the poor law, enabling them to make subscriptions and donations to these bodies.

The home nursing service is for the most part provided through district nursing associations, the majority of which are affiliated directly or through the appropriate County Nursing Association to the Queen's Institute of District Nursing and are under the supervision of the Institute. The district nurse is a familiar and welcome figure, particularly in country areas. In co-operation with the doctor she visits the patient's homes, tends the sick and the injured, and acts as adviser and educator in health matters. In many districts she acts also as midwife and health visitor by arrangement with the local authority. In all some 8,000 district nurses are at work over the whole of England and Wales.

The income of the associations is derived from subscriptions and donations, payments made by patients directly or through a contributory scheme, and grants from local authorities. The proportion received from public funds has increased in recent years, and especially since the Midwives Act 1936 placed on supervising authorities the duty of providing a domiciliary midwifery service. This duty is frequently discharged by the district nursing associations in return for a grant from the authority.

There is little doubt that, with some development, and with closer co-ordination with other branches of the health services, home nursing could play an even greater and more useful part. The need here is for extending and strengthening a service which has fully proved its value, and for linking it intimately with general medical practice and with hospital treatment.

The health of the school child.

For the school child, over the age of five, or from the time of his first attending school, there has gradually developed during the present century a special school medical service. Towards the end of the nineteenth century certain special provision was made for the care of blind, deaf, defective and epileptic children; but the origin of the school medical service may be traced directly to the Report of the Interdepartmental Committee on Physical Deterioration which was issued a few years after the South African War. As a result of this Report the Education (Administrative Provisions) Act was passed in 1907 setting up a regular system of medical inspection and empowering authorities to provide certain types of treatment. From then onwards, a system of increasing medical inspection and care of the health of the school child has been steadily built up. It is now based mainly on the provisions of the Education Act of 1921 and is one of the subjects falling within the scope of the Education Bill now before Parliament.

The operations of the present school medical service are broadly of three kinds. First, it provides for the regular medical inspection of all children in public elementary schools, in secondary schools, and in certain other schools. Second, it provides for the medical treatment, as well as inspection, of children in public elementary schools—but in regard to other schools there is no obligation (only a power) to provide treatment. Third, it enables the educational system, with its regular contact with parent and child, to influence both in principles of healthy child life, and to assist and guide them in securing that the child resorts to the kinds of medical treatment or care that it may need. The first and last of these functions are essentially aspects of the educational system, as such, and it is the second—personal medical treatment—that is of most interest for the purpose of the present review.

Responsibility for arranging this medical treatment rests with the local education authorities. There are at the moment, for elementary education, 315 of these, and they include counties and county boroughs and certain non-county boroughs and urban districts; for higher education, there are 146 of these, all counties and county boroughs. The present provision made by local education authorities for medical treatment varies considerably—in some areas dealing only with the treatment of teeth, eyes, ears, nose and throat, and minor ailments; in others extending to such matters as orthopaedic treatment and certain provision for rheumatic cases and for maladjusted children. The authorities are required to recover the cost of treatment from the parents, unless they are satisfied that this would not be reasonable. Some of the treatment activities are conducted in the schools themselves, some at clinics, provided for the purpose by the local education authorities, some by arrangements made between these authorities and hospitals or other independent agencies.

The local education authorities' organisation for these purposes includes school medical officers, whole time or part time, the chief of whom is in nearly all cases also the medical officer of health of the local authority concerned and combines his school functions with his general public health duties; it also includes school nurses, who are able to do much of the follow-up work in direct contact with the home and the parents (and who may combine their duties with those of a health visitor) and school dentists and other technical officers. A valuable activity of the education authorities, side by side with this medical work, is the provision of good school meals and extra nourishment. This has been greatly expanded since the beginning of the present war, is no longer limited (as it was in earlier days) to children whose parents are necessitous or who cannot readily get to their homes at mid-day, and will remain an important feature in the proposed educational reorganisation.

The central supervision of the school medical service rests with the Board of Education, under powers delegated by the Ministry of Health, and a close association of its work with general public health policy is assured by the two Departments enjoying the services of a single Chief Medical Officer, and by regular arrangements made through him for the co-ordination of the medical work at the centre in both fields.

Dental Services.

The existing publicly organised dental services are of several kinds, and apply to various classes or groups of the population.

Through the National Health Insurance scheme many—but not all—of the 21,000,000 persons insured under the scheme can get what is known as "dental benefit." In fact, nearly two-thirds of them, or some 30 per cent. of the population, are probably eligible for this benefit, which first began to be provided in 1921. It does not take the form of direct public provision of dental treatment, but of a money payment of the whole or a part of the approved cost of treatment. The individual obtains treatment for himself from any dentist who is willing to treat him, under certain conditions and at certain scales of fees which are centrally regulated by the scheme. Most dentists in private practice are willing to accept the "dental benefit" patient in this way, although there is no obligation to do so and no "panel" system comparable to that on the medical side of the Insurance Scheme. Whether

"dental benefit" is obtainable by any insured person, depends upon the ability of the Approved Society (or branch) to which he belongs to make payments for this benefit out of its surplus funds. Although probably about 13,000,000 people are eligible for this benefit, it is noteworthy that only some six or seven per cent. of them actually claim it in any given year.

Under the maternity and child welfare service most local welfare authorities arrange—in varying degree—for dental treatment for expectant and nursing mothers and, where necessary, for children under five. The majority do this by providing a service directly, at their welfare clinics (or at school clinics dealing with older children), others by arranging through private dentists or hospitals. The service includes the provision of dentures in the majority of cases. No charge is usually made for fillings or extractions, but for dentures most authorities recover what the mother can reasonably afford. This service dates back to the Maternity and Child Welfare Act of 1918, though its main development is more recent.

Dental treatment is also provided as part of the arrangements for the treatment of tuberculosis, by the county and county borough councils. Here the main object is to deal with cases where the state of the teeth prevents the full benefit of tuberculosis treatment (e.g., by interfering with nourishment) and, although this limitation is not too strictly observed, the arrangements are only an ancillary activity of the main tuberculosis service. The arrangements vary locally, being sometimes provided at the sanatoria themselves, sometimes at other centres by the dentists employed for the maternity and other services described, sometimes by private dentists.

In the schools the school medical services of the local education authorities provide dental inspection and treatment, in varying degree. School dental officers and dental attendants and other staff are appointed directly by the authorities. The work is done mainly in clinics or in certain country districts in the schools themselves. There is no statutory restriction on the scope or nature of the treatment which can be given—although it will be remembered that the school medical treatment service is at present a duty of the authorities only in the case of elementary schools, and a discretionary power in other cases. In actual fact, the dental service provided (every education authority has a dental scheme) varies within wide limits, dependent largely on the number of children who accept the offer of treatment, and although it does not (in the view of the Board of Education) represent anything like a fully adequate service for the school child it was before the war one of the most rapidly expanding branches of school medical work.

Apart from these publicly organised services the individual citizen must depend on his own private arrangements. He may have access to special dental hospitals (where these exist), or to some of the general hospitals where he will normally be asked to pay what he can reasonably afford, or he may use facilities which some business houses or industrial organisations provide for their employees, or some charitable or voluntary organisation in his neighbourhood. Otherwise he seeks treatment privately from a dental practitioner in the ordinary way; or if he is in serious financial need and requires urgent treatment he may seek the assistance of the poor law, which in most areas will arrange for essential treatment in the last resort.

Ophthalmic Services.

The position in regard to the public provision of ophthalmic services is very like that in regard to dental services. "Ophthalmic benefit" under the National Health Insurance scheme is the principal method of obtaining ophthalmic advice and treatment and spectacles, and about half the insured groups, or some 25 per cent. of the population, are eligible for benefit. There are two ways in which spectacles are obtained—either through a medical practitioner with special experience of ophthalmic work who normally gives a prescription for any necessary spectacles to be made by a dispensing optician, or through a sight-testing optician. The Approved Society (or branch) which provides ophthalmic benefit is required to pay the cost of ophthalmic treatment up to a maximum amount the cost of an authorised ophthalmic examination, and the whole or part of the cost of spectacles if they are needed.

Ophthalmic treatment is open to schoolchildren through the school medical service. Arrangements for this form of treatment, usually by specialists, are made by all education authorities. It is one of the most comprehensive of all branches of school medical work and provides a more comprehensive ophthalmic service than is available for any other section of the community. Apart from this service, only partial and irregular public facilities are available, for example through the out-patient departments of some special and general hospitals or through the poor law. Otherwise the citizen must rely on private arrangements.

