A National Health Service: The British White Paper*

THE BRITISH WHITE PAPER on a National Health Service was made public on February 17. In it the Minister of Health and the Secretary of State for Scotland recommend the establishment of a National Health Service "which will provide for everyone all the medical advice, treatment and care they may require." The proposals are offered at this time for discussion in Parliament and in the country but not as fixed decisions. "The Government will welcome constructive criticism and they hope that the next stage—the stage of consultation and public discussion—will enable them to submit quickly to Parliament legislative proposals which will be largely agreed."

The British Medical Association has given the proposals a "cautious welcome" and plans to send a copy of the White Paper, together with an analysis of it in relation to the principles already adopted by the profession and a questionnaire prepared by the British Institute of Public Opinion, to every doctor, whether civilian or in the armed forces, at home or abroad, member or nonmember of the Association.

The Prime Minister, speaking to the Royal College of Physicians on March 2, emphasized the desire of the Government for constructive criticism of the plan. "We ask your aid. We invite your counsel."

Background of the Government's Proposals

The White Paper proposals have been prepared and are put forward against a background "of constructive thinking and discussion during the last quarter of a century." These recommendations for an improved health service, summarized in Appendix B of the White Paper, started only a few years after National Health Insurance was enacted in 1911; shortly after medical benefits became payable it was recognized that there was a strong case for adding consultant services to the general practitioner services provided. In 1920, a Consultative Council on Medical and Allied Services, appointed by the Minister of Health, with Lord Dawson of Penn as chairman, reported and recommended 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 contemplated, as does the present Paper, the coordination of municipal and voluntary agencies as the basis of the scheme. In the same year a similar Consultative Council appointed by the Scottish Board of Health, under the chairmanship of Sir Donald MacAlister, urged that a complete and adequate medical service should be brought within the reach of every member of the community; the report made a number of recommendations designed to ensure that the family doctor (on whom the organization of the Nation's health service should be based) would be provided with all supplementary professional advice and assistance, and proposed that the State insurance medical service should be extended to cover persons of the same economic level as insured persons and dependents of insured persons.

In 1921 the Voluntary Hospitals Committee, with Lord Cave as chairman, recommended an Exchequer grant to meet the immediate needs of the hospitals and proposed the establishment of permanent machinery to coordinate the work and finances of voluntary hospitals throughout the country through a central Voluntary Hospitals Commission and local voluntary hospitals committees for county and county borough areas. The Government accepted the findings of the Committee to the extent of providing an Exchequer grant for the voluntary hospitals, but the long-term proposals were not carried into effect. Sixteen years later similar proposals were made by a Voluntary Hospitals Commission established by the British Hospitals Association under the chairmanship of Lord Sankey.

One of the most complete official surveys of Scottish health services and health problems ever attempted was published in 1936 in the Cathcart report of the Committee on Scottish Health Services. Their recommendations assume throughout that the separate medical services must be integrated and that the coordinated medical service should be based, as far as possible, on the family doctor. The latest official report on hospital problems—issued by that Committee, under the chairmanship of Sir Hector Hetherington—contains detailed recommendations for setting up five regional hospital advisory councils in Scotland, makes various suggestions for improved cooperation between hospitals, and deals at length with financial arrangements as affecting the future voluntary hospital system.

Throughout the period between the two wars, the British Medical Association was active in focusing the mind of the medical profession on constructive proposals for extending and developing the existing health services. In 1930 and again in 1938 the Association issued comprehensive proposals for *A General Medical Service for the Nation*, and in 1942 the Medical Planning Commission, organized by the Association, issued a draft *Interim Report* offering for the consideration of the medical profession far-reaching suggestions for improving the medical services of the community.[1] Other organizations making recommendations include Medical Planning Research,[2] representing for the most part the younger elements in the profession, the Society of Medical Officers of Health,[2] and Political and Economic Planning (P E P).[1]

Without attempting to review the whole field of recommendations, the White Paper declares that, in very general terms, "the principles most frequently recurring in the presenta-

*This summary, prepared in the Division of Publications and Review, Office of the Executive Director, is based on *A National Health Service* (Cmd. 6502, London, 1944, 85 pp.) and *A National Health Service, The White Paper Proposals in Brief* (London, 1944, 32 pp.), both issued by the Ministry of Health and the Department of Health for Scotland.

[1] A brief statement of some of the proposals was carried in the *Bulletin*, December 1943, pp. 11–21.

