The Making of the National Health Service

John E Pater

King's Fund historical series 1

The Making of the National Health Service
John E Pater

John Pater devoted forty years of work to the former Ministry of Health and the Department of Health and Social Security. Rather than giving an account of personal reminiscence during those years, the author has compiled an invaluable documentary work, the result of careful research among documents released by the Public Record Office; reports of Hansard; papers of the Royal College of Physicians and the Royal College of Surgeons; and reports and comments published in the *British Medical Journal*, *The Lancet* and the newspapers of the day.

Sir George Godber, former Chief Medical Officer of the DHSS, writes in his foreword, 'There are so many false impressions about the course of events in the 1940s that an accurate study such as this is of great interest now and will be invaluable to historians. No one could have done the job better than John Pater: he was there at the time and took part in it all on the inside.'

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The Making of the National Health Service

King Edward's Hospital Fund for London

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The Making of the National Health Service

BY
John E Pater

Foreword by
Sir George Godber
GCB DM FRCP DPH FFCM

King Edward's Hospital Fund for London

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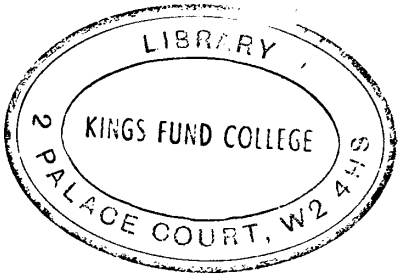

Introduction to the King's Fund Historical Series

John Pater's book, *The Making of the National Health Service*, starts a new venture for the King's Fund, in the shape of an historical series. The Fund has for many years published books and papers in its special field of hospital and related services. A linked series is something new. While our main concern is with the present and the future, we believe there is also value in documenting the past—and indeed a responsibility to do so. Accordingly, we will from time to time publish in this historical series other books that explain how health and social services have developed, with particular (but not exclusive) focus on the United Kingdom.

John Pater's book provides an excellent starting point for the series. He describes the currents, the initiatives and the compromises that led to the setting up of the National Health Service and to the form it took in 1948. As Sir George Godber says in his foreword, John Pater is uniquely equipped for this task, since (as a towering figure in the Ministry up to his retirement in 1973) he has an insider's knowledge, and yet also has an historian's scrupulosity and a certain sardonic detachment. The story itself is an important one, for the establishment of the National Health Service remains a social experiment of the first magnitude. In retrospect, one tends to assume that its form was in some sense preordained. It is as well to be reminded of the complex forces that shaped it, and of the parts played by individuals, including Nye Bevan.

We look forward to adding further titles to the series whenever suitable material is available.

RJM

Secretary

Foreword

John Pater has written an invaluable record of the events surrounding the introduction of the National Health Service, not as reminiscence but as the result of careful research among contemporary documents. Some of the material from the government side has become available in the Public Record Office only recently with the lapse of time. Some of the rest is only to be found in the papers of organisations which were on the other side in negotiations. Some was published in the press, in Hansard and in the professional journals. There are so many false impressions about the course of events in the 1940s that an accurate study such as this is of great interest now and will be invaluable to historians. No one could have done the job better than John Pater: he was there at the time and took part in it all on the inside. There may be minor differences in interpretation but the essential facts I know to be right, even to the opening anecdote in which I was the duty medical officer who found the leeches (though the date was August Bank Holiday and the beneficiary was the injured American Ambassador in an eye hospital on the south coast).

Pater gives generous credit to various senior colleagues. He does not reveal—and it should be said—that he was their chief support. He largely wrote the London regional hospital survey for Gray and Topping and he went on to be the main organiser of the ministry's part in launching an entirely new hospital administration. This text should not appear without a tribute to the skill and effort of its author which were no less important to the successful introduction of the NHS than the contributions of those he rightly extols.

GG

1981

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Introduction

Introductory notices are apt to arouse doubt in the mind of the reader about the contents of the book which follows—*qui s'excuse s'accuse.* A few preliminary words of clarification and acknowledgment are, however, unavoidable.

In the first place it must be made clear that the scope of this account is limited to England and Wales. There was some joint action with Scotland, especially by government ministers, and thinking and discussion there went on along parallel lines, with results which did not differ significantly from those reached in England; but in some respects the National Health Service in Scotland has a history peculiar to itself, and that is not described in the following pages. Secondly, it will be apparent that no attempt has been made to assess and judge the emergent NHS from the standpoint of later experience. The account is limited to the events ending with the 'Appointed Day' of 5 July 1948. Thirdly, it should be said that, although the writer played a part in the events described, the account is not based on reminiscence (still less on any diary of the time) but on documentary evidence, mainly unpublished and all contemporary.

Mention of the documentary evidence leads naturally to grateful acknowledgment of the help so readily given by a number of bodies and persons. Most of it came from the Public Record Office, whose staff were most helpful within the limits of the system they have to operate (of which more in a moment). I am also very indebted to the British Medical Association, the Royal College of Surgeons and the Royal College of Physicians for their permission to study uncatalogued papers in the possession of the latter college relating to the period 1941–48, and to the secretary and library staff of the college in doing so. The BMA also permitted me to consult its records of the negotiating committee of

1944–48 as well as to work in its library, and I am most grateful to the secretary, Dr E Grey-Turner, and his staff for their assistance. To two other libraries and their staffs I am also indebted for help, namely that of the Department of Health and Social Security in Alexander Fleming House, and that of the King's Fund Centre in Camden Town, and to both I extend my appreciation and thanks. Documents which I have consulted in the Public Record Office and those of the RCP are referred to in footnotes in the following pages. All other documents are listed with the references at the end of the book.

It must be added that the public records system as it currently operates presents the enquirer with some difficulties (none of them, it should be emphasised, the fault of the PRO staff). Research for this book revealed several deficiencies. First, there was a good deal of duplication of papers, not only between different sets but within a single set. Second, papers which purported to be in chronological order were frequently out of order. Third, unimportant ephemeral papers appear to have been preserved while important items were missing. And fourth, records which under the thirty years rule should theoretically have been available were not in practice, because they were in one file with other later papers not due for release. The effect of these characteristics of the records—all, it would appear, due to the way government departments weed and deposit their papers—is to cause a good deal of frustrating search, and to make it impossible even in 1981 to provide a fully documented account of events in 1946 or even earlier. It is to be hoped that a review of the system will provide a remedy in the near future.

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Origins to 1939

The story is told that shortly after midnight of 4 July 1948 the duty medical officer at the Ministry of Health in Whitehall was disturbed by the ringing of his telephone. He answered, to find himself confronted with an unusual request. A general practitioner in the country claimed to be in urgent need of some leeches, which he asked the ministry to supply immediately. Since the use of leeches in general practice was rare if not obsolete, the odds were that this was not a genuine distress call, but a waggish attempt to catch out the much discussed but very newly born National Health Service. The duty medical officer determined that the attempt should not succeed. Summoning up his clinical memories he recalled that leeches were occasionally used in eye conditions, and that an eye hospital might therefore have some in stock. He called Moorfields Eye Hospital, and sure enough the hospital had some leeches and undertook to send them as soon as possible to the general practitioner who had asked for them. With pardonable pride the duty medical officer rang up and told the doctor that his leeches were on the way. The National Health Service had survived its first crisis.*

Why was the service born on 5 July 1948 and not earlier or later? What were its origins, and how was it brought to fruition? Was it invented by William Beveridge, as seems to be the popular belief? Was it planned and built by the medical profession, as Charles Hill appears to imply in his autobiography?[66] Did it spring from the fertile mind of

* I am grateful to Sir George Godber for correcting the details of the story in his foreword to this book. His true version makes a better story than the one I have related, though it is the latter which has passed into the folklore of the NHS.

Aneurin Bevan, as Michael Foot suggests in his biography?[25] Or should its origins be sought elsewhere, in a more distant past?

Royal Commission on the Poor Laws and Relief of Distress 1909

A case can be made for pointing to the Elizabethan Poor Law as the first evidence of an organised health service, and poor law medical relief whether institutional or outdoor did continue as one strand of the services right up to 1948; but there were later and more important elements. One was the philanthropic movement of the eighteenth and early nineteenth centuries which gave birth to the voluntary hospitals in many towns. Another was the sanitary revolution of the mid-nineteenth century, the era of mains and drains and the first public housing, accompanied by the provision of isolation hospitals for smallpox and other infectious diseases. All these laid an essential foundation for subsequent personal health services—a foundation which countries of the Third World and some of their western advisers still tend to overlook. Yet another was the introduction of the services for the health care of schoolchildren in 1907, stimulated by public concern at the physical shortcomings of recruits to the army during the Second Boer War. Nor should the ordering and reform of the medical profession through the Medical Acts of 1858 and 1886 be overlooked. But perhaps the most relevant starting point for an examination of the origins of the NHS is the report of the Royal Commission on the Poor Laws and Relief of Distress of 1909,[101] and particularly the minority report whose best known authors were Beatrice Webb and George Lansbury.[80]

The majority of the commission not unnaturally concentrated on recommendations calculated to improve the poor law system, and its proposals were largely embodied in the Poor Law Act of 1930.[55] They called for the transfer of responsibility from the Guardians to the county and county borough councils, which *inter alia* should appoint a medical assistance committee for health services with members drawn from the health committee, the local branch of the British Medical Association, the voluntary hospitals and other voluntary bodies. They urged the abolition of the general mixed workhouse and the development of specialised institutions working closely with the voluntary homes and hospitals of the area. A more original proposal was for the creation of dispensaries which workers below a certain level of wages were to be encouraged to join, paying a subscription which would entitle them to free choice of doctor on the dispensary list, adequate medical assistance

at a charge within their means and institutional treatment on the recommendation of the dispensary doctor.

The minority saw the problem of medical care quite differently. In its view the poor law should be abolished, and a unified medical service provided by counties and county boroughs through their health committees. Treatment, both domiciliary and institutional, was to be available to all according to their need, but not necessarily free of charge—indeed it was proposed that registers should be kept of all cases receiving treatment, with a local registrar to assess and collect charges fixed nationally by Parliament. These views were based on a scarifying analysis of the defects of the existing services. The poor law institutions, where two-thirds of the sick were being cared for in mixed workhouses, were condemned as a grave public scandal, and poor law infirmaries were understaffed, unspecialised and had no visiting physicians or surgeons. Voluntary hospitals were better in quality but too small, badly distributed and restricted in their scope.

The domiciliary services were if anything rather worse. The poor law district medical officers were underpaid, were not expected to advise on care or the prevention of disease and had no contact with the local authority health services. Nor had they any relationship with institutional care. As a result, the public health was being gravely affected, especially by the uncontrolled spread of tuberculosis. The so-called 'free dispensaries' provided by voluntary bodies, including the outpatient departments of voluntary hospitals, were overcrowded, and the treatment given in them was superficial—mere 'shops for giving people large quantities of medicine'. The medical clubs financed by workmen's subscriptions underpaid their doctors, gave inadequate treatment, and in any case did not cater for the chronically sick and others who would be poor insurance risks or for dependants. In the minds of the authors of the minority report, the solution was clearly a full-time salaried medical service, for they examined and dismissed the idea of a medical insurance system on several grounds. In the first place, they regarded it as quite impracticable to collect weekly contributions from everybody (they apparently did not think of the weekly stamp), and considered that it would be opposed by trade unions and friendly societies alike, particularly as it would be the first poll tax imposed on the English people since 1381. Similarly, they regarded free choice of doctor as deleterious, because they thought it would lead to 'medical demagogy', doctor competing with doctor for patients by bribing them with unnecessary prescriptions or certificates of ill-health.

Between them, the majority and minority reports of the royal commission raised all the issues which were to be debated right up until 1948 in relation to the provision of medical care, with the one exception of the planning of hospital services on a regional basis. Should a health service be comprehensive—that is, including treatment and care for all types of disease and disability, not forgetting prevention—or should (for example) mental illness and deficiency be excluded? Should the service be available to everyone or only to identifiable groups such as those under some prescribed income limit? Should it be free when required, and financed by some form of insurance or taxation or local rates, or should it depend on charges for services? How should doctors, dentists and other professionals be paid? How should the service be administered centrally and locally? What part, if any, should the professions play in the administrative process? And finally, what should be the role of the voluntary hospitals? These were the main problems which had to be solved as time went on.

National health insurance

It is ironic that the first step to be taken to promote health care, following the Royal Commission on the Poor Laws and Relief of Distress, was the introduction of a scheme of medical insurance of the kind so roundly condemned by the minority report. In two senses the scheme was the result of that report. In the first place, the report had aroused expectations of reform, which the scheme was intended to satisfy, at least in part; but in the second place, the scheme aimed to divert public attention from the much more comprehensive demands of the minority report and to provide a defence against them for the Liberal government. In another sense, too, the insurance scheme flowed from the commission's study of the problem of poverty. Lloyd George saw ill-health as a primary cause of poverty, and it was as an attack on poverty by cash payments during absence from work due to sickness—in parallel with old age pensions—and not as a scheme of medical care that he brought forward his proposals. He was much impressed with Bismarck's insurance schemes in Germany, and he visited that country in 1908 to study them at first hand.

The upshot was the introduction of the National Health Insurance Bill in 1911, aimed at relieving poverty among manual workers during sick absences and also at providing a minimum medical care service ('medical benefit').[54] The scheme was restricted to manual workers and those non-manual workers with incomes of less than £160 a year (later

increased to £250, and later still to £420), and it did not cover their dependants. The range of services given was also narrowly limited, extending only to diagnosis and treatment within the scope of a general practitioner, and to the supply of 'proper and sufficient medicines' and a few appliances. Cash benefits were administered by 'approved societies'—that is, friendly societies approved as efficient for the purposes of the scheme—and the more wealthy of them paid for additional forms of health care such as dental treatment or glasses. These societies were also represented on the local insurance committees set up for the local administration of medical benefit, together with members appointed by the county and county borough councils and representatives of the doctors. Because the medical profession insisted on national agreements for their remuneration and other terms of service, and because there was a uniform tariff for chemists' prescriptions and pricing by joint committees, there was little for insurance committees to do, so the Royal Commission on National Health Insurance in 1926 recommended the transfer of their functions to the county and county borough councils.*[100]

A scheme so limited in scope—excluding, on the one hand, consultant and specialist services and any form of institutional care and, on the other hand, almost all women and children—was clearly of limited value, and early steps were taken to extend it. In 1914, Parliament voted funds to provide outpatient consultant and specialist services, but the war stopped any action. The royal commission of 1924–26 recognised the need for extension but was inhibited by its anxieties about the economic situation (11 per cent unemployment in 1926) and the burdens of taxation on industry. As its first priorities it named the provision of specialist services and higher cash benefits, but it regarded dental benefit for all, though desirable, as too expensive, and extension of services to dependants as prohibitively costly. There was also a complicating factor beginning to appear in the form of public health services provided by local authorities, and this had to be taken into account. The commission saw maternity services as its third priority, but it looked

* This verdict was confirmed by the Cathcart committee on the Scottish health services in 1936,[30] and was a view held down the years by almost everyone except the medical profession; but in the revised form, first of the executive council and subsequently of the family practitioners' committee, a separate local administrative body for the general practitioner services has survived even the reconstruction of the NHS in 1974.

hopefully to the local authorities to provide them, and also to cover services for dependants as part of a general health service not based on insurance. Indeed, in agreement with the evidence given by the BMA, the commission looked for development generally by way of a unified service closely coordinated with the growing number of services in the hands of local government. Hospital inpatient treatment it considered not only too costly for the NHI scheme but also unsuited to an insurance basis, because it thought this would imply a guarantee of admission to hospital which could not be given—a somewhat odd conclusion having regard to the contemporaneous rapid growth of hospital contributory schemes, which were a form of insurance against charges for hospital treatment but gave no guarantee of care. A minority of four members of the commission was less inhibited—they recommended not only the steps suggested by the majority but in addition extension to maternity services, to dependants and the inclusion of dental and ophthalmic benefits, any costs over and above the existing insurance contributions to be met by rates and taxes.[79] In practice, little action followed the majority report, and none at all that of the minority.

The commission's enquiries, however, revealed one important and, indeed, fascinating fact, that the BMA now accepted the NHI scheme with equanimity—even some enthusiasm. In view of the bitter battle the BMA had fought against Lloyd George's proposals in 1912–13, this was a remarkable *volte face,* consummated by the BMA's declaration in 1922 of its support for the continuance and improvement of the scheme. It is true that in its evidence the BMA emphasised the importance of other health measures—adequate housing, open spaces and recreation, smoke abatement, pure milk and medical research—but there was little adverse criticism of NHI, rather a desire that it should be extended both in scope and coverage for all with an income below £200 or thereabouts, and for their dependants. At the same time, the BMA looked for a service coordinated, and in some way unified, with the local government health services—tuberculosis, venereal diseases, maternity and child welfare, school medical service, isolation hospitals and poor law medical services both hospital and domiciliary—preferably under an *ad hoc* local health authority.

Haldane and Dawson

In taking the line it did in evidence to the royal commission, the BMA may well have been harking back to the blueprint for a comprehensive

health service drawn up a few years earlier by the Minister of Health's consultative council on medical and allied services. Both minister and council were products of the 1914–18 war, which acted as a solvent for social change no less than World War II. A Ministry of Reconstruction was at work from early 1917 planning the post-war future, and one of its justly celebrated achievements was the reorganisation of the machinery of central government elaborated by the Haldane committee.[44] That committee included among its recommendations the creation of a Ministry of Health for England and Wales to take over the functions of the Local Government Board and of the NHI commissions of the two countries, together with various other health responsibilities of other government departments, but not including health in industry or the armed forces.

Even before the committee's report was published, a Ministry of Health Bill was introduced into Parliament on 7 November 1918,[51] and the ministry itself was established on 1 July 1919. The first Minister of Health was none other than the Minister of Reconstruction himself, Dr (later Viscount) Christopher Addison, and the first permanent secretary of the new department was Sir Robert Morant, a member of the Haldane committee and chairman of the English NHI Commission. In its report, the Haldane committee had put great emphasis on the importance to departments of having advisory bodies 'to make available the knowledge and experience of all sections of the community affected by the activities of the Department', and it is therefore not surprising that an early step by the Minister of Health was the appointment of the consultative council on medical and allied services with fifteen medical and five non-medical members under the chairmanship of the future Lord Dawson of Penn. In October 1919 they were invited by the minister 'to consider and make recommendations as to the scheme or 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'. With remarkable despatch they published their proposals, in what they called an 'interim report' by May 1920.[38]

What they had produced was, in fact, nothing less than the outline of a national health service; and in doing so they laid down the main principles and raised the main issues which governed the pattern of discussion for nearly thirty years. Their starting-point was that the growth of medical knowledge and the complexity of the resulting measures necessary to ensure health made it essential to provide a new

and extended organisation for the purpose. They regarded the domiciliary services—general practitioner, pharmacist, nurse, midwife, health visitor—as the bedrock, but on the grounds of efficiency and cost urged that institutional care was also required to cover the span of services necessary. They emphasised the importance of preventive medicine as well as curative (they put great stress on 'physical culture' for all), and saw both as being provided by the general practitioner in the first instance. Finally, they insisted that the services must be available to everyone, though not necessarily free of charge.

The pattern of provision proposed was fivefold—domiciliary services, primary health centres, secondary health centres, 'supplementary services' and teaching hospitals (that is, hospitals with medical schools attached). The domiciliary services, including 'communal' services such as maternity and child welfare, school health, tuberculosis, venereal disease and physical culture, would be based on the primary health centre, which was conceived as a cottage hospital with these and additional functions such as consultant outpatient clinics, a dental surgery, an ambulance station, residential accommodation for nurses and midwives working 'on the district' as well as those staffing the hospital, and a doctors' common room. General practitioners would normally continue to practise from surgeries at their own homes, but might if they wished be provided with surgery accommodation at a primary health centre by the local authority; and 'collective surgeries' were encouraged on an experimental basis (whether these were intended to be group practices is not clear). Secondary health centres corresponded with what have now come to be called 'district general hospitals', that is to say, larger units in selected towns staffed by consultants and specialists to whom the general practitioners would refer patients from their own homes or from the primary centres. There would be private wards where the consultants could admit and charge their own patients, and public wards where a standard charge would be made. Consultants would be paid on a time basis for the proportion of their time spent on public patients, but pathologists, radiologists and 'communal services' officers (who would also be hospital-based) might be whole-timers. Consultants and specialists would be selected for appointment by a committee representing the hospital, the doctors of the area, the local health authority and the appropriate medical school.

The 'supplementary' services were those special services regarded as needing separate institutions, such as tuberculosis sanatoria, convalescent homes, mental hospitals, mental deficiency institutions, epileptic

colonies, orthopaedic centres and fever hospitals. At the apex of the system came the teaching hospitals with their medical schools, which would act as centres of reference for difficult and highly specialised treatment, and would spread their mantle of learning over the secondary centres in their sphere of influence. Teaching would be provided in 'communal services' (preventive medicine) no less than in curative work.

Certain other general conclusions were outlined. Voluntary hospitals they considered should continue and should receive grants for their contribution to the services. Research should be encouraged at all levels, fostered by the universities and the Medical Research Council. The service should have a uniform system of medical records in order to promote efficiency. Salaried whole-time practice (with rare exceptions) was condemned, as they saw it as tending to discourage initiative, to dimmish the sense of responsibility and to encourage mediocrity. On the other hand, free choice of doctor was regarded as essential. The local administration of the services they thought should be the responsibility of one health authority in each area (undefined), which might be either a statutory committee of a local authority or an *ad hoc* body. In either case, it should be representative of the medical profession, three-fifths of the members being elected by the people of the area and two-fifths being professionals with a majority of doctors. In addition, there should be in each area a local medical advisory council of ten to twenty members elected by the local doctors, with the principal (administrative) medical officer and his two chief assistants as *ex officio* members. The principal medical officer would be the administrative head of the service, and his two chief assistants would be responsible for curative and preventive services respectively.

This outline of a comprehensive health service left a number of loose ends, some of major importance. The report left entirely open how the cost of the service was to be met. Clearly, it assumed that domiciliary services would be paid for through an NHI scheme, which was, after all, only seven years old at the date of the report. Furthermore, it came down in favour of hospital charges (though some members favoured a free service) which it saw as being covered by some method of insurance also—a concept later embodied in hospital contributory schemes. No doubt it was assumed that 'communal' services (and perhaps dental care, too) would be free, being paid for by the local health authority, like the provision of physical culture, which was seen as a joint responsibility of the health and education authorities in each area. The nature of the

local health authority was also left somewhat in the air, but there was no sign of the hostility to local government control which was such a prominent bogy to the medical profession later on. Central administration was not mentioned, as it was presumably taken for granted that the newly created Ministry of Health would carry that burden, and indeed that it would take it up in the near future.

There is a very real sense in which the story of the making of the NHS is the story of the long-delayed implementation of the Dawson report, for that report covered almost the whole ground and laid down a pattern of services which was adopted almost unchanged after a lapse of more than a quarter of a century. At the time, 1920, no such delay was foreseen. It is some measure of the post-war euphoria—making the country 'fit for heroes to live in'—that the report when published carried a brief statement by the Minister of Health holding out the prospect of early legislation on the proposals and on the related reform of the poor law. In fact, of course, neither took place; nor did the consultative council ever produce a final report on medical and allied services to follow up its interim one. It has been said* that the conclusions of the interim report carried little weight because they were opposed by a substantial body of opinion on the council, and the production of the report was rushed so that the dissidents were prevented from expressing their opposition or reservations. Whether or not this is so, the short outburst of post-war optimism was abruptly ended by the economic and social turmoil of 1920 and 1921. Development of a comprehensive health service was out of the question; reductions in expenditure were considered essential. By February 1921, the Ministry of Health had sent a circular to local authorities (circular 182) urging on them the need for 'rigid economy of public resources', and a few months later the Geddes economy axe began to swing, one of its first blows being to reduce the staff of the ministry itself by more than one-third (from about 6500 to just over 4000). The economic climate was one in which no new service could have come into being.

Quite apart from the blow dealt by the economy drive, a second severe blow to progress was the sudden death of Sir Robert Morant in March 1920. He was a most remarkable man, a legend among administrators even in his lifetime, a man of vision and boundless energy, always ready to seize the opportunity when it offered and to create it when it did not. There exists in the Public Record Office a memorandum unsigned and

* By Sir Edward Forber, PRO MH 80/24

undated which sets out what were believed to be his plans for the future of the health services.* First came their separation from the poor law, and their unification in the hands of the county and county borough councils acting through a health committee composed in part of co-opted experts (an element he regarded as very important). He was hostile to the idea of *ad hoc* health authorities, as he considered they would concentrate on treatment to the detriment of prevention (an accusation often levelled at the NHS itself), and prevention—sanitation, housing, safety of food—was a local authority job. Secondly, he envisaged the unification of the hospital services, again in the hands of the counties and county boroughs but with joint provision seen as necessary in some areas. The voluntary hospitals he saw as doomed. Thirdly, he wanted domiciliary services available to all, based on a better remunerated general practitioner working from a clinic where the doctor could meet and discuss problems with his peers as a form of continuing medical education, supported by a public nursing service. He planned also for improved midwifery services as a career for women; for a public dental service with a higher status for dentists; for psychiatric hospitals very different from the traditional asylums and including separate units for early cases; and for the development of medical research as a separate career. (He was the creator of the Medical Research Committee—the precursor of the MRC—when chairman of the Royal Commission on National Health Insurance, and it has been said that he found Sir Walter Fletcher to be its first secretary; but he deliberately transferred responsibility from the Ministry of Health to the Privy Council in order to provide the widest possible basis for the council's field of operation, not limited to England and Wales.)

As early practical propositions, all these plans for the health services died with Morant. But even if he had lived, with all his drive and clear-sightedness, it is doubtful whether things would have been very different; the government and its successors were too set on retrenchment for any development to be undertaken.

The Cave committee

There was, however, one field in which action of some kind could not be avoided. The voluntary hospitals, which provided nearly all the facilities for acute medical and surgical care in the country, had been hard hit by

* PRO MH 79/377

the war (as was to happen again in World War II). Income, consisting largely of voluntary gifts and legacies, had risen since 1913 by 67 per cent, but costs had risen by 138 per cent, so that most of the hospitals—including the major London teaching hospitals—were running large deficits. The Minister of Health, therefore, appointed a committee of enquiry under Lord Cave in January 1921 to consider the financial position of voluntary hospitals and to make recommendations for action to assist them. As expected, the committee found that 321 of the 565 hospitals making returns in England and Wales had deficiencies on normal income.[43] The London Hospital and King's College Hospital had already had to close beds, and an overall deficiency of £1 million was forecast for 1921, not allowing for any necessary improvements and extensions.

Financial help from public funds was therefore essential, but in the committee's view it should be strictly limited and temporary because continuing support would be likely to undermine the voluntary system. To this system the committee attached the greatest importance. It considered that public provision of hospitals would be more expensive because it would be necessary to pay medical staff in full and voluntary contributions would cease. Voluntary service on governing bodies and in other ways would also be lost, as would the personal relation between patient and doctor and nurse which, the committee alleged, 'would be difficult to reproduce under an official régime'. Finally, the voluntary hospitals were regarded as the most important centres of medical teaching and research. For all these reasons the committee recommended a financial subvention for not more than two years amounting to £1 million in 1921 and a possible further grant in 1922. In addition, grants up to a total of £¼ million should be available on a £1 for £1 basis towards the capital costs of improvements and extensions. These monies were to be administered by a specially appointed representative hospitals commission at the centre, with a local voluntary hospitals committee in each county or county borough to advise on grants and to coordinate voluntary hospitals and poor law infirmaries in the area. Voluntary hospitals were to be encouraged to adopt proper accounting systems and cost accounting, to undertake cooperative buying and to provide convalescent hospitals on the outskirts of big towns. They should also systematise their appeals for funds and, in particular, they should develop contributory schemes of weekly payments by wage-earners to which employers should contribute. Payment by patients should also be encouraged, but not the provision of private beds.

The committee's recommendations were accepted by the government in principle, and a commission was set up with Lord Onslow as chairman to carry them out, but the proposal for capital grants was rejected and the maintenance grant was reduced to £½ million. In practice, this proved to be enough. Voluntary hospitals' income recovered more rapidly than had been expected by the Cave committee, and their finances were largely transformed by the growth of contributory schemes. But there remained a problem of financing additional accommodation, and in 1924 the Onslow commission was asked to look into the need and the remedy. The commission concluded that 10 000 more beds were required,[42] and that State grants were necessary, which should be of up to 50 per cent of the capital cost with a maximum of £400 a bed.[41] This recommendation was rejected by the government in 1926, and no grant was given.

Almost equal lack of success attended the efforts of the commission to promote the local coordination of hospitals and their management efficiency on the lines proposed by the Cave committee. In only a handful of areas did any kind of continuing coordinating body emerge, and their influence was small. The proud independence of the individual hospital was too strong (only two-thirds of the 845 voluntary hospitals in England and Wales, with a total of 44 000 beds, had bothered to make returns to the Cave committee at the outset). Even by 1937, when another commission set up by the British Hospitals Association with Lord Sankey as chairman reported,[10] pleas were still needed to promote regional coordination of effort, uniform accounting, grouping of hospitals into a service pattern, reciprocity of contributory schemes, and so on—pleas which, once again, fell mainly on deaf ears.

One ear, however, was not deaf—that of Lord Nuffield. Persuaded of the vital importance of hospital cooperation, and stimulated by (Sir) William Goodenough (of Oxford and Barclay's Bank) and Walter Hyde (an Oxford alderman), he came forward in 1939 to found and endow the Nuffield Provincial Hospitals Trust, whose remit was to promote the local and regional coordination of hospital services. In addition to the recommendations of the BHA commission, the idea of the trust derived from the example of King Edward's Hospital Fund for London, and the influence of hospital developments by local authorities under the Local Government Act 1929,[48] but particularly from the practical example of the Berks, Bucks and Oxon Regional Hospitals Council in coordinating hospital services in that area. Since the beginning of the century, the King's Fund had served as a coordinator of voluntary hospitals in

London by a judicious use of the carrot and the stick; the carrot being financial help with income or grants for capital expenditure directed in accordance with a considered policy, the stick being inspection by experts, both medical and non-medical, known as 'Visitors'. The fund walked delicately, and relied on persuasion and education rather than power, producing information designed to promote good and efficient management, such as comparative statistics, accounting systems and *ad hoc* reports on particular problems. It was this kind of coordinating supervision which the BHA commission hoped to see introduced among provincial voluntary hospitals, and which the Nuffield Trust sought to emulate. But the trust sought to go further: to develop the coordination of voluntary and local authority hospitals as well.

By this time, the hospital sections of the Local Government Act of 1929 were at last beginning to bear fruit. The Act's operation had, unluckily, been immediately followed by the economic crisis of 1931 and the depression, which had delayed its effective use. But now in a number of places public hospitals began to flourish, particularly as the 'poor law stigma' was wearing off. At once, the problems of cooperation between voluntary and public hospitals became more acute.

On several occasions since the 1914–18 war this question had surfaced, and had even led to some controversy. Neville Chamberlain as Minister of Health found himself, to his surprise, in very hot water when in October 1926 he suggested in a speech at Coventry that there ought to be closer cooperation between the voluntary hospitals and the public authorities, and that one way of developing it might be for each suitable area to have a 'central authority' for hospital policy on which the voluntary hospitals would be represented and from which they might receive grants while retaining their own independent management. *The Times* condemned the notion, declaring that 'the voluntary system is by far the best system of hospital administration which it is possible to devise'; and Chamberlain had to write to *The Times* to make clear his opposition to a State medical service provided by whole-time salaried doctors, while at the same time emphasising the urgent need to deal with hospital policy problems in each area as a single whole to avoid duplication and waste, and the dangers to the voluntary hospitals' future if they did not join any body set up for the purpose. A little later, the BHA naively enquired of the ministry what sort of cooperation might be undertaken, and the following suggestions were made for local consultation and discussion: allocation of patients to different hospitals by type of disease; demarcation of the functions of each hospital, and planning for

improvement or extension accordingly; sharing of resources, by vacant beds in local authority hospitals being made available to the voluntary ones; medical staffs of voluntary hospitals taking responsibility for beds or patients in local authority ones; and clearing houses for admissions to hospitals in an area.*

In October 1927 the matter surfaced again and on 15 October Chamberlain stated that, while progress was dependent on poor law reform (at last included in the legislative programme), the cooperation of voluntary and public hospitals was urgent, as evidenced by the thousands of beds empty in poor law hospitals and the long queues for admission to the voluntary hospitals. Once again, on 1 December, he had to make it clear in the House of Commons that he did not contemplate the voluntary hospitals coming under the control either of the State or of the local authorities, but he urged the need for consultations locally in order to arrive at an agreed plan for hospital provision in each area. *The Times* returned to the attack on 2 December, and accused Chamberlain of 'ambiguous language' and of having a plan (or 'ideas') up his sleeve. In extravagant language, *The Times* expressed its wholehearted support for the voluntary hospitals, and disparaged the development of poor law hospitals except under voluntary hospital auspices. The chairman of Charing Cross Hospital was even more outspoken.†

In the next year came the introduction of the Local Government Bill, one of whose principal objects was to secure the transfer of responsibility for public hospitals from the poor law authorities to the public health authorities on the lines proposed by the minority report of the royal commission nineteen years before. The royal colleges had views on this matter, which they conveyed to Chamberlain in November 1928. For the physicians, Sir John Rose Bradford pressed the need for those responsible for public hospitals to include voluntary hospital experts. Lord Moynihan, for the surgeons, deplored the low standards of poor law hospitals (due in his view to the outdated medical superintendent system), and urged that they should be staffed like voluntary hospitals, and general practitioners given laboratory facilities and contacts with them. Lord Dawson suggested that public assistance committees (the new poor law committees) should include coopted voluntary hospital

* PRO MH 58/160

† PRO MH 79/512

experts, that the PACs should be required to have a hospital subcommittee and to include voluntary hospital people on it, and that committees should be appointed to cover larger areas (such as those of the ministry's poor law inspectors) to study overall policy and to be composed of representatives of the voluntary hospitals, the local authorities, the general practitioners and the university. In addition, he proposed that hospital staff appointments should be made by a special appointments board. Neville Chamberlain replied that the Bill could not impose cooption but only permit it (which it did), and all the rest must depend on administrative action.*

One requirement the Local Government Act imposed, by Section 13, was that the local authority must, before providing hospital accommodation, consult representatives of the voluntary hospitals and their medical staff serving the area. The hope was that this would develop into the sort of standing coordinating body of which Chamberlain had spoken in the past. In a few places it did—in 1937 such bodies existed, with varying degrees of effectiveness, in Birmingham, Bristol, Liverpool, Manchester, Newcastle, Oxford and Sheffield.† Elsewhere, consultation took place—by November 1933 more than half the county and county borough councils had had formal consultations, and another quarter were cooperating.‡ But no one could regard the general position as satisfactory. The voluntary side continued to look down on the local authority hospitals with their poor law associations, and to develop independently (they did not have to consult the local authorities before doing so); the local authorities regarded themselves as providing most of the hospital services (which in terms of numbers of beds they did) including all the long-stay care. They disliked having chronically sick patients transferred from the voluntary hospitals, and objected strongly to the lack of reciprocity over consultation about development. They also greatly resented the fact that voluntary hospitals could pick and choose whom to admit, while they as public authorities were obliged to admit anyone in need of care.

As a result, the climate in many areas—notably London—was not so much that of cooperation as of cold war. It is, therefore, not surprising

* PRO MH 58/162

† PRO MH 58/314

‡ PRO MH 58/209

that in April 1938 the Ministry of Health's medical advisory committee, consisting of nine leading doctors with the chief medical officer in the chair, urged the issue of a circular to local authorities which would press them to develop cooperation with voluntary hospitals through joint boards or otherwise, to use their powers under the Local Government and Public Health Acts to coopt doctors on committees and subcommittees, to employ general practitioners part-time for maternity and child welfare and other services, and to consult medical advisory committees elected by the doctors of the area. The circular reached proof stage by August, but the Munich crisis killed it.

Health services before 1939

Hospitals were by no means the only local authority health service developed between the two wars. Just as the Second Boer War had given rise to the school medical service, so World War I gave a strong impetus both to the growth of maternity and child welfare and also to the provision of venereal disease clinics at public expense. The Public Health (Tuberculosis) Act of 1921[56] required county and county borough councils to provide a service of outpatient and inpatient treatment of tuberculosis for all. The Mental Treatment Act of 1930[49] substituted 'hospital' for 'asylum', and 'mental patient' for 'lunatic' and encouraged voluntary treatment as an alternative to certification—the first steps towards modern psychiatry for many years. The Midwives Act of 1936[50] required the responsible local authorities to provide an adequate home midwifery service for their areas. And the Cancer Act of 1939[45] similarly required the provision of special centres for radiological treatment of cancer, but the outbreak of war prevented its operation. Reform touched even the poor law district medical service where, in some places, the salaried officer was replaced by a panel of local general practitioners, paid by capitation fee, among whom the poor law patients had free choice.