Industrial Medical Services.

In addition to the services described there are various medical activities associated specially with industry and employment, which need to be mentioned although they are not primarily concerned with the personal medical advice and treatment of the individual but more with general welfare and the environmental conditions of his work. Although they can all be referred to loosely as "industrial medical services", they vary considerably in kind.

First, the Factory Acts provide for arrangements for factory inspection which include medical as well as other Inspectors. The history of the direct intervention by the State in industrial welfare and working conditions is a long one, and most of it is not relevant for the present purpose. Sufficient to say that it has its origin, well over a century ago, in the appointment after 1802 of factory "Visitors" by the Justices of the Peace (mainly to enforce the legal requirements affecting the employment of juvenile labour) and that this arrangement was superseded by the first Government inspectorate of factories after the Factory Act of 1833, from which the line of succession of the present system can be more or less directly traced. The first appointment of a medical inspector was not made until about the end of the 19th century; but the medical side of the factory inspectorate has since developed into an important and well-known arm of the service, and now occupies the whole-time services of more than a dozen medical inspectors. In addition, however, the Inspectorate has, for over 100 years, been assisted by part-time doctors (formerly called Certifying Surgeons, now Examining Surgeons, and now numbering about 1,700) whose duties included the investigation of cases of accident and industrial disease as well as investigating the physical suitability of juveniles for factory employment and periodically examining workers employed in various unhealthy processes—in connection with preventive measures (including, where found necessary, the suspension of individuals from the particular kind of work). Their investigation of accidents (but not of cases of disease, poisoning, gassing, and other special cases) was dropped in 1916, but the other sides of their work have been developing. This organisation is not designed to provide personal medical treatment and advice to the individual worker; it is designed as an integral part of the highly technical machinery for promoting, fundamentally through the employer, safety, health and welfare in factories and other premises within the scope of the Inspectorate.

Next, industrial concerns often appoint works medical officers, full-time or part-time, who are in a rather different position. An intermediate kind of case is where the firm arrange for the Examining Surgeon to carry out additional functions at the works, beyond those for which they are legally required to employ him, so that he is substantially a part-time works doctor. These "works doctors" are engaged mainly to keep an expert eye on the medical aspects of the factory's work and hygiene, on the effects of environment upon the health of the workers, on the wise adjustment of types of work to the workers' capacity, on arrangements for dealing with accidents and emergencies, and generally for the giving of proper medical advice to the factory management. Before the war, arrangements of this kind were often encouraged by the Factory Inspectorate, and the Factories Act of 1937 gave wider powers to the Home Secretary to order employers to make arrangements for medical supervision in their factories. Further, in 1940, the Minister of Labour and National Service made an Order, under Emergency Powers, requiring munitions and other firms to appoint works doctors if directed to do so. Formal directions under the

Order have not been found necessary; but, since it was made, many more firms have in fact appointed whole-time or part-time works doctors, so that there are now some 175 whole-time doctors of this kind and about 700 exercising substantial medical supervision in the factories on a regular part-time basis. The "works doctors" do not, any more than the Factory Inspectorate, exist primarily as a personal medical service; but in connection with their functions of advising the management and dealing with preventive and first-aid measures in the factory they often provide, incidentally and as a matter of common-sense utility, a certain amount of useful personal medical advice to the factory employees on the spot—perhaps particularly in war-time with its reduced opportunities for ordinary medical consultation outside working hours and its greater need for uninterrupted attendance at a place of work.

The Ministry of Supply, in its capacity of factory employer, has on similar principles developed a medical service in connection with its Royal Ordnance Factories. This service, as might be expected in a large industrial undertaking, includes a central organisation concerned with the general problems of the particular classes of factory under consideration, in which medical and other technical experts play their part, combined with a service of works doctors who look after conditions at the individual works in conjunction with other experts there, and who incidentally, as in other cases, give a certain amount of personal medical advice. Similarly, but on a smaller scale, the Air Ministry and Admiralty make arrangements for medical services at their civilian industrial establishments.

For the mining industry, the Ministry of Fuel and Power has found it increasingly desirable to enlist the medical expert in its national organisation dealing with working conditions and welfare in the industry, and it also encourages greater use in the mines themselves of medical advice on the "works doctor" principle. These activities also involve some entry into the field of personal medical care, but they do not set out to provide any full separate medical service. The miner, like other industrial workers, is within the scope of the National Health Insurance scheme and has recourse to hospital and other services on the basis already described. The Miners Welfare Commission has also been active in mining areas, in assisting in the provision of additional facilities (such as X-ray installations or physio-therapy centres at hospitals).

Generally, in these and other industrial medical services, the picture is not one of personal doctoring and individual health advice organised in vocational groups. It is not a question of separately organised medical treatment services for classes of industrial workers as distinct from the rest of the population. With few exceptions (like the arrangements for the police and for certain Post Office workers, referred to under the paragraphs on general medical attention above) the main health and treatment services, already summarised in this paper (National Health Insurance, the local authority services, the hospitals, and so on) apply in the main to the people or to sections of the people irrespective of their particular form of vocation or employment—for the most part equally to the worker in the field or in the mine or in the factory or elsewhere. The "industrial" medical services are primarily concerned with enlisting the medical expert in the supervision of general industrial welfare and organisation. They are not a direct personal treatment service, though to the extent indicated they are sometimes concerned incidentally with personal advice or limited treatment.

General.

This, then, is a broad outline of the picture of the health and medical services—the main picture, but not by any means the whole picture. A full review would have to detail the multitude of voluntary and private and semi-public efforts of a host of associations, trusts, societies, clinics, institutions and other organisations and groups, which have sprung from private initiative or from public charity over a long period of years. It would have to analyse the many local variations of both statutory and non-statutory services, the many different kinds of experiment in grouping and combination of services locally, the attempts made both recently and earlier, in different quarters, to relate separate services more closely to each other and to "rationalise" the pattern here and there. There is no room to deal with all this. The general picture given is perhaps enough to reveal the essential features of the present situation.

THE PRESENT HEALTH SERVICES IN SCOTLAND.

General.

The health services in Scotland had the same origin and their development has followed much the same course as the health services in England and Wales. There has been the same evolution from the measures taken by public authorities at the beginning of last century to relieve the destitute sick, followed later in the century by the development of the environmental public health services and the treatment of infectious diseases, to the expansion of the personal health services in the present century. There has been the same haphazard growth of these services through the years, leaving much the same gaps to be filled and the same kind of problems to be solved. This being so, a description of the history and the present state of the health services in Scotland would inevitably repeat much of what has already been said in this Appendix. But the development of the services in the two countries has not been uniform. Some of the Scottish services differ in their scope and organisation from the corresponding services in England and Wales; others, such as the Highlands and Islands Medical Service, have no English counterpart at all. The following paragraphs draw attention to the most important of these differences.

Local Authorities.

The Local Government (Scotland) Act, 1929, substantially reduced the number of local authorities concerned with the health of the people. The health services (excluding for this purpose the environmental services—general sanitation, water supply, drainage and housing) are now administered by the 55 "major health authorities," namely, the county councils, of which there are 31, and the town councils of large burghs, of which there are 24. A large burgh is one nominally with a population of over 20,000. The school health service, however, is administered only by the county councils and the town councils of the four Cities (Edinburgh, Glasgow, Aberdeen and Dundee), which are education authorities.

Hospital and Consultant Services.

In broad outline, the development of the hospital services in Scotland has been similar to that in England and Wales. The two hospital systems—voluntary and local authority—have grown up side by side in much the same way in both countries. But the voluntary hospitals in Scotland still provide much the bigger part of the institutional service for the treatment of acute medical and surgical conditions. Before the war there were some 220 voluntary hospitals with a total of over 14,000 beds. On the other hand, local authorities have entered the "general" hospital field only in recent years and so far have provided only some 5,500 beds in nine local authority general hospitals. With one small exception, these hospitals are found in the four Cities. There are still about 1,700 beds in public assistance institutions accommodating the "chronic sick" coming within the scope of the poor law.

The tradition of the Scottish voluntary hospitals is to afford free treatment. There has been very little development of the pay-bed system; and it is not customary to ask the patient in ordinary wards to make a payment towards the cost of his treatment. While there are organised schemes in offices, factories and work places, for collecting subscriptions for hospitals, little has been done to organise voluntary contributory schemes of the type found in England and Wales. Local authorities which have provided hospitals for the general sick apart from the poor law are obliged by statute to charge a reasonable sum towards the cost of the patient's treatment. But there is no power to charge for the hospital treatment of infectious disease. (Further reference is made below to infectious diseases hospitals and sanatoria.)