[2] See the *Bulletin*, March 1943, pp. 43–48, for a brief summary.

tion 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."

In October 1941, the White Paper continues, the Government announced their intention to ensure, by means of a comprehensive hospital service, that appropriate hospital treatment should be readily available to everyone in need of it. Responsibility for the enlarged services was to be placed with the major local authorities, in close cooperation with voluntary agencies working in the same field; it was expressly recognized that the service would have to embrace areas larger than those of most of the existing local authorities and that the full use of the powerful resources of the voluntary hospitals, as well as the coordination of their relationships with the local authorities, would be essential. 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 organized for the Minister by the Nuffield Provincial Hospitals Trust—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.

In February 1943 the Government announced acceptance of Assumption B of the Beveridge proposals for a comprehensive unified system of social insurance and allied services—that a comprehensive national health service, for all purposes and for all people, would be established. "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."

Evolution of the Government's proposals was planned in three stages. In the first, 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. The second stage would be one of public discussion in Parliament and elsewhere, when everybody—the public generally, for whom the service would be designed, the doctors and the hospitals and the local authorities and other organizations 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 to serve as a focus for detailed discussion. In the third stage, the Government would settle what exact proposals they would submit in legislative form for the decision of Parliament.

General Nature of the Government's Proposals

The new health service in all its branches will be free to all, apart from possible charges for certain appliances. "Those who prefer to make their own arrangements for medical attention must be free to do so. But to all who use the service it must offer, as and when required, the care of a family doctor, the skill of a consultant, laboratory services, treatment in hospital, the advice and treatment available in specialised clinics (maternity and child welfare centres, tuberculosis dispensaries and the like), dental and ophthalmic treatment, drugs and surgical appliances, midwifery, home nursing and all other services essential to health. Moreover, all these branches of medical care must be so planned and related to one another that everyone who uses the new service is assured of ready access to whichever of its branches he or she needs." Participation in it will not be compulsory for either medical practitioners or the public.

The White Paper points out that much of what is required is already provided in one or another of the existing health services. "The problem of creating a National Health Service is not that of destroying services that are obsolete and bad and starting afresh, but of building on foundations laid by much hard work over many years and making better what is already good." The need for a new attitude toward health care is perhaps the most important point. "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."

The services proposed by the Government at this time are grouped into three main categories—a general practitioner service, hospital and consultant services, and local clinic and other services. Arrangements for general medical practice are described as the most important part of the proposals for a comprehensive program and at the same time the most difficult. "The family doctor is the first line of defence in the fight for good health; it is to him that every citizen using the new service will look for advice on his own health and the health of his family; and it is generally through him that access will be had to the many other forms of medical care which the National Service will provide." In determining the best form of general medical practice, the report says, "The Government fully agree that 'grouped' practices, to which numerous privately arranged partnerships point the way, must be placed in the forefront of their plans for the National Health Service and their proposals are designed with this in view." Because of lack of sufficient experience to determine the best conditions under which individual doctors can best collaborate or the extent to which in the long run the public will prefer the group system, and because the system could not be adopted every-

where simultaneously, the plan proposes that the new service shall be based on a combination of grouped practice and separate practice, side by side. "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 will first be started. It will then be possible to watch the development, with the profession, and to decide in the light of experience how far and how fast a change over to this form of practice should be made.

"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 in this form the advantages of the group system can be most fully realised, though it will also be desirable to encourage grouped practice without special premises. They intend to design the new service so as to give full scope to the Health Centre system."

To implement a fully organized system of hospitals—termed "the keystone of the National Health Service"—two main problems must be solved. The first concerns the cooperation and working relationships between the voluntary hospitals, the oldest established hospital system, and the steadily developing system of local public hospitals. "The Government's proposals are based on the fullest cooperation between the two hospital systems in one common service." The second problem is to determine the areas most suitable for hospital organization, and bring the various separate and independent hospitals together in a working plan for each area.

Tied in closely with the hospital services should be consultant services, the report declares. Lack of such services in the present National Health Insurance is "perhaps the most marked gap in the range of health services provided." The form the new consultant services should take is not outlined in detail, however, pending the report of the Committee on Medical Schools now sitting under the chairmanship of Sir William Goodenough. "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. There is also need for a more even distribution."