This movement from salaried poor law medical officers to general practitioners was an example of the change for which the BMA was pressing in relation to several of the local authority services. Antenatal and postnatal care, child welfare, the inspection and treatment of schoolchildren, and tuberculosis outpatient treatment had all developed on the basis of salaried whole-time staff working from clinics provided by the local authority. Each was regarded by the BMA as an encroachment on the province of the general practitioner (and to some extent of the

specialist also), and the desire to defend his position was, in part, the origin of the proposals for a general medical service for the nation, first produced by the BMA in August 1930 and in a slightly revised form in November 1938.* There were more altruistic motives also at work—the BMA had demonstrated its public spirit in its reports on nutrition (1933), fractures (1935) and physical education (1936)—and these it now followed up with a comprehensive plan for the development of health services as a whole.

The first principle laid down was the importance of 'positive health' and the prevention of disease no less than the relief of sickness—housing, nutrition, physical education and health education were quoted as examples. The second principle was the availability of a general practitioner of his choice for every person. The third was the availability, normally through the general practitioner, of consultant and specialist services, laboratory and other auxiliary services, and institutional care. And the fourth was the coordination and development of the service through a planned national policy with a statutory requirement for local authorities to consult the profession.

General practitioner services were seen as being provided by the extension of the NHI scheme to cover all persons with incomes of less than £250 a year and their dependants, including the self-employed, those over 70, poor law patients and dependants of members of the armed forces. Dental and ophthalmic services should be available on the same basis, and consultant services (including radiological and pathological examination) also, normally in the consulting room or the patient's home. Representative local medical bodies were to decide eligibility to go on the list of consultants, with an appeal to a central professional body. Maternity care should be the responsibility of the general practitioner, calling in the consultant if required, with a midwife as maternity nurse. Hospital beds should so far as possible be under the control of the general practitioner, with laboratory and ambulance services and home helps available. The hospital service was to be based on the closest cooperation between voluntary and local authority hospitals, and planned regionally with a teaching hospital or similar large hospital with specialist units as the focus. Other hospitals would be grouped round it and integrated with it, including general practitioner hospitals. Hospital medical staff should normally be part-timers en-

* *The British Medical Association's Proposals for a General Medical Service for the Nation.* A BMA pamphlet, 1938.

gaged also in private practice with pay beds at their disposal, and all should be paid for their public work. The public health work of local authorities would continue so far as environmental services, epidemiology, nutrition and physical education were concerned, but antenatal and postnatal clinics and the treatment of schoolchildren through the school medical service would no longer be required. On the other hand, inspection of schoolchildren would continue, as would tuberculosis and venereal disease services, and child welfare centres as places of educational and social work.

Administration, centrally and locally, should be unified. At the centre this was seen as already largely existing in the Ministry of Health, but locally reform was needed. Responsibility should be placed on county and county borough councils and district councils with minimum populations of 75 000 in rural areas and 100 000 in urban, with a regional body for hospital services. There should be a statutory committee including medical members for each authority, and local administration of the NHI elements of the service should be in the hands of a body like the NHI committee. There should also be recognised central and local medical advisory bodies, with the medical officer of health as the administrative head, chief adviser and liaison officer with the local medical profession.

The resemblances between these proposals and those of the Dawson report of 1920 are very close. Although during the eighteen years which separated the two reports there had been growth and development, the pattern of services had changed little and their coordination was as far removed as ever. As the Political and Economic Planning report on the British health services put it in 1937, 'a bewildering variety of agencies, official and unofficial, have been created during the past two or three generations to work for health mainly by attacking specific diseases and disabilities as they occur . . .'[96] It is therefore scarcely surprising that the BMA in 1938 should be prescribing much the same remedies as were recommended by the medical experts of the immediate post-war period.

From another angle, light is shed on the state of services in 1939 by a report produced in 1943 by the Hospital Almoners Association in connection with the surveys of hospital services then in progress.* It constitutes a formidable exposure of the deficiencies of those services. The south of the country was seen as better off than the north, and town than country, but almost everywhere conditions were poor. There was a

* PRO MH 77/18

shortage of beds in voluntary hospitals but little cooperation with the local authority ones. Outpatient clinics hardly existed in the latter, and in rural areas they were generally absent. Specialist services for children were lacking outside London and a few large towns. Facilities for treatment of venereal diseases were inadequate outside London, Leeds and Birmingham. Deep x-ray units for cancer treatment were patchily available. And there was a shortage of orthopaedic surgeons to treat fractures. The needs were legion: more occupational therapy, hearing aid clinics, speech therapy, child guidance centres, psychiatric units attached to general hospitals, more tuberculosis beds, proper dental treatment, more maternity beds, full home help services, nurseries for children. The care of the chronic and aged sick was stigmatised as 'a national disgrace'. Other problems were the inadequacy of transport and of convalescent accommodation; the reluctance of the non-insured to call in the doctor because of the cost, leading to late diagnosis and treatment, and of the insured to report sick because of the low level of sickness benefit; and the obstacle to treatment in local authority hospitals presented by the 'law of settlement'.* The time for change was only too obviously over-ripe.

Preparing for World War II

But change was at hand, at least for the hospitals. War was clearly approaching, and the belief given expression by Stanley Baldwin that 'the bomber will always get through', together with the known casualty rates suffered from bombing in the Spanish civil war, led to an expectation of substantial numbers of air-raid victims who would need urgent treatment. Early in 1938, a rapid assessment was made of the beds which might be made available. This was the first survey of hospitals undertaken in England and Wales since 1863, and it revealed some 78 000 beds in voluntary hospitals and 320 000 in local authority hospitals, including sick beds in public assistance institutions, of which 150 000 were in mental and mental deficiency institutions and 35 000 in isolation hospitals and tuberculosis sanatoria.†

* When a patient needing hospital treatment did not live in the local authority's area, that authority insisted upon payment by the local authority in whose area the patient lived. This 'law of settlement' led to endless argument about which was a patient's true area of residence.

† PRO MH 77/25

Planning began at once, and in June 1938 responsibility for casualty and base hospital services was transferred from the Home Office Air Raid Precautions Department to the Ministry of Health, followed by first aid and mobile units and ambulances in December. Advised by a committee chaired by Sir Charles Wilson (later, Lord Moran) the ministry embarked on the daunting task of allocating hospitals, both voluntary and local authority, to their wartime functions; upgrading selected public assistance institutions into surgical hospitals; building temporary wards and other units for thousands of beds; accumulating supplies of all kinds; recruiting medical and other staff; and organising a nation-wide system of evacuation and transfer of patients to meet the expected flow of casualties. (It quickly became obvious that it would be impossible to provide the numbers of beds and other facilities considered necessary by the air-raid experts, but the best was done that was possible—and, fortunately, the estimated numbers never were needed.)

The Emergency Hospital Scheme, as it was called—or the Emergency Medical Service, as it was also known—was organised on the basis that the existing authorities, voluntary or local government, continued to run their hospitals within a regional framework, but the ministry dictated what role each hospital should play. Doctors were appointed to act as hospital or group officers with powers to order the admission, transfer or discharge of patients as the pressure of events required. Other medical staff were enrolled and employed by the ministry, and posted to the hospitals to act on the instructions of the medical director-general of the service. The objective was to maintain a pool of empty beds immediately available for casualties in each large urban area ('casualty hospitals') by transferring other patients to hospitals linked with them and located so far as possible outside the built-up areas ('base hospitals'). This was the 'sector system' which, in London, consisted of wedge-shaped areas radiating from the centre and based on the teaching hospitals. Regional 'special centres' were set up for the more highly specialised forms of treatment (fractures, plastic surgery, burns), and consultant advisers—leaders in their specialty—employed regionally for consultation by hospital medical staffs. Treatment was influenced not only by the issue of clinical guidance but also by the huge expansion of pathology, blood transfusion, pharmacy and rehabilitation services.

As the war went on and social circumstances changed, what had been a service originally designed for civilian casualties and the sick and wounded members of the armed forces became almost a national service, covering the sick of all kinds transferred from inner city hospitals,

unaccompanied evacuated children, civil defence workers, transferred war workers, seamen, other evacuees, industrial fracture patients and so on. The ministry also found itself compelled to become involved in the salaries of nursing staff and others, with the accommodation provided for resident staff, with laundry services and with catering facilities. In the end, what emerged was a single integrated regionalised hospital service under close central supervision through local officers responsible to headquarters, an addition of some 80 000 beds and considerable facilities and equipment of all kinds, and a large ambulance transport fleet. Furthermore, hospital consultants and specialists who previously had been 'honoraries' at voluntary hospitals had become accustomed to fixed, if modest, part-time salaries. A greater contrast with the pre-war hospital scene could scarcely be imagined.*

Outside the hospital world, the picture of the health services in the early part of the war differed little from that of twenty years earlier. The NHI scheme was still restricted in scope to general practitioner treatment, and although the income limit for insured persons was raised from £250 to £420 at the beginning of 1942, dependants were still excluded. Under the poor law, the district medical service continued, coming under increasing strain with the evacuation of so many children and non-insured adults, and tending to grow on a 'panel' basis. Poor law infirmaries and institutions still catered for many, especially the chronic sick and long-stay patients, though increasingly they were being transferred to public health administration and upgraded, reaching a high standard in a few areas such as London, Middlesex, Surrey, Liverpool and Birmingham. Other local authority services had grown considerably in volume and variety—antenatal and postnatal clincs, child welfare centres, tuberculosis dispensaries, health visiting, home midwives, even a few home nurses and home helps—often in partnership with some local voluntary body. But the salient features were still unevenness of quality, gaps in provision and almost complete lack of coordination apart from the framework imposed on the hospitals by the EHS. There remained a long way to go to reach anything like the comprehensive service envisaged by the Dawson report.

* PRO CAB 117/211

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Planning for reconstruction: 1939–42

The Ministry of Reconstruction did not emerge during World War I until its third year was nearly past; in World War II there was no such ministry, but planning for the post-war future began within a year of its outbreak, when in May 1940 Arthur Greenwood, as Minister without Portfolio in the War Cabinet, was given responsibility for a Reconstruction Problems Committee with a small staff. Even as early as the first months of the war, a group of senior officers of the Ministry of Health was working on ideas for the shape of post-war health services. Earlier still, when Walter Elliot became minister in the latter part of 1938, an internal Office Policy Committee had seen as the next developments the extension of National Health Insurance by covering dependants and by including the provision of consultation and specialist services; a statutory dental benefit; cancer treatment (adopted in the 1939 Cancer Act[45]); a home nursing service; and a statutory duty on local authorities to fill gaps in the hospital services on the advice of regional coordinating committees representative of the voluntary hospitals as well as of the local authorities.*

Now, however, other concepts were canvassed. In the first month of the war, Walter Elliot raised the question whether the Emergency Hospital Scheme should not be turned into a permanent State hospital service. So bold a notion led the permanent heads of the ministry to consult the experience and wisdom of Sir Edward Forber, who had recently retired as chairman of the Board of Inland Revenue but had been deputy secretary of the Ministry of Health for some years. He took

* PRO MH 79/409

the view that the minister's idea was a non-starter, at any rate at that time. The regionalisation of the hospitals brought about by the war for casualty purposes seemed to him irrelevant to a peace-time service; and he thought that any hospital service plan must depend on, and be geared to, the future organisation of medical services as a whole. His solution, outlined in May 1940, was therefore some form of enquiry into the priorities for developments in health services of all kinds.* But this, too, was regarded by the ministry as a non-starter in wartime, and attention concentrated on the hospitals.

These were first on the programme for two main reasons. The first was the state of voluntary hospital finances. As early as March 1938, Sir Frederick Menzies, chief medical officer of London County Council, had raised privately with the minister (then Sir Kingsley Wood) his fears about the financial position of some of the teaching hospitals in London. In May, Menzies, with Herbert Eason, medical superintendent of Guy's Hospital and principal of London University, from the voluntary side, met the permanent secretary, Sir George Chrystal, and the chief medical officer of the department, Sir Arthur MacNalty, to explore the situation. It was said that King's College Hospital had already appealed to the LCC for financial help, that Guy's Hospital was in danger and that St Thomas' Hospital and the Middlesex Hospital were in difficulties. The suggestion made by Eason was that the LCC might help by paying the voluntary hospitals for their treatment of London patients. This was regarded as a possibility in relation to the teaching hospitals, but Menzies would not countenance payments to the voluntary non-teaching hospitals in London.

Further meetings of officers with the King's Fund, the London Voluntary Hospitals Committee and others, indicated that the position was not as serious as at first suggested, but that the teaching hospitals were handicapped by the 'excess' costs arising out of their teaching function which were not properly the financial responsibility of the medical school, such as heavier staffing requirements, more expensive supplies and equipment, bigger space. Accordingly, a meeting was arranged to consider possibilities, with Chrystal in the chair, attended by representatives of the King's Fund and the London voluntary hospitals on one side and the LCC—including Herbert Morrison—on the other. The former said that the annual deficiency of the voluntary hospitals was about £300 000 a year, excluding capital works, and might

* PRO MH 80/24

be increased following the Athlone committee's recommendations on nursing.[31] A solution would be a payment for 'in-county' patients by the LCC. Lord Dawson urged the appointment of a joint voluntary–LCC advisory board on hospital policy and functions in London, with grants to voluntary hospitals on the advice of the board. Herbert Morrison was not disposed to be helpful. He pleaded that the LCC was in financial difficulties itself, and held out no hope of grants or payments for patients. He thought there was room for joint organisation and action among the voluntary hospitals themselves. Were all of them economic units? Perhaps there should be a survey, and the King's Fund should make grants only to those units which were efficient, and the others should be closed. He undertook to report back to the LCC; but on 10 March 1939 its hospital and medical services committee formally decided to take no action.

If the finances of voluntary hospitals were shaky before the war, the war rendered them precarious. Not only were costs in general going up, there were also special factors at work. The demands made on them by the EHS constituted one obvious additional burden. Another was the necessity of meeting some, at least, of the recommendations of the Athlone committee. This inter-departmental enquiry into nursing conditions, reporting in December 1938, had produced some sweeping proposals for national salary scales at higher rates, a maximum 96-hour fortnight, four weeks' annual leave, improved living conditions and reforms in training. The committee also suggested grants to voluntary hospitals to help them meet the cost of the additional staff and other expenditure involved, and these were in due course made from the Exchequer and distributed through the British Hospitals Association. While this expense was falling on the voluntary hospitals, the income from pre-war sources was dropping—gifts and contributory scheme payments were down. It is true that the EHS constituted not only a burden but also a welcome and steady source of support, paying for beds kept empty to receive casualties as well as for services provided; indeed it was profitable to keep beds empty and turn away ordinary civilian patients who needed admission until the financial arrangements were changed. But clearly a time would come when these sources of funds would become a trickle, and would eventually dry up altogether, and then the voluntary hospitals would be in Queer Street. Planning for after the war was vital to their survival.

The second reason for early thinking about hospitals was the activity of the Nuffield Provincial Hospitals Trust. After informal exchanges with

the then minister, Walter Elliot, Lord Nuffield wrote formally on 5 December 1939 to tell him of his gift of one million shares in Morris Motors (estimated to produce an income of £115 000 a year) for the purpose of financing a trust to encourage regionalisation in the provinces—London was regarded as covered by the King's Fund—on the lines of the Berks, Bucks and Oxon Regional Hospitals Council. The trust was duly set up, and met for the first time on 6 March 1940 with Walter Hyde as secretary. A regionalisation committee was appointed with the task of covering the whole country with regional and divisional (subregional) councils representative of hospitals of both categories, and also a distinguished medical advisory committee with Sir Farquhar Buzzard, the Oxford Regius Professor of Medicine, in the chair. Successive ministers of health—first Malcolm Macdonald and then Ernest Brown—gave their blessing to the undertaking, and the ministry's chief medical officer, Sir Wilson Jameson, served on the medical advisory committee. Walter Hyde, supported by Sir Farquhar Buzzard, was untiring in travelling the country to stimulate action, so appreciable progress had been made by the middle of 1941. The concept of a regional element in the hospital service of the future was becoming widely accepted.

Post-war hospital policy

The first meeting of officers of the ministry to consider post-war hospital policy took place on 7 December 1940. Various possibilities were canvassed at this time, including that of regional health boards with executive powers, to be part elected and part appointed, and to work through local committees; and regional hospital councils to take over all local authority and voluntary hospitals.* But the views which held were more conventional. A ministry paper of January 1941 began with the assumptions that a new hospital policy would have to operate before there was any possibility of local government being reorganised on a regional basis; that the aim of an adequate hospital service for all could be realised only by laying a statutory duty on some authority to provide it; and that no government would want such a service to be administered by the minister direct or by a corporate body supervised by the minister. This left the major local authorities (that is, the county and county borough councils), or some kind of regional body appointed *ad hoc,* as the

* PRO MH 80/24

possible statutory units responsible for the hospital service. A regional body covering an area capable of being self-sufficient for services, and based on a teaching hospital with a medical school, would be needed to plan the service, but would probably be less efficient as manager of individual hospitals than the counties and county boroughs. It might, however, lay down rules for management, set standards for equipment, advise on senior medical appointments (and perhaps also of matrons), take part in Whitley Council negotiations on nursing salaries and undertake inspections.

The regional body's main task would be to draw up a scheme of hospital provision for the region using all the existing hospitals in consultation with their managers. The scheme would need the approval of the minister, or of a commission responsible to him, and when approved would be carried out by the local authorities and voluntary governors concerned. Efficient voluntary hospitals should be continued, and should be wholly within the service (apart perhaps from a few beds for paying patients) or wholly outside it. They would admit any patient needing treatment of a kind which the regional scheme provided for them to give, and would be paid by the local authority. In return they would have to accept inspection and supervision of standards. Patients would be charged for treatment, but insurance through hospital contributory schemes would be encouraged.

It was considered that the constitution of regional bodies, but not the boundaries of the regions, should be laid down in the necessary legislation, and that they might be made up of representatives of the counties and county boroughs, the voluntary hospitals, doctors, nurses, perhaps pharmacists, and insurance committees; but the local authorities should nominate not less than two-thirds of the membership because the statutory responsibility would be theirs.

A note of February 1941 by (Sir) Arthur Rucker suggested alternative possibilities—an elected regional health authority which would be responsible for all health services including general practitioners, who in urban areas would be whole-time salaried officers. The day-to-day hospital administration would be delegated to the local authorities and voluntary governors. Teaching hospitals would be given a special status, and perhaps financed through the University Grants Committee, but in general the regional health authority would precept on the local authorities—that is, impose a financial levy on them—and give grants in aid to individual counties and county boroughs and voluntary hospitals. Other revenue would come from health insurance, compulsory up to a

certain limit and voluntary for others, from costs recovered from the non-insured subject to a means test, and from the Exchequer.*

Sir John Wrigley, deputy secretary of the Ministry of Health, looked at the same problems from a different angle. He urged the importance of wide public participation in the running of the service as distinct from provision by an efficient centralised machine. Central government was rightly responsible for national cash benefits, where there was no place for a local representative body; but all health services should be provided by the county and county borough councils as a statutory duty, and should be available to all. It might in some areas be necessary for smaller counties or county boroughs to be combined in joint boards; and it would certainly be necessary to plan hospital services over a regional area which would include a teaching hospital. But the regional body should be small and advisory in character with inspectorial functions, having not more than six members selected for their knowledge and experience (including one or more 'customers'), and served on a part-time basis by an officer drawn from one of the authorities of the region without any team of subordinates. The regional body would be consulted by the minister before any grants were given to the local authorities.

This form of regional body was suggested on the argument that no kind of representative authority was likely to emerge on a basis wider than that of the county, and that an *ad hoc* elective regional health authority would be unlikely to generate any popular interest in the electorate. The financial foundation for the service needed more exploration. Recovery of costs after the event was ineffective, but the insurance contribution required to foot the bill was likely to be so high as to be a burden on the wage-earner, even with some monies coming from the Exchequer and some from local rates. And somehow the needs of the non-insured had to be met. For the future the probable trends seemed to be the salaried employment of general practitioners by local authorities, little private practice, payment of all hospital medical staff and the disappearance of the voluntary hospitals.

In August 1941, Sir John Maude, the permanent secretary since 1940, summarised the results of thinking so far.† Ideally, he would like to see all medical services reorganised simultaneously, but this was not likely

* PRO MH 77/25

† PRO MH 77/26

to be practicable. Therefore, the hospitals should be tackled first, not because they were most in need of reform but because a reversion to the pre-war hospital world would probably be impossible at the end of the war. He assumed that the existing local government structure would continue unchanged, that there would be little difference in general practice and that there would be no compulsory insurance to cover hospital treatment costs. All types of hospital should come into the service except mental illness and mental deficiency institutions, which did not need to be organised on a regional basis. Dental treatment in hospital should also be excluded because of the shortage of dentists and the possibility of treatment in the dentist's own surgery. The hospital services should be organised regionally with a regional body, which could not be elective (because no one would bother to vote) or chosen and appointed by the minister (because that did not accord with English tradition). It should therefore be nominated by the local authorities, voluntary hospitals, doctors, nurses and the university, with a chairman possibly appointed by the minister. For financial simplicity, it would be best for local authority hospitals to be owned by the regional body, but this would be strenuously opposed by the counties and county boroughs, especially if the voluntary hospitals were not taken over in the same way. Accordingly, the primary duty of the regional council would be to draw up a scheme for the provision by the counties, county boroughs and voluntary hospitals of hospital facilities adequate to meet all needs. The scheme would be drawn up in consultation with all parties, and subject to the approval of the minister; when approved it would be binding on all. Voluntary hospitals would be able to provide pay beds, but their main finances would come from public funds and the amount would depend on the size of their own resources. Reliance should be placed on voluntary contributory schemes, the proceeds to be paid into a regional pool, with charges and recovery of costs from non-contributors. There should be an Exchequer grant supplementing the 'block grant' paid under the Local Government Act 1929,[48] some of which would go to the regional council to cover their expenses and grants to special centres, and the remainder of the cost of the service would fall on the rates. Voluntary hospital income would probably dry up, but only gradually, and teaching hospitals should be helped through the UGC.

Up to this point, planning within the ministry had gone slowly, and only so far as more urgent preoccupations allowed. Suddenly, overt action of some kind became essential. On 12 August 1941, there appeared in the *Star* an attack on the voluntary hospitals by Lord

Latham, the leader of the LCC. He pointed out, quite accurately, that the major part of the hospital services was being provided by the local authority hospitals and not by the voluntaries, and from this drew the conclusion that any coordinated post-war service must be run through and under public control, that is, by the local authorities. He went on to accuse 'plotters' of aiming at a national board and regional boards which would be appointed and not elected bodies, and therefore undemocratic and not under public control. The right course was for a comprehensive health service to be provided to national standards by local authorities assisted by adequate Exchequer grants, and for the voluntary hospitals to come into the service on that footing if they wished to continue in existence.

Latham had, of course, two targets in mind. One was the voluntary hospitals and their spokesmen, but the other was the Nuffield Trust whose regionalisation activities, blessed as they were by the Minister of Health, were beginning to cause alarm in the breasts of other local authority members besides those of the LCC. Something must be done, and done quickly. Chrystal (who was by then secretary of the Reconstruction Office) wrote to Maude the day after the article appeared in the *Star*, asking for proposals about the future of the hospitals for consideration by his committee.* Maude replied that Latham's outburst was due to some action taken by the Nuffield Trust, from whom he expected to hear shortly; he would then be in a position to put forward fairly complete proposals. In fact, a draft parliamentary question and answer constituting a statement of policy was prepared and shown in strict confidence to representatives of the County Councils Association, the Association of Municipal Corporations, the LCC, the King's Fund, the BHA, the Nuffield Trust, the British Medical Association and the UGC. The LCC remained strongly opposed to a regional council (as proposed by the Nuffield Trust) in London, and suggested as an alternative a survey of hospitals in the London area by one or two medical officers to be appointed by the minister, their job being to draw up a plan for the future pattern of services without any regional committee. The idea of surveys commended itself to the other parties, so a revised draft was sent to Chrystal on 27 September. This was rapidly agreed by Arthur Greenwood, Kingsley Wood, Chancellor of the Exchequer, and Tom Johnston, Secretary of State for Scotland, and a

* PRO CAB 117/211

statement was made in the House of Commons by Ernest Brown on 9 October.[67]

Only three weeks before this statement on government policy, PEP had published a broadsheet urging the transformation of the EHS into a national hospital service coordinated by and through regional officers of the Ministry of Health. The ministerial statement made it quite clear that this was not the government's intention. Its solution was a comprehensive service making appropriate treatment readily available to all needing it, and provided by the voluntary and local authority hospitals in partnership, but with the county and county borough councils charged with the statutory duty of securing its provision. The service would be planned over areas substantially larger than those of individual local authorities, and highly specialised services would be based on a teaching hospital and other centres serving wider areas. Voluntary hospitals would be paid for the services they gave, and there would be Exchequer grants towards the cost of the service, including increased educational grants for the teaching hospitals. Further details were left for later discussion after surveys of hospitals had been undertaken to provide the information needed for planning. The first survey would cover London 'and the surrounding area', and the valuable work already done by the Nuffield Trust elsewhere would be fully used in any provincial surveys.

As might be expected, in view of the wide confidential consultations undertaken before it was made, the policy statement received a warm welcome both in supplementary questions immediately following it and in two debates, on 21 October 1941 and 21 April 1942. There were a few critical voices—Aneurin Bevan thought that the 'maintenance of voluntary hospitals and their subvention by public funds and flag-days [were] increasingly repugnant to the conscience of the public', and that the government's policy was therefore 'repugnant to every Labour minister on the bench—or ought to be'. Some other Labour members criticised the voluntary hospitals for their financial instability and undemocratic character. But in general the principles outlined were thought to be right, and there was readiness to await the result of the promised surveys before taking further action.

The beginning of the London survey was announced in the House of Commons on 2 December 1941,[68] with the appointment of (Sir) Archibald Gray and Dr Andrew Topping as the two surveyors. Gray was not only a distinguished dermatologist, and president of the Royal Society of Medicine, but also the former dean of University College

Medical School and of the faculty of medicine of the University of London. Topping was deputy medical officer of health and school medical officer of the county of London. They were charged with the task of surveying all the hospitals (except mental hospitals and mental deficiency institutions) in London and the surrounding area and, on the basis of this information and of the policy statement of 9 October, of advising what area should be served by a hospital system centred on London and what changes or improvements would be needed to make it effective. These terms of reference were later spelled out in more detail for the guidance of the surveyors in London and in the provinces.* The assumptions to be made were that the EHS would be wound up but that the accommodation and equipment provided by and for it would become available; that local authority and voluntary hospitals would remain in their existing ownership; and that the hospitals should be regarded as providing the services as they were in 1938. On this basis, the surveyors were to ascertain the types and amounts of accommodation, staff and equipment; to find out the flow of patients (and why they came to London hospitals); to recommend what facilities each hospital should provide, what was redundant and what more was needed, and where should facilities be located (for example, should bombed hospitals in central London be rebuilt elsewhere?); to define the area which should look to London for at least some types of specialised treatment; and to assess the hospital transport facilities and advise on the operation of the ambulance service. This was indeed a formidable task, involving the inspection of hundreds of hospitals and innumerable local discussions, and it is not surprising that it took until 1945 for the survey reports to appear.

One early consequence of the statement of policy and the launching of the London survey was a meeting of Maude and Wilson Jameson with representatives of the Nuffield Trust, the CCA and the AMC to try to decide the trust's future line of work, and to calm the fears of the local authorities about its activities. It was explained that there had been requests from the north-west (Lancashire, Cheshire and North Wales) for a survey, and the minister proposed to arrange it, but it would be increasingly difficult to find suitable surveyors. The trust's representatives were willing to finance surveys elsewhere in the country and to appoint surveyors in consultation with the ministry. It was agreed that this should be the line of advance, and that the trust's other activities

* PRO MH 77/22

should be suspended to await the findings of the surveys.* In March 1942, detailed arrangements for the trust's participation were hammered out. The trust wanted to include a non-medical administrator in each survey team, and this was agreed, though the two ministry teams were medical only. It was also accepted that the terms of reference, the guidance given to surveyors, and the questionnaires to be used should be the same for all the surveys; and that the surveyors should be approved by the ministry after consulting the BHA, the CCA and the AMC. At this time it was intended that the survey reports, which were to be made to the trust and transmitted to the minister with the trust's comments, should be confidential in order to allow frank comment and criticism, and that the minister should send suitably edited versions with his comments to the locally interested parties for their discussion and the production of proposals.† As things turned out, however, it was finally decided in April 1944, after publication of the White Paper on the National Health Service,[32] that all the reports should be published in full; and the London report—the first to appear—duly saw the light in April 1945.‡

Towards a comprehensive health service

While these developments were in progress on the hospital front, other steps were being taken by various parties towards planning a comprehensive health service. Within the ministry itself, exploration was going on of possible reforms of the general practitioner service. It was estimated that the insured population was 18.5 millions and that their dependants numbered 14.75 millions, the two together constituting 80 per cent of the total population; and that the total cost of providing medical benefit for dependants would be £9.5 millions, that is a contribution of just under 2½d (old pence) per week.§ An analysis of the idea of a salaried service threw up some interesting points. First, the growth of local authority services to meet specific needs (such as maternity and child welfare) not met by the general practitioner

* PRO MH 77/26

† PRO MH 77/19

‡ PRO MH 77/20

§ PRO MH 77/25

represented an encroachment on what he regarded as his domain and aroused his hostility. Secondly, the Cathcart committee's report of 1936 on the Scottish health services,[30] like the BMA, had rejected the notion of a salaried service, which, it thought, ruled out free choice of doctor, would militate against the 'family doctor' concept because of postings and promotions, and might be more expensive than the well-tried capitation fee system. All the desirable improvements—refresher courses for doctors, better supervision, greater efficiency—were, in its view, attainable without a salaried basis of service. Thirdly, although salaried employment was familiar and accepted in the public health and hospital worlds, there was no experience on which to build a salaried general practitioner service.

At the time of the opposition of the BMA to the NHI scheme in 1912–13, however, the NHI commission had had seriously to consider the possibility, and in doing so had arrived at certain principles. These were, first, that the doctor should be employed by the local insurance committee, not by the commission, in order to take account of local circumstances. (In 1941 terms, this might mean employment by the local hospital authority, which would be responsible for domiciliary services also, but salaries and terms of service would have to be nationally determined.) Secondly, it was regarded as impracticable to have a whole-time salaried service for insured persons only—the whole-time doctor could not be debarred from attending non-insured people, for example the family of the insured—and the whole population must therefore be covered. Thirdly, a part-time salaried service would be likely to result in the sacrifice of the insured to private patients and must therefore be rejected. The NHI commission's conclusion was that the aim must be a whole-time salaried service for the insured and their dependants, with doctors and assistant doctors and a superintendent for each suitable area. It looked for this service to be backed by clinics, laboratories and home nursing.*

How far these ideas were acceptable thirty years later it would be for subsequent discussions to reveal. At this stage, the BMA began its own explorations. In January 1941, it announced the setting up of a Medical Planning Commission, with the cooperation of the royal colleges, the Scottish Royal Corporations, the Society of Medical Officers of Health and one or two smaller bodies, to study the effect of war-time developments on the medical services present and future. The commission had

* PRO MH 77/26

upwards of seventy members, including leading figures such as Lord Dawson, (Lord) Moran from the Royal College of Physicians and (Lord) Webb-Johnson from the Royal College of Surgeons. At the first meeting on 7 May, Sir Henry Souttar, a consultant surgeon of The London Hospital, and then chairman of the council of the BMA, was elected chairman, and five committees were set up to study general practice, special practice, public health, hospitals and teaching hospitals, together with a coordinating committee consisting of the chairman of the commission and twenty members drawn from the five study committees.

From the outset, it came under criticism from some members of the profession, who conducted a brisk correspondence in the *BMJ* during 1941. The commission was considered unrepresentative (too many old men, too many consultants, not enough general practitioners, especially country doctors); its appointment was condemned as 'hole and corner'; it would lack the views of the younger men who were all away at the war. (To some extent, the last point was met by the independent exercise mounted by a group of under-forties who launched their own 'Medical Planning Research' in June 1941 and invited—and widely received—contributions from all sources, especially younger doctors.) The correspondence in the *BMJ* did not limit itself to the commission, but ranged over the whole question of a State medical service, by which was usually meant a whole-time salaried general practitioner service. This concept came in for heavy criticism on the usual grounds—the impracticability of free choice of doctor in a salaried service, the danger of bureaucratic interference with clinical freedom, the sapping of initiative and ambition; but rather more surprising, in the light of the profession's subsequent unrelenting hostility to the idea, was the volume of support for a salaried service. It was suggested that the receipt of a salary did not necessarily suppress initiative or ambition—witness the judiciary, the episcopate, leading politicians, government service, teaching, the armed forces, and most leaders in industry and business. Free choice of doctor was largely a fiction, since the vast majority of patients never changed their doctors and in any case had little or no means of judging the real quality of different practitioners. The buying and selling of practices was not only distasteful but also tied a load of debt round the neck of the entrant to the profession which took years to shed. Competition for patients led to a commercialism among doctors, and to professional isolation, whereas a salaried service would make for cooperation as well as providing security.

Some of these arguments are reflected in a comprehensive memorandum prepared in the ministry in March 1942 which formed the framework of official thinking on the subject for the next twelve months. This memorandum was shown unofficially to Dr George Anderson, the secretary of the BMA, and may indeed have had some influence on the conclusions of the BMA's Medical Planning Commission. It began by indicating that there was not the same urgency for change in this branch of the medical services as there was in the hospital service (a judgment modified later with a growing realisation of the need to meet the problems of the thousands of doctors who would be entering general practice for the first time or would have no surviving practice to go to on demobilisation at the end of the war). But it was argued that planning of the general practitioner service was essential because the Beveridge committee's report was likely to propose both the divorce of medical services from insurance and their wide extension to dependants and others; because the poor law would probably be abolished, raising the problem of some alternative to the district medical service for the medically destitute; and because sweeping changes might well be proposed by the BMA's Medical Planning Commission. It was assumed that the new service must cover the whole population—it would be possible to exclude those over some prescribed income limit, but this would be contrary to the whole philosophy of the public health (and education) services—but that private practice would continue on a small and probably diminishing scale and would be provided by doctors outside the public service.

On these assumptions, should the new arrangements be based on a panel system of the NHI type or on a whole-time salaried service? In favour of the panel system, it could be argued that competition stimulates effort and promotes a higher standard of practice; that it permits free choice of doctor by patient, and of patient by doctor, in a way that would be more difficult in a salaried system; that it preserves confidentiality which might be breached in a hierarchical service; and that it allows for partnerships and assistantships. On the other hand, a panel system resting on an unrestricted right of doctors to take part makes any kind of selection impossible, and removal almost impossible, even in cases of notorious unfitness to practise. Furthermore, the right to combine public and private practice makes it impossible to ensure the proper care of public patients; there is little or no supervision of the quality of the doctor's work; competition leads to wasteful prescribing and lax certification; the employment of assistants could be abused; and

sale of practices (which, incidentally, demonstrates that free choice of doctor is theoretical rather than real) is objectionable on the grounds that it enables an inexperienced young doctor to take on a large practice but at the same time saddles him with a load of debt. Other disadvantages of a competitive panel system are that it hinders team practice and cooperation and is difficult to improve—business partnerships do not constitute a base stable enough for providing the scientific facilities and equipment needed for good work—and that the reputation of public practice is lowered by the existence of two classes of practice. Again, a panel system covering the whole population would involve either low remuneration for all doctors, including the senior experienced practitioner, or high incomes even for juniors without experience, and there would be no improvement in remuneration as service lengthened and experience grew. Payment for treating patients (the item of service basis) was considered impracticable, on the grounds that it would defeat the principal object of the service—that is, to encourage early diagnosis and treatment. In any case, certification for sickness benefits made free access to the doctor essential. The conclusion must be that the general practitioner service should be on a whole-time salaried basis.