Between the wars, the re-organisation of the Scottish hospital services was widely discussed and a number of important committees reported on the subject. Considerable support has been given to the view that Scotland both requires and lends itself to a regional co-ordinated hospital service, comprehending both the voluntary and local authority hospitals. This view takes account mainly of the fact that the country's key hospitals as well as the medical schools are all to be found in the four Cities of Edinburgh, Glasgow, Aberdeen and Dundee, and that

these centres are natural focal points for a regional organisation. The conception of four hospital regions based on these Cities, with a fifth based for geographical reasons on Inverness, has thus become the common currency of all discussions on Scottish hospital policy. The recently published report of the Hetherington Committee not only re-affirms this conception but makes definite proposals for setting up Regional Hospital Councils with primary advisory functions.

Scotland has for long suffered from an acute shortage of hospital accommodation and the waiting list problem has been serious. This gives special importance to the fact that the Emergency Hospital Service, organised originally for the treatment of air-raid casualties, has added some 15,000 new beds to the country's total hospital provision. Of these, 8,000 are in annexes at existing hospitals, and 7,000 are in seven completely new hospitals. While these beds are in buildings of emergency construction and while their number will be materially reduced to conform to peace-time standards of bed-spacing and the like, they will form a welcome addition to the post-war hospital service. The annexes are administered by the hospital authorities responsible for the parent hospitals to which they are attached: the seven new hospitals are directly administered by the Department of Health for Scotland.

Fortunately, little call has had to be made so far on the emergency hospital organisation for the treatment of air-raid casualties and beds have therefore been free, within the limits of the available nursing staff, for other purposes. For example, emergency beds have been used to great public advantage in relieving the waiting lists of the voluntary hospitals: up to the end of 1943, some 24,000 patients had been admitted for treatment from these lists.

The existence of staffed beds in the emergency hospitals under the Department's direct control with full consultant and diagnostic facilities available has also facilitated an interesting and successful experiment in preventive medicine, involving the close co-operation of the family doctor, consultant and hospital services. This was originally known as the Clyde Basin Experiment which had its origin in reports received from various sources towards the end of 1941 suggesting that war strain, long hours, and the black-out were affecting the health of the working population in Scotland, including that of young women who had entered industry for the first time. At the same time it was becoming clear that the man-power needs of the nation required the organisation of the civilian medical services on lines which would secure that early and correct diagnosis and treatment were available for any condition which threatened to impair the working capacity of war workers or to leave a war aftermath of chronic invalidism. Accordingly, early in 1942, the Secretary of State launched the experiment for the benefit of young industrial workers between 18 and 25 years of age, in the West of Scotland. Family doctors in the area were asked to refer to the Department's Regional Medical Officer patients in a debilitated state or showing symptoms suggesting the need for expert diagnosis. The experiment was successful from the start and by the end of the year it was extended to cover war workers of all ages in the whole of the industrial belt. It is now known as the Supplementary Medical Service Scheme. Under the scheme, the Regional Medical Officer, either himself or with the aid of consultants, makes a thorough examination of every case referred to him; a full range of consultants is available for the purpose. Where necessary, the Regional Medical Officer arranges for the patient's admission to hospital for observation and full clinical investigation or to a convalescent hospital if rest or "building up" is needed. Where on medical grounds a change of work seems desirable the Regional Medical Officer consults the Ministry of Labour and National Service. A full report is furnished to the family doctor in every case for his future guidance and, in selected cases, follow-up work is undertaken.

Up to the end of 1943, some 6,300 patients had been referred to the Regional Medical Officers for examination. The scheme has shown what can be done in bringing the family doctor into close and effective contact with the consultants and the hospitals—contacts which have evoked the warmest appreciation from doctors and patients alike.

Infectious Diseases Hospitals.

As in England and Wales, it was not until the middle of the nineteenth century that organised steps were first taken to deal with infectious diseases.

Glasgow's first municipal fever hospital was opened in 1865. Two years later the Public Health (Scotland) Act, 1867, empowered local authorities for the first time to make provision for the prevention and mitigation of epidemic, endemic or contagious diseases. These powers included one to provide hospitals for the sick generally but by the Public Health (Scotland) Act, 1897, this power was limited to the provision of hospitals for those suffering from infectious diseases.

This Act of 1897, which is still the principal Public Health statute applicable to Scotland, is the basis of the present system of public health administration. It made compulsorily notifiable throughout Scotland the diseases which previously had been notifiable only in the areas of local authorities which had adopted the Infectious Disease (Notification) Act, 1889, and it gave powers to the Central Department to require the notification of other diseases. Through the years the list of notifiable diseases has been considerably extended.

Many local authorities combined to discharge their duties under the Act of 1897 with regard to the treatment of infectious diseases. The Local Government (Scotland) Act, 1929, in reducing the number of local authorities responsible for this service to 55, consequentially reduced the number of hospital combinations. There are now 12 joint boards providing infectious diseases hospitals on behalf of 23 of the authorities. In all, there are 109 infectious diseases hospitals with about 7,600 beds, excluding beds for the treatment of tuberculosis. Sixty-six of the hospitals have less than 50 beds. The institutional treatment of infectious diseases in Scotland is entirely free.

Tuberculosis.

Responsibility for the treatment of tuberculosis in Scotland is included in the general responsibility for treating infectious diseases laid by the public health statutes on the 55 major health authorities. There is no separate statutory provision dealing with tuberculosis as in England and Wales and in particular there is no specific power to provide for the after-care of persons who have suffered from tuberculosis.

The main features of the tuberculosis schemes derive from the efforts of the late Sir Robert Philip who in 1887 laid in Edinburgh the foundation of an anti-tuberculosis organisation based on the association of the dispensary, the sanatorium and the farm colony. The higher techniques in the treatment of tuberculosis have been greatly developed since these early days, but the basic principles of this pioneering effort still hold good.

Local authorities were at first slow to follow Sir Robert Philip's lead. One or two of them in 1904 experimented with the isolation of pulmonary tuberculosis in spare wards of infectious diseases hospitals, but it was not until 1906 that substantial progress began to be made. In that year the Local Government Board for Scotland (at that time the central Department) made pulmonary tuberculosis compulsorily notifiable and extended to this disease the statutory obligation which already rested on local authorities to deal with certain other infectious diseases.

Before the war, there were about 5,300 tuberculosis beds in Scotland, of which about 4,700 were in local authority institutions. Although some of these beds were converted to other uses when war broke out, alternative arrangements including the provision of beds in the Department's emergency hospitals, have resulted in a net increase in the available bed accommodation.

The incidence of tuberculosis is relatively higher in Scotland than in England and Wales, and it has tended to increase in war-time. There are empty beds available for tuberculosis patients which cannot be used for lack of nurses. This has produced a lengthening waiting list of sufferers requiring institutional treatment, one of the distressing features of the present state of the public health.

Venereal Disease.

There are about 50 out-patient clinics and centres in Scotland for the treatment of venereal disease. Some are in voluntary hospitals but many have been specially provided.

Mental Health Services.

Provision for the care and treatment of persons suffering from mental disorder is made by local authorities under the Lunacy (Scotland) Acts, 1857 to 1919.

While these Acts make some provision for voluntary patients, no specific powers have been conferred on local authorities with regard either to voluntary patients or to out-patient diagnosis and treatment. There is indeed no counterpart in Scotland to the English Mental Treatment Act of 1930. Nevertheless, this part of the service has developed steadily in recent years. In 1942, 14.2 per cent. of the admissions to mental hospitals provided by local authorities were voluntary patients.

There are 23 local authority mental hospitals in Scotland, of which 13 serve combinations of two or more authorities. The 23 hospitals had 12,800 patients on 1st January, 1943. Four single authorities and two combinations have no mental hospitals of their own but depend on contracts made with the Royal Mental Hospitals (or Asylums).

There are seven Royal (or Chartered) Mental Asylums which originated under endowment schemes and are the oldest of the existing institutions for the insane in Scotland. On 1st January, 1943, they had 5,300 patients.

Provision for the care of mental defectives is made under the Mental Deficiency (Scotland) Acts, 1913 and 1940. As in England, the war of 1914-18 checked developments under the 1913 Act, and institutional provision is still very inadequate. On 1st January, 1943, there were 3,900 mental defectives in certified institutions and 1,750 under guardianship. Five of the 13 institutions are managed by joint boards or joint committees. One of the largest of the institutions and two small ones have been provided by organisations other than local authorities.