Clinics and other local services—the third branch of the Government's proposals—"must include arrangements for home nursing, midwifery and health visiting." The existing or future local clinics and similar services for maternity and child welfare and other special purposes are also to be included. "As time goes on and the new scheme gets into its stride, there will be room for experiment and innovations in the way in which these various local services are provided. In particular, there will be opportunities for associating the family doctor more closely with the work of special clinics—e. g., child welfare centres. But, whatever developments there may be in the clinics and other locally provided services, the introduction of the new service will not mean that any existing facilities are abandoned, but rather that they will be increased and strengthened to meet the wider objects in view."

Costs of the comprehensive health services—estimated at £148 million a year—"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." Questions of the disability benefits payable during sickness at home or during periods of free maintenance in hospital are termed matters for the Government's later proposals on social insurance, to be published in a later Paper.

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 . . . 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 . . .

"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 . . . 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."

The Government's proposal is that central responsibility shall rest on the Minister of Health (for England and Wales) and the Secretary of State for Scotland, who are answerable directly to Parliament and through Parliament to the people. "Indeed, no other arrangement is possible, having regard to the magnitude of the scheme and the large sums of public money that will be involved." But while the service will be under general Ministerial control, only one part of it—the general practitioner service—will be in the main centrally administered. For the other services, local administration is postulated under the major local government authorities—the local 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; these are the "new joint authorities" referred to in the report, who will have the duty of securing all the hospital and consultant services covered by the area, either through their own provision or through arrangements with the voluntary hospitals in the area, and responsibility in the 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.

Both at the center and locally, special new consultative bodies are proposed, to ensure development and operation in close association with professional and expert opinion. At the side of the Minister, but independent of him, the Government would set up by statute a Central Health Services Council, to consist possibly of 30 or 40 members representing the main medical organizations, the voluntary and publicly owned hospitals (with both medical and other representation), medical teaching, and professions like dentistry, pharmacy, nursing, and midwifery. The Council will be appointed by the Minister in consultation with the appropriate professional bodies, and will select its own chairman and regulate its own procedure. Expenses of the Council will be met from public funds. The Council will be consultative and advisory, not an executive body. 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 thinks it right to express an expert opinion." Comparable local health services councils are proposed for each area of every joint authority.

Organization of the general practitioner services is seen by the Government as demanding a high degree of centralized administration, because of the nature of the services involved and the freedom of choice offered both the patient and the doctor for coming into or remaining outside the system. "As the doctors will be remunerated from public funds, the Minister himself must be ultimately responsible for the central administration." Much of the actual administrative details, however, are to be the responsibility of a Central Medical Board, which, like the Central Health Services Council, will be predominantly professional, although it will differ from the Council in that it will have executive powers. The proposal is that the Board shall be a small body, under a regular chairman; a few of its members will serve full time and the rest part time. "Since the Minister will be responsible for its policy, the Board must be appointed by him, but all appointments to it will be made in close consultation with the profession."

"The Board will in each case be the 'employer' of the doctors who take part in the new service and it is consequently with the Board that the individual doctor will be in contact, whether he is engaged in separate practice or in group or Health Centre practice." Practice in health centers, however, raises a problem, since "it would be difficult to place on local authorities the duty of providing, maintaining and staffing the Centres and give them no voice in the employment of the doctors who work there." It is proposed, therefore, that a doctor employed in a health center will be appointed by the Board and the local authority jointly, with his terms of service centrally negotiated and settled; his service in the center would be terminated only by the joint decision of the Board and the local authority, or, if they fail to agree, by the Minister.

Official Summary of the Proposed Services

The Government's official abridged version of the White Paper includes the following summary (pp. 28–32) reproduced here verbatim.