An estimate was made of the cost of such a service. It was proposed that surgery premises and supporting staff should be available at publicly provided clinics where five or six doctors would be based, with a ratio of one doctor to 2000 persons; home nursing and dental treatment would be included, and drugs, medicines and some appliances supplied. Thirty per cent of the medical staff would receive salaries of £1300 a year and the remainder £800, together with a non-contributory pensions scheme. The total cost of the service was estimated at £35 millions.

The administration of the service should rest with local government—a professional corporation was out of the question for a service financed from rates and taxes, because it must be answerable to some elected body. This base was to be found in local authorities, which had also the advantage of already administering the other health services. But the disadvantages were that many of the authorities covered areas too small to constitute an adequate unit; a single service rather than a number of local services would be more attractive to the profession which would, in any case, insist on national scales of remuneration and terms of service; and the intimacy and confidentiality of medical care made administration by local authority committees inappropriate. Moreover, it would not be possible for dismissal to be the responsibility of the local authority, because the profession would be strongly opposed; yet

selection, promotion and discipline ought all to be in the hands of the employer. Some alternative to local government employment must be found.

A possible solution might be this. The minister would be responsible to Parliament for the general supervision of the service, but the central administration would be in the hands of a central medical board of ten members, mostly medical, appointed by the minister after consultation with the BMA, the CCA and the AMC. The board would advise the minister on questions of remuneration and other major terms of service, would select entrants to the public service and seek to ensure their employment (for this purpose, also controlling the intake to medical schools to avoid excess production) and would remove employees from the service. The local authorities, grouped to form units providing for not less than 200 000 population, would engage doctors for practice in their areas, and would be able to terminate their employment at six months' notice. But this would not exclude the doctor from the service; the board would seek other employment for him, with 'unemployment pay' while he was without a post. The board would be responsible for arranging refresher training, employ an inspectorate and referees with regard to certification, and play some part in promotions. Local authorities would be required to set up public medical service committees or subcommittees, which would include medical members.

BMA Medical Planning Commission

Meanwhile, the BMA Medical Planning Commission had been active, and in May 1942 it produced its draft interim report.[76] This, it was at pains to make clear, did not represent the conclusions of the commission, only tentative recommendations which it would consider further when the profession had made its reactions known. (In fact, like the so-called 'interim' Dawson report of 1920, it was the only one produced.) It saw the objects of a medical service as being to provide not only the relief of sickness but also the achievement of 'positive health' and the prevention of disease; and to make available to everyone all necessary services, both general and specialist, and both domiciliary and institutional. For these purposes, it proposed as a long-term plan new central machinery in the form of a government department or corporate body responsible to a minister for all civilian medical services, including industrial health and the care of war pensioners, with a medical adivsory committee. New local machinery should consist either of local authorities within a

reorganised local government ('regional authorities') with normally a minimum population of half a million, delegating the administration of health services to a committee which would include medical members and have alongside it a medical advisory committee, or of new regional councils responsible for the health services and made up of representatives of the local authorities, voluntary hospitals and the medical profession. General practice in the future it saw as being group practice from health centres established by the government or otherwise, where preventive and curative work would be concentrated. This bore some resemblance to the 'primary' health centres proposed by Dawson in 1920, but did not—as his proposals did—provide a link between hospital and general practice by the inclusion of a few beds and consultant clinics. General practitioners would be remunerated on a part-time salaried basis, but with a variable element depending on the number of their patients, and retirement and widows' pensions would be paid. The sale of practices would cease, with compensation for loss of capital values. Hospitals would be unified under a regional body, and consultants would be employed whole-time or part-time (mainly the latter) on a salaried basis.

All this the commission saw as a long-term process. For the immediate post-war period, it proposed the extension of NHI medical benefit to dependants and other persons in the same income groups, with the inclusion of consultant and specialist services, some experiments in group practice, and the creation of regional hospital councils for each 'natural' hospital area, consisting of nominees of the central authority, the major local authorities, the voluntary hospitals and the doctors. These councils, which might have executive as well as advisory functions, would plan the pattern of hospital services for their areas and advise what role each agency should play; and they should, of course, have an advisory medical committee.

Having outlined these long-term and short-term proposals, the commission posed a series of questions to the profession. Did the doctors agree with the objects of a medical service as stated? Should free choice of doctor and patient be an essential feature? Should group practice be a part of a future service? Should the service cover the whole population (the '100 per cent principle') or only a part, and, if the latter, what part? Should the basis of coordination be by the way of the extension of NHI, or a whole-time government service or some other method? If the last, were the commission's suggestions acceptable?

In a number of respects, the commission's views were quite radical—

surprisingly so in the light of the profession's past policies and later attitudes. It was new that the BMA was willing to contemplate local administration by local authorities, even if they were to be reorganised local authorities. The emphasis on group practice, the support for publicly provided health centres, the idea of part-time salaries for general practitioners, the abolition of the sale of practices—these were almost revolutionary concepts. Yet the *BMJ* was welcoming to the report, speaking of the general recognition of the 'need for a comprehensive medical service . . . to the benefits of which every member of the community will have access unhampered by economic limitation or geographical disposition', and accepting that 'general and special practitioners and the voluntary hospitals cannot take their rightful place in an ordered scheme of medical services without some sacrifice of independence'. It insisted that free choice of doctor should be maintained and that, at least in part, the doctor should be paid in a way dependent on the success of the doctor–patient relationship; and it pointed to the dangers of a salaried service—political and bureaucratic control, more highly paid administrative posts to the detriment of clinical medicine, weakening of personal responsibility for the patient and the transformation of the profession into a body of routine 'safe men'.[75]

The September meeting of the BMA representative body was also generally welcoming, accepting most of the commission's recommendations but adding some glosses of its own. It agreed that group practice with health centres should be a feature of a future medical service, but opposed any supervisory control in clinical matters and any formation of groups by an outside authority. By a majority of two (94 to 92), it accepted the '100 per cent principle' against the official BMA line in favour of covering 'a section of the community only'; but it wholly rejected any idea of a whole-time salaried service, and opposed even a part-time salary for general practitioners. It considered that payment by patients should continue, either through insurance or direct, but opposed any control by approved societies; and it expressed a strong preference for central administration by a corporate body rather than by a government department.[12]

The BMA annual panel conference in November, representing local medical and panel committees, was less warm in its welcome. It would only go so far as to say that group practice on a voluntary basis deserved favourable consideration, and that health centres were acceptable in principle if voluntary. A public service should cover only compulsory

NHI contributors, their dependants and others of like economic status; there was insufficient information to decide on the method of remuneration of general practitioners; and the sale of practices was a perfectly proper activity, though it was recognised that it might need reviewing if a medical service came into being.[5]

Medical Planning Research

November also brought with it the publication of the interim general report of Medical Planning Research, prepared by a small editorial group from material supplied by over 200 members mainly under the age of forty-five.[77] It was presented for comment by anyone interested, with the aim of producing a final report six months later (but, like the other interim reports, this one was final, too), and its principles were proclaimed to be scientific objectivity based on evidence and the greatest benefit for the greatest number. In short, it represented the views of the more radical younger members of the profession. The field covered was much wider than that of the BMA's Medical Planning Commission.

Demographic, economic and social questions including housing and planning were all discussed, and a complete social security system worked out, which would be the setting for a comprehensive health service. A 'Social Security Board' responsible to the Minister of Health was to administer the scheme, which would be based on universal contributions together with a large sum from the Exchequer making up the social security fund (estimated at £1050 millions a year). From this fund would be paid all cash benefits and pensions and also the cost of the health service. A 'National Health Corporation' would be appointed by the Privy Council on the advice of the Prime Minister and the Minister of Health after advertisement. It would have not more than seven members (a lay chairman, three doctors and three laymen) who would hold office for five years with the possibility of reappointment, once but no more. The corporation's work would be reviewed by Parliament every five years, and its charter would be revised every ten. Its director-general should be a doctor 'except in very exceptional circumstances' (not defined), and it should have a general advisory council and other advisory committees. Hospitals would remain in their existing ownership, but the corporation would take over the EHS and pensions hospitals and would be empowered to build hospitals and clinics as necessary, and to buy out other hospitals if they did not fulfil the requirements of the service. The hospital service would be administered

through senior regional officers—usually doctors—in twelve regions for the whole of Great Britain, with advisory committees to advise them. The main coordinating body in each region would be a regional hospital committee on which local authorities and other hospital-owning bodies would be represented, and its task would be to lay down the pattern of regional services, allocate functions to individual units and distribute funds. There should also be local health committees to bring local problems before the regional committee and to give health information to the local community, and these would be attended by representative general practitioners. (This idea appears to foreshadow the community health councils created in 1974.)

General practitioners should increasingly work from health centres and be remunerated by a basic salary varied according to qualifications and experience, a capitation fee and fees for special work or private practice, with free choice for patient and doctor. The sale of practices should be abolished, and vacancies filled by a small board made up of representatives of the region, the medical advisory committee and the practice where the vacancy occurred. Health centres should have between six and twelve doctors with a room each, a small operating theatre, x-ray room, pathology room and dispensary, and accommodation for home nurses and midwives and health visitors. The health centre would undertake all maternity and child welfare and school medical services, linked with the local hospital which would supervise the pathology and x-ray work. There would be assistant doctors on six to twelve month appointments, and there might be two dentists.

Specialist services should be organised on a parallel and not a hierarchical basis (that is, through equal 'firms' and not directed by a medical superintendent), and should be provided only by specialists, all of whom would do outpatient as well as inpatient work. A consultant 'firm' would have forty to eighty beds and associated outpatient clinics, and the number of patients in the consultant's care would be limited. All inpatient facilities needed by a patient should be under the same roof, and single-bed wards should be available on medical grounds as well as for private patients. Hospitals would be of three types—'key' hospitals with 1000 or more beds, which would receive patients referred from smaller local hospitals, and long-stay units attached to key hospitals. All key hospitals would teach medical students, and one in each region would have a medical school attached. There would be a minimum of three key hospitals to a region, but there might be as many as ten. Local hospitals would be located so that no patient lived more than fifteen

miles away, and general practitioners would be responsible for minor illnesses, maternity care and chronic sick patients; but other work, including outpatient clinics, would be done by consultants from the related key hospital, though they might be assisted by general practitioners.

The administration of the hospitals should be in the hands of medical or lay administrators responsible to a lay board with a representative medical committee alongside, and there should be a similar nursing committee. The 'social physician' (medical officer of health) should be based in the local hospital with consultant status, and be responsible for 'community health'—that is, advising the local authorities of the area on environmental matters, the registration of births, marriages and deaths, vital statistics, organisation of medical records, preventive services and the need for new health centres. All medical staff appointments at hospitals, which could be whole-time or part-time, should be advertised, and selection carried out by boards representing the regional medical officer, the regional medical committee, specialists in the subject and assessors from other regions. At the key (teaching) hospital at least one whole-time post in each major subject should be a professor appointed by the university. Salaries should be uniform, a whole-time senior consultant receiving £1500 to £2000, a deputy £900 to £1400, a senior registrar £600 to £800 (non-resident) and a registrar £450 to £500 (non-resident).

Beveridge

Up to this time, the various schemes brought forward seem to have about them a certain air of unreality, of the debating of abstract propositions which might—but more probably might not—one day take concrete shape. Now, however, an event took place which altered the whole climate of discussion and introduced a note not only of realism but also of urgency. On 1 December 1942, the Beveridge report on social insurance and allied services was published.[58]

The Beveridge committee, consisting of Beveridge as chairman and a group of senior civil servants from the government departments involved in the administration of cash benefits and pensions, was appointed in June 1941 to survey social insurance schemes and their interrelationship and to make recommendations which might include extensions of the schemes. After a time, it became clear that some major decisions of policy would arise in the course of the committee's work,

and it was therefore concluded that the report and recommendations should be those of Beveridge himself, with the departmental representatives acting as advisers and taking no responsibility on policy questions. There was continuing consultation between Beveridge and the Ministry of Health about a future health service as well as other matters, both before and after a first draft of the report was circulated in July 1942. But with his hands freed from departmental ties, Beveridge could—and did—make sweeping proposals. These centred on a single universal social security scheme, insuring against interruption of earning power whether because of sickness, disability, old age, unemployment or injury, with flat-rate contributions and benefits, the whole to be administered by a new Ministry of Social Security which would be responsible also for assistance on the basis of a means test 'for a limited number of cases of need not covered by social insurance'. Benefits were aimed at 'guaranteeing the minimum income needed for subsistence'.

The whole edifice rested on three assumptions: that separate allowances would be paid out of taxation for the maintenance of dependant children; that a comprehensive health service available to all would be provided by the health departments divorced from any conditions of insurance contributions; and that policy would be directed to the maintenance of employment and the avoidance of mass unemployment. It was the second of these assumptions—the celebrated 'Assumption B'—that brought discussions about a future health service down to earth with a jolt.

In Beveridge's mind a national health service for all and rehabilitation for employment by medical treatment and industrial retraining were essential to a satisfactory system of social security, for several reasons. First, it was only common sense that, if high benefits were to be payable during sickness, every effort should be made to reduce the number of people needing them. Secondly, on the same grounds, early diagnosis and treatment were to be encouraged. Thirdly—and as something of an afterthought—a health service was necessary 'to ensure the careful certification needed to control payment of benefit at the rates proposed in this report'. What precise form the service should take, and even how it should be financed, were matters for the health ministers to determine in consultation with the professions and authorities concerned, but some views were expressed. 'Primary' medical care was needed by everybody and, if the proposal for a universal contribution for social security was accepted, that medical care would have to be available for all (the '100 per cent principle'), not just for 90 per cent of the population, as some

were suggesting. It was a moot point whether the contribution should cover hospital inpatient care; but if it did, a major source of voluntary hospital income would be swept away. It might well be reasonable to make a 'hotel' charge to inpatients but this would have to be low—not more than ten shillings a week could be regarded as being saved in the household budget through admission to hospital. In the same way, charges for appliances, including dentures and glasses, would be justifiable to encourage their careful use. But whatever might be the final decision on these points, the social security contribution should include an amount entitling every citizen to all forms of treatment—medical, dental or subsidiary—without a treatment charge, and this part of the contribution should be paid over to the health ministers as a part payment of the total cost of the health service.

The Beveridge report captured the public imagination in a way that was quite remarkable in the middle of a war for survival, and rapidly became a best-seller. Beveridge himself promoted his proposals with almost messianic fervour, addressing gatherings of all kinds all over the country. The result was that when the report came to be debated in the House of Commons for three days in February 1943,[102] expectation ran high of early action on the lines he had suggested. Speaking for the government, Sir John Anderson (Lord Waverley), then Lord President of the Council, made clear its first reactions without announcing any final decisions—as was very reasonably maintained, these would have to depend on the overall financial position at the end of the war, and on the other priority claims on the country's resources—but some definite views were expressed. The government accepted the principle of universality, but not the linking of levels of benefit to minimum subsistence levels—this it considered impracticable—or the phasing in of high old-age pensions over a period of years. The government preferred payment of these pensions from the outset, but at a lower level (a decision which over the years has led to the present unexpectedly large numbers of recipients of supplementary benefits). It also regarded five shillings as the right rate of child allowance instead of the eight shillings a week proposed by Beveridge, and argued that the difference was made up by benefits in kind such as free or cheap milk and school meals. But the government fully accepted 'Assumption B', and welcomed the concept of a comprehensive medical service not bound up with social security. This it saw as the consummation of a long process of development, marked most recently by its proposals for post-war hospital policy and by those of the BMA Medical Planning Commis-

sion's draft interim report. The government thought that responsibility for the service must rest on a public authority—'public health must not be many people's business and nobody's responsibility'—that is, on local government working over larger areas and in collaboration with voluntary agencies. Free choice and the doctor–patient relationship must be maintained to the greatest possible extent, and this was not inconsistent with group practice from health centres. Private practice and care should continue as an alternative to the service, and the position of the voluntary hospitals would be safeguarded. (These were the principles that had been put by the health ministers to their colleagues on the Reconstruction Priorities Committee in a paper of 2 February.*)

To many members of the House, the government's approach appeared grudging and half-hearted, and there were calls for pledges of immediate action, and particularly for the creation of a Ministry of Social Security. Nor was opinion mollified by the statement that a team of civil servants with Sir William (later Viscount) Jowitt, Minister without Portfolio, in charge would begin at once the task of working out the scheme, and that the health ministers would be consulting those concerned about a comprehensive health service. Somewhat unexpectedly, an appreciable number of members voted against the government at the end of the debate, including Arthur Greenwood who had proposed the government-supported motion on which it had hung. It was clear that the mood of the House, as well as of informed opinion outside, favoured urgent discussion of the way forward.

A rather different note was, however, struck in a debate on the Beveridge report in the House of Lords on 1 June,[7] on a motion by Lord Derwent. He held that 'the medical provisions of the Beveridge plan . . . do not appear to be designed to further the best interests of British medicine or of the population', and he regarded the proposals as 'a Trojan horse which the Ministry of Health are attempting to introduce into the camp of the medical profession'. He echoed the attack made by Charles Hill in his speech to London doctors on 16 May (see below), and said that the BMA had resolved on 23 March to oppose the handing over of control of the hospitals to local authorities in favour of an independent body representing local authorities, voluntary hospitals, doctors and the ministry. There was a danger of depersonalisation of medicine if it were put in the hands of local authorities.

* PRO MH 80/24

Lord Dawson complained that, after years of turning a deaf ear to the idea of progress, the ministry was now trying to hustle. The Beveridge report gave as the primary interests in the health services the limitation of disease by prevention and cure, and the need to ensure careful certification; these were the wrong motives for a health service, which should rest on its own merits. Local government in some form—often combinations of authorities—should be the seat of ultimate administrative authority, but it should be advised by expert representatives, mainly hospital medical staff. This should be the first step, and it should be tried out for two years. Health centres needed trial on an experimental basis also; and all government medical services should be brought under the Ministry of Health.

Lord Moran endorsed these criticisms and added others. The central authority must carry the confidence of the profession; a medical council of twenty members should therefore be appointed, fifteen of them nominated by the profession, to advise on all general policy questions and to publish its advice, to act as a court of appeal in disputes between local authorities and their medical staff, and to serve as an appointments bureau. Group practice from common premises was very desirable, and did not mean necessarily the end of free choice of doctor, but doctors feared that under local authority control they would become the playthings of local politics. The solution might be ten or twelve regional bodies based on the universities. A good consultant service was essential, and as a basis it required a list of qualified consultants, which was then being drawn up by the royal colleges in accordance with university-based advice. Improved distribution of consultants was also needed. It was desirable that a royal commission be set up to work out a scheme for a service.

Replying for the government, Lord Snell made the very reasonable point that there were no 'medical provisions' in the Beveridge report as Lord Derwent appeared to think; but the motion was in principle the same as the policy of the government. His own experience (in the LCC) did not confirm the alleged reluctance of doctors to become local authority servants. But whatever the position might be, the government's policy was to continue the discussions then in progress, leading to publication of views for general discussion before any legislation was introduced.

Attitudes of the BMA and the ministry

By early 1943, the attitudes of the different parties and the main heads for discussion had become fairly clear. First, there was the question of the scope and availability of the proposed service. The medical profession saw the scope of the service as being all-embracing, including industrial health; the health ministers thought to exclude industrial health (as too closely involved with other factory inspectorate work) and services for the mentally ill or handicapped (on the grounds that the lunacy and mental deficiency law must first be reformed). The ministers had reservations about the practicability of covering dentistry because of the shortage of dentists. On the other hand, the ministers looked for a service available to the whole population, while the doctors showed signs of preferring one limited to those with an income of less than £420 a year or thereabouts, though by a tiny majority the BMA representative body had voted for availability to all.

There was general agreement that the hospitals should continue under their existing managements, but brought together in a planned pattern by some form of regional body. Ministers had in mind payment of the voluntary hospitals in two ways: 'hospital service payments' for patients treated and for beds held vacant for the public service, and subsidies according to the financial circumstances of individual hospitals (teaching hospitals would receive grants through the UGC). These ideas were not yet known to the parties, so there were no counter-proposals on this score.

No specific changes to the community services had been suggested, but the common expectation was that, with the development of general practice in groups from health centres with supporting nursing and other staff, much of the work done by salaried local authority doctors would be transferred to general practitioners. This was a comparatively minor aspect of the changes looked for by ministers in the pattern and structure of general practice. They saw the appropriate local authorities as responsible for medical as well as hospital services, employing salaried general practitioners for the purpose and providing the necessary health centres, with interim arrangements for group practice from their own surgeries until the centres were built. A central medical board would draw up a public medical service roll of both specialists and general practitioners entitled to serve, and would help them to secure posts in hospitals or with the local authorities. If the royal colleges (as was then expected) compiled lists of consultants and specialists, only

those on the lists would be able to serve, and they would be selected locally from short lists of three recommended by medical advisory appointment committees. The sale of practices would cease, and compensation would be paid for loss of capital values.

Such was the thinking within the Ministry of Health; medical opinion was more conservative. There was acceptance of whole-time or (preferably) part-time salaried employment of consultants, but the BMA rejected the idea of whole-time salaried general practice and opposed even payment in part by salary. It accepted the principle of group practice from health centres, provided that the groups were self-constituted and experiments were undertaken as a preliminary to any general action. Abolition of the sale of practices was also rather reluctantly accepted. But the doctors thought that patients should pay for services in some way or other, while ministers were thinking of social security contributions only, apart possibly from a 'hotel' charge to hospital inpatients.

The form of central administration preferred by the BMA was a national corporation rather than the Ministry of Health. This would have alongside it a medical advisory committee—a concept accepted by ministers in relation to administration by them. The difference of view on local administration was sharper. Ministers saw this as the job of local hospital and medical services authorities, which would be the counties and county boroughs or combinations of them. In consultation with the local medical profession and voluntary hospitals, they would prepare, and submit to the minister for approval, 'schemes' for the provision of services for their areas, which *inter alia* would lay down the functions to be performed by the voluntary and public hospitals. The 'schemes' would be drawn up by a statutory committee of the authority which would include members representing the doctors and voluntary hospitals, and would be subject to the advice of regional councils looking at the pattern of services over the whole region. These councils would also include medical and voluntary hospital representatives. The BMA, on the other hand, regarded the reform of local government as essential to provide a basis for the 'regional' administration of the health service with medical representation and a medical advisory committee; an alternative (and probably the BMA's preference) would be the creation of new regional councils to run the service, made up of local authority, voluntary hospital and medical members.

Finally, there was the problem of the timing of the introduction of any new comprehensive service. This presented an almost insoluble

dilemma. Many regarded it as indefensible that far-reaching decisions should be taken and acted on when so many doctors, including all the younger ones who would be most affected, were away on active service and unable to take part in making the decisions. On the other hand, if action were not taken, thousands of doctors would be demobilised at the end of the war not knowing whether they should seek to buy practices or count on a public service. This factor, combining with the relation of a health service to the implementation of the Beveridge report, was the one which weighed with ministers and imported urgency into their thinking. The BMA was in less of a hurry. It thought in terms of an interim arrangement for the two-way extension of NHI and the regionalisation of hospital services as an immediate step, and the introduction of a full comprehensive service as a longer term exercise.

It was against this background of doubt and conflict that discussions now began.

3

The first round: 1943–44

Although the prospects were uncertain, the health ministers embarked on the discussions with the main interested parties in March 1943 in a mood of hopeful optimism. The statement of future hospital policy of October 1941[67] had been well received, and there seemed to be no reason to expect great difficulties from the voluntary hospital world or from local government. Some hesitancy on the part of the medical profession was expected, but the available evidence suggested that the profession's past thinking was open to quite substantial change. The younger doctors, through the report of Medical Planning Research,[77] had expressed quite radical views. The Medical Practitioners' Union—a small rival of the British Medical Association and affiliated to the Trades Union Congress—had gone so far as to propose in August 1942 the take-over of all hospitals, both voluntary and local authority, by new *ad hoc* area health committees composed of local authority members, doctors, hospital administrators and others, and the introduction of a whole-time salaried general practitioner service. The *British Medical Journal*, which normally reflected the state of mind of the BMA, had welcomed the Beveridge report,[107] urging its full acceptance, and on that basis was ready to agree to cooperate in preparing a scheme for a comprehensive medical service if its character, terms and conditions were agreed with the profession and if private practice were still permitted. It saw the '100 per cent principle' as a possible difficulty, but thought it did not necessarily imply a whole-time salaried service (which was, of course, unacceptable). It therefore regarded this as an occasion on which the medical profession could 'take a forward-looking view without any sacrifice of professional principles'. In any case, in its attitude towards the Medical Planning Commission's report,[76] the profession had already taken a forward-looking view. The position at the

end of the war would be fluid and, therefore, favourable to change, thought ministers, and although transition to a new system—which would have to be introduced simultaneously over the whole country—would be difficult, the shock to the profession could be mitigated by allowing part-time practice to existing general practitioners (though not to new recruits) and, in suitable cases, by favourable pension terms for those over 65, and by giving the profession itself the task of grading doctors for the purpose of remuneration.*

The first discussions

After telling his recently appointed medical advisory committee the general nature of his proposals on 4 March, the Minister of Health met the three main interests—the medical profession, local authorities and voluntary groups—on three successive days beginning on 9 March, in order to arrange the programme for the discussions. A memorandum was sent in confidence to each group in advance, giving an outline of his thinking. The main principles were that the service should be unified and comprehensive; available to all (but not compulsorily—private practice would still be possible); free at the time of need subject perhaps to a hospital inpatient charge and payment for some appliances, as Beveridge had suggested; with free choice of doctor and full use of voluntary hospitals and other resources. The need was also mentioned of efficient certification and of preventive and rehabilitative services to protect the social insurance fund. The administration of the new service should be based on local government, in the form of suitable groups of counties and county boroughs (though there might be a few ungrouped authorities), with the medical profession playing an important part. A central medical board would have functions in relation to the employment of doctors and other matters. Voluntary hospitals would continue to be managed by their own governors in accordance with arrangements made by the new health authorities, but would need to accept Rushcliffe rates of pay for nurses (that is, national scales laid down for the first time by the Rushcliffe committee in 1943[40] and subsequently revised periodically), some control over medical appointments and unified admission systems. In return, they would receive support from public funds, and private pay beds could continue if desired. The general medical service would be based on health centres housing group practices. Other

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questions, such as the sale of practices or the provision of dental services, were left for future consideration.

At the meeting with the doctors, the minister suggested the formation of a small group to carry out detailed discussions with officers of the department, and it was agreed that the circulated memorandum should not be published. Instead, a letter was sent the following day by Sir John Maude to Dr George Anderson, secretary of the BMA, for publication, and this emphasised the non-committal nature of the discussions and made it clear that there would be the opportunity of consulting the profession generally at a later stage when the government had formulated concrete proposals. The same line was taken with the Association of Municipal Corporations, the County Councils Association and the London County Council, which emphasised the importance of its responsibility to the local government electorate; and with the British Hospitals Association, King Edward's Hospital Fund for London and the Nuffield Provincial Hospitals Trust, who, in their turn, stressed the need to safeguard the principles of the voluntary hospital movement, the importance of medical advisory committees at all levels and the desirability of gradualness.

Within the ministry, there was further thought about the organisation of general practice. Three papers written at this time (not, apparently, shown to the profession) discuss the merits of whole-time and part-time service, and methods and rates of remuneration.* On the first point, it was considered that while part-time public practice combined with private practice could be tolerated as a transitional arrangement, it could not be accepted for new entrants, or as a permanent feature of the scheme. Unlike panel practice under the National Health Insurance scheme, a service available to the whole population would not need any private practice to maintain the doctor's income or to cater for the non-insured. If public and private practice were combined, the former would be considered inferior, with a poor law taint about it; and a young entrant would be tempted to spend his energies in building up his private practice. The doctors' fear of a salaried service was, it was thought, as much as anything a fear of the red tape associated with doctoring in the armed forces; but this was not an inevitable accompaniment of salaried employment. Indeed such a service could offer freedom from the worry of buying practices, from competition to recruit patients, from the burden of heavy insurance for retirement, and so on, and could

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provide a good career with a wide range of remuneration, full scope for clinical ability and professional safeguards.

On methods of remuneration, the capitation fee system was regarded as incompatible with the group practice concept; it would involve competition for patients under the same roof and, in any event, would lead to misuse of certification and excessive prescribing. It might also be difficult to base a satisfactory pension scheme on payment by capitation fee.

On rates of remuneration it was calculated that the average general practitioner, taking into account his liabilities for practice expenses, purchase of practice and life insurance for retirement, was then receiving a net income of £800 a year or less. It was therefore suggested that assistants should receive a salary of £400 on first entry, that principals should receive £650 rising annually by £30 to £1200 (some in larger centres receiving £1400) and seniors in charge of five or six health centres £1600. On this basis, the average income would be £1000 less £50 superannuation contribution, or £950 net. By way of comparison, the top salaries then payable in the Emergency Hospital Scheme were £1400 for a consultant adviser and £1300 for a group officer. A medical officer of the Ministry of Health received £850 to £1200, a senior medical officer £1400 to £1600, a divisional MO of the LCC received £800 to £1000, an SMO £1200 to £1600 and a principal MO £1700 to £2000.

Further papers were also prepared for circulation to the three parties to the discussions. That for the local authorities, after rehearsing the departmental views on the need for early action, concentrated on an outline of a proposed local administrative structure. It was argued that, to carry responsibility for a hospital service, the local authority must command substantial financial resources and a broad base for the employment of staff, and contain hospitals capable of providing all normal services. It should also serve both town and country—that is, the hospitals, which were usually located in the towns, must admit patients from the area round about without hindrance and the general practitioners from the town should not have to be on several panels or look to several employers.

One way of meeting these requirements would be to have a system of elected regional bodies; but that would involve a royal commission on local government first and at least two years' delay. The solution must therefore be combinations of counties and county boroughs—joint boards set up by statutory order with representation of the constituent authorities according to population, but with a not too large membership. The inclusion on the board, or on committees of it, of

non-elected members such as doctors or voluntary hospital governors would need to be considered. It might be sensible for some functions to be delegated by the boards to local committees of councillors and others, and for the boards' budgets to be approved by the constituent authorities, with the minister as arbiter in the event of disagreement. Where, exceptionally, the new health authority was not a joint board but a single authority it would need to have a statutory committee with non-elected members on it. The cost of treating hospital inpatients would be met by the area of residence in accordance with a standard charge fixed (probably for the whole country) by the minister. The cost of outpatient treatment would be met by the authority of the area in which it was given.

A similar paper on administrative structure was given to the doctors. This stated the essence of the proposals: the central responsibility on the minister with a strong medical advisory committee; a central medical board to supervise the conditions of employment and the interests of doctors in the service; specially constituted health authorities locally with medical participation or advice; and local planning and administration in accordance with a locally prepared scheme on which the doctors and others would be consulted and which would be subject to approval by the minister.

The paper for the voluntary hospitals, while outlining the same proposals, concentrated on the items of special concern to them, particularly on how they would be financed in a public service. It was suggested that they should receive a flat-rate payment of perhaps £1 a week for each bed provided under the local scheme, and that inpatients should pay fifteen to twenty shillings a week which the voluntary hospital would receive, though the money would be collected by the health authority (contributory schemes would find a future in insuring against these charges). The health authority would also make grants to voluntary hospitals as needed. In preparing the local scheme, the health authority might be required by statute to consult the voluntary hospitals, which should also have representation on the authority or its committees; the authority, in return, might have representation on the voluntary hospital governing body.

There now followed, from the third week in March to the end of July, a series of meetings with these three parties, and special meetings with one or two other groups, to hammer out proposals which could be published for general discussion before the government reached conclusions and put forward legislation. The meetings were usually between a

group of representatives and a few officers of the ministry, with the occasional personal attendance of the minister. Those with the local government spokesmen were amicable and, for the most part, not too contentious; both sides talked the same language and understood one another. The same could not be said of the discussions with the voluntary hospitals and the doctors, where suspicion and mistrust surfaced very soon.

The proposed administrative structure

Between 25 March and 27 July, five meetings took place between the local government representatives and ministry officers.* On the local authority side, the principal spokesmen listed were Sir George Martin of Leeds for the AMC; Dr Maples, chairman of Hereford County Council, Sir Joseph Lamb of Staffordshire and (Sir) Fred Messer of Middlesex for the CCA; and Lord Latham and Mr Somerville Hastings, an ear, nose and throat surgeon and a pillar of the Socialist Medical Association, for the LCC. The main heads of discussion were the local administrative structure, the representation of medical and voluntary interests, and finance. At the third meeting, on 16 April, a departmental paper was considered which broadly stated the views so far developed. It was suggested that the new health authority should have thirty to sixty members, and should usually be a joint board of two or more counties or county boroughs on which some nominees of the local doctors and voluntary hospitals would sit. The committee structure would be for each authority to decide, but each committee would include a small medical element and all hospital committees would have a voluntary element. Schemes prepared by the authority and approved by the minister would define a pattern of area committees, together with their functions and constitution. A majority, or 60 per cent, of the members of these committees would be from the health authorities, but there would also be representation of district councils, doctors and voluntary hospitals, and some coopted 'experts'. Individual institutions would have management committees appointed by the area committees.

This outline was generally acceptable to the local government spokesmen, but while the AMC and CCA were prepared to consider 'outside' membership of the health authority itself, the LCC was opposed; and while the two associations were prepared to accept nominees of the

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doctors and voluntary hospitals, the LCC wanted appointment by the authority from a list of names submitted by the doctors and voluntary hospitals. Throughout the discussions, fears were expressed that this kind of *ad hoc* solution would lead to the break-up of local government. And there was hostility to a system which involved precepting—that is, the raising of funds by levies made on constituent authorities. It was suggested that this objection might be diminished if the constituent authorities were authorised to review the health authority's expenditure. It was agreed that the new authorities must be responsible for domiciliary and clinic services as well as for hospitals, and also that there should be medical advisory committees nominated by the profession—the LCC again dissenting.

Towards the end of the discussions the proposal to include the mental health services was disclosed; and this led to misgivings by the local government representatives about finance. They pointed out that so far no allowance had been made for the cost of these services or for rehabilitation; they considered that too little had been allowed for health centres, and that the cost of the hospital service would rise because the voluntary income of the voluntary hospitals would fall rapidly. They therefore pressed for an Exchequer grant of 50 per cent of the whole expenditure on the services, and not merely on the additional cost of them which was the formula laid down by the Local Government Act of 1929.[48] They urged that any payments made to the voluntary hospitals should come from the health authority and not (as had been suggested elsewhere) from a central pool distributed by the minister.

By the time the exchanges with the local government spokesmen were half completed, rumours of what was being said were beginning to spread, and this evoked a protest from the associations of the district councils that they were not being included in the talks. This led to pressure for more public discussions. It was then explained that the intention was to wind up this series of meetings by the end of July and, as soon as possible thereafter, to produce a White Paper of proposals for general debate.*

The fears of the voluntary hospitals

As expected, the local authorities had not proved too difficult; the voluntary hospitals were quite another matter. Three bodies were

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involved: the BHA, led by Sir Bernard Docker, its chairman and chairman of Westminster Hospital, and Sir George Aylwen, treasurer of St Bartholomew's Hospital; the King's Fund, led by Sir Ernest Pooley, chairman of the fund's distribution committee and clerk of the Drapers' Company, and Lord Dawson; and the Nuffield Trust, with a sort of watching brief, led by Sir Farquhar Buzzard. Others took part from time to time, including Lord Horder, Dr Charles Hill and Sir Bertram Ford, chairman of the Hospitals Contributory Schemes Association. Three meetings were held between 30 March and 17 June, and a fourth, with the HCSA representatives on 2 July.*

At the first meeting, deep displeasure was expressed with the minister's proposals. These did not, in the eyes of the voluntary hospital representatives constitute the 'partnership' with the local authorities they were expecting, but rather domination of the voluntary hospitals by the local authority, led by the medical officer of health. Nor did the proposals provide for coordination on a regional basis as they had understood it. The voluntary hospitals had had unhappy experience of the local authorities' failure effectively to carry out the spirit, if not the letter, of Section 13 of the Local Government Act 1929 which provided for consultation with them on hospital matters. There ought to be a central hospital body as well as local ones. Furthermore, any payments made to voluntary hospitals should be for services rendered and not by way of a 'subvention'. In vain was it pointed out that the policy statement of October 1941 (with which they had then agreed) had been specifically in terms of a statutory duty laid on local authorities, and that the proposals now made embodied safeguards for the voluntary hospitals. The representatives were not mollified, and went away to produce their own counter-proposals.