Central supervision of the lunacy and mental deficiency services is the responsibility of the General Board of Control for Scotland, the members of which are appointed by the Crown on the recommendation of the Secretary of State.

The Committee on Scottish Health Services pointed out the need for the revision and consolidation of the Scottish lunacy and mental deficiency laws, and this problem is now being considered by a Committee appointed for the purpose under the chairmanship of Lord Russell. The former Committee also emphasised that the outstanding need of the mental health service was for a co-ordinated movement to deal with early mental and nervous disorders. It is in this field that the service has been chiefly lacking.

Maternity and Child Welfare.

The local organisation of the maternity and child welfare service is the responsibility of the 55 major health authorities. There is no counterpart in Scotland to the minor authorities of England and Wales.

Local authorities had no statutory powers to undertake child welfare work till 1915, when they were empowered by the Notification of Births (Extension) Act to attend to the health of expectant and nursing mothers and of children under five years of age. At the end of 1919 schemes for this purpose were in operation in areas comprising 55 per cent. of the population: ten years later the percentage had risen to 94: and since the passing of the Local Government (Scotland) Act, 1929, the remaining 6 per cent. of the population has been covered.

The scope of the service is broadly similar in the two countries, resting as it does on the employment of doctors, midwives, health visitors and specialists, and on the apparatus of clinics, centres, nurseries, maternity hospitals and homes. But there is one noteworthy difference. The Maternity Services (Scotland) Act, 1937, created a domiciliary maternity service which differs from that in England and Wales in that, while the English service is based on the midwife alone, the Scottish service is based on the doctor-midwife combination. That is to say, under the Act of 1937 it is now a duty on every local authority in Scotland to make available to all women, who are to be confined at home and who apply for the service, the joint care throughout pregnancy, labour and the puerperium of a doctor and of a certified midwife, with the advice and help, so far as it is practicable to provide it, of an expert obstetrician at any time if the doctor thinks this necessary.

There are some 1,400 practising midwives in Scotland, including 90 whole-time employees of local authorities.

While the maternal and infant mortality rates have shown a big improvement over the years, the position in Scotland is still much less favourable than that in England and Wales. The recently published Report of the Orr Committee examines the problem of infant mortality in Scotland and, among other things, calls attention to the poor liaison between the hospitals, the family doctor and the child welfare service.

Home Nursing.

The Queen's Institute of District Nursing have 1,050 nurses operating in Scotland. The District Nurse plays an important part in many areas as health visitor and tuberculosis nurse under the local authority schemes. She has a special importance in the sparsely populated rural areas where clinic services are remote or non-existent. Under the Maternity Services (Scotland) Act, 1937, many of the authorities are dependent on the District Nurses for their midwife services. In respect of these various statutory services, the District Nursing Associations are subsidised by the local authorities concerned.

The Health of the School Child.

The first step taken in this field was the appointment in 1902 of the Royal Commission on Physical Training (Scotland) to inquire into the physical condition of school children. The Commission found that data on the subject hardly existed, but that army recruiting returns showed a disquieting proportion of unfit applicants for military service. After a medical examination of 1,200 children in Aberdeen and Edinburgh, the Commission recommended that school boards should undertake the medical inspection of school children and record the results. This finding was emphasised by the Interdepartmental Committee on Physical Deterioration in 1904. Four years later the Education (Scotland) Act, 1908, provided for the medical examination and supervision of all school children, and authorised school boards to employ doctors and nurses for the purpose.

This was followed by the passing of the Education (Scotland) Act, 1913, which empowered school boards to provide for the medical treatment of children of necessitous parents. More recently, the Education (Scotland) Act, 1942, in effect places a duty on education authorities to arrange for the medical treatment of any school child who is unable, for the lack of treatment, to take full advantage of the education provided.

As already indicated, the local authorities for school health administration are the 31 county councils and the town councils of the four cities of Glasgow, Edinburgh, Dundee and Aberdeen, which constitute the 35 education authorities of Scotland. Central responsibility rests with the Secretary of State who exercises his functions through the Department of Health for Scotland.

The Highlands and Islands (Medical Service) Scheme.

The Highlands and Islands area is the only part of Scotland—and for that matter the only part of the United Kingdom—in which an attempt has been made to organise a complete medical service available to all classes. The keystone of this structure is the Highlands and Islands Medical Service, a unique effort in co-operation between the State and doctors in private general practice, which has revolutionised medical provision in the area. A Sub-Committee of the Scottish Health Services Committee, reporting in 1936 on the suitability of the Service to the peculiar conditions of the Highlands and Islands, suggested that it might even provide a model on which to build the future medical service in Scotland as a whole. Now that the time is come to consider this larger issue the Highlands and Islands Medical Service is of special interest and worth examining.

The Medical Service was set up following the investigation of the Dewar Committee who reported in 1912 that on account of the sparseness of the population in some districts, its irregular distribution in others, the configuration of the country and the climatic conditions, medical attendance was uncertain for the people, exceptionally onerous or even hazardous for the doctor and generally inadequate. The Committee also reported that the straitened circumstances of the people precluded the adequate payment of doctors by fees alone. The result was the passing of the Highlands and Islands (Medical Service) Grant Act, 1913, which constituted the Highlands and Islands Medical Service Fund, annually replenished

by Parliament, for the purpose of providing and improving means for the prevention, treatment and alleviation of illness and suffering in the area. The Fund is administered by the Department of Health for Scotland.

The area covered by the operations of the Medical Service comprises the seven counties of Argyll, Caithness, Inverness (excluding the burgh of Inverness), Ross and Cromarty, Sutherland, Orkney and Zetland, and the Highland District of Perthshire. This area covers more than half the land surface of Scotland but contains less than one-fifteenth of the total population.

A single visit in the Highlands and Islands may involve a doctor in a journey of many miles lasting some hours. Fees which would adequately recompense the doctor in these circumstances would be beyond the means of all but a few of the population. The basis of the Medical Service, therefore, is that it should provide medical attendance to beneficiaries at uniform fees irrespective of the distance which the doctor may have to travel. This is secured by paying grants to the doctor to compensate him for his travelling and his time, in return for which he undertakes to attend to his patients at modified fees. This modified fee system applies to the families and dependants of insured persons, uninsured persons of the crofter and cottar classes, and others in like circumstances who could not otherwise pay for their medical attendance. These arrangements have led to an enormous increase in the number of visits paid to beneficiaries. Where the grant payable on the basis of mileage travelled would not provide the doctor with an adequate income, the payments out of the Fund are calculated with reference to the net income of the practice so as to provide the doctor with a reasonable living. This applies in 23 out of a total of 153 subsidised practices. The doctor's income is, of course, not derived wholly from the Fund. But what is received from this source is usually a substantial supplement to his other sources of income—National Health Insurance capitation fees, payments from the County Council for public appointments, and fees from private patients.

The Medical Service is provided in consultation with the County Councils in the area, but the contract takes the form of an agreement entered into directly between the doctor and the Department. On a vacancy arising in a single-doctor area the County Council advertises for a local medical officer to undertake public assistance, school inspection and tuberculosis work. The Department then consider whether they are prepared to enter into an agreement for Medical Service work with the doctor whom the County Council propose to appoint. In areas with more than one doctor, the new doctor may receive no public appointment and the Department conclude their agreement with him independently of the County Council. It is a condition of each agreement that the doctor uses a car for the purposes of his practice.

The Department do not exercise any detailed control over the doctor's services: there is no interference whatever with his professional practice. Medical officers on the Department's staff visit doctors in the area periodically to smooth out difficulties and to keep the Department generally in contact with the administration and development of the Service. This method of central administration, free from restrictive conditions and anything resembling vexatious control, has proved an outstanding success: it has satisfied the Department's reasonable requirements and is acceptable to the doctors.

Special arrangements are made to provide the doctors with holiday reliefs and with opportunities for post-graduate study. The Fund also assists in the building of doctor's houses and in the improvement of existing houses.

But the test of the Medical Service is primarily not what it does for the doctor—and it does much for him—but what it does for the patient. The answer here is clear. The "quite inadequate" general medical service, described by the Dewar Committee in 1912, is a thing of the past and in every district in the Highlands and Islands the services of a doctor are available on reasonable terms. And the doctors which the Medical Service attracts are generally of a better type than some that were to be found in the area before.