1. *Scope of the new Service*
   (a) A National Health Service will be established. This service will be available to every citizen in England, Scotland and Wales.
   (b) There will be nothing to prevent those who prefer to make private arrangements for medical attention from doing so. But, for all who wish to use the service it will provide a complete range of personal health care—general and specialist, at home, in the hospital and elsewhere.
   (c) The service will be free, apart from possible charges for certain appliances. (Questions of disability benefits will be dealt with in later proposals on social insurance.)
2. *Structure of the Service*
   (a) Central
   (i) Central responsibility to Parliament and the people will lie with the Minister of Health and the Secretary of State for Scotland.
   (ii) At the side of the Minister there will be a professional and expert advisory body to be called the Central Health Services Council. The Council will be a statutory body and its function will be to provide professional guidance on technical aspects of the Health Service. There will be a similar body in Scotland.
   (b) Local
   (i) Local responsibility will be based on the county and county borough councils, which are the major local government authorities now. They will administer the new service partly in their present separate capacities over their present areas, partly—as the needs of the service require—by combined action in joint boards over larger areas.
   (ii) Areas suitable for hospital organisation will be designated by the Minister after consultation with local interests.
   (iii) The county and county borough councils in each area will combine to form a joint authority to administer the hospital, consultant and allied services; in the few cases where the area coincides with an existing county area the authority will be the county council of that area.
   (iv) At the side of each new joint authority there will be a consultative body—professional and expert—to be called the Local Health Services Council.
   (v) Each joint authority will also prepare—in consultation with the Local Health Services Council—and submit for the Minister's approval an "area plan" for securing a comprehensive Health Service of all kinds in its area.
   (vi) County and county borough councils combining for these duties of the new joint authority will also severally be responsible for the local clinic and other services in accordance with the area plan. Responsibility for child welfare will be specially assigned in whatever way child education is assigned under the current Education Bill.
3. *Hospital and consultant Services*
   (a) It will 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.
   (b) The joint authorities will 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.

(c) The powers of present local authorities in respect of these services and the ownership of their hospitals will pass to the joint authority.

(d) Voluntary hospitals will participate, if willing to do so, as autonomous and contracting agencies; if so, they will observe the approved area plan, and certain national conditions applying to all hospitals in the new service alike; they will perform the services for which they contract under the plan, and receive various service payments from both central and local funds.

(e) Special provision will be made for inspection of the hospital service through centrally selected expert personnel.

(f) Consultant services will be made available to all, at the hospitals, local centres, or clinics, or in the home, as required; they will 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.

(g) Measures for improving the distribution of consultants, dealing with methods of appointment and remuneration, and relating the consultant service to other branches of the new service generally, will be considered after the report of the Goodenough Committee.

4. *General Medical Practice*

(a) Everyone will be free, under the new Health Service, to choose a doctor—the freedom of choice being limited, as now, only by the number of doctors available and the amount of work which each doctor can properly undertake.

(b) Medical practice in the new service will be a combination of grouped and separate practice.

Grouped practice means practice by a group of doctors working in cooperation.

Separate practice means practice by a doctor working on his own account—broadly similar to practice under the present National Health Insurance scheme, but with important changes.

(c) Grouped practice will be conducted normally, though not exclusively, in specially equipped and publicly provided Health Centres. In England and Wales, the Centres will be provided and maintained by county and county borough councils—in Scotland, by the Secretary of State with power to delegate to a local authority.

(d) General practice in the National Health Service will be in the main organised centrally under the responsible Health Ministers. All the main terms and conditions of the doctor's participation will be centrally settled, and much of the day-to-day administration will be the function of Central Medical Boards—one for England and Wales and one for Scotland—largely professional in composition, and acting under the general direction of the Health Ministers.

(e) The main duties of each Board will be:—

(i) To act as the "employer" of the doctors engaged in the public service. Thus, the Board will be the body with whom every doctor will enter into contract. In the case of practice in Health Centres in England and Wales, however, there will be a three-party contract between the Board, the local authority and the doctor.

(ii) To ensure a proper distribution of doctors throughout the country. For this purpose the Board will have power to prevent the taking over of an existing public practice or the setting up of a new public practice in an area which is already "over-doctored."

(f) It is not proposed that there should be a universal salaried system for doctors in the new service. Doctors engaged in Health Centres will be remunerated by salary or the equivalent; doctors in separate practice normally by capitation fee. In some cases—e. g., grouped practice not based on a Health Centre—remuneration by salary or the equivalent could be arranged if the doctors concerned so desired. Rates of remuneration will be discussed with the medical profession.

(g) It is not proposed to prohibit doctors in public practice from engaging also in private practice for any patients who still want this. Where a doctor undertakes private in addition to public practice, the number of patients he is permitted to take under the National Service—and consequently his remuneration—will be adjusted.

(h) Young doctors entering individual practice in the public service for the first time will normally be required to serve for a period as assistants to more experienced practitioners, and the Board will be able to require them to give full time to the service if necessary.

(j) Compensation will be paid to any doctor who loses the value of his practice—e. g., by entering a Health Centre or because he is prohibited from transferring the practice to another doctor on the ground that there are too many doctors in the area.

Superannuation schemes will be provided for doctors in Health Centres and the possibility of providing them in other forms of practice will be discussed with the profession, and the practicability of abolishing the sale and purchase of public practices will be similarly discussed.