A paper of 14 May, which the BHA and the King's Fund had prepared, was considered at the second meeting on 26 May. They proposed a central hospitals board with eighteen members—six from the local authorities, six from the voluntary hospitals, three doctors and three from the ministry itself—and with a staff of its own, both medical and lay. This board would advise the minister on policy, the planning and administration of the hospital service, the role of individual hospitals, local development schemes and the allocation of central funds. All payments to the voluntary hospitals should be for services; and since

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monies from the rates through the local authority would undermine voluntary support, they should come from the centre, with contributory schemes continuing to meet maintenance charges to patients. Locally, the health authority should have one-third of its members drawn from the voluntary hospitals and the medical profession, with a parallel local hospital advisory board composed of equal numbers of the three parties and advising on all hospital matters, with the minister (advised, in his turn, by the central hospital board) arbitrating in the event of disagreement. Individual hospitals should appoint their own staff, and patients should have free choice of (suitable) hospital.

To these proposals the ministry responded that a central hospital board was acceptable as an advisory, but not as an executive, body, though it would need to mesh in with any medical advisory body which might be set up. Central payments to voluntary hospitals presented some difficulties, because local authorities might be expected to demand similar payments from the Exchequer, which was not the intention. Both sides went away to think some more.

At the third meeting, on 17 June, some accommodation was reached. It was agreed that there should be a central hospitals council of voluntary and local authority hospital experts, chosen by the minister, with advisory powers like those proposed for a medical advisory council. The local health authority should be responsible at that level, but with a local advisory council of the same type, which would be consulted on hospital service plans and be free to express its views at all times; and there would be inspection of hospitals by 'visitors', lay as well as medical. The voluntary hospitals would receive standard service payments from the health authority so long as they carried out their part in the service, and also 'Beveridge' money—that is, a proportion of the social insurance contribution—from the minister, the amount to be based upon the number of beds. This money might be pooled and allocated, on the advice of a central voluntary hospital body, rather as the BHA had distributed Exchequer grants to help in meeting the cost of implementing the salary recommendations for nurses made by the Rushcliffe committee.[40] Finally, on 2 July, a meeting with the HCSA representatives, assuming a hospital maintenance charge of a maximum of £1 per week, agreed that there would be a continuing place for the contributory schemes to meet this charge, and any that might be made for dentures or other appliances.

The doctors' dissent

For the purpose of conducting discussions with the minister, the medical profession set up a representative committee, forty strong, with members drawn from the BMA, the three English royal colleges and their Scottish counterparts, the Society of Apothecaries, the Society of Medical Officers of Health and the Medical Women's Federation, of whom nineteen were general practitioners.

In order to follow the course of subsequent events, it is necessary first to look at the nature of the constituency represented by this body, and particularly at the machinery of the BMA. Although they might belong to one or more of the other bodies, most doctors were, and are, members of the BMA and, of those, most were general practitioners, whose interests consequently bulked large in the BMA's thinking. In the BMA machine, the council of seventy members and permanent staff were the executive, but the power of decision rested with the representative body, of about 300, which met normally once a year. Only the well established practitioner could afford the time for local and central policy-making, so the representative body tended to voice the conservative views of the older doctors. Furthermore, as Eckstein has pointed out,[23] the BMA suffered from the apathy of most of its members. This cut two ways. In the first place, it meant that its leaders and officers had considerable power in formulating policy, though they then had to sell that policy to the representative body. But, secondly, it meant that they had difficulty in mobilising support when action was needed, a fact well illustrated by the failure to secure significant contributions to the 'fighting fund' it tried to create in 1946. This difficulty led, in turn, to the somewhat flamboyant and even exaggerated style of campaigning undertaken when important issues were, in their eyes, at stake. The royal colleges, representing the views of consultants, and newcomers to medical politics, could adopt a more objective and moderate approach in controversy.

These characteristics of the medical profession's organisation soon became apparent. After the procedural meeting with the minister on 9 March, the *BMJ* reported that the minister had asked for representatives to discuss a comprehensive health service 'from the ground' without a preconceived plan and without commitment on either side.[18] A letter of 10 March from Sir John Maude to Dr George Anderson, the BMA secretary, confirmed that when the discussions were complete, the government intended to submit its conclusions to the profession for full

consideration and for the expression of views. On the basis of these assurances, a special representative meeting of the BMA resolved to accept the invitation to discussions, but on condition that the full machinery of the association would be used during and at the end of them (and, in any case, before any negotiations or the submission of proposals to Parliament) to ascertain the profession's views; and that every practicable step would be taken to enable all doctors, and particularly those in the armed forces, to express their views. The meeting also approved the composition of the representative committee.[22]

In this rather suspicious atmosphere, discussions began on 25 March with officers of the ministry.* The doctors' suspicion was perhaps not wholly unjustified. To the profession generally, the image of the Ministry of Health was of a department which since 1920 had shown little or no interest in a comprehensive health service, or even in extending NHI. Nor had it campaigned, as had the BMA, for improved nutrition for the lower income groups, for the reorganisation of facilities for the treatment of fractures or for the pasteurisation of milk. To general practitioners, particularly, the ministry was the unsympathetic skinflint which had fought them over the level of the NHI capitation fee no less than seven times since 1920. The ministry also had the reputation of ignoring the advice of its medical advisory bodies (beginning with the Dawson report of 1920) and, in general, of subordinating its medical and other professional staff to a dominant lay administration. Any approach from such a source must surely be met with a guarded response.

Indeed, the first medical reactions were not so much guarded as highly critical. At the first meeting, the doctors concentrated on criticism of the paper put to them. The central authority should not be the Minister of Health but a national corporation. When it was pointed out that, in relation to Parliament, the position of a corporation would not differ from that of a minister, the doctors said that, whatever the authority was, it should have responsibilities limited to health (excluding housing, for example), but should assume responsibility for all civilian health functions such as those of the Ministry of Labour for health in industry, the Post Office and the Ministry of Mines. Any central medical advisory committee should be largely nominated by the profession, and it—or perhaps the proposed central medical board—should deal with the schemes for services to be prepared by the health

* PRO MH 77/26

authorities. They objected to local authority control, unless the authority had medical representatives on it and a medical advisory committee alongside, and did not see why a public service should be in the hands of publicly responsible elected people. They preferred central control through regional bodies created *ad hoc*. Finally, they insisted that every doctor must have the right to take part in the service on qualification—there was no need for a central medical board as well as the General Medical Council.

At the second meeting, on 15 April, these points were reiterated and others raised. The doctors' representatives were told that the aim was a service available to the whole population, not just a section of it, and that it should be free on delivery, with the possible exception of a maintenance charge to hospital inpatients. It was agreed that the new service would absorb the maternity and child welfare and school medical services. On the coordination of the government's medical responsibilities, the chief medical officer, Sir Wilson Jameson, outlined proposals for unified medical staffing of departments. On the subject of local organisation, objection was raised to the recent ministerial speech at Watford implying control by existing local authorities; but, in reply, attention was drawn to the policy statement of 9 October 1941 which included planning over larger areas. The need for representation of the profession on the locally responsible bodies was accepted—either a small number with voting powers or a larger number without—and for a medical advisory body. The respective responsibilities of the joint health authorities and the individual counties and county boroughs needed further thought, but it was agreed that medical terms and conditions of service must be nationally determined. The spokesmen called for an early paper from the ministry on the nature and functions of the local bodies and on the terms of service, particularly the kind of contract proposed.

This paper was duly drafted and sent to the representative committee; and it caused a furore. It embodied the concepts developed within the ministry for a whole-time salaried service based on health centres, and the reasons for this proposal. It set out the levels of salary suggested: £400 on first entry; £650 with annual increases of £30 to £1200 for principal general practitioners, with some at £1400; and senior posts at £1600—rates which compared favourably both with parallel posts in central and local government and with the practitioners' pre-war incomes. But the committee was appalled, and reacted by a letter of 12 May to the minister, setting out its objections in detail.*

* PRO MH 80/24

The committee said it was so critical of the principles of the minister's proposals that it must ask him to meet the representatives for a re-examination of the whole position. It was not clear to the committee that any progress was being made in developing proposals on social security (which ought to be concurrent with medical services planning). There was thus a suspicion that the medical profession was to be sacrificed on the altar of political expediency. It also appeared that the minister was being pressed to set up a State medical service in order to control medical certification. The minister's proposals were not comprehensive: the Board of Education would still control the school medical service; the Ministry of Labour, industrial hygiene; the Home Office and the Ministry of Pensions, their respective medical services. Locally, the proposals created administrative chaos, splitting the services between a number of authorities in each area. There should be one central authority, and only one authority in each local area. The proposals for a general practitioner service based on health centres went far beyond the BMA's Medical Planning Commission's report (which, in any case, was an interim report only). That commission had approved the principle, but wanted development with specific conditions and safeguards—an experiment was necessary. Nor did the representative committee regard health centre practice as requiring a whole-time salaried service: if it did, the public interest would suffer. The great majority of the profession was opposed to becoming a branch of local government service. The patient should be able to select his doctor, and selection should be reinforced by a method of remuneration which provided an incentive to good work. Finally, the present process of discussion was not adequate to the importance of the problems involved. Proposals were being indecently hurried in order to give the public the impression that something was being done about a comprehensive health service, and to have the machinery of certification in working order before the social security scheme was implemented. The proper way forward would be by way of public discussion through a royal commission.

As if this broadside were not enough, the next move from the medical end was a fighting speech by the deputy-secretary of the BMA, Charles Hill, to a mass meeting of London doctors on 16 May. Leaks about the government's salary proposals (regarded as generous) had appeared in the Beaverbrook press, and this gave a reason for revealing in public the nature of the discussions. Hill said he felt compelled to tell the meeting what were the non-committal ideas so far put forward for consideration. The minister had rejected the suggestion of administration by a corporation, but would set up a medical services council to advise him,

and a central medical board with executive powers 'in certain domestic matters'. Local administration would be in the hands of local authorities normally grouped in joint boards. General practice would be based on health centres which might cover public health clinical work, and general practitioners would be paid a salary to avoid competition between doctors under the same roof. Existing practitioners would be permitted to give part-time service, but new entrants would have to serve whole-time. The central medical board would admit doctors to the service, and remove them from it, and help them to find employment with a local authority.

This was a fair statement of what was proposed, but what followed was a violent frontal attack. Why was the government in such a hurry to set up a comprehensive service? In Hill's view, it was the need to control the profession so as, in turn, to control certification for sickness benefits. In any case, what was proposed was not comprehensive: there was to be no unification of the medical responsibilities of government departments; local authority responsibilities for health services would remain divided; and mental health services were to be excluded (the last had been confirmed in a letter of 4 May from Maude to Anderson, and was motivated by the need to reform the law on mental health before the services could be reformed). A further objection was that the general practitioner service was to be based on a new and wholly untried concept, that of health centres. Finally, the translation of doctors into a branch of local government was quite unacceptable to a free profession.[112]

The *BMJ* reported that this address 'was received with unusual acclamation'. Battle was joined on the following day, 17 May, when the representative committee met the minister himself. He expressed surprise and disappointment at the profession's attitude. His proposals arose out of the Beveridge report, and were those of the government not merely of his ministry and constituted only a part of the work that was going on on the report as a whole. The urgency arose from the need to have a clear picture to put to doctors on demobilisation from the armed forces and to plan for the winding-up of the EHS. The procedure adopted was that of consultation with the profession without commitment, but so far he had had no constructive criticism from it. A royal commission was, of course, a possibility, but it would be seen by the public as putting the whole matter into cold storage. He therefore asked again for a small group to discuss in depth with his officers. It appeared that the main objections of the profession were to a salaried

service and to the local authority's role. He would welcome alternative proposals.

The representative committee replied that it was willing to continue discussions, but they should be public. Its proposals were that both central and local health administrations should be unified, that health centres should at first be experimental and should be staffed by autonomous groups of doctors not employees, and that a royal commission should work out central and local unification. It was opposed to a salaried service—the BMA report of 1938 and that of its Medical Planning Commission had shown their views (in the light of subsequent developments, this was a statement of doubtful validity). The committee was, however, ready for a small group to pursue discussions on a purely non-committal basis, and it was agreed that a statement be issued about the meeting. This was duly published by the representative committee in the *BMJ*.[117] It said it had been agreed that discussions based upon the minister's tentative proposals would be unfruitful, and that the committee had sought withdrawal on 17 May. The minister had replied that there was no government commitment beyond that made by Sir John Anderson in the House of Commons on 16 February, and none to a particular form of medical service. He (the minister) had agreed to regard his own proposals as 'in the discard'. On that, the committee had agreed to non-committal discussions.

There followed a series of three meetings between the doctors: usually listed as present were (Sir) Henry Souttar, a senior surgeon of The London Hospital; (Lord) Webb-Johnson; (Sir) Harold Boldero, registrar of the Royal College of Physicians; (Sir) Guy Dain, then a general practitioner in Birmingham; Dr E A Gregg and Dr A Talbot Rogers, two general practitioners; Dr George Buchan, an MOH; Dr George Anderson and Dr Hill; and officers of the ministry. A fourth meeting was held with the minister. The main issues were the central organisation; local organisation; availability of the new service; methods of employment and remuneration; sale of practices; and the powers of the central medical board. On the first point the doctors continued to urge that the Ministry of Health should be responsible only for the health services, which should include those for which other government departments were currently responsible. There was agreement on an advisory medical services council, but the doctors suggested that the central medical board might be a committee of it, in spite of their very different functions, and that the board and not local authorities should be the employer of general practitioners. Locally, they still opposed placing

responsibility on existing authorities or groups of them, and wanted regional coordinating bodies, pending the reform of local government which, it was acknowledged, could not be awaited before action was taken on a health service. They pressed for the inclusion of mental health services, and it was agreed that the Board of Control—the guardians of the law of mental illness and mental deficiency—should be asked to look at the possibilities again.

The '100 per cent principle' was discussed at length. Availability to all was fundamental to the Beveridge scheme, but the doctors wanted an income limit so as to protect private practice. It was thought that to apply an income limit to the self-employed would be difficult; there was no such limit on manual workers in the NHI scheme at that time. It might be necessary for people to opt out of the public service if they wanted private care, or for the public patient to produce a medical card, and to pay if he failed to do so. The combination of public and private practice by the same doctor raised other issues. This was the course preferred by the profession, which did not want him to be dependent on only one source of income. If it were followed, no income limit would be necessary. It was suggested that the new entrant to general practice might be required to serve whole-time for a period, after which he could opt for private practice as well; but this must be dependent on the needs of the service.

On methods of remuneration, the doctors pressed for the same basis as in the NHI scheme, though they thought that a basic salary and capitation fees would be generally acceptable to them (an opinion not borne out by later events). It was agreed that the aim was family doctoring for all, which would involve some redistribution of staff; but the representatives considered that this would result automatically from supply and demand without any need for action by a central medical board.

The sale of practices would have to be abolished with a 100 per cent service. Sale within health centres would be impossible, and this would mean that other practices would cease to have any saleable value. Compensation could be given in the form of pensions. Finally, the representatives came back to their suggestions of extending the NHI scheme, and of undertaking an experiment with health centres as the first step, together with *ad hoc* regional hospital bodies. They were told that the aim was to publish a White Paper of proposals for public discussion early in September.

On 14 July, the final meeting took place with the minister. Souttar

summarised the profession's views: first, all branches of practice should be treated as one service; second, central control should rest with a corporate body responsible to the minister for medical services only; third, the need to cover the upper income groups should be reconsidered; fourth, the proposed medical advisory council and central medical board should be fused and given executive powers; fifth, 'subjection' to local authorities as then constituted was quite unacceptable, and substantial medical representation on any local administrative body was essential; sixth, the scheme should be introduced by stages, the first being the two-way extension of NHI, thus giving time for the reform of local government; and seventh, the forthcoming White Paper should not state conclusions but pose questions for discussion. This last point the minister accepted, saying that full weight would be given to the profession's views. No one was in any way committed by the talks that had been held, and they must remain confidential until the publication of the White Paper.

Debate within the medical profession

At this point, developments took place on two fronts—publicly by way of debate within the medical profession, and privately by way of discussion within government. The former culminated in fourteen principles adopted by the BMA representative body in September.[111]

1 The improvement and extension of social and environmental conditions should precede or accompany any reorganisation of medical services.
2 The necessary quantity and quality of staff and resources should be assured, medical research developed, medical education maintained at a high standard and economic barriers to medical services removed.
3 The State should coordinate and augment resources, and not invade the freedom of the patient or the doctor.
4 A salaried service was against the public interest, and local authority control was rejected.
5 Free choice was basic, and any public service must preserve and encourage it.
6 The State should not invade the doctor–patient relationship.
7 The method of remuneration should reinforce free choice by being related to work done or patients accepted by the doctor.

8 Everyone should be free to consult his doctor within the service or privately.
9 Consultants should be hospital-based, and private consultant practice should continue.
10 The central administrative structure should be a corporate body responsible for all civilian health services only, which should have a medical advisory committee representative of the profession and be free to publish its findings. Locally, new administrative bodies should be set up covering wide areas and including representatives of local doctors and voluntary hospitals, with medical advisory committees.
11 All branches of medical practice should be regarded as one service, and a scheme for general practice should not precede other reforms.
12 Pending the implementation of the tenth principle, the NHI scheme should be extended to dependants and those of like economic status, and should include specialist, laboratory and hospital facilities. Those above the income limit could be voluntary contributors.
13 Experiments in group practice and health centres should be launched by the government and profession in agreement, and any development should await the result of the experiments.

The final (fourteenth) principle was embodied in the Delphic utterance that the comprehensive health service should be available to all, but that it was unnecessary for the State to provide it for those willing and able to provide it themselves.

From all this two things were apparent: first that the discussions with the ministry had had little or no effect, and second that the BMA was beginning to go back on its earlier broad acceptance of the report of its Medical Planning Commission. *The Lancet,* which as a wholly independent medical journal was ready throughout the various controversies to take a more objective view than was open to the *BMJ,* permitted itself two comments. In its opinion, the extension of the NHI scheme, 'an extraordinarily elaborate mechanism for excluding about ten per cent of the population', was an obsolete solution, and it hoped the government would not waver in its determination to introduce as soon as possible a service based on Beveridge's 'Assumption B'. It also considered that 'given guarantees of professional autonomy, a salaried doctor might be in a position to offer the best type of personal help to the patient. But this has yet to be proved . . .'[26]

For what it was worth, the minister was also given some encourage-

ment by the Socialist Medical Association—a small body, by no means wholly medical, whose spokesmen were led by Mr Somerville Hastings, Dr Horace Joules of the Central Middlesex Hospital, Mr Alec Bourne of St Mary's Hospital and Dr Stark Murray of Kingston Hospital. This group met the minister on 26 March. They wanted a comprehensive service for all, administered by enlarged local authorities divided into health districts with 100 000 population, with a thousand-bed hospital for each district, and general practice based on health centres, twelve practitioners serving a population of 20 000 as salaried whole-time officers, but with the patient having free choice of doctor. They saw the use of voluntary hospitals (with local authority representatives on their boards) as interim only, and looked for complete unification ultimately, with medical teaching at every major hospital. They supported the idea of selection of consultant staff by a specially appointed panel, and part-time private consultant practice as an interim arrangement, with clinicians being paid not less than a medical superintendent.

The Cabinet and the White Paper

Within government, the discussions now passed from the ministry to the Reconstruction Priorities Committee of the Cabinet, to which the health ministers brought their proposals first on 30 July.* They proposed that, except in a few areas (for example, London and Middlesex), joint health authorities of two or more counties and county boroughs should be responsible for all the services, including general practice, but with some central control over appointments and dismissals. But they recognised that the local authorities did not like this pattern, particularly the need for precepting on the constituent bodies. Herbert Morrison agreed that local authority areas were, in general, too small for administration of the hospital service, but hoped this could be overcome by arrangements for pooling resources over larger areas for purposes of supply, laboratory facilities and, perhaps, the employment of consultants. He disliked precepting, and feared the damage to local government which would result from transfers of function to larger units—a fear shared by Lord Jowitt. Ernest Bevin, on the other hand, suggested the national administration of the service with local advisory committees—a proposal which, it was pointed out, would be virtually the destruction of local government.

* PRO CAB 87/12

The proposal for general practice was that part-time private practice should be allowed, but that new entrants should be required to serve whole-time in the public service for (say) five years in order to ensure that enough doctors would be available to it. The health ministers said they intended to formulate provisional proposals for publication in a White Paper for general discussion before legislation. Some ministers were doubtful of the wisdom of doing so without further consultation with the medical profession.

Discussion was resumed on 18 August, centring on the hospital structure. The AMC and CCA wanted a comprehensive study of local government before any changes were made, but the Reconstruction Priorities Committee was agreed that proposals for a national health service could not wait for that. A suggestion was made of 'hospital councils' on which central government representatives might sit, which would appoint management committees for particular hospitals, but this did not find general favour. Sir John Anderson, Chancellor of the Exchequer, suggested joint health authorities as the normal pattern, but with hospital-owning local authorities being given an option to run their own hospitals under the same conditions and controls as the voluntaries. At the next meeting, on 8 September, this solution was not thought satisfactory, and Tom Johnston, Secretary of State for Scotland, urged that in Scotland joint authorities must be formed to carry the necessary responsibility. With Herbert Morrison still dissenting, the health ministers' view was accepted. They also got provisional agreement to the publication of a White Paper setting out provisional conclusions and alternatives.

On 16 September, the committee looked at the general practitioner service, which Ernest Brown proposed should be locally administered by the new joint authorities in the interests of a unified health service, but with responsibility for the distribution of doctors and some other matters resting with the central medical board. Tom Johnston maintained that the whole general practitioner service must be centrally administered in Scotland. It was then suggested that local committees composed of representatives of the joint authorities, the doctors and, perhaps, the existing local authorities should perform functions like those of NHI committees, and the health ministers were asked to draw up a scheme on these lines for consideration. Clinic services Ernest Brown now said he was prepared to leave with the counties and county boroughs, with delegation to county districts where education functions were delegated. These changes led him to suggest, at the next meeting on 15 October,

that some framework of coordination would be necessary and that, therefore, joint authorities should be required to submit to the minister schemes for coordination which would be binding when approved by him—a concept agreed by the committee. He also proposed, with the support of Sir Walter Womersley, Minister of Pensions, that there should be a charge for hospital inpatients' maintenance. This was strongly opposed by Tom Johnston and Ernest Bevin, and the health ministers were asked to draft papers on this point, together with a draft White Paper covering the whole service.

Finally, the committee returned on 1 November to the problem of charges for maintenance while in hospital. Tom Johnston renewed his arguments for free maintenance, pointing to the contribution to costs which would come from social insurance contributions. Ernest Brown urged against this the serious effect on the voluntary hospitals' income if no charge were made and all proceeds from contributory schemes ceased. Sir John Anderson came down on Tom Johnston's side, but wanted a deduction for maintenance to be made from disability benefits and possibly also from children's allowances. The committee asked the health ministers to discuss the position with the voluntary hospitals on this basis.

On reflection, Ernest Brown wrote on 8 November to the Chancellor that the question was too difficult to raise with the voluntary hospitals, and that both the BMA and the local authorities would oppose the idea. On the basis of 1938 figures, the effect would be to reduce the voluntary hospitals' income from £6 millions a year to £1 million, with the result that nearly half the income of the provincial voluntary hospitals, and one-third of that of the London hospitals, would have to come from public funds, instead of seven to eight per cent. He suggested a confidential talk with two or three people, with the Chancellor present (presumably to make it clear to the voluntary hospitals where the proposal had originated).* This was almost the last act of Ernest Brown as Minister of Health, for in the same month he was succeeded by Henry Willink.

A first draft of the White Paper, prepared like its successors by (Sir) John Hawton, was considered at a series of meetings on 10 and 11 January 1944 by what had by this time become the Reconstruction Committee chaired by Lord Woolton, Minister for Reconstruction and a

* PRO MH 77/27

member of the War Cabinet.* The draft followed the lines of the proposals already discussed, and Herbert Morrison again pointed out the dislike of local authorities for joint boards, while Tom Johnston wanted the major Scottish authorities to administer their own hospitals. It was agreed that on this point Scotland should differ. The committee would not accept that the members of the proposed advisory 'Central Health Services Council' should be nominated by the medical organisations, nor that it should be able to publish its views. The committee insisted on appointment by the minister after consultation, and on the presentation of reports by him. Local health services councils, on the other hand, could be permitted to express their views confidentially to the minister.

The arguments for and against a hospital maintenance charge were once more rehearsed, and the minister was asked to consult the voluntary hospitals about abolishing all payment and to consider (without informing them) the possibility of a *per capita* sum being paid to voluntary hospitals for patients treated in them.

On the general practitioner service, the Lord President (Clement Attlee), Herbert Morrison and Ernest Bevin preferred whole-time public or private practice but not a combination of both, and Bevin urged the vigorous development of health centres. The Secretary for Dominions Affairs (Lord Cranborne) and the President of the Board of Education (R A Butler) thought that a salaried service ran the risk of falling standards, and for that reason supported a right to private practice. The Chancellor pointed out, while agreeing that private practice should be minimal, that all depended upon the full cooperation of the doctors. It was concluded that group practice from health centres should be pressed to the fullest extent found to be desirable, with doctors paid a salary; but at the outset of the service they must be allowed private practice, and group practice outside health centres should also be promoted. Doctors should have contracts with both the central medical board and the local health authority, but appointment and dismissal would rest with the board. The sale of practices was agreed to be undesirable in the public service, but it was thought that its abolition would lead to State control in filling every vacancy. The suggestion was therefore made of excluding the sale of practices so far as they comprised public patients brought into the practice after a fixed date. As this would need discussion with the profession, the only mention of the matter in the White Paper should be

* PRO CAB 87/5

to draw attention to the likelihood that the sale of practices would disappear with the development of health centre practice. A further draft White Paper and a shorter version for the general reader were to be prepared and presented to the committee as soon as possible.

Before the committee met again, Lord Woolton, at the prompting of Lord Horder who had sent him a copy of the voluntary hospitals' memorandum of the previous May, met their representatives headed by Sir Bernard Docker and Lord Southwood, to discuss the effect on the hospitals of a scheme for free inpatient treatment and maintenance. The Chancellor, the health ministers and (Lord) Jowitt were also present. The voluntary hospitals no longer favoured a maintenance charge, but Docker said the government must make it clear that public funds would not cover all their costs. He thought voluntary contributions could be raised to fill the gap. Others were less optimistic, believing that while this might be true of London hospitals, the provincial and smaller hospitals would probably be in difficulties with the almost certain undermining of the contributory schemes. It was, however, agreed that no charge should be made, that the government would publicise the existence of the 'gap', and that the health ministers should consider further the methods of collecting voluntary funds and the future of the contributory schemes.*

On 4 February, a redrafted White Paper was put to the committee and approved, subject to three further points raised by Herbert Morrison. First, the proposals relating to private practice would be badly received by the Labour Party, so whole-time public practice for new entrants should be required for (say) five years. Second, there should be an option for whole-time salaried practice outside health centres. These two points were accepted. Third, in his view, something should be said in the White Paper about the sale of practices. On this it was decided to point out the incongruity of increasing the value of practices by introducing a public service and then having to pay higher compensation in consequence. With these changes, the committee unanimously submitted the White Paper on 9 February to the War Cabinet, which approved it for publication on 17 February and general discussion thereafter. But there was a last minute hitch. The Prime Minister (whose doctor was Lord Moran) said he thought further discussion was needed, and at the Cabinet meeting on 15 February he enquired whether the future of private practice and of the voluntary (especially teaching)

* PRO CAB 124/442

hospitals were sufficiently safeguarded, and to what extent was there to be any interference with the right to practice as a consultant.* The answers were apparently satisfactory, and the decision of 9 February was confirmed.

Dentists and others

During the exchanges with the doctors, the voluntary hospitals and the local authority associations, several other bodies asked to be seen by the ministry to express their views but, with the exception of the pharmacists, they were invited to await the publication of the White Paper. The representatives of the pharmacists (as distinct from the company chemists) were received by the minister on 26 August 1943, when they pressed for the greater professionalisation of their role. They thought that an adequate service could be provided in the future as in the past through chemists' shops, and there would need to be some protection against competition from local authority-employed pharmacists if they were proposed. But they wanted a central body coordinating local professional committees, setting standards, defining terms of service and regulating the entry of new recruits. Having made their points, they then allowed the matter to rest for the time being.

Action was, however, taken on the question of the future dental service. There would be a severe shortage of dentists if dental treatment were to be provided for everyone. A review was conducted by an internal Ministry of Health committee which reported in February 1943.† It revealed that dental disease was widespread but demand for treatment was very low. Only five per cent of recruits to the armed forces were dentally fit, and in three Ordnance factories surveyed the proportion fit was only one per cent. Yet 14 million people were members of approved societies providing dental benefit under NHI, of whom only six or seven per cent claimed benefit annually. It was estimated that 12 000 dentists were in practice, and that 60 000 would be needed to give all the treatment now theoretically necessary; but far fewer would be needed if treatment were made available to all, and only 13 000 to 14 000 would be needed to maintain the dental fitness of the population once it had been achieved. This lower figure was therefore suggested as the target

* PRO CAB 65/41

† PRO MH 77/124

for dental schools to aim at. Expectant and nursing mothers, children and young people up to the age of 17 should have priority treatment: this would require 3500 dentists. The remaining number could meet the needs of the adult population at existing demand rates, and the use of ancillary staff would help to meet any larger demand. It was thought that local authorities might be given a power (but not a duty) to provide dental clinics for all and to pay 'dental benefit' for those going to a private dentist. The treatment given should include dentures, but these would carry a charge of half of the cost, while conservative treatment would be free. But it was concluded that before any final proposals could be framed there should be an enquiry into the means of developing a dental service for all, how to secure an adequate supply of dentists, the conduct of the profession and the needs for research. Accordingly, on 8 April 1943, the minister announced the appointment of a committee under the chairmanship of Lord Teviot, with eighteen members, of whom eleven were dentists and three civil servants, to make the necessary investigations.

One other development related to the health service at this time was the work of the inter-departmental committee on medical schools, chaired by Sir William Goodenough of Barclay's Bank and the Nuffield Provincial Hospitals Trust. The committee was appointed by the two health ministers in March 1942, and in its enquiry into the organisation of medical schools it was charged to pay special attention to facilities for clinical teaching and research, to the London schools and the possibilities of amalgamation, to the appointment and payment of teaching staff (an increase in the numbers of whole-time teachers was regarded as essential), and to postgraduate education. Wilson Jameson, chief medical officer of the Ministry of Health, played a prominent part in the creation of the committee and was a member of it, and other members included two future chairmen of regional hospital boards—Sir John Stopford, vice-chancellor of the University of Manchester, and Dr Janet Vaughan, later principal of Somerville College—and one of the hospital surveyors of the London area, (Sir) Archibald Gray. So the relationship with the future health service was close indeed.

4

The second round: the Willink plan 1944–45

The White Paper on a national health service duly appeared on 17 February 1944[32] and, as intended by the government, at once became the subject of public debate and of long discussion with the parties most concerned. Indeed, the greater part of 1944 and the first half of 1945 were taken up with retreading almost all of the ground covered during 1943, and in seeking modifications of the proposals which would commend them particularly to the medical profession.

The White Paper scheme

In these days, the White Paper would have been a Green Paper, as were the proposals for reform of the NHS structure drawn up by Kenneth Robinson in 1968 and by Richard Crossman in 1970, for it was a consultative document, not a statement of policy. As the foreword said, '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.' It was a vain hope. Already by 1 March, Bernard Docker had written to the minister expressing the British Hospitals Association's objections.* This was no partnership of voluntary and local authority hospitals—there was no suggestion of separate hospital advisory bodies, either central or local; there was no representation of voluntary hospitals on the proposed joint authorities or their committees; there was no guarantee that those

* PRO MH 77/100

authorities would have any regard to the advice of the (mainly non-hospital) local health councils; and the financial position of the voluntary hospitals was made very difficult by the combination of free treatment and the requirement of continuing voluntary income.

Elsewhere, the White Paper was more favourably received. Unlike most such documents, it had the advantage of being the product not of several pens but of one—that of (Sir) John Hawton—and its style and presentation were widely praised. So was its approach. The purpose was made quite clear. '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 them 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 proposals were seen as evolutionary not revolutionary, as the natural development in a long and continuous process of building up health services. They were also seen as not free from dangers. 'There is a certain danger in making personal health the subject of a national service at all. It is the danger of over-organisation . . . 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 a means, and never for one moment as the end.' Some would hold that in the 1974 restructuring of the NHS this salutary warning was not sufficiently heeded.

The proposals dealt with the administrative structure, central and local, the position of the voluntary hospitals, the general practitioner services and other services, in that order. At the centre, the minister must be responsible. A corporation, suggested by some as an alternative, could not be given independent powers of decision on major financial matters, nor could it be empowered to over-rule elected local authorities. But the minister would have at his side an expert advisory central health services council of thirty to forty members, primarily but not wholly medical, electing its own chairman, able to tender advice on its own initiative and being consulted on draft regulations; and the minister would publish an annual report of its work. There would also be an executive central medical board, a small body, mainly professional in composition, with part-time and whole-time members, with which all

general practitioners would be in contract. The board's consent would be needed to fill practice vacancies or to start a new practice, and it would make appointments to health centres, act as an employment bureau and advice centre, and arrange refresher courses. Local committees of the board would replace insurance committees for the discharge of minor functions.

Locally, responsibility would rest with joint authorities—that is, joint boards of counties and county boroughs. Two elements were regarded as essential to the local administration: democratic responsibility and full professional guidance. Local authorities embodied the first; but most of them were too small to provide all normal hospital services, and local government boundaries between town and country presented an obstacle which must be removed. For most areas, therefore, the solution must be joint boards, charged with the duty of providing a complete hospital service partly directly and partly indirectly through the voluntary hospitals. They would be required to draw up a hospital plan in consultation with those hospitals and to submit it to the minister for approval. Similarly, they would prepare an area plan for coordinating these and the other services, including general practice; but the clinic and domiciliary services, including health centres, would be provided by the individual counties and county boroughs. All local authority hospitals would be transferred to the ownership of the joint authorities, but child welfare services would be devolved to minor authorities, wherever the school health services were devolved under the Education Bill then before Parliament. Like the minister, the joint authorities would have at their side an advisory council of professional and other experts, which would be free to initiate advice and to submit views to the minister; but the notion that local authorities or their committees should have outside professional members was rejected.

Proposals were made to safeguard the voluntary hospitals, whose resources, experience and organisation the government expressed itself as anxious to enlist. 'It is certainly not their wish to destroy or diminish a system which is so well-rooted in the goodwill of its supporters.' It was therefore suggested that they should be paid for services rendered (but not totally reimbursed, since that would be the end of the voluntary movement) through two channels—a standard payment centrally determined but made by the joint authority, and a grant from central funds representing their share of social insurance contributions, which might, if desired, be pooled and allocated according to need. All hospitals would get the latter grant, and all would be required to observe national

rates of pay and conditions of service for their staff, to be open to inspection and audit, and to accept a common method of appointing senior medical staff. The consultant and specialist service would be hospital-based and appropriately remunerated, and a system of advisory panels would be introduced to prepare short lists for appointments.

Two principles were laid down governing the general practitioner service—that patients must be able to choose their doctor as freely as the availability of doctors allowed, and that doctors must be free to use their clinical knowledge and skill in the way they thought best. There were arguments for and against a salaried service, and in the government's view a totally salaried service was not necessary. On the other hand, a mere extension of National Health Insurance was not enough, because a proper distribution of doctors was needed which supply and demand could not reliably effect, and because of the wide agreement on the need for teamwork in general practice; that is, for group practice. This system, however, needed more experience before it could be introduced nationally; so although health centres would be provided, in which competition for patients would be intolerable and some form of salary would be required, there would be 'separate' practice outside the centres remunerated by capitation fee. Part-time private practice outside health centres would be permissible. Remuneration and terms of service would be determined nationally.

In order to ensure a service for everyone, the distribution of doctors must be regulated. This would be effected by the central medical board, whose consent would be required before a doctor entered an area to practise either as a successor to a retiring doctor or as a newcomer. The size of lists of patients would be adjusted to the amount of private practice done, and all new doctors would spend a period as assistants. The sale of practices would be a question for later discussion with the profession, but compensation would be paid when the value was lost; for example, when a doctor gave up his practice to go into a health centre, or when the CMB refused the appointment of a successor in an over-doctored area. It would, in any case, be anomalous if the introduction of a public service raised the value of a practice and, therefore, the amount of compensation payable. A superannuation scheme would be part of health centre practice and would be considered for 'separate' practice.