A similar improvement has been effected in the nursing service. This was lamentably deficient before 1912, partly because of the difficulties of travel in the area, and partly because voluntary effort did not suffice to maintain an adequate

service. Liberal grants are therefore made out of the Fund to district nursing associations towards the cost of employing district nurses, and providing them with houses and motor cars and cycles. There are now over 200 nurses at work throughout the area, nearly double the number working in 1914. Almost all are fully trained nurses, and all are certified midwives.

There have been developments beyond the primary essentials, medical and nursing. The Royal Infirmary, Inverness, has been largely rebuilt (the work being assisted by substantial grants from the Fund); and it now occupies a pre-eminent place in the hospital resources of the area. The Lewis Hospital at Stornoway has likewise benefited and, with its latest extensions, is able to provide a comprehensive service which obviates the transfer of many patients to mainland hospitals. Arrangements have been made with other hospitals for the employment of full-time qualified surgeons. Thus grants are paid towards the salaries of surgeons attached to hospitals at Lerwick, Kirkwall, Golspie, Fort William, Wick and Thurso. Additional subsidised services include a medical consultant at Inverness, a dental service for the people of Skye and part of the Outer Isles, a massage service for Caithness and Sutherland, a special service for the treatment of tuberculosis in Zetland, Lewis and South Uist, where the incidence of this disease is high, and an ambulance service. The air ambulance has now become a familiar feature of the service: patients, in urgent need of treatment, are flown to the Glasgow Infirmary from islands lying off the west coast.

The amount of grants paid out of the Highlands and Islands (Medical Service) Fund for the various services during the year ended 31st March, 1943, was just under £100,000.

APPENDIX B.

EARLIER DISCUSSIONS OF IMPROVED HEALTH SERVICES AND AN OUTLINE OF EVENTS LEADING UP TO THE PREPARATION OF THIS PAPER.

It was recognised very shortly after the inception of medical benefit under the National Health Insurance Scheme in 1913 that there was a strong case for supplementing the general practitioner service with a consultant service. Preparations for this were advanced at the outbreak of the 1914-18 war. The war put an end to further progress in the matter, but towards its end a series of discussions took place between the National Health Insurance Commissioners and leading members of the medical profession on the general subject of the extension of health services.

Shortly after the establishment of the Ministry of Health in 1919, a Consultative Council on Medical and Allied Services was appointed by the Minister under the chairmanship of Lord Dawson of Penn. This body was invited to consider and report on schemes "requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area".

Space does not permit describing in detail the recommendations made in the valuable report of this body which was published in 1920, but the general conception which its authors had in mind was that of a comprehensive scheme under which all forms of medical service would be made available, under suitable conditions, to the population at large. The report recommended the establishment of Health Authorities for local administration and it contemplated, as does the present Paper, the co-ordination of municipal and voluntary agencies as the basis of the scheme. It is worth noting that the Council justified their recommendations "because the organisation of medicine has become insufficient and because it fails to bring the advantages of medical knowledge adequately within reach of the people".

In the same year (1920) a Consultative Council on Medical and Allied Services appointed by the Scottish Board of Health under the chairmanship of Sir Donald MacAlister reported on a somewhat similar remit. Their report urged that "a complete and adequate medical service should be brought within the reach of every member of the community." They made a number of recommendations designed to ensure that the family doctor (on whom the organisation of the nation's health service should be based) would be provided with all supplementary

professional advice and assistance, and they proposed that the State insurance medical service should be extended to cover persons of the same economic level as insured persons and dependants of insured persons. These and their other proposals provided a basis for much of the later discussion on the requirements of a national health service.

In 1921 there was issued the report of the Voluntary Hospitals Committee under the Chairmanship of Lord Cave, which had been set up by the Minister of Health to consider the financial position of the voluntary hospitals. In addition to recommending an exchequer grant to meet the immediate needs of the hospitals, the Committee proposed the establishment of permanent machinery to co-ordinate the work and the finances of voluntary hospitals throughout the country. This machinery was to consist of a central Voluntary Hospitals Commission and of local Voluntary Hospitals Committees for county and county borough areas. The report of the Committee touched on many of the problems with which this Paper is concerned, though its scope was limited to recommendations affecting voluntary hospitals. The Government accepted the findings of the Committee to the extent of providing an exchequer grant for the voluntary hospitals of £500,000 (not £1,000,000 as the Committee had suggested), but the long-term proposals of the Committee for the establishment of co-ordinating machinery were not carried into effect.

Sixteen years later the position of the voluntary hospitals was again reviewed by a body established under the chairmanship of Lord Sankey by the British Hospitals Association, and known as the Voluntary Hospitals Commission. The report of this body, like that of its predecessor, proposed the establishment of central and local bodies with co-ordinating functions and recommended a system of exchequer grants in aid of the voluntary hospitals.

In 1936 the report of the Committee on Scottish Health Services—(the Cathcart Report)—was published. The Committee reviewed the whole of Scotland's health services, personal and environmental, and made many important recommendations within a national health policy for promoting the "fitness" of the people. The recommendations of the report assume throughout that the separate medical services must be integrated and that a co-ordinated medical service should be based, as far as possible, on the family doctor. The report is too comprehensive in scope to lend itself to brief quotation, but it is one of the most complete official surveys of the country's health services and health problems yet attempted. The recommendations of the Committee have already formed the basis of legislation in particular fields.

The latest official report on hospital problems is that recently issued by the Committee which, under the chairmanship of Sir Hector Hetherington, was appointed by the Secretary of State to advise on various post-war hospital problems in Scotland. This report contains detailed recommendations for the setting up of five Regional Hospital Advisory Councils in Scotland. It also makes various suggestions for improved co-operation between hospitals and deals at length with financial arrangements as affecting the future voluntary hospital system.

Other helpful contributions to the study of hospital problems have been made from time to time by many other bodies, including the British Hospitals Association, the King Edward's Hospital Fund for London, the Contributory Schemes Association and most recently the Nuffield Provincial Hospitals Trust which has combined theory with practice in its well-known enterprises in paving the way for greater local co-ordination in the hospital services.

Throughout the period between the two wars, the British Medical Association have been active in focusing the mind of the medical profession upon constructive proposals for the extension and development of the existing health services. In 1930, and again in 1938, they published comprehensive proposals for "A General Medical Service for the Nation", and in 1942 the Medical Planning Commission organised by the Association issued a draft Interim Report which offered for the consideration of the profession far-reaching suggestions for the improvement of the medical services of the community. Salient passages from this important document are quoted in the body of this Paper. Other publications in this field of

which mention should be made are a report issued by a professional group known as Medical Planning Research and representing for the most part the younger elements in the profession, a proposal for a National Health Service by the Society of Medical Officers of Health and a valuable and mainly factual report published by Political and Economic Planning (P.E.P.) in 1937. These publications, and many others too numerous to be mentioned, have been supplemented by copious discussion in the columns of the professional and the lay press.

It is not possible, within the limits of this document, to review all this field of political and professional literature, but it may be said in very general terms that the principles most frequently recurring in the presentation of plans for future developments are the following:—

(1) that there should be made available to every individual in the community whatever type of medical care and treatment he may need;

(2) that the scheme of services should be a fully integrated scheme and that in particular a much closer linking up between general practitioner services on the one hand and consultant and hospital services on the other ought to be achieved; and

(3) that for certain services, particularly the hospital service, larger areas of local administration are needed than those of any existing kind of local authorities.

It is against this background of constructive thinking and discussion during the last quarter of a century that the proposals in the present Paper have been prepared and are put forward.

The Government announced—in October, 1941—their intention to ensure, by means of a comprehensive hospital service, that appropriate hospital treatment should in future be readily available to everyone in need of it. The declared basis for this was to be a new duty upon major local authorities, in close co-operation with voluntary agencies working in the same field, to see that a full hospital service, of every necessary kind, was made universally available; it was expressly recognised that this would mean designing the service over areas larger than those of most of the existing local authorities and that the full use of the powerful resources of the voluntary hospitals, while putting their relations with the local authorities on a more regular footing, would be of the essence of the scheme. To pave the way a detailed and expert survey was started on the Minister of Health's behalf—partly conducted directly by the Ministry and partly organised for the Minister by the Nuffield Provincial Hospitals Trusts—of the hospital services already available in each area in England and Wales. This survey is now nearing its completion. So also is a similar survey in Scotland, instituted by the Secretary of State.

Then, more recently, the report of Sir William Beveridge having taken as one of the bases of its proposals the assumption that a comprehensive national health service, for all purposes and for all people, would be established, the Government announced in February, 1943, that they also accepted this assumption.