(k) Arrangements for the supply of drugs and medical appliances will be considered and discussed with the appropriate bodies.

5. *Clinics and other services*

(a) It will be the duty of the joint authority to include in its area plan provision for all necessary clinics and other local services (e. g., child welfare, home nursing, health visiting, midwifery and others), and to provide for the co-ordination of these services with the other services in the plan.

(b) County and county borough councils will normally provide most of these local services. The exact allocation of responsibility between the joint authority and the individual county and county

borough councils will be finally settled in each case in the approved area plan; but the principle will be that services belonging to the hospital and consultant sphere will fall to the joint authority while other local and clinic services will fall to the individual councils.

(c) Child welfare duties will always fall to the authority responsible for child education under the new Education Bill.

(d) New forms of service, e. g., for general dentistry and care of the eyes, will be considered with the professional and other interests concerned. In the case of dentistry the report of the Teviot Committee is awaited.

6. *Organisation in Scotland*

(a) The scope and objects of the service will be the same in Scotland as in England and Wales, but subject to certain differences due to special circumstances and the geography and existing local government structure in Scotland.

(b) The local organisation in Scotland will differ from that in England and Wales and will be on the following lines:—

(i) Regional Hospitals Advisory Councils will be set up for each of five big regions. The Councils will be advisory to the Secretary of State on the co-ordination of the hospital and consultant services in each region.

(ii) Joint Hospitals Boards will be formed by combination of neighbouring major local authorities (county councils and town councils of large burghs) within the regions to ensure an adequate hospital service in their areas. The Boards will 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 will also arrange with voluntary hospitals.

(iii) The joint boards will prepare a scheme for the hospital service in their areas and submit this to the Secretary of State, who will consult the Regional Hospitals Advisory Council before deciding to approve or amend it. The powers of the Secretary of State will be strengthened to enable him to require major local authorities to combine for any purpose proved necessary after local enquiry.

(iv) Education authorities (county councils and town councils of four cities) will retain responsibility for the school health service and clinics, until the medical treatment part of the school service can be absorbed in the wider health service. Existing major health authorities (county councils and town councils of large burghs) will normally retain responsibility for the ordinary local clinic and similar services; the necessary co-ordination will be secured through their membership of the joint hospital boards and through the Local Medical Services Committees (below).

(v) Local Medical Services Committees—advisory bodies consisting of professional and local authority representatives—will be set up over the same areas as the Joint Hospitals Boards. The Committees will advise the Secretary of State on local administration of the general practitioner service and will provide liaison between the different branches of the service.

7. *Finance*

It is estimated that the cost of the new National Health Service will be about £148,000,000 a year compared with about £61,000,000 spent from public funds on the present health services. The cost will be met from both central and local public funds. The arrangements as affecting the various local authorities and the voluntary hospitals are fully considered in the White Paper and more briefly in this paper.

British Medical Association Comment

On February 18, the day after the White Paper was released, the British Medical Association issued the following statement, quoted here verbatim: [8]

(1) Clearly it is too early to give a considered judgment on the White Paper within a few hours of its publication.

(2) In any case, it is the duty of the British Medical Association, before expressing a view on behalf of the whole profession, to ascertain that view. The procedure to be followed in ascertaining that view will include in the next few weeks sending to every doctor, member or non-member, civilian or Service doctor, at home or abroad, (1) a copy of the White Paper, (2) an analysis of it in relation to the principles already adopted by the profession, and (3) a questionnaire prepared by an independent expert body, the British Institute of Public Opinion. In addition, and pending the result of that questionnaire, the White Paper will be considered centrally in all the Committees of the Association, and locally at meetings of the profession. This procedure will take time, but so important are the issues involved that it must in no way be sidetracked. What is said now must inevitably be first reactions of responsible people, rather than the considered view of the Association.

(3) But this can be said:—

(a) With the Government's objects, to make available to everybody in the country who needs it, irrespective of age, sex or occupation, an equal opportunity to take advantage of a comprehensive health service, the medical profession is in the fullest sympathy. It will play its full part in achieving this object.

(b) The Government lays down certain principles. They include freedom for people to use or not to use the service, and freedom for doctors to work inside the service, outside the service, or both. They include freedom for the doctor to undertake his professional work without interference, the preservation of the doctor-patient relationship, and the family doctor conception. These principles the medical profession unreservedly accepts, and it will use its influence in subsequent negotiations to maintain them.