Other services to be provided would include home nursing as well as home midwifery, dental care, and sight-testing and glasses. Estimates of

cost were necessarily approximate, but it was thought that in the first year the total cost of the whole service would be £132 millions compared with £54.5 millions in 1938–39 for an incomplete service.

Parliamentary debates on the White Paper

On 16 March, Willink in the Commons[86] and Woolton in the Lords[88] brought forward a motion welcoming the White Paper, as a means of eliciting public reactions. Willink emphasised its four principles: comprehensiveness, freedom of the individual, democratic responsibility and professional guidance.

To supporters of the voluntary hospitals he pointed out how their finances would be assured. The proposed Exchequer payment would produce an income, on a 1938 basis, of £6.5 millions compared with £5.3 millions actually received from contributory schemes in that year. The payments they would get from local authorities would far exceed the £0.9 million of 1938, and for teaching hospitals there would be special teaching grants. The points made in the debate (including the customary attack by Sir Ernest Graham-Little) were wholly predictable. From the right, fears were voiced about the future of voluntary hospitals and private practice; from the left, about the combination of private with public practice. There were supporters of a salaried service, of regional hospital bodies, of electing representatives to the CHSC and of bringing all governmental health functions under the Minister of Health—the last three had been the BMA's proposals. In summing up for the opposition, Arthur Greenwood supported the government motion, making a special plea for services for the mentally ill, and accepting the scheme as 'a very substantial instalment of a bold public health service'.

The debate in the Lords was more interesting. Woolton commended the White Paper in much the same terms as Willink in the Commons, but Moran proposed an amendment regretting the absence of enough detail (especially on the subject of the consultant service) to enable the House to give a considered judgment. He criticised the lack of unification of central government's health responsibilities; the fact that the profession was not to elect the CHSC, which was not to be free to publish its own reports; the 'startling' powers of the CMB to distribute doctors by a 'negative pressure process' and to require new entrants to serve whole-time (though he suggested that consultants should be

employed by the board and not by the hospitals); the loss of interest and content of the work of medical officers of health through the creation of joint authorities; the absence of professional representation on the joint authorities; the danger that a salaried general practitioner service in health centres would lead to loss of incentive to good work (some form of extra payment for special work was needed); the inadequacy of the health centre concept as set out in the White Paper, which should extend to maternity and child welfare work, health visiting and health education (he commended and, indeed, urged early experiments in providing health centres, as likely to be attractive to young doctors after the war); and the threat to the finances of the voluntary hospitals.

Dawson welcomed the White Paper as 'a bold effort, reasonable in its unfolding, and because of its good English attractive reading', but considered that its principles were not embodied in its proposals. To him, health centres seemed to be an insidious method of introducing a whole-time salaried service (in any case, they ought to have beds attached to them as proposed in his report of 1920). The CHSC ought at least to be half made up of elected members of the profession; the CMB was a bureaucratic invention in danger of civil service control. The joint authority hospital areas were too small—there should be regions based on a key (wherever possible, a teaching) hospital, again as proposed in 1920. There should be professional representation on the joint authorities, though not necessarily with a vote. The voluntary hospitals should be helped financially in the same way as aided schools under the Education Bill; that is, they should receive payments covering all their running costs and half their capital costs.

Horder saw the White Paper primarily as threatening private practice and the voluntary hospitals, two institutions vital to British medicine. He called for separate hospital boards centrally and locally; that is to say, the policy of the BHA, which was also urged by the BHA spokesman, Lord Luke. Lord Donoughmore, speaking from a background of working with the King's Fund, and no doubt with one eye on the London County Council, asserted that local authorities knew little about hospitals—look at the way they had failed to consult the voluntary side as intended by Section 13 of the Local Government Act 1929—and they should have experts included amongst their membership. There should also be regions centred on teaching hospitals, especially in London, which should be divided radially as it was in the Emergency Hospital Scheme.

The doctors' reaction

Parliament's reaction might be described as friendly; that of the BMA was more suspicious, and rapidly became hostile. While *The Lancet*[4, 98] favoured the scheme, regarding the criticisms of the voluntary hospital spokesmen as unreasonable, defending the idea of a central medical board, and urging widespread experiment with health centres and with different methods of remuneration, the *British Medical Journal* was distinctly critical: of the tendency towards a whole-time salaried service, of the probable falling away of voluntary support for the voluntary hospitals and of private practice, and of the CMB's role in the distribution of doctors.[119] Early in March, following the sudden death of George Anderson, Charles Hill was appointed secretary of the BMA, and on 5 March he spoke to a meeting of the BMA Metropolitan Counties Branch on much the same lines as he had adopted at its meeting ten months earlier, sharply criticising the White Paper proposals and imputing bad faith to the government.[120]

To help the consideration of the proposals, the BMA representative committee put to the minister a list of no less than forty-four questions, which, after a short meeting with Willink himself, were discussed at length by Dain and Hill with Wilson Jameson, Arthur Rucker and John Hawton on three occasions, and finally answered in writing.* This exchange of views was largely a repetition of the previous year's discussions, raising many of the same points—the unification of central government's responsibility for health services; a corporation instead of a minister in charge; a partly elected medical advisory body with freedom to publish its advice and with its own medical secretary; opposition to the CMB both as a means of distributing doctors and as employer (the alternatives suggested were the employment of doctors by the joint authorities operating through a committee with delegated powers and with medical members, or contracting with a separate local body of the NHI committee type); opposition to salaried whole-time employment in health centres; the need for hospital committees of the central and local advisory bodies with equal representation of both types of hospital; an experiment with health centres controlled by the CHSC; the safeguarding of private practice and of free speech for doctors in the

* PRO MH 77/30B

public service; the postponement of legislation until doctors in the armed forces were back in civil life.

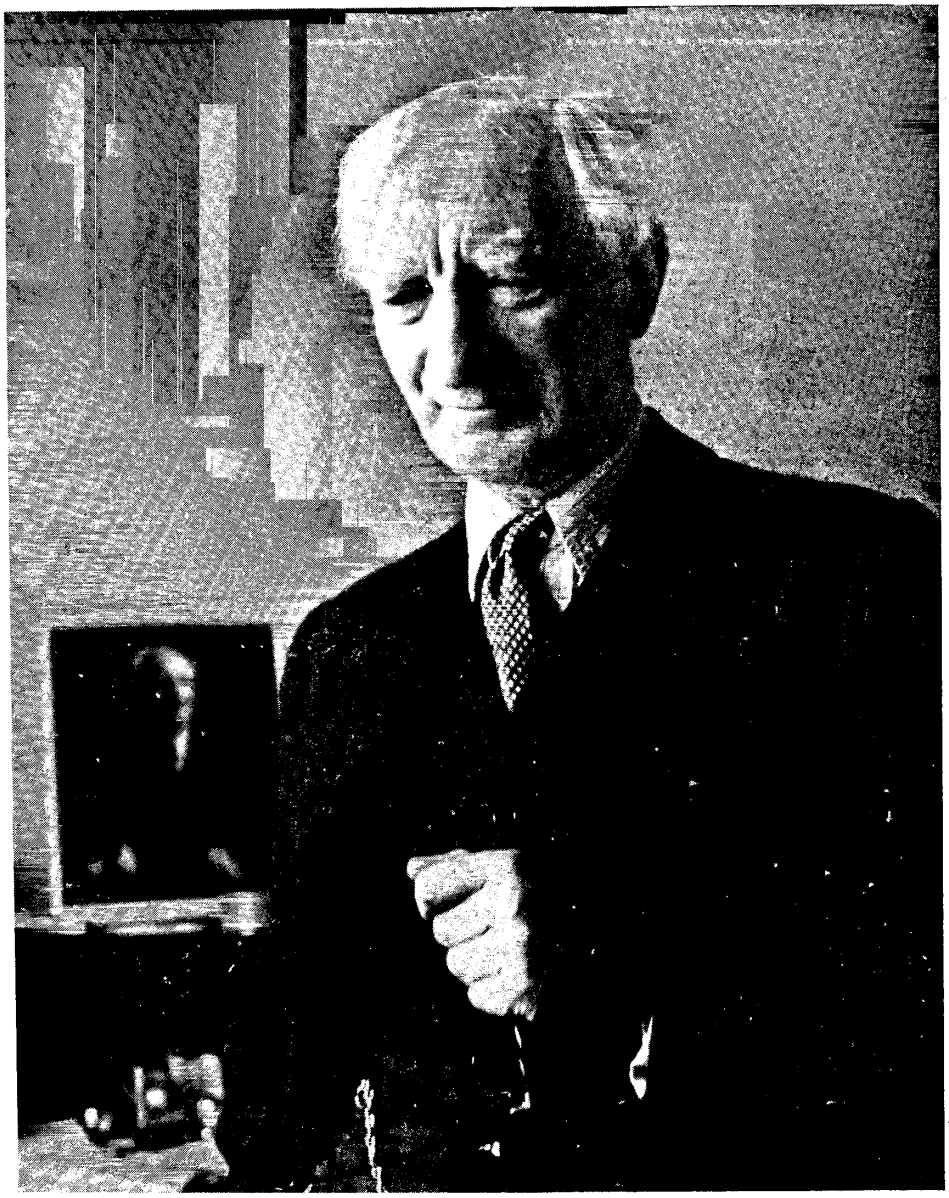
On the basis of these exchanges, the BMA council in May produced a report on the White Paper couched in emotive terms.[3] This was a *medical* and not a *health* service: and the government was displaying a lively interest in setting it up when many doctors were away in the forces. Reforms could well await their return. There was a suspicion that the government's proposals had first been inspired by a desire to control an independent profession in defence of the social insurance fund. Environmental conditions, housing, nutrition, research (to which the government's contribution was niggardly), were all as important as a national health service. Past experience suggested that neither the Ministry of Health nor local authorities were equipped to run such a service.

From these general criticisms, the BMA's report turned to the form of the service itself. The first essential was freedom—clinical freedom for the doctor, freedom to practise in the service and outside it, free choice of doctor and patient, with the general practitioner as the foundation. The proposed central structure was unsatisfactory: because of the minister's preoccupations with other 'non-health' functions combined with a lack of responsibility for other civilian health services, notably industrial medicine; because the CHSC did not have medical members elected by the profession, or the right to make its views known to Parliament and the public; and because of the objectionable powers given to the CMB. The proposed local administration would be chaotic. The joint authorities would plan and administer the hospital service but would only plan the other services (including health centres), which would be provided and run by individual counties and county boroughs. The right solution was to set up regional councils representing the local authorities, the voluntary hospitals and the medical and other professions to plan all the services and to distribute funds according to a plan approved by the minister. The county and county borough councils should each have a statutory medical advisory committee with independent powers of publishing its views which the authority would be required to consult, and from which members would be coopted as representatives on the appropriate committees of the authority itself. The White Paper proposals meant that the voluntary hospitals would be submerged, controlled by their local authority 'partners'. Health centres must be the subject of full experiment before any conclusions could be reached about their desirability or their operation; but in any case salaried practice in them was objectionable as the 'thin end of the wedge' of a State salaried

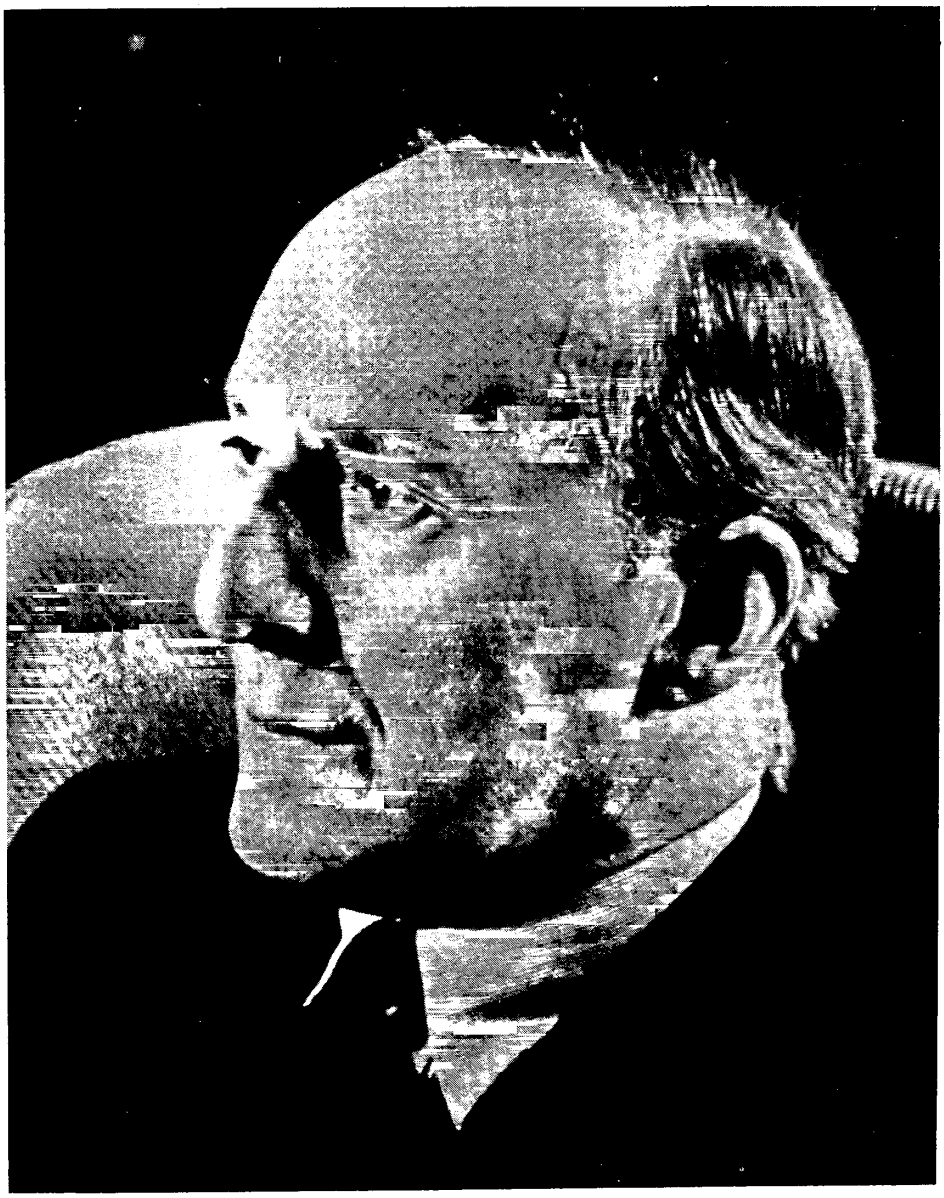
Lord Dawson

Ernest Brown

William Wilson Jameson



Lord Beveridge



Henry Willink

Lord Moran

Guy Dain

Charles Hill

Aneurin Bevan

service run by local authorities, and remuneration there as elsewhere should be related to work done or responsibility accepted—that is, item of service or capitation fee payments. Finally, a call was made for compensation for loss of sale value of practices to be worked out at once, whether or not it became necessary later.

As well as producing this report, the BMA put in hand, through the British Institute of Public Opinion, a poll of doctors on their reactions to the White Paper, and the representative committee of the BMA was reformed into a negotiating body of thirty members, which was expected to start work after the annual representative meeting of the BMA in July. But at this point the war intervened. Preparations for the Normandy landings made travel restrictions necessary, and the BMA had to be asked to postpone the ARM until later in the year.

Meanwhile, the minister felt he must react publicly to the innuendos of the BMA and the *BMJ*. A leader in the *BMJ* commenting on the BMA council's report explained that it was not against reform, but against some specific proposals such as the employment of doctors by local authorities, the threat to the future of the voluntary hospitals and the tendency to a whole-time salaried service. The BMA saw the inspiration of the White Paper as political rather than medical, and insisted that there should be no legislation in war-time with the younger doctors away on active service.[6] To this Willink replied in a speech in his Croydon constituency on 17 May, rebutting what *The Times* called the doctors' 'persistently voiced suspicion of the intentions of the Minister of Health and the Government'.* He described the suggestion that the government was promoting proposals in order to control medical certification as a 'preposterous accusation'. Planning for a national service must proceed during the war in order to have a ready framework for those doctors returning from the forces. The government needed no reminder from the BMA about the importance of prevention and of environmental conditions, but it would welcome some constructive suggestions. There, for the moment, the argument rested.

Local authority reaction

The pause on the medical front did not mean that action had stopped. On the contrary, a series of meetings was held with other interested

* PRO MH 77/31

parties. Between June and December, the local authority representatives were seen on six occasions to discuss various points. In August, for example, spokesmen for the metropolitan boroughs came to object to the transfer of their personal health services (especially maternity and child welfare) to the LCC; and in December a discussion took place with the County Councils Association and the Association of Municipal Corporations about the inclusion of mental health services in the NHS, a White Paper proposal accepted by the local authorities. It was considered that joint boards for mental services should continue, but with responsibility for the whole of the services, not only for hospitals (that is, including outpatient clinics, consultant services and psychiatric units at general hospitals); and that visiting committees should be abolished. The Board of Control would continue to carry out quasi-judicial functions, but responsibility for the services would lie with the Ministry of Health.

The main question for settlement was, however, the local administrative structure, and as the year wore on ideas on this changed considerably. In June, separate meetings were held with the CCA and the AMC, when the CCA suggested that the joint authorities, while owning the hospitals and being responsible for planning and finance, should delegate day-to-day management of them to the existing counties and county boroughs. The AMC went further in the same direction, objecting to joint authorities as unwieldy, difficult to man and having to rely on precepting. The AMC wanted them, therefore, to be planning bodies only, the statutory responsibility for the hospital service to rest on the individual county and county borough, and the minister to have financial or other sanctions to ensure observance of the plan.

For the ministry, Maude and Rucker rehearsed the objections to each of these proposals, and a paper written in the ministry at this time developed some of the difficulties.* So far, two main ideas had surfaced in opposition to the White Paper's proposals for joint authorities. The first was that they should be planning bodies only, with hospitals staying in their present ownership; the second was that they should be 'regional' bodies centred on medical schools. The first idea was open to the objection that planning would be useless unless implemented, and how could plans be implemented if that depended on a battle between the

* PRO MH 77/30B

joint authority and the owners of the hospitals? To rely on 'direction' by the minister or to withhold grant would either be ineffective or damage the service. In any case, many counties and county boroughs were not large or wealthy enough to provide a service; on the other hand, delegation from a joint authority to an individual county or county borough would be delegation from the weak to the strong. Finally, if joint authorities were planners only, it would be difficult to recruit for them either good members or good staff. The second idea, that of a 'regional' body, appeared unnecessary. If joint authorities were executive as well as planning bodies, the regional function would be limited to a few highly specialised facilities and the appointment of senior medical staff; and these could be covered by *ad hoc* arrangements, bringing in the appropriate experts.

These were the arguments put by the minister to representatives of the BHA when they met on 3 August, and to a small medical group on the following day. He told the BHA that he could not accept its proposal for a central hospital board—the responsibility for the service must be his—nor for a separate central hospital advisory body. Locally, too, he thought that any hospital advisory body should be part of the local health services council. To the doctors' group he pointed out that its idea of existing local authorities being required to carry out a regional plan would involve a non-elected body taking decisions involving the expenditure of large sums from the rates and taxes, and that, in practice, it would be very difficult to compel an unwilling county or county borough to carry out someone else's plan. He accepted the group's views on the need for influential local advisory bodies, but not for representation on the joint authorities or their committees, to which the local authority associations were strongly opposed. On the CHSC, while he thought some *ex officio* membership might be reasonable, he could not accept election, nor the right to publish advice.

BMA poll

In the *BMJ* of 5 August was published the report of BIPO on the poll of doctors about the White Paper proposals.[116] The main results were as follows.

	percentage	*number*
overall response	48	26 000

	percentage of overall response
unfavourable to White Paper	53
against central structure	51
for outside experts on joint authorities	78
thought free choice of doctor infringed	58
against local authority as party to contract for service in health centre	53
for service covering whole population	60
for free hospital care	69
for joint boards for hospital service in large areas	63
for GPs to be in contract with CMB	55
for CMB's control of entry of doctors into particular areas	57
thought unreasonable compulsory whole-time service for young doctors	66
for health centres	68
for stopping sale of practices	52
for remuneration by salary for GPs in health centres	25
for remuneration by basic salary plus capitation fee in health centres	30
for capitation fee outside health centres	55
for right of CHSC to publish its advice to the minister	91

Perhaps under the influence of this expression of professional opinion, before renewing discussions in the autumn, the minister tried out on his colleagues some possible concessions, at a meeting of the Reconstruction

Committee (as it was now called) of the Cabinet on 2 October.* The first was that the CHSC should have some *ex officio* members, some nominated by the profession and some chosen by the minister; and that he should be under an obligation to publish the council's advice, which could be accompanied by his comments on that advice. The committee accepted the idea of some *ex officio* membership, but would have none of the other suggestions—a body with members nominated by the doctors would be another negotiating body; and the CHSC's job was to advise the minister not the public, so he and not the CHSC must decide what should be published. Next came the suggestion for several separate central advisory bodies instead of the CHSC with committees. This, it was agreed, should be explored with the interested parties. Thirdly, it was proposed to separate planning and execution at the local level, so that planning for an area would be done by a local council composed of members of the local authority, voluntary hospitals and of the professions, with a small regional body of experts. The committee was prepared for this idea to be discussed with those concerned, but insisted that the council must have a local authority majority because of the financial consequences of its planning work. And professional representatives (especially nurses!) must be excluded because they would have no financial responsibilities. The fourth matter was the powers of the CMB, and the committee accepted the minister's suggestions that the requirement to seek consent to entry into practice in a new area should be replaced by a simple closure of entry to over-doctored areas, and that the obligation to serve whole-time on first entering the service should be dropped. Lastly, the minister thought that instead of a doctor in a health centre being in contract with the local authority he should be the tenant and pay rent. The committee disagreed.

Fortified by his colleagues' views, Willink embarked on further exchanges with the BHA and the doctors. He tried out the ideas of the two-tier local structure and of separate advisory bodies at the centre. The BHA was favourably disposed. The doctors did not object to the two-tier local structure, provided that all planning bodies had medical members, but they opposed separate central advisory bodies, and continued to urge election of some of the members and the right to publish advice. Nor did they object to the CMB having a power to close over-doctored areas, but they saw no need for the CMB anyway—the doctor could be in contract with the hospital authority or with a local

* PRO CAB 87/6

NHI committee-type body. On the minister's behalf, Rucker put the same proposed local structure first to the AMC and then to the CCA. The AMC generally welcomed the ideas; the CCA urged that there should be substantial local authority representation on the boards of voluntary hospitals, that the hospital plan should be initiated at regional level and that the individual authorities should draw up preliminary plans for consideration by the local health services planning council.*

Now came the annual representative meeting of the BMA, which lasted for four days, from 5 to 8 December.[13] The starting point for the debate was the BMA council's report of the previous May which had heavily criticised the White Paper proposals, together with the innumerable hostile motions sent by branches. The ARM endorsed and sharpened the council's criticism. It declared itself not prepared to cooperate in a service with the administrative structure proposed, and called for a 'thorough and impartial enquiry'. Pending more information about professional and administrative arrangements, the meeting reaffirmed the view that a comprehensive service should be available to all needing it but that it was unnecessary for the State to provide for those who wanted, and were able, to provide for themselves. Any legislation should proceed by stages, the first being the widening of the scope of the NHI scheme to cover inpatient care, specialist services and auxiliary services. When that had been done, the next step could be taken—that of extending the NHI scheme to the dependants of the insured and to others in the same income group. Finally, the council's report was adopted in general, but the ARM added the rider that the central and local administrative structures must be agreed before there was any discussion of other issues such as the '100 per cent principle', remuneration or compensation for loss of practice values. The judgment of *The Times* on the morning after the meeting was that 'it emerges only that the conference has willed almost all the ends and rejected almost all the means'. *The Lancet* thought that some of the criticism was constructive and reasonable, but 'opposition to the White Paper has been cultivated by zealots', and the claim for 'a predominant share in the organisation and control of the medical services' laid the profession open to ridicule.[89]

Negotiations with the doctors

Whatever the doctors' views might be, at least the way was now open for negotiations to begin, and on 12 January 1945 the minister met the

* PRO MH 77/30B

negotiating committee, which had Dain as its chairman, Webb-Johnson as vice-chairman and Hill as secretary.* They urged that the proposed NHS should be wholly separated from any insurance scheme for social security, and that the timing of its introduction should depend on medical needs and possibilities and not on the need to operate such a scheme. On this basis, they proposed progress by stages as suggested by the ARM, the first stage being the extension of the scope of the NHI scheme. To these views the minister replied by pointing out the inevitably close connection between health and social insurance arrangements, because the widespread payment of benefits during sickness must be accompanied by measures to reduce the incidence of sickness as far as possible. Circumstances might make it necessary to introduce some parts of the health service before others, but the objective must be to work out a comprehensive service for all. Whatever resources were available at any given time should be available to the whole community without any limitations of employment, insurance status or income level.

The committee then turned to the minister's own responsibilities, and pressed for him to take over all civilian government health services and to shed all his 'non-health' functions such as old age pensions and housing. Willink agreed the need for close coordination of the government health services but doubted the practicability of concentrating them all in the Ministry of Health—a judgment no doubt influenced by the fact that the minister then responsible for industrial health services was Ernest Bevin. He also said that, in the interests of the health services themselves, he would regret the loss of housing, water supply and other public health responsibilities.

From January until the end of May there were frequent discussions with the doctors, as well as meetings with other parties, aimed at framing modifications to the White Paper proposals which would make them more generally acceptable. For example, at the end of February tentative revised proposals were put to the BHA for their views.† The plan now provided for one central advisory body (the CHSC) but with statutory standing committees, one of which would be a hospital committee with twenty-four members—nine from the voluntary hospitals, of whom three would be CHSC members; the same from the local authorities; and six medical members of the CHSC. The CHSC itself

* PRO MH 77/30B

† PRO MH 77/100

would have thirty-seven members—nineteen medical, of whom six would be *ex officio* members, with five members each for the voluntary hospitals and the local authorities, and eight other various experts. If desired, the CHSC could appoint a joint secretary with the one appointed by the minister, and it would make an annual report which the minister would be obliged to publish, unless the public interest seemed to him to forbid it.

Locally, there would be ten regional councils based on medical schools, with the tasks of advising on the planning of the services and, particularly, on their regional aspects, such as short-listing candidates for consultant posts. The chairman and two members would come from the university; and the doctors, voluntary hospitals and local authorities would each have four members. The main planning body for each combined county and county borough area would be the area planning council, whose job would be to produce a plan for approval by the minister covering all the health services of the area. The chairman of the planning council would be appointed by the minister, and membership would comprise eighteen local authority members, six doctors, three voluntary hospital members, one dentist, one nurse and one midwife. The hospital part of the plan would be prepared by a special hospital planning group, which might have equal numbers of members from the local authorities, the voluntary hospitals and the doctors. Plans would go from the area to the minister and the appropriate regional council simultaneously, and the minister would have to consider the regional council's views before reaching any decision. The voluntary hospitals would get funds from two sources: from the Exchequer, on the basis of the number of beds made available to the public service, and from an area 'clearing house' into which local authorities would make payments for patients treated in the voluntary hospitals in the area. These proposals commended themselves to the BHA, and in April it accepted them.

The negotiations with the doctors were rather more tortuous. By the middle of March, a report on them was ready which, in form, was a report of the negotiating committee but, in fact, was an outline of a modified scheme prepared by the minister. This report was considered by the BMA council in confidence on 21 March, and by the other constituent bodies of the committee a little later. A copy of it was sent (confidentially at the minister's request) to every member of the profession preparatory to a special representative meeting of the BMA on 3 May. Thus, the contents of the report became very widely known,

but not officially to Parliament or anyone outside the medical profession. Not unnaturally, Willink was attacked in the Commons more than once during April and May, defending himself by saying (quite accurately) that the report was that of the BMA and not his. Also, during April, *The Lancet* sought to encourage the SRM to reach sensible conclusions in May. It urged acceptance of the '100 per cent principle'—how could anyone be justifiably excluded from the service if all had paid social insurance contributions? The White Paper basis was the right one—'the service will be there for everyone who wants it, 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'.[70] *The Lancet* took up two objections raised against the whole process, the first why should there be any changes, and the second why the hurry? On the first, the editor pointed to the overlapping of existing services, accompanied by wide deficiencies, uneconomic use and costs which deterred people from seeking treatment. The pooling of resources was essential. The White Paper recognised the need for the continuance of the voluntary hospitals, the importance of the doctor–patient relationship and the place of professional advice in running the new service. The proposals did not constitute a State medical service but an alternative to it. On the second point, the need for hurry, *The Lancet* pointed out the desirability of reaching an agreed solution before any election in order to avoid divisions on political party lines. But there were other, weightier reasons: the need to provide something better at the end of the war for those returning from the forces, the need to rescue the voluntary hospitals, the desirability of maintaining the wider distribution of specialist services brought about by the EHS, the need to make clear to young doctors returning to civilian life what their prospects were likely to be and the need to make the best use of what would necessarily be a shortage of doctors.[122]

Like the modified scheme, the proceedings of the SRM were confidential, and no report of them was made public; one was, however, circulated privately for the information of the profession.* This revealed general approval of the Willink plan subject to certain conditions. Once again it demanded that the Minister of Health be responsible for all civilian medical services of government but that he should have no non-health functions; it insisted that regional planning of services and their local integration must be effective; and 'single executive authority'

* RCP papers

areas must be revised (this was aimed particularly at the idea of one such authority for the whole of London). The medical members of all advisory and planning bodies should be appointed in agreement, not merely in consultation, with the profession, which should also nominate members for co-option on the health committees of local authorities. Area planning councils should have more medical members, and each local authority should have a medical advisory committee. Regional councils should have coordinating functions; for example, to advise the minister on the efficiency of the services, and on reduction of grant as a disciplinary measure. Health centres should be the subject of wide experiment before adoption, and doctors in them should simply rent accommodation from the local authority. The CMB should be dropped. But one step forward was made—the SRM accepted the principle of a 100 per cent service.

Sale of practices and other matters

While the discussions of modifications of the White Paper scheme were in train there were several developments in other fields associated with it. Two affecting general practitioners were the Spens committee to enquire into proper levels of remuneration, and consideration of the future of the sale of practices. The first was originally proposed in a letter of 17 May 1944 from Maude to Hill, but its birth was long and painful. The BMA had to be convinced that the idea was not dependent on the White Paper proposals, that it would be relevant to any form of remuneration and not just to salaries, and that there would be exploration of the issues 'from the ground up'. Step by step, the terms of reference and the membership were agreed: four doctors chosen by the BMA, four lay members acceptable to both sides, and Sir Will Spens, master of Corpus Christi College, Cambridge, and a deputy regional commissioner, as chairman (but not the first choice). Not until 9 February 1945 was the committee formally appointed with joint secretaries from the BMA and the ministry.*

The problem of the future sale of practices was very troublesome. The White Paper left the question open, but the position remained unsatisfactory, as the minister explained to his colleagues on the Reconstruction Committee in a paper discussed on 12 March 1945.† The uncertainty

* PRO MH 77/172

† PRO CAB 87/10

about the future was already affecting the sale of practices and the profession wanted a clear statement of intention. If the sale of practices was regarded as inconsistent with a national health service, then it would probably be best to prohibit it, pay compensation and introduce a pension scheme for doctors. But there were snags. What was to be done about the sale of the doctor's house or surgery? How would practice vacancies be filled? How could the upheaval at the end of the war be dealt with? Willink suggested that the best course would be to defer a decision until there were two or three years of experience of the new service, and then to have a committee of enquiry. Meanwhile, the government should say that if this ultimately resulted in the abolition of the sale of practices, compensation would be paid, but not for any enhancement in value attributable to the new service. This proposal was opposed by Willink's fellow health minister, the Secretary of State for Scotland, who wanted an immediate enquiry. Delay would not make the decision any easier, and the doctors' opinion poll had shown a majority in favour of abolition. The matter was adjourned for further discussion by Woolton with the two health ministers.

On 20 March, the Reconstruction Committee again tackled the question, this time on the basis of a joint paper circulated by the three ministers. They now agreed that a decision should be postponed, but that the prospective Bill on the health service should include a clause making it clear that any future compensation would not be increased through practice values being raised by the service. Meanwhile, a government statement should be made immediately. This should recognise the case for abolition, but point out that it involved practical difficulties and was not essential to the new service, and that a firm decision could not be reached until there had been experience of the working of the service. No steps should therefore be taken yet, but there should be an enquiry when experience was available. If then the decision was in favour of abolition, compensation would be paid, but not for increased value produced by the service. The statement should add that the government recognised that doctors leaving the forces would need to be able to find the money to buy practices on first entry, and this problem would be discussed with the profession. The committee accepted this plan, and authorised the health ministers to negotiate with the profession with a view to an early statement. This was duly made by Willink on 3 May 1945.

Two other relevant developments were the report of the Goodenough committee on medical schools in May 1944[35] and the beginning of the

publication of the reports of the hospital surveys in April 1945. The Goodenough report was long, but its length was matched by its importance. *The Lancet* said it was 'one of the most important documents of the century'.[27] Not only did it recommend university control of all medical schools, more whole-time teaching posts and the admission of women to the all-male schools, it also wanted fewer schools in London, hospital 'centres' (that is, grouped units) as the base for schools, pre-registration hospital appointments for newly qualified doctors, thorough reform of the medical curriculum by the General Medical Council and much increased Exchequer grants for medical education. Almost all these ideas were carried out in the next few years.

Contrary to the original intention, it was decided in April 1944 that the only sensible course was to publish the hospital survey reports in full, whatever embarrassments might result (they were, in fact, few). The London survey, covering the whole area south-east of a line from Lyme Regis to Bedford and Harwich, appeared first, on 12 April 1945,[29] and the others followed over the next few months. They all painted the same picture of the immediately pre-war hospital scene, overlapping yet inadequate services, accommodation lacking both in quantity and quality, too little cooperation, absence of specialists outside a few big centres. They highlighted the need to break down the divisions between the voluntary and local authority hospitals, and between counties and county boroughs, and to bring hospitals together in groups constituting a single general hospital—at first housed in separate units but ultimately in one. These groups would form a district hospital for each appropriate area providing all specialist services, except a few more highly specialised facilities which would be provided on a regional basis. The facts revealed by the survey reports, and the conclusions which clearly flowed from them, had wide and deep influence upon public and professional thinking about hospital services during 1945 and later.

Dental services

Another major development during this period was the formulation of proposals for a comprehensive dental service. In May 1944, officers of the Ministry of Health and the Board of Education agreed that, whatever other arrangements were made, local authorities should continue to employ dentists to provide a priority service for mothers and children, and that they might also arrange to use for the benefit of the priority classes the services of dentists in the NHS. But to make progress

it was essential to have the views of the Teviot committee, and that committee appeared to be moving extremely slowly. Accordingly, on 9 September, Willink wrote to Teviot asking for a short interim report on general principles; for example, whether to plan now for a comprehensive service for all, whether to arrange priority for some groups.* Suggestions were needed urgently, because decisions must be taken on what was to go into a draft Bill, and before that could happen there must be discussions with the profession. Could a short report be available by the end of October? The answer was that it could. Recommendations were sent to the minister on 24 October in favour of the inclusion of a comprehensive dental service within the NHS from the beginning, and the interim report was published in November.[34]

Immediately, proposals were drafted to put to the dental profession. Dentists would be free to join the service or not, to serve whole-time or part-time and to accept or reject patients; patients would be free to use the service or to be treated privately. There would be a full trial of basing a service on health centres. A central dental board, like the CMB, would be the contractor with the dentist and pay him, the scales of pay being nationally determined; and local insurance committee-type bodies would continue. Local authorities would employ salaried staff or make arrangements with general dental practitioners for priority treatment for mothers, children and adolescents. Like doctors, dentists would play a full part in the advisory machinery of the service.