The Health Ministers thereupon approached the medical profession, the voluntary hospitals and the major local government authorities, from each of whom they wanted—on a proposal of this magnitude—to obtain all possible help and expert guidance from the outset. It was arranged with them that, for the first stage, they should appoint small groups of representatives of their own choice and that these groups should take part in general preliminary discussions.

The programme was that there would need to be three stages in the evolution of the Government's proposals.

There would be a first stage, in which a preliminary exchange of ideas would be conducted informally and confidentially and without commitment on either side—to enable the Ministers to get a general impression of the feeling of these representatives on some of the main issues involved and to help them to clear the ground.

This second stage would be one of public discussion in Parliament and elsewhere. It would be the stage at which everybody—the public generally, for

whom the service would be designed, the doctors and the hospitals and the local authorities and other organisations which would be concerned in it or affected by it, and those men and women (including doctors) who are now engaged in the Armed Forces—would be able to discuss what was proposed and to voice their opinions about it. To assist in this the Government would issue a White Paper which would serve as a focus for detailed discussion.

The third stage would then be one in which the Government would settle what exact proposals they would submit in legislative form for the decision of Parliament.

For the first stage the representative groups were duly formed. In England and Wales, for the medical profession the British Medical Association, in collaboration with the Royal Colleges, brought together a representative group of medical men and women. For the voluntary hospitals representatives of the British Hospitals Association and the King Edward's Hospital Fund for London, with representatives of the Nuffield Provincial Hospitals Trust joining as observers, together formed a group. For the major local government authorities the County Councils Association, the Association of Municipal Corporations and the London County Council combined to form the third group.

Separate arrangements were made by the Secretary of State for Scotland for discussions with representatives of the medical profession in Scotland, the Scottish local authority associations and the Scottish Branch of the British Hospitals Association. These separate discussions took account of Scottish experience and of geographical, administrative and other differences.

Discussions took place with each group on those aspects of a comprehensive service which most affected them. For the purpose of discussion the Ministers offered to each group—in memoranda and orally—a series of suggestions and ideas for them to consider. They made it clear throughout that they welcomed criticism and alternative suggestions and were not at any stage confronting any of the groups with a predetermined scheme. They received suggestions from the groups on many of the subjects involved, and discussion from the outset was on the frankest basis. Inevitably there was divergence of opinion on some of the issues involved, which each group approached from a different background of experience and opinion, but the discussions were useful as a preliminary sounding of the expert view.

The present White Paper does not purport to sum up the discussions which have taken place, or to reflect any agreement or represent any views reached in these discussions. That would be inconsistent with the terms on which the discussion were undertaken.

APPENDIX C.

POSSIBLE METHODS OF SECURING LOCAL ADMINISTRATION OVER LARGER AREAS THAN THOSE OF PRESENT LOCAL GOVERNMENT.

On the assumption that for certain aspects of the health service, particularly the hospital service, there is need for larger areas of local administration than exist for these purposes now, and that the body responsible for the administration must be representative of and answerable to the electors of the area, there are, broadly speaking, three possible courses:—

- (1) to establish a directly elected body for the sole purpose of administering these parts of the health service;
- (2) to establish a directly elected body for the purpose of administering a group of services including these parts of the health service;
- (3) to secure joint action by the councils of the existing counties and county boroughs which make up the proposed area of administration.

The creation of a directly elected local authority for some particular purpose would run counter to modern developments in local government, which have been towards replacing the system of special authorities for the administration of particular services (such as Boards of Guardians and School Boards) by the system of authorities covering a wide range of functions. But, apart from that

the process of electing a one-purpose authority operating over a fairly large area is not likely to arouse sufficient public interest to attract an adequate proportion of local voters to the poll. Moreover, the system—if generalised over all the social services locally administered—would create an impossible complexity of separate authorities for separate local administrative functions, each requiring separate local election, each operating over a different area, and each requiring separate arrangements for rating or precepting in order to obtain its local revenue.

An alternative suggestion, of establishing new local authorities over wider areas for a substantial group of local services, has been canvassed in recent years. For instance, a proposal for comprising in a single local administrative area the county of Northumberland, part of the county of Durham, and four county boroughs lying on either side of the Tyne, was made in the Majority Report of the Royal Commission on Local Government in the Tyneside Area (1937) and it was recommended that six of the major local government services—Public Health (Medical and Allied Services), Education, Public Assistance, Police, Fire Brigades, and Highways—should be administered by a body with jurisdiction over the whole of this area. Proposals of a similar kind have been made in various quarters since the outbreak of the present war.

An authority performing so many important functions would need to be directly elected. But its establishment would involve a major alteration of the structure of local government. It would deprive county councils of practically all their chief functions—if, indeed, the few minor functions left could be held to justify their continued existence at all; and it would so denude county borough councils of their powers as to leave them with functions in some respects less than those of the "minor authorities" of to-day. Recent publications of the various local government associations and other bodies have shown that there is a wide divergence of view as to the future pattern of local government. It is clear that this must be the subject of a comprehensive inquiry, which could not be instituted under present conditions or completed in a short time. Settlement of the machinery of the new health service cannot await the conclusions of such an inquiry and the passing of any consequent legislation.

The only practical course—pending a general review of local government—is to use the present machinery and the existing facilities for securing such combinations of authorities as may be necessary. This means the application (and possibly some adaptation) of the well-established practice of securing larger administrative units by joint action.

The advantages and disadvantages of administering particular services by combinations of local authorities organised as joint boards have often been argued. The members of the Tyneside Commission, referred to above, differed on the point, the majority regarding the joint board system as "undemocratic", the signatory of the minority report taking the opposite view and recommending the extension of the system as going a considerable way to meet the problems with which that area was faced. The general convenience of arrangements which make it possible to have an area of administration exactly appropriate to any particular service, and to set up an authority for that area, chosen by persons who are themselves direct representatives of the local electorate, cannot be denied. But it is true that the system, if completely generalised, would leave the constituent local authorities who choose the members of the boards with little to do beyond nominating those members, instead of administering services themselves.

Other objections are often advanced. It is said that joint boards tend to attract the more elderly and less effective members of the constituent councils, and that their efficiency is thereby diminished. This is a matter of impression. It may be that, even if it is true, it is due not to the nature of joint boards but to the subject matters with which they happen to deal. A joint board administering (say) an infectious diseases hospital or a sewage disposal system—although its activities may be not less essential to the public welfare—may well attract less interest than would be taken in housing or education, two subjects which excite the keenest interest among local administrators. In any case, this particular weakness of the joint board system, if it exists, is one for which the remedy lies in the hands of local authorities themselves.

Another common criticism is that the powerful weapon of precepting on constituent authorities for funds weakens a joint board's sense of financial responsibility; or—to put it another way—that the members of a joint board, being indirectly elected and therefore at two removes from the ratepayers, have not the same need to justify policy to their supporters as the members of a directly elected authority. There may be something in this, but it is a point which could be met; *e.g.*, by requiring the joint authority to submit to its constituent councils (at intervals of, say, one or two or three years) estimates of their proposed expenditure, for the approval of all—or of a specific majority—of those councils. Some means of removing deadlocks (probably by way of arbitral powers vested in the appropriate Minister) would be needed, unless a majority decision were to be binding. This device, coupled with a more regular habit among the constituent councils of examining, and if necessary debating, the annual and other reports of the joint board, would go a long way to preserve a proper relation of the board to its constituent councils and the electors.

It is also said that the joint board system is bad in that it separates the services entrusted to it from the rest of the main machinery of local government. So far as the health service is concerned, the answer is the practical one—that the need to settle areas of proper size and resources for certain aspects of the service is urgent, and that (temporarily at least) the joint board seems to be the only practicable means of doing this. There need be no question of ruling out any wider development of local government which may later emerge, as the need for new services and extensions of existing services reveals itself. But that is a matter of long-term policy, for which the establishment of a comprehensive health service cannot be delayed.

APPENDIX D.

REMUNERATION OF GENERAL PRACTITIONERS.

The National Insurance Act of 1911 did not itself lay down any method by which the doctors taking part in the service were to be remunerated, nor did it fix the amount of the remuneration. The former has from the outset been prescribed by regulation, the latter negotiated between the Government and the profession or on some occasions determined by arbitration. For the former, the Medical Benefit Regulations have from the start envisaged two systems—one by way of a capitation fee for each person for whom the doctor had accepted responsibility, and the other by way of fees for services actually rendered. Provision is made for combinations and variants of these two systems, but with certain minor exceptions the capitation fee quickly became universal, chiefly owing to the difficulty of checking over-attendance under the other system.