(c) The profession welcomes the general policy of building on existing foundations, of welding together what is already there, adapting and adding to it, until a comprehensive service is achieved, however long that may take.

[8] Mimeographed release.

(d) Within this framework of objects and principles, much remains to be worked out. There are many points to be clarified, as for example—

(1) the experimental character of Health Centres, the professional arrangements therein;

(2) the relationship of individual family doctors to hospitals;

(3) the mode of appointing and distributing consultants;

(4) the compensation for loss of capital value of general practices;

(5) the machinery by which the public will intimate its desire to avail itself of the service in whole or in part;

(6) the future of voluntary hospitals and contributory schemes, and

(7) not least important—the functions of the proposed Central Medical Board.

Those and other points will need to be clarified and details worked out. Indeed, the success of the scheme will largely depend on such details.

(e) The Government has not accepted the proposal for a corporate body, preferring to adhere to the method of the Minister and Department, without concentrating health functions in one department. On this point there will be misgivings. The success of central machinery will depend largely on the extent to which and the method by which medical advice is utilized. A comprehensive personal health service should not in the public interest be administered in the traditional departmental manner.

(f) Heavy responsibilities are allocated to a Central Medical Board, a wholly or mainly Civil Service structure. The profession sympathizes with the Government's desire to secure an equitable distribution of doctors. But in the public interest individual doctors must be protected from unwarranted or unnecessary interference with the type and place of their practice. No attempt must be made to regiment the medical profession of the future by the insidious process of imposing on new entrants to the profession conditions which encourage the development of a whole time state salaried service.

(g) The local administration conforms to the existing pattern of local authorities, except for the creation of new joint bodies for the administration of hospital and allied services over wider areas, and for planning health services generally over wide areas. The conception of wide areas has the support of the profession. The profession will no doubt press for a proper place for expert advice coupled with responsibility within the proposed new bodies.

(h) These local government proposals must be regarded only as a temporary expedient until the larger question of local government areas and functions generally is tackled. There will still be more than one local authority, as there will be more than one central authority, dealing with health issues.

(i) In the plans for hospital services there is much detail to be worked out. For example, as at present proposed, the hospital authority, consisting only of elected persons, will own the local authority hospitals, and so have an especial pride in them, but may exercise a measure of control, under central guidance, of voluntary hospitals, with whom they enter into contracts. Unless great care is taken, there will be a danger that voluntary hospitals will lose the initiative and independent spirit which have been the mainspring of their public service. They may suffer a control financial and other, which, by its rigidity will endanger their future work.

(j) The general effect of the government's proposals is to leave the voluntary hospitals with a margin of money themselves to find but at the same time to take away a main source of finding that money, namely, the contributory scheme. What is suggested is not what the Minister has promised—a real partnership on equal terms—but an arrangement involving the subservience of voluntary to local authority hospitals.

The contributory scheme, as we know it today, would seem to have no place in the new order of things.

(k) Views on the appointment and distribution of consultants—a very important question — must await clarification and details. They are vague in the White Paper.

(l) In regard to general medical practice, the profession will urge that no rigid form of Health Centre organisation should be created, unless and until widespread experiment has been undertaken. To criticise a uniform construction and distribution of Health Centres is not to criticise the idea. But Health Centres must not be thought to represent the Heaven-sent solution of the problem of medical organisation. Where grouping of practices is undertaken it should be done freely, and not under compulsion from above.

(4) To sum up, the White Paper provides a framework within which we believe it to be possible to evolve a good comprehensive medical service, though its worth to the public and its acceptability to the profession will depend on the clarification and on negotiation on many important points. If the principles with which it opens are the principles which permeate the stages to come, we are hopeful that the profession's full co-operation will be achieved. Our immediate reaction is one of cautious welcome.

The Prime Minister's Statement

Addressing the Royal College of Physicians on March 2, the Prime Minister urged that it muster its strength behind the Government's health proposals, because, he said, "disease must be attacked whether it occurs in the poorest or richest man or woman simply on the ground that it is the enemy." The whole destiny of Britain depends on the health of its people after the war and the Nation's power to recover from the punishment of war. "The plan we have put forward is a very large-scale plan and in ordinary times would rivet and dominate the attention of the whole country," Mr. Churchill said. "It is not a rigid or arbitrary plan. We welcome constructive criticism. We claim the loyal and active aid of the whole medical profession."