An informal discussion with the secretaries of the dental associations on 12 January 1945 showed that there was little difference of opinion. There was some advocacy of a dental advisory body separate from the CHSC, and of the inclusion of at least two dentists on each local planning body (reflecting the professional division between the '1922' dentists admitted to the register on the basis of experience only, and the graduates of the dental schools). It was also thought that some of the part-time members of the CDB should be elected by the profession, or at least be appointed after consultation with it. There was agreement on the idea of local insurance committee-type bodies; on payment by way of a fee for each item of service (except in health centres, where the proposal was for salaried employment); with prior approval of some forms of treatment by a central professional body; and on the dentist's obligation to include in his estimate all the work he thought necessary to produce dental fitness. A formal meeting of representatives of the

* PRO HM 77/124

profession with ministers was equally encouraging, though doubts were expressed about the survival of private practice. The ministers said that no decision had yet been reached on the question of charges for dentures or other appliances, and they offered a 'Spens committee' on the remuneration of dentists. This was followed by a series of meetings with officers of the ministry on the details of the scheme.*

Pharmaceutical services

Similar meetings with the pharmacists began on 7 March 1945.† The ministry's view was that the arrangements in the new service for the supply of drugs and appliances should be, as nearly as possible, the same as under the NHI scheme, but the whole population would receive them not just a section of it. This was explained to the representatives, as was the then current revision of the White Paper scheme. Pharmacists would be in contract with a local committee which would include pharmacists among its members. In experimental health centres, dispensing services might be provided but no one would be compelled to use them. On 3 May, discussions were resumed, when the pharmacists pressed for a share in the planning and administration of the service at all levels. The CHSC complex should include a standing pharmaceutical committee; pharmacists should be represented on the area planning council; and there should be a pharmacists' committee at county and county borough level. It was promised that the first of these points would be considered; the second was unnecessary, because pharmacy services would not be dealt with by the council; the third would certainly exist, in parallel with the insurance committee-type body. At a further meeting, on 15 May, new matters were raised. The pharmacists wanted all hospital and clinic dispensing to be done by them or under their supervision (this was accepted); some control over the opening of new pharmacies (this was regarded as unlikely); dispensing in pharmacies to be under the pharmacist's 'direct and personal' supervision—a hit at the company chemists, which was noted for later consideration; a continuing ban on gifts to pharmacists or rewards for services, and the regulation of advertising.

Two days later the company chemists had their say, urging the

* PRO MH 77/124

† PRO MH 77/120

continuance of the right of a firm or body corporate to take part in the service, asking for representation as allowed to the pharmacist and opposing any restriction on the opening of new pharmacies.

Nursing

Another professional group seen on several occasions was the nurses.* Representatives of the Royal College of Nursing met the minister on 2 May 1944, when he explained that nurses would be members of the central and local advisory bodies and of the inspectorate it was proposed to create, and that there would be a home nursing service available to all. While interested in these points, the Rcn was more concerned to raise others—the role of nursing in health centres; the need for genuine student status for student nurses, with separation of the finances of the training school from those of the hospital, and grants for them as recommended by the Athlone committee[31]; the reform of the constitution of the General Nursing Council.

In September 1944 and again in April 1945, officers of the ministry met representatives of the Queen's Institute of District Nursing and other bodies concerned with home nursing to discuss the pattern of the new service. This, it was thought, would follow that of the Midwives Act 1936, which gave a statutory duty to counties and county boroughs to provide a service and, in doing so, to prepare schemes for the minister's approval, making full use of the voluntary district nursing bodies.†

Later meetings during the first half of 1945 discussed the main revised White Paper proposals when, like other professional groups, the nurses argued for a bigger place in the sun—the nomination of nursing members of the proposed standing nursing advisory committee by the profession itself; two places on the CHSC as well as one for a midwife, and the same on local area planning councils; the 'recognition' by the minister of local nursing committees to be set up and financed by the profession.

Optical service

The opticians presented a particularly knotty problem. Opinion was sharply divided on how to organise a service for the whole population.

* PRO MH 77/160

† PRO MH 77/30B

The medical view was that it should be based on testing and diagnosis by a medical practitioner and dispensing by an optician to his prescription. To the Faculty of Ophthalmologists this meant diagnosis by a full specialist; but to the National Ophthalmic Treatment Board (an organisation of doctors and dispensing opticians operating under the wing of the BMA) it meant diagnosis also by general practitioners with some special experience. Both shared the belief that sight-testing opticians had not, and could not have, the knowledge necessary for full diagnosis of eye conditions and might, therefore, fail to refer to a doctor a patient needing medical treatment.

The sight-testing opticians contested this assessment of their abilities. They wanted the service to be based on them, with reference of patients to a doctor by them if necessary. This they urged at a meeting on 8 May 1945 ('VE Day', which, much to their delight, Winston Churchill was celebrating in the adjoining conference room by waving to the crowds in Whitehall). On 24 May, a compromise scheme was put to them, by which an ophthalmologist would be responsible for diagnosing pathological conditions but the optician for sight-testing and dispensing. The NHI arrangements would be extended to the whole population, but there would also be hospital eye clinics on an experimental basis, staffed by ophthalmologists and whole-time salaried opticians. Patients would be free to go to either, but if the eye clinic experiment was successful that would become the sole form of service. This compromise was summarily rejected by the opticians. They resented being turned into medical auxiliaries—their aim was registration as an independent profession. They objected to salaried employment, and demanded representation on the planning and administrative bodies of the service.* Argument about the form of the eye service went on right up to the date of the beginning of the NHS, and even beyond.

The fate of the Willink scheme

By May 1945, the need for decisions on the NHS was becoming urgent. On 18 May, Woolton wrote to Willink pressing for the early introduction of a Bill (preliminary drafting had in fact been in progress since February).† Willink replied that a revised draft of his proposals would

* PRO MH 77/74

† PRO CAB 21/2032

be ready by 24 May when the last meeting with the negotiating committee was to be held, and suggested a talk after that. At the meeting of the negotiating committee, Dain began by enquiring what the future course of events would be. The profession wanted to make it clear that it was not opposed to a national health service, but to introduce a Bill at that time (by then, Labour ministers had left the government) might look like a party political manoeuvre which they would wish to avoid. Willink replied that he could only say that there would clearly be no Bill before 27 July (when the result of the general election would be known). But if no statement of policy were made by the caretaker government, this too might throw the matter into the political arena.

Dain summarised the profession's view that negotiations should continue, with emphasis on certain points. These were that one minister should be responsible for all civilian health services; that standing advisory committees at the centre should be appointed by the overall advisory body and not by the minister; that members should be appointed in agreement with the profession; that regional councils should conduct running surveys of the services and report to the minister, should see area plans on their way to the minister, and should advise him on grants to the administering bodies; and that area planning councils should have a subordinate body for planning non-hospital as well as for hospital services. Webb-Johnson added that London and the adjacent areas should be divided radially for planning purposes, and Moran emphasised the importance of the role of the regional councils.*

On 28 May, Willink sent to Woolton a draft Cabinet paper setting out the revised proposals and suggesting an early statement of their nature together with an announcement of the intention to introduce a Bill based on them if the government were returned at the pending election. This Woolton commended to the Prime Minister on 1 June, proposing the publication of a short paper; and on 4 June a draft paper was submitted to the Cabinet. But on 6 June, a meeting of ministers was held to consider what should be included in the election manifesto about the NHS, and whether a paper should be published.† Those present, in addition to Woolton and Willink, were Beaverbrook, Ernest Brown, Hore Belisha and Rosebery.

The first question was quickly settled—the manifesto should promise

* RCP papers

† PRO CAB 21/2019

a comprehensive health service and legislation in the first session of Parliament. It should emphasise that the service would be available for all and all would contribute to the cost, but no one would be denied care through inability to afford it. The professions would have full scope in guiding the new service; there would be free choice of doctor; the universities would have influence in shaping the service; the voluntary hospitals would remain free and be in friendly partnership with the local authority hospitals. A promise was also made of more maternity beds, better care of children with the encouragement of nursery schools and day nurseries, and improved nutrition.

The second question was not so easy, and opinion was quite sharply divided. Willink wanted to publish a short White Paper showing the progress made in the discussions of the 1944 proposals, and the modifications now proposed to meet the criticisms of them. It was argued that opposition would be reduced by the publication of the new proposals; that the Conservative caretaker government would be thought by those (not a few) who knew of the existence of revised proposals to be delaying progress planned by the coalition government if no White Paper was issued; and that parliamentary candidates would find difficulty in answering questions if they did not know the modified proposals. On the other hand, it was urged that the publication of a White Paper late in the session would preclude any debate in the House, and so give rise to criticism, while early publication would open the door to damaging attack from the opposition and would provide it with ammunition for its own election campaign. Government candidates might be exposed to detailed criticism and cross-examination. The new proposals would be represented as weakening the coalition government's plan, and as the first of a series of withdrawals from the reconstruction plans announced in that government's White Papers. The conclusion was against publication; but it was suggested that the health ministers should submit to the Cabinet a short statement of the main modifications made, and seek authority to announce the changes in general terms which could be used by government supporters in the election.

What were these modifications? They were summarised at the time like this.

Central organisation The central advisory body would be reinforced by statutory standing committees on special subjects, which would have direct access to the minister. The body would prepare an annual report which the minister would be bound to publish unless it was contrary to the public interest. The CMB would be dropped.

Local organisation The area health authorities would be planning bodies only, with no administrative functions, and would cover areas with populations of half a million upwards. They would have about thirty members, eighteen from the local authority and twelve from the voluntary hospitals and medical profession; but a special group composed of equal numbers of voluntary hospital and local authority members would prepare the hospital part of the plan. Regional bodies, appointed by the minister and consisting of about fifteen members drawn from the appropriate university, local authorities, voluntary hospitals and doctors, would advise area authorities and the minister on the wider needs of the region, and would set up machinery for advising on consultant appointments.

General practitioners Health centres of various kinds would be provided, maintained and staffed by the local authorities, but on an experimental basis under close ministerial control. Doctors in health centres, like those outside, would be in contract with a local committee of the familiar NHI type. These committees, one for each county or county borough, would be half lay and half professional, one-third of the lay members being appointed by the minister and two-thirds by the local authority. They would be responsible for contracts with the professionals practising in the area and for discipline on the lines of the NHI system. There would be no bar on doctors entering practice in any area, but there would be special payments to induce them to go to unattractive areas. The sale of practices would continue, subject to a full enquiry after some years.

Dental and eye services A priority dental service would be provided for mothers and children, and a free treatment service for others if they could find a dentist to take them. The eye service would be based on the same principle, but further discussion of its organisation was needed.

Local authorities Each county and county borough would be required by statute to appoint a health committee with a proportion of non-local authority expert members; for example, doctors.

Voluntary hospitals These would draw a standard service payment from a 'clearing house' for each planning area, and each county and county borough would make a payment to the clearing house for every patient from their area treated in a voluntary hospital.

Other developments Public health laboratories would be provided for a bacteriological service. There would also be a national blood transfusion service.

Briefly, it can be said that these modifications consisted of a series of

concessions intended to mollify medical and voluntary hospital criticisms of the original White Paper. And they might well have done so, as both the negotiating committee and the BHA had unofficially indicated. But the price paid included not only the abandonment of important elements, such as controls on the distribution of doctors, the rapid development of health centres, and the cardinal principle of combining planning and execution in the same local hands, but also the creation of a planning and administrative system of almost unworkable complexity. It was perhaps just as well that this structure did not survive the 1945 general election.

In accordance with the decision of the ministers' meeting of 6 June, a minute was addressed to the Prime Minister on 16 June seeking approval to the main points of a speech to be made 'on Tuesday or Wednesday next week' announcing the modified scheme and promising a Bill in the first session of the next Parliament.* The reply was unfavourable. It was thought better to keep silent and await any attack from the opposition (which did not, in fact, materialise). But work on the scheme went on, and at a meeting of the Home Affairs Committee on 13 July—more than a week after the election, but nearly two weeks before the result was known—Willink promised a draft Bill by September at the latest. It was the last flicker of life in the dying government on the subject of their painfully elaborated plan.

* PRO MH 77/30A

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The third round: Bevan's solution 1945–46

Once more there was a lull in the planning of the National Health Service as the Labour government took over after their sweeping victory in the July election. The new ministers had to find their feet; and in any case the new Minister of Health had more problems, and more urgent problems, to tackle than the future NHS—the daunting difficulties of war-damaged housing, and the demand for more houses after so many years without any new building. But what kind of proposals could be expected from the Labour government for the NHS?

Pre-election Labour views

In many quarters, the advent of the new Minister of Health was greeted with alarm and despondency, and that for two reasons—the proclaimed past policy of the Labour Party on health service matters, and the personality of the minister himself.

So far as Labour's views were concerned, it was true that the Socialist Medical Association in June 1944 had welcomed the White Paper, particularly the proposals for a service which would be comprehensive and free at the time of need. The SMA recognised and accepted that concessions must be made to the voluntary hospitals and the private practitioners in order to secure their willing cooperation; it urged the rapid establishment of health centres; it opposed the creation of the central medical board and preferred direct contracts between general practitioners and the joint authorities; it called for workers' representation on local bodies, the right of advisory councils to publish their reports, and early legislation.

But the earlier views of the Labour Party itself had been much more radical. In April 1943, in *National Service for Health*,[72] it had proposed, amongst other things, the creation of elected regional authorities for all local government purposes, with a health committee to plan the health services for the region. The services would be administered by the major local authorities, which would pay voluntary hospitals for the patients they treated and would be represented on their governing bodies. All hospitals would have to conform to plans for organisation and administration approved by the minister, and to submit to departmental inspection. Health centres would be set up with eight to twelve general practitioners and with home nurses and midwives, health visitors, home helps and social workers. In the health centres and throughout the service, all doctors would be whole-time staff and would be debarred from private practice.

If Labour's views in general caused alarm, much more so did the person of the new minister. Aneurin Bevan was young, vigorous and left-wing. He had gained the reputation of rebel even before the war, and during it had been a constant critic of Winston Churchill who had called him a 'squalid nuisance'. It was surely to be expected that such a man would advance proposals radical in the extreme, and pursue them with dogmatic zeal. The doctors and the voluntary hospitals waited with some degree of apprehension, not altogether unshared by the civil servants in the ministry.

The first indications of policy came, however, not from Bevan but from Greenwood (Lord Privy Seal) and Morrison (Lord President of the Council) on the second day of the debate on the Address on 17 August.[71] The former said that because of the 'muddle' left by Willink it would take some time to produce proposals for the NHS. These would therefore come after those for national insurance. The secret negotiations conducted by Willink with the British Medical Association would be disregarded, and it would be necessary to go back to the original White Paper as a starting point.

Willink retorted that there was no muddle, and the work he had undertaken should not be treated as nugatory. He had envisaged the NHS as beginning at the same time as the national insurance scheme, if not before, because it was urgent to let young doctors returning from the forces know how they would stand, and to settle the future of the voluntary hospitals. It had always been intended that there should be discussions with those concerned about the White Paper proposals, and these discussions had been conducted not only with the BMA but with

all parties. In the course of them, it had become clear that the voluntary hospitals and the doctors wanted a fuller share in planning the service, and feared local authority control; that the White Paper had given too little place to the influence of teaching hospitals with medical schools; that the voluntary hospitals objected to receiving payments from the local authorities; and that general practitioners opposed the powers of the proposed CMB. But by the end of May, without any sacrifice of substance, general agreement had been reached on the way forward, and the drafting of legislation had become possible. Herbert Morrison replied that the new government fully intended to introduce legislation during that session, but it must first determine its shape. He understood that Willink's negotiations had resulted in material departures from the White Paper proposals, but the caretaker government had never made known what the discussions had produced, as it should have done, and further thought would therefore be needed.

Bevan and the doctors

While thinking went on within the walls of the health departments about the form the government's proposals should take, tentative contacts were made between the new ministers and the professions. The first was a dinner party at the Café Royal on 25 October, when Bevan was entertained by Dain, Souttar, Moran, Webb-Johnson, J B Miller and Hill, and several similar functions followed.* They were social occasions only, though not wholly devoid of political overtones. Bevan needed to find out for himself what sort of people he would be having to talk to, the doctors needed to know what kind of Minister of Health the Welsh left-winger would turn out to be. Both were moderately pleasantly surprised at their discoveries. To Bevan it soon became apparent that the medical profession was not the immovable monolithic object it seemed to be—on the contrary, there were several currents and cross-currents of opinion within it. In the same way, the doctors found him different from their expectations. He could roar as gently as any sucking dove; 'obviously clever and charming, with the cherubic outlook and manner of a boy' was one early judgment.[65] In conversation he was witty, open-minded and very ready to listen and to learn; by no means the ranting dogmatist of political caricature. Discussion with someone of this calibre might be worthwhile.

* RCP papers

By early October, Bevan was ready to put to his colleagues proposals for dealing with the central problem of the NHS structure, namely the organisation and administration of the hospitals. A decision in principle on this was urgently needed. Legislation depended on it, and a Bill was essential that session to keep in step with the national insurance scheme, to maintain in being the developments achieved by the Emergency Hospital Scheme, and to make their future clear to the doctors returning from the forces.

Bevan's solution was as simple as it was radical. All the hospitals, local authority as well as voluntary, should be taken into national ownership and administered by appointed local bodies with voluntary membership exercising powers delegated by central government. In a Cabinet paper of 5 October he set out his case.* He began by pointing out that, under the proposals so far discussed, voluntary hospitals would in future be getting 70 per cent—80 or 90 per cent in some cases—of their income from public funds. Logically, this should involve public control in proportion, creating a sort of hybrid between the voluntary and the public hospital; but this was unlikely to reduce the opposition of the voluntary hospital world, and would do nothing to contribute to the reform of the hospital services. The best solution would be a clean takeover, whether by some form of local authority or by central government. Most local authorities were unsuited to running hospital services; they were too small and their boundaries were irrelevant to service needs. Their record as hospital authorities (with a few honourable exceptions) was not good. In any case, the need was for a service planned and provided on a national scale, with a new blend of technical expertise and public representation. A new local government unit did not meet the case, because direct election of such a body would be impracticable, and any kind of joint board would be at two removes from the electorate, unpopular because it would be a precepting body and difficult to man with good quality membership. Nationalisation was the answer: to produce a single service with uniform standards for all. The additional cost would be small, involving only the loss of contributions to the voluntary hospitals. On the local authority side, an adjustment of the relationship between central and local taxation was necessary in any event. Only the teaching hospitals would not be taken over because of their special role in both teaching and innovation.

The administrative structure of the new service would consist of

* PRO CAB 21/2032 (CP(45)205)

regional boards under the general direction of the minister but with the maximum decentralisation of administration, and district committees for 'natural' hospital areas, appointed by the boards but with delegated powers for day-to-day running of the hospitals. The officers of the boards and committees would be appointed as officers of the minister, with interchange between the regions and the ministry, but medical and other staff would be appointed and paid by the boards as the agents of the minister.

Bevan thought these proposals would cause an outcry from the voluntary hospitals and the local authorities, but that the doctors might well be in favour because they would overwhelmingly prefer a nationalised to a local government service. He would need to have some discussion with the local authorities and others, but he had no intention of starting up a new series of negotiations.

The reception given to these proposals in Cabinet on 11 October was mixed. George Buchanan supported them for Scotland, except for the exclusion of the teaching hospitals. Bevan explained that he did not propose exclusion of the teaching hospitals from the service but a special position for them within it. George Isaacs (Minister of Labour and National Service) and Addison (Dominions Affairs)—perhaps with his memories of the Dawson report of 1920—supported them; Dalton (Chancellor of the Exchequer) reserved his position; Greenwood feared that such a radical plan would take years and protracted discussions to bring to birth.

But the chief opponent, as appeared from a paper he put in on 12 October, was Herbert Morrison, Lord President.* Morrison argued primarily as the defender of local government in general, and of his past empire, the London County Council (the largest hospital authority in the country), in particular. He pointed out that a similar idea for a national police force had been rejected on two grounds—the first that it would centralise control, and the second that it would weaken local government. The creation of regional boards and district committees would not overcome the objections to centralisation because, if they were subject to the minister's direction, delegation to them would be regarded as ineffective, but on the other hand they could not, in a State system, be allowed to spend Exchequer money without approval. The weakening of local government would be very serious: it would be losing gas and electricity, probably transport and possibly water, and if the Minister of

* PRO CAB 21/2032 (CP(45)227)

Health's logic were followed it would lose other health functions. Two other objections were that the proposals were outside the Labour Party's election programme and would divide the party, with damaging effect on the local government elections due in the spring; and that they would delay the advent of the NHS because prolonged negotiations would be needed. The conclusion could only be that the disadvantages of the minister's proposals outweighed their advantages.

Bevan retorted at length and in detail to rebut this attack.* First, he noted that Morrison did not challenge the view that centralisation was the way to an efficient hospital service, but that he feared the repercussions. These Bevan had considered, but he was convinced that they could be overcome, and that the difficulties of any alternative scheme were even greater. There were three main objections to any less radical solution. First, if voluntary hospitals were receiving up to 90 per cent of their income from public funds they could not be left under independent management—to do that would have a more damaging effect on Labour opinion than that feared by Morrison; but to hand them over to local government would raise a tornado of opposition. Second, a local government hospital service would be unequal in operation over the country, which would be unjust to a public paying equal contributions. Third, neither of the existing hospital systems was adequate, and it solved nothing to put one under the other—the only remedy was a new and different system. Morrison had argued for a pattern of joint boards; but, quite apart from the objections to joint boards on constitutional grounds (precepting, remoteness from the electorate, and so on), any such pattern would split the health service, because hospitals would be in the hands of the boards but other services in those of the individual authorities. The alternative would be to have joint bodies for planning only, but this would meet none of the three main problems, nor provide an efficient service.

Next, Bevan countered Morrison's objections. The proposed centralised national service must be planned to avoid rigidity. Local administration would be the job of regional boards and district committees, which would be agents of the minister but agents with substantial executive powers subject to broad financial control. It was hoped to find the right people to serve on these bodies to make this devolution of power possible. This pattern need not involve any weakening of local government. There must be a rationalisation of local government

* PRO CAB 21/2032 (CP(45)231)

anyhow, in order to ensure a proper distribution of functions and of expenditure between it and the Exchequer; and there would be plenty left for local government to do.

The political consequences of his proposal did not seem to Bevan to be serious. They were in accord with the spirit, if not with the letter, of the election manifesto, and they looked forward to the regionalisation of local government with which the Labour Party was sympathetic. He doubted whether they would lead to any loss of votes in the forthcoming local elections, as they would have the support of the great majority of doctors, of the more far-seeing local government opinion and even of the wiser voluntary hospital supporters. The possibility of delay was serious. There must be a Bill this session, and that meant an early decision. But there was no need for negotiations to be conducted all over again. He would make clear that the principles were settled and not open to discussion, but many details would need discussion which would not be in the Bill itself. This might mean more argument on the second reading of the Bill, but less at the committee stage.

In Cabinet, on 18 October, opinion was still divided. Addison again supported Bevan, as did Tom Williams (Agriculture) and Ellen Wilkinson (Education). Chuter Ede (Home Secretary) was fearful of the take-over of local authority hospitals. Jowitt (Lord Chancellor) suggested that the minister should have powers of direction instead, with a reserve power to take over. Alexander (First Lord) thought more detailed examination was needed, and that, if teaching hospitals were to have special arrangements made for them, so should special hospitals of a national character (here he clearly had in mind the Manor House Hospital which had been founded by the trades unions). The Prime Minister summed up by suggesting that the differences between the views of the Minister of Health and those of the Lord President were less fundamental than they appeared. In either case, the major part of the cost of the hospitals would have to come from the Exchequer, and the membership of regional boards and district committees would be much the same as that of joint boards under the Lord President's scheme. The opinion of the Cabinet seemed generally in favour of the minister's proposals; but, while approving them in principle, it would want to look at them again when details had been worked out. The social services committee, with the Lord President and any other ministers interested, should consider the detail and report back. Meanwhile there should be some discreet soundings of government supporters, without revealing precisely what the government had in mind.

While the Cabinet's remit was being pursued, action was taken on other fronts. On 8 November, Churchill, as leader of the opposition, enquired by private notice question the position on hospital policy,[69] in view of statements in the press that the Cabinet had decided to take over all hospitals. Attlee replied that no decision had yet been taken (which was formally correct), that his enquiries had revealed no leak and that one should not believe everything in the newspapers—even the *Daily Herald.*

On the same day, Charles Hill wrote to Bevan on behalf of the negotiating committee asking about the resumption of discussions,[73] and was assured that Bevan would meet the committee before the government decided what proposals to put to Parliament. It was not intended to begin a new and protracted series of negotiations, but the profession would have the opportunity to express its views to him. Accordingly, the committee prepared itself for action by adopting a statement of basic principles from which it would not depart, and issued it to the press for publication on or after 14 December. The '100 per cent principle' had already been conceded. The new statement was an expression of professional fundamentals, seven in number.

1 In the public interest, the profession is opposed to any form of service leading directly or indirectly to the profession as a whole becoming whole-time salaried servants of the State or of local authorities.
2 The profession should be free to exercise its skills, the individual doctor being fully responsible for the care of his patient, with freedom of action, speech and publication, and no interference with his professional work.
3 The citizen should be free to choose his family doctor and (in consultation with that doctor) his hospital, and to choose whether to use the service or not.
4 Doctors should be free to choose their form and place of work without government or other direction. (On this, *The Lancet* had some sensible comments.[21] There was a clear need for a better distribution of doctors, which better remuneration and working conditions such as health centres would help to encourage, but this would not be enough. If the proposals for the CMB could be modified by requiring consent for entry only to areas designated as adequately served, then 'direction' of this kind would closely resemble the economic 'direction' of the past.)

5 Every registered medical practitioner should be able to take part in the service.
6 The hospital service should be planned on the basis of natural areas centred on universities.
7 There should be adequate representation of the profession on all administering bodies in order to contribute to the efficiency of the service.

Of these principles, it would be fair to say that all except the first and the fourth were entirely in line with the government's own views.

The other main question on which action was taken at this time was the future of the selling of practices. The new government could not accept the caretaker government's shelving of the issue, and Bevan accordingly brought to the Cabinet on 23 November a paper proposing abolition.* Compensation would be paid at 1939 values, and there would be a contributory pension scheme for all future NHS doctors. This was approved by the Cabinet on 3 December for announcement in Parliament on 6 December. Bevan then said that it would be incompatible with an efficient service to leave exchanges and creation of practices and the distribution of doctors unregulated. But intervention would probably prevent the sale of practices, so this warning was being given in advance of the main NHS proposals. Full compensation would be payable, and there would be immediate discussions with the profession on the steps necessary to carry out this decision.[78] There followed negotiations to determine the total amount of compensation to be payable if abolition were eventually carried into law, which resulted in the global figure of £66 millions at 1939 values being agreed in March 1946.

Bevan and the dentists

This period also saw the arrival of the final report of the Teviot committee on dentistry, published early in 1946.[33] It estimated that a comprehensive dental service would require a total of 20 000 dentists in active practice, and it therefore recommended that the annual entry of students to dental schools be raised to 900, compared with 340 before the

* PRO CAB 21/2032 (CP(45)298)

war. Dental schools should be separate legal entities and integral parts of universities, and priority should be given to building new schools and improving old ones with a special government grant of £1.25 millions. Dental students should receive grants, and a special grant of £150 000, rising to £300 000, a year should go to increasing dental teaching staff receiving national scales of remuneration. There should be a separate dental council (instead of a committee of the General Medical Council) to govern the profession, to advise on the curriculum (which should be reviewed with the object of shortening it without lowering standards), and to inspect courses and examinations. Postgraduate training and refresher courses should be developed, and much more dental research promoted. Any introduction of dental operative assistants should await proof of a shortage of dentists, but there should be an immediate experimental scheme of training for dental hygienists, and proper training arrangements for dental mechanics and dental attendants. (The dentists were, and continued to be, chary of any form of 'dilution'.)

These and other points were taken up at meetings of the dentists with the minister on 14 January, 22 February and 18 June. Most of the Teviot report was, in fact, adopted and put into effect over the next few years. So far as the service itself was concerned, the dentists were generally content with the framework proposed. This consisted of a central professional body with branch offices to approve estimates of work proposed by the individual practitioner other than minor or routine procedures; priority for mothers and children at first and for adolescents later; practice from health centres so far as possible (the dentists did not share this enthusiasm for 'clinics'); and a Spens committee to advise on remuneration. In the debates which followed, the dentists tended to echo the doctors, but with much less fervour of opposition. The Spens report on dentists' remuneration, published in May 1948,[37] combined with the under-estimates of the amount of work which could be carried by a dentist in his own surgery, produced very high incomes at the outset of the service, and this also no doubt helped to commend the service to the profession.

Preparing the Bill

By 13 December, Bevan was able to produce a Cabinet paper submitting proposals covering the whole service and approved by the social services committee, and seeking authority to prepare a Bill for consideration by

the Cabinet as soon as possible in the new year.* He pointed out that this was an opportunity for a complete overhaul of the health services which might not happen again for many years. It was important, therefore, to give the proper role to both central and local government, and to enable professionals to have a proper voice in guiding and providing the services. The paper went on to outline the service in the shape in which it later appeared in the Bill, including basic salaries and capitation fees for general practitioners, private and amenity beds in hospitals, and charges for home helps, supplementary articles, 'luxury' appliances, and renewals or replacements due to negligence. The finances of the scheme were presented like this.

	1939 £m	*Proposed* £m
NHI contributions (NI in future)	11.2	35.7
Exchequer	3.0	103.3
Rates	40.3	6.0
Voluntary contributions	11.5	—
Total	£66.0m	£145.0m

A Scottish paper put in at the same time supported the proposals, with some modifications to meet Scottish circumstances: the ambulance service to be run by regional boards and not local authorities; the local executive committees to cover several (much smaller) local authority areas; and health centres to be provided by the Secretary of State not by local authorities. The expenditure was put at £17 millions for Scotland, compared with £7.6 millions in 1939.

The welcome given by the Cabinet to these proposals on 20 December was less than enthusiastic. Addison repeated his support, welcoming the provision of pay beds in hospitals and hoping that it might be possible to prohibit NHS consultants from practising in nursing homes. Dalton was generally favourable, but could not accept the financial implications until there had been a review of local government expenditure as a whole in relation to the block grant and the Exchequer. He also insisted on close financial control over the regional hospital boards, and an efficient system of comparative costing. Greenwood doubted whether a Bill

* PRO CAB 21/2032 (CP(45)339).

would be possible that session, in view of the difficult negotiations which would be needed. Morrison and Chuter Ede reaffirmed their misgivings, that the probable weight of opposition made negotiations necessary before a Bill could be introduced.

Bevan disagreed. He had explained to government supporters why unorthodox forms of medicine could not at present be within the NHS, and had persuaded Labour doctors to accept his proposals instead of a whole-time salaried service. He must have a Bill that session to keep in step with national insurance, and he intended to negotiate on the basis that the main features of the scheme must stand, and that any concessions must be such as could be made administratively. In talking to the local authorities, he would not hold out any hope of a reduction in their rate burden. He and the Scots pressed for the preparation of a Bill. The Prime Minister said that the Cabinet should see the heads of the proposed Bill before any drafting was done, but discussions with the local authorities and others could go on at the same time.

In the first week of 1946, therefore, the heads of the Bill were brought to the Cabinet and a paper sent in confidence to the interested parties as a basis for discussion. On 3 January, Bevan again sought approval to immediate drafting of the Bill.* If it were introduced in March, it could be passed that session. He estimated that the Bill would have about fifty clauses; detailed provisions would go into regulations, which would have to be negotiated and would need to be ready by January 1948, when the national insurance scheme would come into operation. The Treasury was unhappy about delegating spending powers to hospital bodies, because of the accounting officer's need to account for expenditure in detail, and about hospital bodies appointing staff who would in effect be civil servants. The Treasury caused the Chancellor to repeat his warning about not encouraging the local authorities to expect relief to the rates through the transfer of hospitals to the State. Bevan renewed his assurances of developing comparative costing and central purchase of supplies. A number of minor points were raised by other ministers: the desirability of requiring general practitioners to take refresher courses; the need for some form of incentive for them to maintain efficiency; the mobility of consultants; local authority representation on hospital management committees for groups of hospitals which did not include a local authority hospital; the representation of trades unions on regional boards; the future of industrial medical services (to be considered later).

* PRO CAB 21/2032 (CP(46)3)

But in the end, the heads of the Bill were approved and drafting was authorised.

With minor variations, the same paper outlining the proposed scheme was sent to a number of bodies—the BMA negotiating committee of course, the local authority and hospital associations, the dentists, the pharmacists and company chemists, the opticians, the nurses, and so on—and during the next two months the minister met upwards of twenty deputations from organisations, including such fringe interests as the medical aid societies and the herbalists. The outline scheme, apart from the hospital proposals, closely followed the 1944 White Paper scheme, but there were some new emphases. The statutory duty to provide the service was now to rest on the minister, directly in relation to the hospital and consultant services, and indirectly in relation to the general practitioner and community services. A basic salary for general practitioners was also a feature, with a medical practices committee to regulate their distribution.

Reactions to the circulated proposals were diverse. After a preliminary meeting with the minister on 10 January, the negotiating committee, at a meeting a week later, decided to approve the idea of a national hospital service administered through executive regional bodies, subject to the composition and functions of the regional and area bodies being satisfactory. But in order to ensure the integration and correlation of the services, the committee proposed that all of them should be administered by the regional bodies, though the general practitioner's contract would be with the local executive council. It also wanted health centres to be provided by the regional body, and health centre staff to be employed by the executive council; and it expressed disapproval of the powers of the medical practices committee.* These and other points were put to the minister at a further meeting on 6 February. The main complaint, then and later, was that the minister refused to negotiate: he simply presented his proposals and then listened to the comments without argument. In this, Bevan's stance was clear. His view was that Parliament must be the first to know his proposals, and only after that would negotiation be proper; and this view he maintained throughout.

The voluntary hospital representatives were divided between those (from the teaching hospitals) who saw some merit in them and those (mainly from the smaller and non-teaching hospitals) who were horrified and outraged by what Bernard Docker was later to describe as 'this

* RCP papers

mass murder of the hospitals'.* The local authorities were divided too. Out of political loyalty, the LCC swallowed the bitter draught of losing its hospitals, provided that the voluntary hospitals were transferred to ministerial ownership also; and on 22 March, just after the publication of the Bill, Lord Latham made a press announcement of the fact. The County Councils Association did not agree: it proposed either joint planning with administration by the individual authorities, or transfer of other health services also with administration by the new boards and committees, both to have fifty per cent local authority membership. The minister would accept neither, nor would he accept the wish of the LCC and the Association of Municipal Corporations for fifty per cent membership of boards, management committees and executive councils. The other professional bodies consulted confined themselves mainly to seeking ampler representation in the central advisory machinery or the local administrative bodies.

Submitting the draft bill to the Cabinet in a paper of 1 March,† Bevan summarised the position following his consultations. The LCC accepted the proposals, subject to some minor points; other local authorities showed some signs of opposition but he did not expect it to be strong. The medical profession was not able to say much; most of its responsible members and leaders were broadly reassured, but vocal opposition could be expected when the Bill was published. The voluntary hospitals were hostile, though their most responsible and experienced leaders accepted the principles of the Bill as reasonable. Some government supporters might criticise the provision of pay beds and the method of paying doctors; but the first was essential in order to enlist the best specialists into the service, and in any case was subject to ministerial approval on grounds of need, and to priority being given to urgent non-paying patients; and the second would be a matter for regulations and, therefore, not a basis for criticism of the Bill itself. There might also be objections that too much was being left to regulations, but this could be defended: first, as being essential to give a measure of flexibility and to enable necessary changes to be made without new legislation; second, as making detailed discussion with the doctors and others possible before final decisions were reached; and, third, as saving parliamentary time during that session. The Scots saw no reason to expect serious

* See page 122

† PRO CAB 21/2032 (CP(46)86)

opposition, but urged the need to pay members of the various administrative bodies under the Bill for loss of remunerative time, as was already done for members of insurance committees and Scottish county councils.

At its meeting on 8 March, the Cabinet approved the Bill, subject to any amendments to the financial clauses agreed subsequently by the Chancellor and the Minister of Health. It also decided that, when the Bill was introduced, a statement should be made on the effect of transferring expenditure for hospitals from local authorities to the Exchequer, and that a committee should be appointed to consider payment for loss of remunerative time.

The Bill was duly introduced and read a first time, and on 20 March was published.[53] The internal opposition within the government was, for the time being, silent—but not completely. Over the next month, Morrison fought a curious rearguard action in correspondence with Bevan, attacking the use of the adjective 'regional' in relation to hospital boards. As he pointed out, it had been decided that as a matter of principle 'regional' should be applied only to areas corresponding with the war-time civil defence regions, and this the hospital regions would not do. Bevan replied that he could think of no suitable alternative, but Morrison came up with the suggestion of 'divisional'. This Bevan rejected in a letter of 17 April. As he said, 'regional' had long been an accepted term in the hospital world, and any confusion with government regions was unlikely. In any case, a change in terminology would be regarded as puzzling and sinister at this stage, particularly after the debate in the Lords on the previous day (when Moran had proposed a motion on the coordination of hospital services). On 24 April, Morrison accepted defeat.