So long as payments for insurance work remained a part only—and in many cases not the major part—of a doctor's professional income, it was difficult to find any rational criterion on which to arrive at an appropriate capitation fee other than by reference to previous fees—*i.e.*, by the limited method of deciding whether any events occurring since the previous fee was fixed were such as to justify its further alteration. It is well known that the original sum fixed in 1912 had regard to the practice of Friendly Societies and Medical Clubs, and that all subsequent sums have been built up from that basis. But it must be expected that in future the bulk of general practitioners will look to the new service for the whole, or substantially the whole, of their professional earnings. Hence, whatever methods of payment are adopted—whether by capitation fees, by salary, or in some other way—the substantial question at issue must be seen in a new light. It must be seen as the question of what is on ordinary professional standards a reasonable and proper remuneration for the whole-time services of a general practitioner working in a public service. Whether this should be worked out in terms of gross or net earnings, whether superannuation rights are to be assumed and taken into account, what adjustments are to be made for part-time work, are matters of comparative detail. When once the main figures have been satisfactorily settled, not only remuneration by capitation fee but remuneration under the salaried or part-salaried systems could be easily determined.

As the White Paper makes clear, the Government do not contemplate the introduction of a universal salaried system, but they propose that doctors taking part in the public service should be remunerated on a basis of salaries or the equivalent in any part of the service in which this form of payment is necessary to efficiency. They contemplate also that it may be possible in certain other cases to offer remuneration by salary where the individual doctors concerned would prefer such an arrangement. In any event, whether payment is on a salaried or part-salaried system or on a basis of capitation fees, two principles will have to be observed in the arrangements made. First, the doctors taking part in the scheme must be assured of an adequate and appropriate income. Second, the aim must be to achieve a system flexible enough to allow for proper variations attributable to extra qualifications and extra energy and interest, as well as representing the reasonable and normal expectations of general practice at all its stages.

The Government fully recognise the importance, and the urgency from a professional point of view, of reaching an understanding on these crucial matters, and they will be ready to discuss them in detail with the profession's representatives.

APPENDIX E.

FINANCE OF THE NEW SERVICE.

ENGLAND AND WALES.

Financial questions were included in the discussions held with the interested bodies before the present White Paper was issued, and are referred to in various places in the Paper. This Appendix sets out the general lines on which the Government think that a reasonable financial basis could be found for the scheme outlined in the Paper, and covers the suggested financial responsibility of the main agencies involved. This basis is suggested as being appropriate to the early years of the scheme. When once the service is well established some simpler basis unrelated to the expenditure of individual authorities may be considered. Further it will be appreciated that any estimates of cost made at the moment can only be conjectural, and it will not be possible to make better estimates until the new scheme is nearing its final shape, and the necessary discussions and negotiations with the interested parties have made progress.

Responsibilities of Local Authorities.

The scheme outlined in the White Paper contemplates that a new joint authority will be responsible for the hospital and consultant services. The new authority will also have the duty of preparing and submitting to the Minister a plan for the whole health service of its area and it is proposed that this plan, taking all the local circumstances into account, should determine precisely how responsibility for the remaining services should be allocated. It is proposed, however, that child welfare responsibilities should always be entrusted to the authority which is also the local education authority, the precise arrangements to be made being governed by the provisions of the current Education Bill as finally approved by Parliament. The intention as regards other local services is that those which are essentially consultant services and thus closely linked with hospital administration should be the responsibility of the new joint authorities, and those which belong more to the sphere of general health care should be the responsibility of county and county borough councils.

The principal new health services which will have to be set up if the White Paper scheme is adopted are home nursing, the provision of Health Centres and new dental and ophthalmic services. In the case of these new services, as in the case of existing services, there will be need for flexibility and it is contemplated that the final allocation of responsibility will be a matter for the area plan. It is assumed, however, that ordinarily responsibility for the provision of Health Centres and for the home nursing service will be assigned to county and county borough councils. But no assumption can be made regarding the other two services. The shape of the new dental and ophthalmic services cannot be foreseen until the report of the Teviot Committee on the former has been received and

discussions on both have taken place with the interests concerned. It is consequently impossible to say at this stage whether the whole or a part of these two services will be administered by local authorities or, if so, which authorities should be made responsible for them.

For the purpose of framing an estimate of the cost of the new health service as a whole however, it is immaterial to know precisely how responsibility for different parts of the service will be allocated among the various local authorities or to a central organisation. The hypothesis on which the figures given below are based must not therefore be read to imply that decisions have been taken on any questions of allocation of responsibility which are left open in the White Paper. The hypothesis selected as convenient for presenting the figures is that the new joint authorities will be responsible for the hospital and consultant service, tuberculosis dispensaries and mental clinics, and the county and county borough councils will be responsible for the provision of Health Centres and for the other existing local services, for the new home nursing service and, if the new dental and ophthalmic services are, in fact, entrusted wholly to local authorities, for these two services as well.

The New Joint Authority.

The scheme outlined in the White Paper contemplates that the new joint authority will take over all hospitals at present provided by rate-payers, including infectious diseases hospitals and mental hospitals* and will make arrangements with voluntary hospitals for the treatment of patients. They will also take over any tuberculosis dispensaries and mental clinics. Suitable financial adjustments will be made between the joint authority and the local authorities in respect of capital assets and liabilities taken over. A new service for which the joint authorities will be responsible is the provision of consultants (based on hospitals). In addition, they will need administrative and technical staff in the exercise of their duty of co-ordinating all the health activities of their area.

The total annual expenditure of all the new joint authorities will be very considerable. For example, in 1938-39 the cost to the existing local authorities of the services to be transferred was:—

	£ millions.
Mental Hospitals	12.3
Infectious Diseases Hospitals	4.2
Other Hospitals and Institutions	14.6
Tuberculosis Services	4.6
	35.7

There was no direct exchequer grant in aid of this expenditure, but there was indirect assistance to the rate-payers through the operation of the block grant to local authorities under the Local Government Act, 1929.

After the war the 1938-39 cost will be considerably increased. There will be some expansion of accommodation and services provided (e.g. for cancer), prices in general will be higher, and nurses' salaries have been increased substantially. In addition the joint authorities will be put to expense in connection with the arrangements to be made with voluntary hospitals, and in providing for the consultant service based on their own and on the voluntary hospitals. In these circumstances the cost to the joint authorities of these services in the years immediately after the war and of their general administrative expenses may approach £70 millions.

As regards the existing services, although there is no direct exchequer grant at present (except for cancer treatment, on which only a small amount was spent before or during the war by local authorities), the Government think that there should be a grant based on the number of hospital beds provided under the scheme. This grant would be substantial and would help to meet the cost of

* The term mental hospital is used in this appendix to include also mental deficiency institutions.

providing the consultant service based on hospitals. The grant for cancer treatment would be discontinued, as would the temporary war-time grant in respect of increases in the salaries of nurses, midwives, etc. In the case of the other new services a 50 per cent. grant is proposed.

For the purposes of this appendix the grant per bed has been taken as £100 per annum in the case of all hospitals other than mental hospitals and infectious disease hospitals and £35 per annum in the case of mental and infectious disease hospitals. A lower grant in the case of beds in these latter hospitals is justified not only on the ground of comparative cost of treatment and maintenance, but because the new scheme broadly does not impose any additional duties on local authorities in respect of treatment. The number of mental hospital beds has been taken as 170,000, of infectious disease hospitals as 40,000 and of other municipal hospital beds as 210,000.

On the above assumptions, the new joint authorities would spend about £70 millions a year. They would receive direct exchequer grants of £6 millions in respect of mental hospitals, £1.4 millions in respect of infectious disease hospitals and £21 millions in respect of other hospitals, a total of £28.4 millions.

The balance of cost—on these assumptions £41.6 millions—would be raised by means of precept on the constituent counties and county boroughs in the area of the joint authority, who would levy a rate for it. The rate-payers would accordingly have to find this £41.6 millions as against the £35.7 millions they had to find in 1938-39. The Government propose that this increased rate demand should be mitigated by an exchequer grant, as explained in the paragraphs which follow dealing with counties and county boroughs.

Counties and County Boroughs.