The Bill's introduction

The contents of the Bill now published were summarised in a covering White Paper,[39] which outlined both the administrative structure and the substance of the service planned by Bevan. The service would be conducted through three main channels: the minister, directly responsible for hospital and specialist services (including blood transfusion and public health laboratories) but acting through new regional and local bodies which would administer the services on his behalf; the counties and county boroughs, responsible for health centres, clinics and domiciliary services; and the executive councils, half professional and half lay (local authority and ministerial appointees), responsible for the general

practitioner services of doctor, dentist and pharmacist. It would be the minister's statutory duty to provide hospital and specialist services, entrusting their administration to regional boards and boards of governors of teaching hospitals. All hospital premises and equipment would become the minister's property, and he would be able to buy other premises and to disclaim those not required for the new service. The endowments of the teaching hospitals would be retained by their new boards, but those of other hospitals would be pooled in a hospital endowments fund whose income would be allocated to regional boards for their free use. Boards would also continue to be able to receive gifts and legacies.

There would be between sixteen and twenty regions, each associated with one or more medical schools. The board members would, after consultation of the appropriate bodies, be chosen and appointed by the minister on the basis of their individual suitability. Regional boards would appoint hospital management committees for hospital groups or individual large hospitals, in accordance with a scheme to be approved by the minister. Boards would plan and run the service subject to direction by the minister, and HMCs would conduct the day-to-day management, including the appointment of nursing and other general staff, who would formally be employees of the regional boards. As much financial freedom as possible would be given to the hospital bodies; for example, through block annual budgets. The boards of governors of teaching hospitals would be directly responsible to the minister, and would take part in planning the service with the regional boards who would be represented on them. Consultants and specialists could be whole-time or part-time, and would be appointed by the boards on the advice of specially constituted advisory appointments committees. Pay beds of two kinds would be provided: 'amenity' beds whereby services would be public and free but a charge made for better conditions (single-bed or small wards); and private beds whereby both services and accommodation would be paid for, but with a maximum on the fees chargeable by the consultants.

The main feature of the general practitioner services was seen as the development of health centres, to be provided by the local authorities but with doctors and dentists working in them in contract with the executive councils. At the outset, all doctors would be able to join the service where they were, and to have private as well as public patients who, in their turn, would have free choice of doctor. Remuneration would be fixed by regulations to be drawn up in consultation with the

profession; but the intention was to have a fixed part-salary varying according to experience and to conditions of practice, and capitation fees which would decrease as the size of the list of patients increased. There would be a contributory pension scheme. In order to improve the distribution of doctors, a medical practices committee would be set up—mainly medical in membership—whose job would be to give consent to new entrants to general practice in an area, or to those wishing to move to a new area. The sale of practices would therefore be inappropriate in future, and would be prohibited. Compensation would be paid for loss of sale values and, unless the number of doctors joining the service was much smaller than expected, the total compensation would be £66 millions. This would be apportioned mainly by the profession itself, and would be payable on death or retirement with interest of $2\frac{3}{4}$ per cent until due.

The dental services were twofold: a priority service for mothers and children and young people through the local authorities, and a general dental service for everyone through the executive councils. Health centres would be developed for dental treatment, and part-time salaries would be payable. A dental estimates board would be set up to approve dentists' estimates for the more unusual forms of treatment, and dentists would be paid on an item of service basis by fees from the executive councils, in accordance with a nationally determined scale.

For care of the eyes, the objective was a service provided by ophthalmologists assisted by sight-testing opticians at hospital clinics; but until this service could be built up there would be a 'supplementary' eye service arranged by executive councils with qualified doctors, sight-testing opticians and dispensing opticians, among whom the patient could choose.

A new feature of the general practitioner service, compared with the NHI scheme, was the creation of a tribunal, with a legal chairman appointed by the Lord Chancellor, to consider cases where an executive council thought that a practitioner should be removed from the service. The right of the practitioner to appeal to the minister was continued.

The local authority services covered not only health centres and clinics but also home nursing and midwifery, home helps, health visitors, ambulances, and vaccination and immunisation. All these services were concentrated in the hands of the counties and county boroughs, which were to be required to appoint a statutory health committee for their administration. Each authority would also be required to submit for the minister's approval a scheme showing how it

proposed to provide the services, including the use to be made of voluntary bodies, and to send copies of the scheme to hospital boards, executive councils and the voluntary bodies concerned so that they could if they wished send comments to the minister before he approved it.

The Bill's financial clauses made clear that most of the cost of the service would fall on the Exchequer, with the help of £32 millions from the NI fund; but local authority services would be paid for through the rates, assisted by a 50 per cent grant from the Exchequer, weighted according to need. The whole question of Exchequer grants to local government would be reviewed as a consequence of the transfer of hospital responsibilities to the minister.

First response to the Bill

The Bill was introduced into the Commons in March, but the second reading did not begin until 30 April, and this gave ample time for opinion to crystallise, and even to be canvassed in a debate in the Lords on 16 April.[64] Some reactions were both immediate and sharp. Docker proclaimed that 'this mass murder of the hospitals and their replacement by State institutions is wholly unnecessary'. The council of the BMA was early in the field with its criticisms.[108] Before the end of March, it had condemned the divided administration of the service through hospital bodies, local authorities and executive councils as fragmenting not unifying it, and proposed that the regional boards should be responsible for all the services. It also wanted the medical members of the Central Health Services Council to be appointed by the profession or to be *ex officio*, and for the standing advisory committees to be appointed by the CHSC, not the minister. It regarded the take-over of the hospitals as unnecessary, but suspended judgment on the service until the composition of the boards and committees was known. It urged experimentation with health centres before there was any attempt to develop them. Control of the distribution of doctors it thought unnecessary and undesirable, and the abolition of the sale of practices was, therefore, unnecessary also. There was no justification for the idea of a basic salary. But the civil rights of doctors should be secured by the Bill, and the industrial medical services should be included in the NHS. It decided on the creation of a 'fighting fund', and asked every member of the profession to guarantee a payment of at least £25 if called upon.[8] (The response was disappointing.) On 10 April, all BMA branches were

circularised to call for amendment of the Bill and to undertake local propaganda.

Other comment was more favourable. *The Times* on 22 March thought that 'Mr Bevan's solution of the hospital problem is at least as good as any yet proposed'. The *Manchester Guardian* on the same day was doubtful of the proposal to allow private fees. 'This is a false freedom that can only survive to the extent that it is abused. It must inevitably poison the doctor–patient relationship. It is the reef on which this splendid venture, with all its prospects for development might founder at the outset.' *The Lancet* saw both sides.[94] It agreed with the BMA that the administration was unfortunately divided, and thought that in the long term regional boards might become health authorities (as they did in 1974). It saw dangers in a centrally controlled hospital service, but thought that delegation and a light rein might meet the case. It considered that a general practitioner would be able to be just as responsible and professionally independent in the new service as hitherto, that the basic salary was a useful concept and that, for a service guaranteeing medical care for all, some form of 'negative direction' like that proposed for the MPC was unavoidable. Furthermore, the structure gave many opportunities for doctors to influence the administration; but more than personal assurances would be needed about the composition of the administrative bodies. All in all, however, *The Lancet* judgment was favourable. 'It is easy to be too much afraid. We should ask ourselves whether, with all its risks, the service contemplated does not give us opportunities. It is a great end—that whatever person can benefit from medical knowledge or skill shall have it without hindrance. The means now proposed to that end may need modification, but they certainly do not call for wholesale condemnation or irreconcilable opposition.'

A little later, *The Lancet* looked at the philosophy of the proposed service and found it sound.[95] The abolition of fees meant, it considered, removing 'from medical practice much of the mercenary element that has been growing more conspicuous for fifty years or more'—the same element mentioned in the Act of 1522 which gave the Royal College of Physicians supervisory powers 'to curb the audacity of wicked men who shall profess medicine more for the sake of their own avarice than from the assurance of any good conscience'.[23] 'In a sharply competitive world,' *The Lancet* went on, 'the dependence of most medical men and women on payment of a fee for each service rendered has led to abuses which we need not enumerate but which ought not to be forgotten at this

moment. The truth is that the doctor–patient relationship in its modern form needs improvement rather than preservation; it can never be wholly satisfactory while the doctor (as someone has put it) is not only a friend in need but also a friend in need of his patient's money; nor while there is competition rather than co-operation between him and his colleagues . . . The traditions of medicine are not concerned with particular modes of remuneration, but with a particular kind of service to others.'

Public debate of the Bill began in the rather curious form of a motion proposed by Moran in the Lords on 16 April, regretting any measures which might impair the efficiency of the general practitioner service but welcoming proposals for the better coordination of the hospital services.[64] Dawson had died a year earlier, so the two leading medical peers were now Moran and Horder. Moran was to prove himself a warm and staunch supporter of the hospital proposals in the Bill; Horder, his constant rival for the presidency of the Royal College of Physicians, an unwearying root-and-branch opponent of the whole NHS concept.

On this occasion, Moran said that he had brought forward his motion (which Horder said was premature) in order to get away from 'sloganeering' to a rational discussion at the level of fact and policy. He recognised the need for a drastic reorganisation of the hospital system. The surveys of the services had shown that one-third of voluntary hospital beds were in units with fewer than a hundred beds, too small to be first-class, and with specialist services provided by untrained people. Nearly one-fifth of local authority hospital beds were in public assistance institutions. Considerable expenditure was needed to restore and maintain the voluntary hospitals, and this probably meant some form of public control. Ministerial control was preferable to being 'handed over, bound hand and foot, to the local authorities'. Some thought that ownership by the minister was unnecessary, and that control through financial grants would suffice, but his own preference was for the minister's proposals which he thought were more practical and would bring coordination, financial peace of mind, freedom from the local authority threat and a special position for the teaching hospitals. It was true that the voluntary hospitals would be lost; but not all those hospitals had been centres of advance, only the teaching hospitals, and voluntary service need not be lost, particularly if the proposed hospital management committees were given more autonomy in the way suggested in correspondence in *The Times* on 9 April by King Edward's Hospital Fund for London and Sir William Goodenough. The composi-

tion of the RHBs was vital to the future service, and they needed to know from the minister what he intended. The members must be hand-picked, not merely representatives. The proposals for the future of hospital endowments he did not see as confiscation but as a wider use for the benefit of all non-teaching hospitals. Finally, he regretted the unhappiness of general practitioners with the Bill, because of their dread of a whole-time salaried service. What the effect of whole-time service on medical practice might be he did not know, but he believed that some form of incentive was needed to maintain efficiency.

Lord Inman, speaking as chairman of Charing Cross Hospital, and Lord Donoughmore as chairman of the management committee of the King's Fund, both supported the principles of the hospital proposals but insisted on the vital importance of getting the right membership of hospital bodies and of wide delegation of powers to them. Lord Luke, as the spokesman of the British Hospitals Association, deplored the destruction of the existing structure, emphasised the need to preserve local interest and voluntary service in the hospitals, and suggested applying to their support the pattern adopted for aided schools under the 1944 Education Act.

Horder was more sweeping in condemnation. He claimed that the Royal College of Surgeons and the Royal College of Obstetricians and Gynaecologists had both dissociated themselves from the proposed transfer of ownership of the hospitals and that the RCP had voted the day before but he could not reveal the result. (Later in the debate, Moran revealed it for him—it was that the college 'approves the central direction and co-ordination of hospital policy provided that the composition of the Regional Boards is satisfactory'.) The King's Fund had called for amendments to provide a real measure of independence for HMCs. The BHA condemned the proposals as not in the interests of patients or the community, and as eliminating local interest and substituting remote control and impersonalisation. The *British Medical Journal* saw the nationalisation of the hospitals as stunting the blending of voluntary and official effort, and perpetuating the evils of officialdom on an even bigger scale than in local government. The whole debate, in Horder's view, was premature.

Premature or not, the debate served to some extent to highlight and sharpen controversy, and thus to prepare the ground for the second reading. Shortly before that the *BMJ*, in deploring the attitude of the press to the doctors, summed up the BMA's criticism.[114] It claimed that the BMA shared Bevan's aims of a comprehensive service available to

all and the administration of hospitals on a regional basis. But it regretted the failure to integrate medical services under the central health department, the administrative separation of the hospital, general practitioner and clinic services, the lack of detail of the composition of RHBs and the failure to make the CHSC really effective (that is, to allow the doctors to nominate its members and freedom to publish its own reports). The State ownership of hospitals meant that they would be run by civil servants and that their medical staffs would be whole- or part-time State employees working under civil service direction. General practice under the Bill would be limited to areas approved by a government committee, and GPs would be paid largely by salary, and would work from centres owned and run by local authorities—the first step on the road to whole-time salaried service. The minister should drop the idea of a basic salary and rely on capitation fees; health centres should be the subject of experiment; and each hospital should be free to work out its own salvation within an overall framework.

Commons debate on the second reading

All this was grist to the opposition mill when it came to the second reading on the three days beginning on 30 April.[81] No doubt there was some briefing of opposition spokesmen by medical opponents of the Bill, but the interests of the profession and of the opposition tended to diverge more and more as time went on, and the controversy became more hysterical and less rational. On this occasion, however, the opposition argued very much in terms of the BMA's criticisms. The main speakers for the government were, of course, Bevan as Minister of Health and Charles Key as parliamentary secretary; and for the opposition, Richard Law (Lord Coleraine) and Willink.

In introducing the Bill, Bevan first outlined the reasons why an NHS was needed at all, and then expounded the methods he had chosen to implement it. A scheme was necessary so that medical care could be available, without financial anxiety, to all who needed it. The NHI scheme excluded dependants and provided no specialist services. There was no real hospital system, the distribution of facilities was faulty and many hospitals were too small for efficiency. 'Although I am not myself a devotee of bigness for bigness' sake, I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one.' Other services were grossly deficient, such as dental care, eye services and hearing aids; and mental health services

were separated from the mainstream. It was fully recognised that there were shortages of all kinds, but the objective was to provide an effective universal service as soon as possible.

Three main instruments were required: the hospitals, the general practitioners and the public health services. Under a social security system, the voluntary hospitals would derive 80 or 90 per cent of their income from public funds. This could not be justified, so they must be taken over. Local authorities could not take them over because they were themselves in many cases too small and their financial capacity too uneven. The only solution, therefore, was to take over both groups and to organise them as a single service. The regional boards would both plan and execute—there would be none of the divorce of execution from planning proposed earlier. Nor would the boards be conferences of delegates, but made up of individuals selected for their personal experience—doctors, local authority members, medical school staff and voluntary hospital governors.

The general practitioners would be in contract with executive councils, not with local authorities (which the doctors resisted) or with the minister, and they would not be civil servants. The executive councils would be half professional in composition. Some redistribution of doctors would be essential, and the sale of practices (which, in any case, was not compatible with free choice of doctor) must go, but with full compensation of £66 millions. There was no truth in the suggestion of 'direction' of doctors. The MPC would simply refuse entry to 'over-doctored' areas. Bevan said he did not favour a full salaried service; the profession was not ripe for it, and remuneration should bear some relationship to zeal. Payment by capitation fee would, therefore, be the main method, but there would be a basic salary also, to help a young doctor starting practice, or to attract doctors to unattractive areas. Although he knew the concession would be repugnant to some, part-time private practice would continue to be possible for both general practitioners and consultants, in the latter case to avoid a rash of private nursing homes.

The third arm of the service, the local authorities, would provide health centres and domiciliary services. It would be impracticable to put all preventive health services—housing, water, sewerage, food inspection, pollution—under the regional board; these must remain with the personal services with the local authorities. There was criticism of a split in the maternity service, but this would be given continuity by the users.

There was criticism, Bevan went on, that there had been no consulta-

tion with those responsible for implementing the Bill. This was not the case; he had himself had twenty conferences with those concerned, and his officers had had another thirteen. But it was true that there had been no negotiation on the terms of the Bill. This had been done to avoid telling others the proposals before Parliament had seen them, and to avoid any commitments which might hinder amendments proposed here. Lastly, there was criticism of diverting charitable funds to other uses. For this there were many precedents; but in any case, the hospital funds would remain with the teaching hospitals, and would still be available to other hospitals as free monies.

Launching the opposition attack, Richard Law accepted the principle of a comprehensive service available to all as embodied in the 1944 White Paper, but said that the opposition differed from the minister in objecting to the abolition of the voluntary hospitals, the weakening of local government and his proposed disciplining of the medical profession. On the first point, there was no need to take over any hospitals; the regional bodies could plan and the local authorities and voluntary hospitals execute, with the application of financial sanctions by the minister if the plan was not carried out. Deficiencies in the hospital service were due only to lack of money. The Bill conferred altogether too much power on the minister. On general practice, Law said that practitioners should have their first loyalty to their patient, and be responsible to their professional judgment. The Bill cut across both these principles by insisting on a part salary paid by the State, the use of premises provided by the State and practice in an area determined by the State. This added up to the beginnings of a whole-time State service; and the abolition of the sale of practices was the removal of yet another incentive to give patients the best possible service.

In the subsequent debate, opposition speakers for the most part repeated or elaborated these objections, while some government supporters found criticisms of their own. There were complaints at abandoning the principle of a whole-time salaried service and allowing part-time private practice; and at the proposal for appointed, not elected, administrative bodies. The hospital survey reports were quoted as evidence in favour of a root-and-branch reorganisation of the hospitals.

Charles Key's reply to the debate concentrated largely on this issue. He argued that the hospital system must be reorganised by planning both geographically and functionally, and that would be impossible unless the voluntary hospitals were taken over. He argued also that the planning body must also execute; but having planned, it could delegate

the detailed management of groups or individual institutions to smaller local bodies. It was intended that the local managers should have wide discretion within an approved budget, and there would be no central approval of detailed items. The local authorities did not provide a valid alternative to regionalisation because their areas were in many cases too small, and there was an in-built dichotomy between the counties and the county boroughs in which most of the hospitals were situated. Joint boards—the only other possibility—were a hopeless form of administration, tending to magnify local claims and differences rather than to unify them.

Willink wound up by criticising the lack of proper consultation; the rejection of the earlier harmonious discussions; the abandonment of the planning of health services as a whole; the subjection of regional boards to ministerial direction; the probability of conflict and confusion between RHBs and HMCs; the use of the MPC to control the distribution of doctors; and the concept of basic salaries. The House divided with a government majority of 359 to 172.

The Bill in committee

While the Bill wound its slow way through the standing committee of the Commons during May and June and on into July, medical criticism of its content continued to mount. The very form the Bill took, with a statutory duty on the minister as its basis, and the framework for wide regulation-making powers to fill in the details, lent colour to some of the main objections. The Bill was seen as conferring unbridled authority on the minister to determine the shape and content of the service, to choose and appoint all the administrative and advisory bodies, and to direct them to act as he wished. It is true that various assurances were given about delegating powers, and about making appointments and regulations only after consultation with those concerned; but the validity of these assurances could not be known until the Bill was law and action began to be taken under it, and those who chose to disbelieve them could justify their attitude by referring to the mistrust aroused by some of the minister's pronouncements as well as by his past political record.

One incident, in particular, created the deepest suspicion in BMA circles. In the course of the second reading debate, Bevan had said that the profession was not ripe for a full-time salaried service, and later, in response to another speaker, he added, 'there is all the difference in the world between plucking fruit when it is ripe and plucking it when it is

green'. This convinced many general practitioners that, whatever disclaimers the minister might utter, his firm intention was to impose a full-time salaried service on the whole profession, and this fuelled their growing mistrust of all his proposals.

On 1 and 2 May, the BMA held a special representative meeting to consider the Bill. The principles and views of the council expressed in March were supported, and a number of resolutions opposing the contents of the Bill were adopted. In particular, the State ownership of hospitals and the confiscation of their endowments were rejected; the continued sale of practices was proclaimed as essential to the freedom of the patient and the profession; any control of choice of area of practice was condemned; and remuneration by capitation fee was insisted upon. A final objection was that medical staff numbers and hospital facilities fell far short of the requirements of a comprehensive service for all.[11] *The Lancet*'s comment was that 'the Council of the BMA secured ... remarkable unanimity in favour of amendments which, taken together, would make the Bill unworkable'.[16]

As the month of May passed, two factors became increasingly clear. The first was the growing difference of views about the Bill held by the consultants represented by the royal colleges on the one hand, and by the general practitioners as represented by the BMA on the other. The second was the unremitting hostility of the latter. On 16 May, the comitia of the RCP adopted a resolution which acknowledged the urgent necessity for the reorganisation of the hospital services and approved the principles of the relevant proposals of the Bill; urged that membership of RHBs—on which much would depend—should be determined entirely by personal fitness for the work (by which was meant a non-representative and non-political basis); and asked that hospitals should have as much administrative independence as was compatible with a regional plan, and that the wishes of donors should be taken into account in dealing with hospital endowments.[19] Here was clear confirmation by representatives of the consultants of the favourable view of Bevan's hospital proposals enunciated by Moran as his personal opinion in the Lords' debate of 16 April.

A series of three meetings between Bevan and representatives of the negotiating committee on 13, 20 and 27 May, provided equally clear confirmation of the continuing opposition of the BMA. Once again an attack was launched on the notion of a basic salary, on control of the distribution of doctors and on the prohibition of the sale of practices. The minister rejected any amendments of principle, but agreed to make

clearer the role of the executive council in the selection of entrants to general practice, and to look further at the effect on partnerships of the sale of practices clauses in the Bill (a knotty and persistent legal problem). He also agreed to consider more protection for private hospital practice: he was anxious, in spite of the opposition of some of his colleagues, to encourage consultants to conduct their private as well as their public practice on hospital premises, by allowing some private beds to be used without any limit on the fees to be charged by the consultant to the patient in them (the so-called 'no ceiling' beds). He rejected any amendment to the proposed hospital structure (though he was considering the degree of autonomy to be enjoyed by HMCs), and the idea of grants to private patients, or of appeals from the proposed tribunal to the courts instead of to the minister; but he agreed to consider the complaints procedure against consultants, and to consult the CHSC on the principles of health centre proposals, if not on individual schemes. To criticisms of the lack of coordination of the various services, he replied by pointing to the procedure laid down in the Bill for the submission of local authority schemes to RHBs and others before approval by the minister.*

Whatever the consultants might think, the general practitioners were unreconciled; and unfortunately there now arose another contentious issue to damage relations between the minister and the BMA, namely revision of the capitation fee for the NHI service. It was agreed that an increase was due but, as usual, there was no agreement about the amount. A basis was, however, provided by the report of the Spens committee on general practitioners' remuneration, which was published on 9 May.† This recommended appreciably higher pay within a public service which, it was accepted, should be applied to the NHI capitation fee as well as to the future NHS. The point at issue was how to relate the one to the other. The minister wanted discussions to cover both; but the insurance acts committee of the BMA (the negotiators for this purpose) said it was empowered to deal only with the NHI fee; and it proposed a level appreciably higher than he thought justified. By correspondence and in discussion, the wrangling over this question dragged on until the end of the year.

In July came the BMA's annual representative meeting, when

* PRO MH 80/37

† PRO MH 77/172 (Cmd. 6800)

opposition to the Bill was further promoted. *The Lancet* had shortly before, in a leader on the committee stage of the Bill in the Commons, given expression to the doctors' uneasiness because it was largely an enabling Bill, and the minister had resisted restrictive amendments in committee in order to retain flexibility. But *The Lancet* also pointed out that the minister had accepted that a full salaried service was not reasonable, and that it was difficult to reconcile free choice of doctor with complete abandonment of the capitation fee system. The compromise of a basic salary was an attempt to secure two desirable objectives—security for the individual practitioner, and some competition 'to sweeten and refresh the service'.[92]

The BMA would have none of this. In a statement at the ARM, Dain as chairman of the council made a strong attack on both the Bill and the minister. The latter, he said, had refused to negotiate on the principles of the Bill (which was quite true, for the reasons given in the second reading debate). What he had, in fact, done was to take the framework of Willink's scheme and graft on to it the principle of nationalisation, 'which makes such an enormous difference to us'. The Bill imposed State ownership of hospitals, destroyed the goodwill of practices, directed doctors where to go and prevented them from moving without permission, and introduced remuneration (at least in part) by salary. All this was quite unnecessary to the efficiency of the service—the proposals 'serve no purpose except to carry out Socialist ideals'. The hospital scheme meant that, for practical purposes, all consultants would immediately become State servants, since all hospital beds both public and private would be controlled by the minister, who might at any time decide to abolish the private ones. The provisions applying to general practice were steps by which the government proposed to bring doctors under State control. Unlike the position in 1911, there was no right for every doctor to enter the service; and the profession could not accept the absence of any right of appeal from a decision of the minister that would take a doctor out of the service. Under the Bill, the minister was a 'complete and uncontrolled dictator', determining the constitution of all committees and councils, which he could do only on the advice of his civil servants, so that 'we ourselves will be employed by and dictated to by the civil servants straightaway'. Now, the minister was not prepared to discuss an increase in the NHI capitation fee separately from the terms of service under the Bill. A conflict was inevitable; and it was therefore proposed to invite all on the medical register in the autumn to say whether they wanted to take part in discussion of regulations to be

made under the Bill, in the knowledge that refusal to take part meant also refusal to take part in the service in any form. The ARM on 24 July endorsed this proposal completely.[118]

Third reading in the Commons

In the debates on the Bill in committee, the minister did, as *The Lancet* said, resist amendment from both sides. He argued against his own side on such issues as whole-time salaried service or private beds in hospitals, and elected as opposed to appointed administrative bodies, and he resisted the opposition's proposals, most of which were repeated at the report stage on 22 and 23 July.[82] Of these, the main points were the delegation of powers by counties to boroughs (including that by the LCC to the metropolitan boroughs); the transfer of the endowments of non-teaching hospitals to the appropriate HMC instead of to a common pool; the restoration of the sale of practices and the abolition of the MPC; and the substitution of appeal to the High Court for appeal to the minister from a decision of the tribunal. All these were rejected on a division, but the opposition continued its attack on the third reading. Somewhat unusually, a considered motion for the rejection of the Bill was tabled on third reading, on the grounds that it discouraged voluntary effort, mutilated local government, dangerously increased ministerial power and patronage, appropriated trust funds against the wishes of the donors, and undermined the freedom and independence of the medical profession. The House divided against the motion by 261 votes to 113. *The Lancet* regretted that Bevan had not agreed on the matter of appeal to the High Court, and had not limited his proposal for basic salaries to unattractive areas and new entrants.[20]

Second reading in the Lords

After the summer recess, debate began again with the second reading of the Bill in the Lords on 8 October.[84] The Lord Chancellor, Jowitt, was the government spokesman, with the unenviable task of securing its passage without substantial amendment through a House composed overwhelmingly of opposition supporters. These were anxious not to appear obstructive, but at the same time to demonstrate that their opposition had had some tangible results. As a consequence, there was a

degree of shadow-boxing, with both sides trying to find amendments which both could accept. In moving the second reading, Jowitt sought to be a moderating and calming influence. He acknowledged that the Bill conferred wide powers on the minister, but pointed out that they would be exercised through regulations which would require parliamentary agreement. This was the right way to proceed, so that change could be made flexibly in the light of experience. For the hospitals there would be delegation of powers from the minister to RHBs and from them to HMCs, who would appoint house committees for individual hospitals. This involved no bureaucratic management from Whitehall, and no additional civil servants. He announced that the minister was prepared to appoint a Spens committee to advise on the remuneration of consultants, like that already done for general practitioners.

For the opposition, Lord Munster criticised the impact of the Bill on local government, and the proposed method of administering the hospitals. He also attacked the 'confiscation' of endowments and the transfer of health functions from the metropolitan boroughs to the LCC.

The Archbishop of York supported the Bill, but with some anxieties about the independence of the medical profession and about the maintenance of local interest in the hospitals. Lord Moran repeated his concerns of the previous April, adding his support to the need for real delegation of powers in the hospital administration, and regretting the dispute with panel practitioners over the capitation fee. Lord Teviot spoke on dental services, the final report of his committee having appeared the previous January.[33]

Lord Horder called for evolution, not the revolution, which the Bill constituted in his eyes. There had been no proper consultation of the profession by the minister; the Bill involved a tremendous centralisation of power, and ran the risk of stereotyping medicine. The prohibition of the sale of goodwill of practices, the MPC's power of negative direction, and the refusal of a right of appeal from the tribunal to the High Court, constituted gross infringements of the personal liberties of doctors.

Lord Beveridge supported all the main features of the Bill which, in his view, set up a true Ministry of Health for the first time. Lord Luke repeated his earlier criticisms from the point of view of the BHA, and said that he accepted the decision of the House of Commons, though the balance of power between the RHBs and HMCs was not yet right. Lord Donoughmore supported the Bill, but emphasised the dangers of over-centralisation and asked for more information about the proposed

regions. Lord Addington urged the delegation of health functions from counties to non-county boroughs.

Amendments in the Lords

The conflict over detail began in committee on 17 October.[85] Jowitt went to some length to expound the philosophy underlying the concept of RHBs and HMCs. He agreed that HMCs must have a real job to do if people were to be willing to serve on them; the issue was how to achieve this together with the essential powers that RHBs must have to plan and to execute their plans. The minister's intention was to prescribe by regulation that HMCs should have full responsibility for the running of their hospitals, but as agents of the RHBs. All officers except some senior staff would be appointed by the HMCs, and the responsibility for expenditure would be theirs. But to keep the legal position clear, it would be desirable not to impinge on the principle that the HMC was to be the agent of the RHB, just as an estate manager was the agent of his employer. Lord Llewellin, for the opposition, complained that the Bill, in fact, gave HMCs no powers or duties at all, and Lord Cranborne asked for further consideration of the position. Subsequently, amendments were carried to give HMCs a corporate existence by enabling them to sue and be sued, and to make clear that, although all staff might be officers of the RHBs, they could be appointed and dismissed by HMCs as agents of the RHBs. Jowitt introduced a further amendment making it the clear duty of HMCs to control and manage their hospital groups while remaining agents of the RHBs.

Other amendments, carried against the government, were one requiring delegation of functions by the LCC to metropolitan boroughs, and another requiring payment of general practitioners to be by capitation fee unless the MPC recommended otherwise in particular cases. Both were rejected by the Commons on 4 November,[83] but others were accepted: ensuring that gifts or legacies to hospitals after the Act came into force should go to the HMC concerned and not be pooled, and that gifts for specific purposes should so far as possible be used accordingly; making clear the HMC's responsibility for the control and management of the hospitals in its group; requiring teaching hospitals to provide for the university such facilities as the minister regarded as needed for teaching and research; giving legal status to HMCs; making clear that the Bill did not affect the research powers of the Medical Research

Council; and laying down that Crown privilege could not be claimed for hospital records.

The doctors and the Act

At last the Bill was law; but what was to happen now? *The Lancet* continued to regret that the minister would not accept a right of appeal from the tribunal to the High Court, though it did go so far as to recognise that the High Court was not the right sort of body to decide whether a doctor was efficient.[93] It also hoped the minister would drop the idea of a basic salary as the profession was so strongly opposed to it as the thin end of the whole-time salary wedge.[106] On the other hand, it thought it a pity that so many doctors concentrated on the risks and difficulties. As had been said in the Lords, 'too many of the doctors have merely expressed their fears and prejudices . . . It has been left to the Minister to generate the momentum that overcomes obstacles, and to enlist the strenuous support of ardent minds.'[110] Effective consultation about the content of the forthcoming regulations was essential, and in that process the medical representatives would be able to show their readiness for real cooperation.

Cooperation was not, however, the note being struck by the BMA. In mid-November, the ballot papers were circulated to doctors, with the question 'Do you desire the Negotiating Committee to enter into discussions with the Minister on the regulations authorised by the NHS Act?' This was accompanied by a report from the committee which claimed that 'the independence of medicine is at stake', and made clear that a negative vote committed the voter to taking no part in the service. The *BMJ* declared that the essence of the principles laid down by the negotiating committee was that 'The medical profession is, in the public interest, opposed to any form of service which leads directly or indirectly to the profession as a whole becoming full-time salaried servants of the State or local authorities'; and it quoted Dain, in a speech at Exeter, 'What the Minister appears to have done is to have taken the Bill which we had partly fashioned, and to have inserted into it the Socialist principles of State ownership of hospitals, direction of doctors, basic salaries for doctors, and abolition of the buying and selling of practices . . . The Act is part of the nationalisation programme which is being steadily pursued by the Government.'[124] (This, incidentally, was regarded by Dain as *not* giving a lead to doctors how to vote in the forthcoming plebiscite.) *The Lancet*'s plea, that the Act derived much

more from past discussions between doctors and the minister than from doctrinaire ideas of the Labour Party, went largely unheard, as did its warning 'Only an affirmative reply will give us the opportunity of seeing the whole structure shaped and completed under the most favourable conditions. Those who reject this opportunity will assume a heavy responsibility.'[125]

In view of the negotiating committee's stance, it is surprising that the final plebiscite vote was so evenly divided: 19 478 (46 per cent) were in favour of discussions with the minister, 22 645 (54 per cent) against. Among consultants the vote was almost equally divided; amongst general practitioners nearly two to one against. The committee had its answer, but what was it to do? In a press statement on 12 December, Dain announced that the negotiating committee would be advised not to enter into discussions with the minister, and a resolution to this effect would be put to an SRM of the BMA on 28 January. On the same day, the minister pleaded for 'wiser counsels'. He had, he said, a duty to carry out Parliament's decisions, and he would consult others on what should be done to give doctors the opportunity to take part. (In fact, on 18 December, after consultation with more than two hundred bodies, the statutory order was made defining the regional hospital areas under the Act.[63]) *The Times* commented 'It is evident that the BMA intends to persist in the rather reckless and emotional agitation which has contributed in no small measure to the outcome of the ballot.' *The Lancet* attributed the result of the plebiscite to several factors: the partial picture presented by the BMA leaders, emphasising the risks and imperfections of the NHS scheme rather than its opportunities; indignation over the capitation fee dispute; a feeling that there had been no proper consultations; the minister's insistence on the basic salary; the recent Willesden incident (when the borough council had tried to compel unionisation of hospital staff); general middle-class irritation with controls and fear of loss of privilege; and the possibility that the minister's powers could be used to produce a bad service not a good one. But *The Lancet* regarded the BMA as being in an untenable position—it could not act contrary to the vote, but the vote was not large enough to justify non-cooperation. The royal colleges might take a different view, and the profession would then split.[99]

6

The final round: 1947–48

From the time when the Bill became law in December 1946 until the 'Appointed Day', 5 July 1948, some twenty months later when it came into operation, the opposition to it was stimulated and maintained almost exclusively by the doctors. The local authorities and even the voluntary hospitals felt bound to accept Parliament's verdict; not so the British Medical Association.

Medical diplomacy

But now it was the differences between the consultants and the general practitioners, which had been building up for some time, which finally led to independent action by the former. Ever since 1940, when the Medical Planning Commission was first proposed, and particularly since Moran had been president of the Royal College of Physicians, there had been some jockeying for position between the two parties. Moran aimed to restore his college to the standing it once held but had largely lost, that of adviser to government on matters of health and medical policy. With this in view, a number of committees were set up by the college to consider and comment on various problems, such as the organisation of industrial health and psychiatric services, and—in collaboration with the other royal colleges—a consultant service for the nation. Proposals for the last were contained in an interim report of November 1944 and a final report of February 1946*, both of which laid great emphasis on the importance of a regionally based service centring on university medical schools. Other steps were taken to create a forum for the expression of consultant opinion as distinct from the opinion of the BMA, which

* RCP papers

Moran rightly regarded as dominated by the general practitioners and their particular concerns.

Thus, in January 1942, a standing joint committee of the three English royal colleges was set up to develop and coordinate consultant thinking. At the same time, a survey of consultant services, parallel to the survey of hospital services by the Ministry of Health and the Nuffield Provincial Hospitals Trust, was put in hand, supported by the minister and assisted by local committees headed by the university vice-chancellors. (At a later stage, this exercise led to a dispute with the General Medical Council, which considered that the identification of qualified consultants was its job; and eventually the whole matter was allowed to drop in favour of selection by *ad hoc* appointments committees.)