As already indicated, this financial appendix is based on the hypothesis that county and county borough councils will remain responsible for clinic services other than tuberculosis dispensaries and mental clinics, the major ones being maternity and child welfare and venereal disease, and will continue to be the responsible authority under the Midwives Act. In addition, it is assumed that they will provide and maintain Health Centres and will administer the home nursing service.

Taking figures of cost for 1938-39, the total expenditure on the services proposed to be transferred to the new joint authorities was £35.7 millions and that on the remaining services was £4.6 millions. Included in this latter figure was the balance of expenditure under the Midwives Act, after taking account of a grant of £.6 million.

The cost of these services will be greater after the war, owing to increased prices generally, to the cessation of fees charged for the attendance of midwives and the increased salaries of midwives and to any necessary expansions. It is proposed that there should continue to be a 50 per cent. grant towards the cost of the midwives service, and with the increased cost the grant may well amount to £1.5 million a year.

In the early years after the war £1 million per annum may be spent on home nursing, though it is difficult to forecast the cost of this service. The Government contemplate a 50 per cent. grant.

The cost of the provision and maintenance of Health Centres is difficult to forecast at the moment. Excluding the remuneration of doctors in the Centres the running costs (loan charges, heating, staff, etc.) of the Centres established during the first year or two would probably not exceed £1 million a year. The Government propose a 50 per cent. grant for this new service.

It will take some time to establish the new dental and ophthalmic services, and it will probably be several years before the net expenditure on the services reaches £10 millions on the former and £1 million on the latter. The Government propose a 50 per cent. grant towards these new services if responsibility for them is placed on counties and county borough councils.

Taking these figures, the total direct expenditure of counties and county boroughs on health services might amount to about £22 millions, towards which

there would be a direct exchequer grant of £8 millions. (Indirect assistance is, of course, also given by the block grant under the Local Government Act, 1929.)

The total amounts falling on the rate-payers would be £41.6 millions under precept from the joint authorities and £14 millions direct expenditure, a total of £55.6 millions. This compares with the figure for these services in 1938-39 of £40.3 millions. The Government would propose that any increased rate demand of this sort should be mitigated by an exchequer grant amounting in total to about 50 per cent. of the increase in any year over the demand in some fixed year taken as standard. If 1938-39 were the standard year, then on the figures given the grant in aid of rates would be about £7.6 millions. The grant would be paid to each county or county borough as a proportion of its increased rate-burden, the proportion being higher for poor areas than for rich, on general block grant principles.

Voluntary Hospitals.

Before the war there were no exchequer grants to voluntary hospitals in respect of their expenditure on the treatment and maintenance of patients. Their income was derived as to about half from payments by patients, either direct or through contributory schemes, and as to the rest mainly from voluntary gifts and legacies and income from investments. During the war they have received payments from the exchequer for work done in connection with the Emergency Hospital Scheme and are at present receiving an exchequer grant towards the cost of increased nurses' salaries based on 50 per cent. of the additional cost they incur under that head.

The White Paper explains the part which it is suggested that the voluntary hospitals should play in the new health scheme. Each voluntary hospital which makes arrangements with the new joint authority for the maintenance and treatment of patients under the general conditions of the scheme will have part of the cost paid to them by the authority. This may take the form of a standard sum per occupied bed per week, varying only with the type of hospital concerned.

In addition, in connection with the arrangements of the joint authority for the provision of consultants agreed sums may be contributed in aid of salaries, etc.

The war-time grant in respect of increases in salaries of nurses, midwives, etc., will cease, but the Government propose a new grant in respect of each bed in a voluntary hospital which, under arrangements made with the joint authority, is used or kept available for patients in the scheme. Outside the arrangements of the scheme, a voluntary hospital will, of course, be free to provide such "private pay-beds" as it thinks fit. Assuming that this grant will be the same as was taken for beds in municipal hospitals, i.e., £100 per annum, and that the total number of beds included in arrangements with joint authorities may possibly amount to 100,000, the exchequer grant would amount to £10 millions. This sum, together with the payments by joint authorities towards the cost of maintenance and treatment of patients, would not cover the whole cost to the voluntary hospitals, which would still be dependent on voluntary resources for a substantial part of the income necessary to balance their expenditure.

The General Practitioner Service.

It is clearly not possible at present to give any but the roughest estimates of the probable cost of the general practitioner service under the new scheme. In 1938, in respect of 17,800,000 insured persons under the National Health Insurance scheme, 17,164 general practitioners as a whole received £8.4 millions, while in the same year £2.4 millions was paid to chemists for fees and drugs in dispensing prescriptions.

For the purposes of this Appendix it is assumed that the cost of the extended service would amount to £30 millions a year for doctors and chemists together.

No account is taken of the cost of any superannuation scheme which may be introduced or of the cost of compensation in those cases where it is applicable.

Total Annual Cost of the Scheme.

On the basis of the rough estimates given in the preceding paragraphs the following table shows the total annual cost of the scheme to public funds and the proportions in which that cost might be borne by the ratepayers and by central funds.

Service.	Cost met from central funds.			Cost falling on rate-payers.	Total cost to public funds.
	(a) by direct grants or payments.	(b) by grants in aid of rates or precepts.	Total cost from central funds.		
	£m.	£m.	£m.	£m.	£m.
Expenditure of new joint authorities	28.4	—	28.4	41.6	70
Exchequer grant to voluntary hospitals	10	—	10	—	10
Expenditure of county and county borough councils ...	8	7.6	15.6	6.4	22
Fees to general practitioners and payments to chemists...	30	—	30	—	30
All services	76.4	7.6	84.0	48.0	132.0

How far the central funds will consist of, or be assisted by, sums of money set aside out of contributions under a social insurance scheme will fall to be considered later. The Beveridge Report proposed that a sum of £40 millions per annum should be available for the new health services. Of this £35.7 millions would be the share appropriate to England and Wales, and if this assistance is assumed the proportions in which the total cost of the new service would fall on the social insurance scheme, the taxpayer and the ratepayer would be, on the foregoing estimates and ignoring the effect of the block grant under the Local Government Act, 1929:—

Social Insurance Scheme	£35.7 millions, or about 27 per cent.
Taxpayer	48.3 " " 36.6 "
Ratepayer	48 " " 36.4 "
	<u>£132.0</u> "

Again ignoring the effect of the block grant, the corresponding table for the incomplete services in 1938-39 would be approximately:—

Contributions under N.H.I. Acts	£m. 11.2 or about 20 per cent.
Taxpayer	3.0 " " 6 "
Ratepayer	40.3 " " 74 "
	<u>54.5</u>

FINANCE IN SCOTLAND.

As explained in the White Paper, certain differences are necessary in the administrative arrangements and reorganisation of the new health service in Scotland, as compared with England and Wales. With one material exception, however, the financial arrangements will be on broadly similar lines in the two countries. That exception concerns the provision, equipment and maintenance of Health Centres, which in England and Wales are likely to be a local responsibility and in Scotland the responsibility of the central authority. This being so, the whole cost of establishing these Centres in Scotland will be met from the exchequer, and the precise adjustments to be made in the grants payable to local authorities under the new scheme to take account of this difference will be a matter for discussion with these authorities.

On the basis of the best information available to the Department of Health for Scotland, the following table gives a rough estimate of the total annual cost of the scheme in Scotland and its approximate allocation between the rate payers and central funds.

Service.	Cost met from central funds.			Cost falling on rate-payers.	Total cost to public funds.
	(a) by direct grants or payments.	(b) by grants in aid of rates or precepts.	Total cost from central funds.		
	£m.	£m.	£m.	£m.	£m.
Expenditure of new Joint Hospitals Boards	3.4	—	3.4	4.6	8.0
Exchequer grant to voluntary hospitals	1.6	—	1.6	—	1.6
Expenditure of county and large burgh councils ...	1.0	1.0	2.0	.8	2.8
Fees to general practitioners and payments to chemists...	3.2	—	3.2	—	3.2
Health Centres2	—	.2	—	.2
All services	9.4	1.0	10.4	5.4	15.8

If it is assumed that Scotland's share of any sum set aside out of contributions, under a social insurance scheme be £4.3 millions (corresponding to the figure of £35.7 millions for England and Wales) the total cost of the new service would fall on the social insurance scheme, the taxpayer and the ratepayer in the following proportions:—

Social Insurance Scheme	£4.3	millions	or about	27	per cent.
Taxpayer	£6.1	"	"	39	"
Ratepayer	£5.4	"	"	34	"
	<u>£15.8</u>	"			

As the expenditure borne on the rates in 1938-39 was roughly £4.4 millions, the net additional contribution from the rates would be £1 million.