When the minister initiated discussions about a comprehensive service in 1943, the BMA regarded itself as speaking for the whole profession in reacting to his invitation, but the colleges insisted on separate individual invitations from the minister to take part, and set up a consultant services committee (on which the BMA was represented) to formulate the views of all consultants and specialists. It was by no means easy to coordinate views or action. A group of BMA-oriented specialists at non-teaching hospitals, who regarded the colleges as dominated by the teaching hospital staffs, formed an association of its own; and the BMA always tended to think that its views were those of the whole profession, and should therefore prevail. Nor was this assessment of the position confined to the English colleges. In the later months of 1946, the Scottish colleges complained that the BMA was neglecting to give proper consideration to views favourable to the Bill, that it assumed that the attitudes of the BMA representative body were those of all, and that it then tried to dragoon the colleges into line.* (All this was a curious reversal of the position in 1912, when the opposition to Lloyd George and his insurance medical scheme was stimulated and organised by leading consultants, who were not affected by it, would not be able to take part in it and were quite out of touch with the ordinary general practitioners. This was demonstrated by the rush to join the scheme in the latter part of 1912, as the great mass of general practitioners were only too well aware of the financial advantages of doing so.)

Such was the climate of opinion in which the royal colleges approached the impasse into which the BMA appeared to have steered itself by the end of 1946. On 5 December, the RCP council resolved in

* RCP papers

favour of discussion and negotiation with the minister on the regulations to be made under the Act. This was after Moran had tried to persuade his fellow presidents to sign a letter in terms acceptable to the minister favouring negotiations, but had failed because Webb-Johnson of the Royal College of Surgeons refused. Webb-Johnson, as vice-chairman of the negotiating committee, was always more favourably disposed to the BMA viewpoint than the other two presidents, and was particularly anxious about the future of private practice. The three then met the minister with the idea that he should publish a statement in conciliatory terms in the *British Medical Journal,* a proposal which commended itself both to the minister and to Charles Hill. Unfortunately, at this point, the *BMJ* produced a leader[124] in terms which so offended Bevan that he declined to proceed. Meanwhile, Webb-Johnson had been criticised for his earlier refusal by the fellows of his own college, so now he joined the other two presidents in a letter to the minister on 2 January 1947.

The presidents expressed their regret that a 'substantial part' of the profession was opposed to the renewal of discussions on the National Health Service, and asked for clarification on certain points, together with an assurance that the minister would try to meet the profession's views. The points they had in mind were, first, the method of remuneration of general practitioners—must a basic salary be a universal feature? Second, as they pointed out, the tribunal from which an appeal lay to the minister was to have three members, two of whom would be his appointees—should not the General Medical Council be involved? Third, must there be interference with the liberty of movement of general practitioners? And fourth, could not specialists be free to practise privately in NHS hospitals?

On 6 January, the minister replied. He emphasised that the doctors would not in any way compromise their position by entering into discussions—at the end of the day each doctor would determine his own course of action. The point at issue was whether the profession wished to influence the formative stages of the new service by taking part in framing the regulations to be made under the Act. His aim had always been full consultation, except that he could not make known his original proposals until they had been presented to Parliament.

On the specific points raised, his answers were these. First, he accepted that the main method of remuneration of general practitioners would be the capitation fee, and he rejected the idea of a whole-time salaried service; but in some cases a basic salary element would be necessary, and it would administratively be most convenient if it were

universal. This was, however, open to discussion. Second, he pointed out that the tribunal was a safeguard for the practitioner additional to those provided under the National Health Insurance scheme, and he would be glad to discuss the procedure before deciding on an appeal from the tribunal to the minister. Third, he did not propose any direction of doctors, only that before entry to practise in a new area a doctor should have the approval of a central committee, seven of whose nine members would be doctors. This would usually be arranged through the local executive council, and entry to a partnership or a group practice would normally be approved as a matter of course. In relation to the fourth point, the basic principle in his view was clinical freedom, and the right of the specialist to practise whole-time or part-time, with or without private practice, or in an honorary capacity. Hospital staff consultants would be able to treat their private patients in pay beds at their own or other hospitals.*

This exchange of letters restored, as *The Lancet* said, a proper perspective. *The Lancet* saw three possible courses for the profession to follow: to accept without demur or comment any regulations the minister chose to make; to negotiate on the basis of the Act in order to get the best possible arrangements; or to reject the Act altogether. Of these options only the second stood up.[121] Fortunately, the BMA came to the same conclusion. At its meeting on 15 January, the BMA council decided to recommend the representative body to enter into discussions with the minister, provided that they were comprehensive and that the possibility of amending legislation was not excluded. The council also proposed a second plebiscite when the discussions were complete. The *BMJ* commended the action of the three presidents, but recognised that it had given rise to criticism and disquiet. The minister's statement contained little of substance, but it showed a change of attitude and tone, and the council's advice should be accepted.[14, 109] On 28 January, after some heated and bitter debate, with accusations of treachery being levelled at the presidents, the BMA special representative meeting adopted the council's resolution by a vote of 252 to 17, and this was immediately conveyed to the minister. Douglas replied on his behalf on 31 January, agreeing to discussions in the light of the resolution; and on 7 February, the negotiating committee, in its turn, expressed readiness to enter into negotiations.†

* PRO MH 77/177

† PRO MH 77/177

But feelings of betrayal still lingered in some quarters, and the RCS fellows thought it necessary to hold a special meeting and to make clear to the press that the college would go along with the profession as a whole. Moran saw no need to appear apologetic. In his presidential address to the RCP later in the year this is how he put it. 'I view the action of the Presidents in a rather more objective light. Instead of conciliatory diplomacy there began an organised spate of inflammatory speeches up and down the country. A fighting fund was started. Tempers on both sides rose. There were indeed some with influence in the Association who saw danger ahead, but it is easier to stir up passion than to allay it. The extremists were in control. The Council of the Association was gradually purged of its more moderate members. Soon the brakes were taken off, the machine got out of control. Those at the wheel shut their eyes and waited for the collision. At that moment the three Presidents jumped on the running-board, jammed on the brakes, and contrived to steer the great, lumbering, skidding machine round the corner. If you think my picture too highly coloured, I must quote one of the pundits of the Association. "The letter of the three Presidents was," he said, "a godsend." The Association was rushing on the rocks.'[19]

Renewed negotiations

Discussions were renewed when the minister met the negotiating committee on 28 February. He welcomed their invitation to discussion: the advice and cooperation of the organised medical profession were essential to him. Dain said that a national health service had long been an ambition of the profession, and the committee was gratified that the minister had accepted a number of its points. But the Act gave him despotic powers. There was, for example, no reason why professional or other bodies should not nominate members to boards and committees. The profession was willing to discuss on the understanding that changes might be necessary, which the minister would father in Parliament. The minister replied that he set no limit to the scope of the discussions, and the possibility of amending legislation was not withheld. With this the negotiating committee expressed its satisfaction.*

The following months of 1947 were taken up, on the one hand, by innumerable meetings of subcommittees of the negotiating committee with officers of the ministry on matters of detail and, on the other, by

* BMA, minutes of the negotiating committee, 28 February 1947

intensive work by the ministry to do all the things necessary to bring the Act into operation. The climate was still sultry, many of the meetings were hot and somewhat bad-tempered, and underlying the bad temper was an unavoidable dilemma. The minister and his department had the responsibility of giving effect to Parliament's decision as embodied in the Act, and doing so in accordance with a tight timetable. But to the doctors any step in the direction of implementing the Act could be seen as an attempt to foreclose the negotiations and jump the gun. This meant, for example, that when the ministry, on 11 January, asked a large number of bodies for names of persons who might serve on regional hospital boards, the BMA consultants and specialists committee advised against letting any names go forward until after the meeting of the representative body on 28 January. Even a year later, when on 2 January 1948 names were sought for members of the Medical Practices Committee, the BMA said that proposals must await the result of the second plebiscite, and did not, in fact, produce their names until 20 May.*

Implementing the Act

The task facing the ministry in implementing the Act was, indeed, formidable. Two new administrative structures had to be created: one for the hospital service and a second for the general practitioner services. This involved the definition of areas of administration; the selection of some hundreds of individuals to make up the new bodies; the delineation of their functions; the prescription of the grades and pay of at least their senior staff and then their recruitment; the framing of guidelines not only for general medical practice in the new circumstances but also for the new dental and eye services; the identification of those hospitals to be excluded from take-over by the service; and the listing of those to be designated as teaching hospitals with their own boards of governors. Guidelines had also to be worked out for the local authority services (home nursing, health visiting, home helps, ambulances and so on), and schemes of provision drawn up by the local authorities after local consultations and approved by the minister. Various other bodies had also to be set up—advisory, like the Central Health Services Council and its standing committees, or executive like the MPC or the Dental Estimates Board.

* RCP papers

The first date fixed for the operation of the NHS and the NI scheme was 1 January 1948, but this quickly became 1 April. And, fortunately for those trying to complete the process of preparation of the NHS, it proved impossible for the insurance scheme to be ready before 5 July, so a few more weeks became available before the 'Appointed Day', as was announced by the Prime Minister on 9 June 1947.

Setting up the structure

Within a week of the Bill receiving the royal assent, a letter was sent on 18 November 1946 to over two hundred bodies, outlining proposals for the new regional hospital areas and inviting comments and suggestions. For London and the south-east, a sector pattern was proposed, with four wedge-shaped areas meeting in central London. This brought immediate pained protest from the London County Council and Middlesex County Council, but the minister—who himself received deputations from both—was not to be moved. He took the view that local authority boundaries, particularly in the London area, were not appropriate to the geographical flow of patients to the hospitals. The necessary order determining the regions was made accordingly on 18 December.[63] On 11 January 1947, the letter went out inviting nominations for membership of RHBs; and the order constituting the boards was issued on 24 June.[59]

Analysis of the membership of the boards showed that the minister had been as good as his word in selecting those to serve. There were local authority members, but nowhere near a majority; there were friends of the Labour cause, but also a good sprinkling of political opponents; leading consultants were included to speak for the profession, as were other professionals such as dentists and nurses; and the 'consumer' or potential patient was represented by a trades union nominee as well as by laymen or laywomen from voluntary hospitals or other sources. All were chosen for their personal qualities and experience, and none as representatives of particular interests.

Once appointed, the RHBs had to be given guidance in the exercise of their responsibilities, for all were finding their way along new paths. On 27 June, a Ministry of Health memorandum was sent to each RHB chairman, together with a list of the members and a letter setting out the salaries and terms of service of their chief officers, the senior administrative medical officer and the secretary. It was explained that, while the boards were the minister's agents, they were to enjoy the largest possible measure of discretion; he wanted them to feel 'a lively sense of

independent responsibility'. No formal service plan would be required, since planning would be a process of continuing informal consultation between the board, the university, the teaching hospital and the minister. In some regions, area committees might be necessary for parts of the region: mentioned as possibilities were Cumberland and North Westmorland; Hampshire, Dorset and the Isle of Wight; Devon and Cornwall; North Lancashire and South Westmorland; and North Wales. In all regions, a committee structure would be needed, together with technical advisory committees, including a liaison committee of medical officers of health; and, in London, a joint liaison committee of the four metropolitan RHBs.

The hospital management committees, which were to administer groups or individual hospitals as agents of the RHBs, should be given the maximum of autonomy in day-to-day management, with the RHB determining major policy and capital works (except minor items) and approving the committee's budget. All hospital staff, apart from some senior medical and dental officers, were to be selected, appointed and dismissed by the HMC, even though they would formally be employees of the RHB. In carrying out their functions, the boards would need to have regard to the resources and requirements of neighbouring boards, and to allow free flow of patients across regional boundaries. The boards of governors of teaching hospitals, while responsible directly to the minister, would be an essential element in the hospital services of the regions, and it would be for the three parties concerned to determine together what functions they should perform.

The staff required by RHBs themselves would in the first place be a senior medical administrator (senior administrative medical officer, SAMO) and a non-medical secretary. Later, there would need to be a mental health medical officer, an architect, a finance officer and a legal adviser.

Boards would be asked to advise on the hospitals to be 'disclaimed' under the Act, that is to say those to be excluded from take-over; and when this had been done there would be lists of hospitals in their possession which would form the basis for grouping for management purposes and for the appointment of HMCs. A scheme for HMCs should be submitted to the minister for approval, showing the hospitals and beds in each group, the proposed number of members of each HMC and what bodies would be consulted in making appointments to them. The aim should be to group together for management purposes those functional units which constituted a single operational entity, and the

maximum number of members on an HMC should be fifteen. Later, it would be necessary to designate some beds as 'amenity' beds, under Section 4 of the Act (that is, beds in NHS hospitals which would be subject to a charge for privacy only) and as 'private' pay beds, under Section 5.

The financial basis of the boards' operations would be an annual budget for each year beginning on 1 April, to be met from the Exchequer. The minister would defray the expenditure of the boards and they, in turn, would defray that of the HMCs in their region.

This memorandum of guidance was followed up a month later by the minister's meetings, first with the chairmen of RHBs and then with their members. On 23 July 1947, there took place the first quarterly meeting of chairmen with the minister in a series which has continued ever since with the minister or his officers. In the afternoon of the same day, the minister addressed some hundreds of RHB members. He again made the point that he must have powers to make regulations and directions in order to discharge his duty of providing a comprehensive health service; but he wanted to give boards the maximum of independence and self-government, which they must in turn confer on HMCs, and HMCs on house committees for individual hospitals. Board members must not regard themselves as delegates with a duty to report back to someone, but as individuals with the experience and dedication needed for their job. They must not forget that they were part of a wider service shared by local health authorities and executive councils, and must seek to work closely with them and with the boards of governors of the teaching hospitals. HMCs should normally be responsible for a group of hospitals, and the mental health services should be integrated. It would be necessary to tap new sources of experience for membership of HMCs. Denominational and some other special types of hospital would be 'disclaimed', but their resources would be available to boards through contracts made with them. Complaints about the service would be inevitable; indeed the Act enfranchised the complainant by providing a specific authority to complain to. On minor matters, he said that the Ministry of Works had been asked to search for office accommodation for the boards; the salaries for the two chief officers, which some had said were too low, should be tested in the market; and for the future determination of salaries and wages in the service, a Whitley Council machinery was being worked out.*

* PRO MH 90/52

In all, 3118 hospitals and clinics were transferred to the minister, with 388 000 staffed and 57 000 unstaffed beds, and 277 were 'disclaimed'. These were mainly hospitals run by religious communities (such as The Hospital of St John and St Elizabeth), or private (such as the Royal Masonic Hospital), or old and disused (such as some smallpox hospitals). The transferred hospitals were grouped into management units by the RHBs, 370 in all, and their HMCs appointed early in 1948. In January, regulations were made defining the respective functions of RHBs and HMCs,[62] embodying the principles enunciated earlier by the minister. These were further elaborated in a memorandum of guidance sent to HMCs in March, again on the lines of that sent the previous June to RHBs, but including some further points—the importance of building up close links with the communities they served, for which their constitution had been designed; the value of an annual open public meeting to give account of their stewardship; the encouragement of voluntary service in the hospitals; the need for and role of house committees; and the place of staff committees in promoting the smooth operation of the hospitals. Other guidance dealt with the organisation (and remuneration) of home visiting by consultants and specialists, the making of contracts for services with hospitals outside the NHS, the apportionment of property shared with local authorities or others, and the division of function in public assistance institutions used for both the sick and the able-bodied. Similar action was taken in relation to the teaching hospitals. On 24 March 1948, the provincial teaching hospitals in the NHS were defined,[60] and in May the London teaching hospitals,[61] and immediate steps taken to select and appoint their chairmen and members.

In parallel with this work on the hospital part of the service, was the setting up of the ECs to run the general practitioner services, to define the scope of those services and the obligations of the professionals providing them. Three sets of regulations, produced only after prolonged discussions with the representatives of the professions concerned, set out the shape of the medical, pharmaceutical, dental and eye services in March and June 1948. The ECs were informed in March about the arrangements to be made and the action to be taken to bring the services into operation; for example, by arranging for doctors to join the medical list, and by publishing lists for the information of the public generally. They were also told of the publicity being planned nationally, and were sent supplies of leaflets about the NHS, with special ones for the dental and eye services, which were also distributed to every household in April

and May. The ECs themselves had been established between May and November 1947, after professional local committees had been 'recognised' for the purpose of nominating the doctors, dentists and pharmacists to serve on them. Regulations of May 1947 provided for the appointment and terms of office of members of ECs and laid down their procedures. The moribund insurance committees helped in the process of setting up their successors by lending staff and premises; and in October 1947 a national conference of ECs was held.

One of the items included in the May regulations was the appointment of ophthalmic services committees by the ECs to run the 'supplementary' eye service; that is, the non-hospital service, which was planned to be temporary only. Accordingly, opticians did not take part in the EC machinery proper, and this appendage was created to cater for them. Not until 1968 was it finally acknowledged that an optician-based eye service was permanent, and the Health Services and Public Health Act of that year amended the constitution of ECs and made the other changes needed to put opticians on a par with other general practitioner services from April 1969.[47]

The local health authorities—that is, the counties and county boroughs—had to frame schemes for providing domiciliary services, clinics, vaccination and immunisation, ambulance services and other facilities. The schemes had to be submitted to the minister for approval, after consultation with the voluntary organisations involved, and copies sent for comment to the RHBs and ECs. A circular of 19 February 1947 (number 22/47) laid down a timetable for the submission of proposals, and two others, of 3 March and 10 July (numbers 66/47 and 118/47), gave guidance on their preparation for all services except health centres. On these, which had been envisaged as the hub of the general medical service, no progress was possible for the present. Circular 3/48 of 14 January 1948 said that because of building difficulties and of the need to investigate the best kinds and purposes of health centres, no general programme was appropriate, and only schemes of particular urgency would be considered. A working party associated with the CHSC was to be appointed to consider the whole concept.

Two other major pieces of work had to be done as part of implementing the 1946 Act: the setting up of Whitley machinery for the service, and a national pension scheme for all types of staff. Both required wide consultation with staff representatives and employing bodies as well as within government, and long discussions, before they finally took shape. Not every detail was settled or every difficulty overcome by

5 July 1948, but here as in the rest of the structure enough was in place and sufficiently strong to bear the first strains of the new order.

Final medical negotiations

While the discussions were in progress between the officers of the ministry and the various subcommittees of the negotiating committee, there was little or no public evidence of developments either in the pages of the medical journals or elsewhere. Almost the only exception was the appointment of another Spens committee in June 1947, this time on the remuneration of consultants and specialists, with Moran as one of the four medical members. But by the beginning of November 1947, these discussions had ended, and the negotiating committee was ready to meet the minister for a round-up of the position reached. The meeting spread over two days, 2 and 3 December, and was anything but harmonious. The committee raised again nearly every point of difference: the distribution of general practitioners and the role of the MPC; the effect on partnerships of Sections 35 and 36 of the Act dealing with the sale of practices; the method of remuneration (particularly the question of a basic salary for every general practitioner); the right of appeal from the tribunal to the courts; the creation of panels of general practitioners and obstetricians for home deliveries (this had been proposed in order to restrict attendance by practitioners on maternity cases to those with competence and experience in midwifery); the availability of pay beds (the minister conceded some 'no ceiling' beds); the method of appointment of consultants; the election of the chairmen of RHBs and HMCs by the bodies themselves; the appointment of medical representatives to local authority health committees; and the nomination by the doctors of professional members to administrative and other bodies. At the end of the meetings, Bevan appealed for the launching of the scheme in an atmosphere of goodwill, not of controversy, but the omens were anything but favourable.*

On 20 December, the *BMJ* published the negotiating committee's statement of its case, and two replies from the minister, one addressed to the individual doctor and the other to the committee.[115] The committee listed twelve points on which, in its view, the scheme needed to be modified. There should be no restriction on the right of general practitioners to enter the service and to choose their area of practice; the

* RCP papers

sale of practices should continue (the sections of the Act dealing with the matter were unworkable); general practitioners should be remunerated by capitation fee except in special circumstances, and consultants by annual salaries with item-for-service payments for home visits; there should be a right of appeal from the tribunal to the High Court; no special qualification should be required of doctors undertaking midwifery; all councils and committees should elect their own chairmen; private nursing homes should be protected against acquisition by the minister; consultants should have the right to practise privately in hospital pay beds, and the proportion of those beds should not be variable by regulation; x-ray and pathology services should be directly available to general practitioners; local authorities should be required to coopt medical members on to their health committees; the remuneration and terms of service of all public health doctors should be negotiated together; and doctors should determine their own representation on bodies set up under the Act.

In his reply to the individual practitioner, the minister made six points. First, any doctor would be able to take part in the service and to do private practice. There would be no interference with his professional judgment, he would be in contract with an EC and not an employee, still less a civil servant. His remuneration would be £2600 gross for 3000 patients, 4000 patients being the maximum, together with any private fees, special fees for maternity work, mileage payments, grants for the training of assistants and discretionary additional payments in difficult areas. For the loss of his right to sell his practice, a total sum of £66 millions would be paid as compensation, to be distributed on the advice of the profession itself. In addition, there would be a pension scheme with a contribution from the doctor of 6 per cent and, if necessary, there would be amending legislation to deal with the problems of partnership agreements. Existing practitioners would be free to continue to practise wherever they then were, but in future consent would be needed to enter practice and this would be refused only in those few areas where no additional doctor was required. No doctor could be directed anywhere. As to the question of appeal against removal of a doctor from the service, it must be noted that the minister's power was limited to *restoring* him, and did not extend to removing him. Practice from a health centre would be entirely voluntary. Finally, there was a medical presence in every main administrative body—RHB, BG, HMC and EC. The CHSC was mainly medical, would be able to initiate advice and its report must be published unless publication would be against the public interest.

The minister's reply to the negotiating committee's statement said that amending legislation was not excluded if required, but that he did not believe anything in the scheme conflicted with the seven principles adopted by the profession in December 1945. On the powers of the MPC, he pointed out that it would be a mainly medical body, would work closely with the local EC and that, on appeal from the committee's decision to him, his powers did not extend to refusing entry to practise if the committee had allowed it. He was ready to legislate on partnership agreements if his legal advice on the effect of the Act was shown to be wrong, and to increase the total compensation if necessary. Remuneration of general practitioners would be from a central fund, made up of the sum of eighteen shillings multiplied by 95 per cent of the population. He could not accept the proposal for appeal from the tribunal to the High Court on removal of a doctor from the service, because in that event he would be unable to answer to Parliament for a doctor he had been forced to retain. On midwifery by general practitioners, that could be undertaken by those regarded as competent by a local professional committee, and others could take part as they obtained the necessary obstetric experience. On the chairmanship of administrative bodies, he agreed that after the first appointment the chairmen of ECs should be elected by them; but he could not agree to the same for hospital bodies because of their agency relationship to the minister, though he would of course take their views into account when appointing. Private nursing homes run for profit would not be liable to take-over under the Act, but the minister must have power to acquire land and buildings for the purposes of the hospital service and, exceptionally, this might be exercised in relation to a nursing home. Private practice in pay beds would be open to all hospital staff members, but it would be impracticable to put a statutory obligation on hospital bodies to allow this because in some areas the facilities might not be available. He was ready to allow some pay beds to be used without prescribing any maximum charges. Junior medical appointments at hospitals would be made by the HMC, senior ones by the RHB on the advice of specially constituted appointments committees. He would encourage local authorities to coopt doctors on to their health committees, but he could not compel them to do so. Lastly, he emphasised that doctors were involved in the administrative structure as never before. The Act represented a degree of decentralisation and of professional administration probably unequalled in any field in which a government minister was responsible.

The reaction of the BMA council to all this was to put out a statement

saying that the minister had not responded to the arguments of the profession on any major issue, attacking him in detail, and concluding that the service as described by him 'conflicts with the traditions and standards of a great profession'.[103] This the *BMJ* followed up in a leader on 3 January 1948 attacking the consultants for making little effective criticism of the minister's hospital proposals and accepting State hospitals as a lesser evil than local authority control. The general practitioners must lead the opposition. Bevan was hoping to divide and rule, and had dangled the bait of some 'no ceiling' beds; but all must stand together against a State medical service.[17] *The Lancet* on the same date was less hostile but still critical. Resistance in the profession centred on the abolition of the sale of practices, which brought with it regulation of movement by the MPC and a basic salary. The BMA council's underlying assumption was that the profession should take no risks and should trust nobody. The minister's answer to them should be conciliatory in deed as well as in word; the questions of basic salary, appeal from the tribunal to the High Court and the effect of the Act on partnerships should all be looked at again.[113]

The BMA's SRM on 8 January supported the view of the council, and declared that the Act was 'so grossly at variance with the essential principles of our profession that it should be rejected absolutely by all practitioners'. The SRM also decided that a minimum vote of 13 000 general practitioners against the Act would be necessary to provide a basis for its rejection. The BMA's efforts were then turned to securing the required vote. In a succession of fiery leaders, the *BMJ* mounted a sustained attack throughout January and February until the day of the plebiscite. On 10 January, it declared that the minister's 'method of negotiation is to alternate blandishments with threats', that he was 'determined to go on with his Act in spite of the fact that he has failed to secure . . . the co-operation of the doctors of this country' and that he was 'contemptuously indifferent to reasoned arguments'. Charles Hill was quoted as saying 'There is one criterion by which as a profession we can measure these matters . . . It is whether these proposals do or do not bring us closer to a whole-time salaried service of the State.' The *BMJ* welcomed, as evidence of hospital staffs' opposition to the Act, the vote of a meeting in London led by Horder on 27 January, agreeing not to take service under the Act until it was modified to secure agreement between the government and the profession; and it condemned as 'evasive, indecisive and lacking in courage' a resolution of the RCP on 29 January deferring any decision until after the SRM to be held on 17 March.

The Lancet tried to moderate the conflict by putting a series of questions to the minister and publishing his answers on 24 January.[104] The first was to ask the purpose of a basic salary, to which he replied that a fixed payment of £300 a year would help beginners in a practice while they attracted patients, would provide a convenient peg on which to hang additional payments such as allowances in rural areas, and would reduce the temptation to build up too large a list of patients. The alternative of a variable capitation fee raised substantial administrative difficulties. On the right of appeal to the courts against removal from the service, the minister said that the job of the courts was to determine whether dismissal was lawful, not whether the person concerned was fit to continue at work. The courts would still be open to every doctor on the first count. The tribunal was a new tier in the appeal machinery and, from the point of view of the doctor concerned, it had over the courts the advantage of privacy. There would be no advantage in having a judge as chairman rather than a lawyer of standing. On the question of partnerships, he proposed to appoint a committee of lawyers to look at the disputed sections of the Act and, if they reported it to be necessary, he would at once seek amendment. He intended that remuneration should be in accordance with the Spens committee's recommendations. Finally, he said that if the NHS scheme were postponed, NHI could not continue because it would be repealed by the National Insurance Act from 5 July. In any case, why should it be postponed? Proposals had been under discussion since 1942, the Act had become law in 1946, and it was time people had the benefit of it. *The Lancet* thought that the BMA drew a revolting picture of the NHS, and the 'lurid appearance is partly the effect of artificial illumination'; but it deprecated equally the belligerence of the minister and of the profession.

Bevan and the Cabinet

Meanwhile, within government, there was beginning to be a certain misgiving about the way things were going. Was it possible that the NHS would not after all start on 5 July, and that the doctors would refuse to work it? On 19 January, Bevan circulated a paper to his colleagues which was discussed in Cabinet on 22 January with the aim of allaying their fears. To his paper he attached a copy of the negotiating committee's case and of his own two replies.* In the paper, he said that

* PRO CAB 129/3 (CP(48)23)

up to the previous autumn there had been a prospect that the doctors as a whole would willingly accept the NHS scheme, and many leading members of the profession were still in favour. But the negotiating committee was dominated by a reactionary and vocal group seeking, partly for political reasons, to stop the operation of the Act, although his own view was that the profession had been treated generously. The BMA was now to hold a plebiscite, and an intensive campaign was being mounted by Charles Hill to secure rejection of the Act. It was clear that the aim was not merely to seek detailed improvements but to sabotage it completely, although Hill knew very well that the personal freedom of the doctor, freedom of choice and freedom to change one's doctor were all maintained in the Act. On individual points there was some uncertainty about the effect of the Act on partnerships, and he proposed to appoint a small independent legal committee to advise, and to introduce amending legislation if necessary. The argument about appeal from the proposed tribunal to the courts was misconceived. It was not for the courts to decide whether dismissal is right on merits but only whether it is wrongful in law, and that matter would still lie with the courts. Argument about a basic salary was odd, having regard to the fact that under the NHI scheme it had been possible to introduce a whole-time salaried service by regulation for the last thirty-six years.

In the discussion,* Bevan said he declined to be drawn into an exchange of propaganda in which he would be at an inevitable disadvantage with those who need not be, and were not, scrupulous about the truth of their facts. Nothing could prevent the doctors from voting against the Act in the plebiscite, but that did not mean that they would not as individuals take part in the service when the time came. He proposed to build up evidence in the press and elsewhere that the Act was proceeding, that the necessary machinery was being set up and that progress was not affected by the opposition. In due course, a guide to the service would be issued to all households, and a sale booklet, films and so on would be produced. The period between the plebiscite vote result and 5 July would be a time when it would be difficult for the BMA to continue its resistance. But in any case, it was essential to keep to the appointed day of 5 July, unless the government wished it to be known that a sectional group had succeeded in 'rejecting' an Act of this Parliament.

The Cabinet endorsed Bevan's proposals, but it was suggested that

* PRO CAB 128/12

more should be done to explain the government's case to the average doctor, and particularly the younger ones. Before the plebiscite vote, Bevan might consider issuing a brief statement dealing with the point about the tribunal appeal and others about which there was misunderstanding. It was agreed that he should consult the Lord President (Herbert Morrison) about further publicity. One result of this may have been the questions and answers in *The Lancet* listed above; another may have been the debate arranged in the Commons for 9 February. If so, this particular exercise was of doubtful value, and probably did the government cause more harm than good.

It was certainly an unusual step to arrange for a debate about an Act of Parliament. In the event,[87] what happened was that Bevan proposed a motion noting that the appointed day for the operation of the NHS had been fixed for 5 July, welcoming this fact, and stating the House's satisfaction that the conditions proposed for the medical profession were generous and in accord with its freedom and dignity. His speech became a violent attack on the BMA. He complained of propaganda and misrepresentation by a small body of spokesmen, 'politically poisoned people', of a 'squalid political conspiracy' and of 'organised sabotage'. The opposition was not, as some had suggested, personal to himself. The doctors had not in the past found Ernest Brown or Henry Willink any more acceptable. Nor was it true that there had been no negotiation. He had himself met the negotiating committee three times before the introduction of the Bill, three times while it was in the committee stage and twice since it became law; his officers had had twenty-eight meetings. The truth was that the negotiating committee could not, and did not, negotiate.

Four main issues had, he said, been raised by the BMA. The first was the abolition of the sale of practices, a proposal made by the BMA Medical Planning Commission in 1942. The second was the proposal for a basic salary, introduced as a support for the young doctor. The third was the uncertainty about the future of partnership agreements. On this, he was setting up a legal committee to look into the problem and, if necessary, he was prepared to introduce an amending Bill. The fourth was a right of appeal from the tribunal to the High Court instead of to the minister. But under the NHI scheme, there was no tribunal, only appeal to the minister. In any case, it could not be for the courts to determine whether employees (miners? teachers? railwaymen?) should be dismissed. The House must assert 'the sovereignty of Parliament over any section of the community. We have not yet made BMA House into

another revising chamber. We have never accepted the position that this House can be dictated to by any section of the community.'

Speaking for the opposition, (Lord) Rab Butler criticised the 'inept manner in which [Bevan] has managed this controversy'. He referred back to Bevan's quip in the second reading debate about plucking the fruit when it is ripe as an example of his tactlessness, and declared that what was wanted was the victory of common sense. He did not oppose the abolition of the sale of practices, but he did want appeal from the tribunal to the courts, the dropping of a universal basic salary and no 'negative direction' of general practitioners. Other opposition speakers took the same line.

This debate undoubtedly caused considerable resentment, even among doctors who were generally well disposed to the NHS scheme. It appeared to be an attempt, in offensive terms, to browbeat the profession into voting for the NHS in the plebiscite. *The Lancet's* comment was that Bevan 'once again showed a preference for strife, and his chief aim was to discredit his opponents'. It could only hope that the BMA council would use its support more wisely than Bevan had used his.[2] But this was not to be. Towards the end of February, the result of the plebiscite showed a vote of more than eight to one against the Act; and, of the consultants, general practitioners and whole-time voluntary hospital medical staff (the three groups regarded as the most significant by the BMA), 4084 favoured accepting service while 25 340 were against. The *BMJ* was exultant. Bevan's misjudgment had been revealed for all to see. The government intended to get a whole-time medical service, and if this government were re-elected it would surely happen. Promises to the contrary were useless—witness the promise given in 1940 that the EHS was not a step towards the introduction of a State hospital service.[90] (What evidence there was for the view that the EHS was a deliberate step in that direction the *BMJ* did not reveal, no doubt for the good reason that there was none.)

On 17 March, the BMA's SRM discussed the next action. Dain said that the minister had tried to split the profession by making concessions to the consultants, but he had failed. He had never intended to amend the Act, and the debate in the Commons on 9 February was an attempt to intimidate the profession. The overall objection to the Act was that, under it, the minister's power was absolute and would lead to the enslavement of the profession. If the Act were not amended to provide proper safeguards, the doctors' independence and freedom would be lost. The Act was only paper; the service itself would not, and could not,

be there to operate on 5 July or on any reasonably approximate date. But the BMA was ready to enter into discussions directed to making medical cooperation possible. The meeting resolved to urge such changes in the Act as were necessary to maintain the integrity of medicine and to prevent doctors from being turned into State servants. It declared that it was not in the best interests of the public or of medicine to enter the service until such changes were made; and it resolved to establish an 'independence fund' to help to finance the profession's activities during its dispute with the government. But it also asked medical members of hospital boards and other bodies to continue their membership for the present.[15]

Medical diplomacy renewed

Once again there appeared to be an impasse; and once again it was intervention by Moran which broke it. Before the RCP comitia met for the annual presidential election on 22 March, he arranged with Bevan for a suitable resolution to be passed at that meeting. But for that to happen, he had to win the election for the eighth time, a record unmatched even by Dawson. On this occasion, the contest with Horder was keener than ever. Both sides marshalled their supporters anxiously and efficiently, so that fellows were present who had not been seen in the college for years. By a narrow margin Moran was victorious; and a resolution was duly adopted affirming the comitia's desire for the unity of the profession and the need for its willing cooperation. It went on to state the belief that this could be furthered if the minister would make it clear in an amending Act that a whole-time salaried service should not be introduced by regulation (and it reaffirmed its opposition to such a service).*

Moran followed this up in a letter of 4 April to Bevan, commending the terms of the resolution, and adding the further suggestion that the proposed basic salary should be restricted to young doctors only. He proposed that Bevan make a statement based on the RCP resolution which was to be published on 5 April. At that point, Webb-Johnson for the RCS and Gilliatt for the RCOG expressed their support for Moran, but the RCS asked also for some move on remuneration.* In *The Times*

* RCP papers

on 7 April, Dain wrote to rebut the newspaper's medical correspondent's suggestion that acceptance of the RCP view would 'go a long way towards meeting the demands of the BMA'. Other modifications of the scheme were also necessary, such as the abandonment of a basic salary.

On the same day, 7 April, Bevan made a conciliatory statement in the Commons, repeated by Addison in the Lords, where it was welcomed by Salisbury, Samuel and Moran. He said that he had received resolutions from the RCP, the BMA and others, and had tried to determine what was really worrying the doctors. It appeared to be an instinctive fear that—although the Act did not propose it, and the government had denied it—the real objective was a full-time salaried service. He had made it quite clear on 4 November 1946 that this was not the intention; but more was needed. The RCP had suggested, with the support of the other colleges, that it should be made statutorily clear that a whole-time service would not be introduced by regulation, but would depend on further legislation. This his colleagues and he himself cordially accepted. An expert committee was being set up to consider the effect of the Act on partnership agreements, and a short amending Bill might be necessary which could also include the matter of a whole-time service. The proposed basic salary of £300 also seemed a threat to many doctors. He now suggested that it should be available to new entrants for three years, at the end of which each could decide whether he wanted to continue it or to go over to remuneration by capitation fee. The established doctor should also be free to choose a basic salary with a lower capitation fee at any time if he wished. Once again he assured the profession that there was no intention of interfering with the rights of doctors to express themselves freely in speech or writing, and that the chairman of the tribunal would be a lawyer of high standing appointed by the Lord Chancellor. He hoped that all this would finally free them from fears of being turned into salaried civil servants. In reply to questions, he said that he was ready to meet the negotiating committee whenever it wished.

Up to this time, the opposition of the BMA had continued without remission. The *BMJ* complained that, by publicising the arrangements for bringing the Act into force, the government was trying to get the public to coerce the doctors.[97] Now, however, the *BMJ* changed its tune. It supported the welcome given by the executive committee of the BMA council to the minister's move, and the council's invitation to him to receive a deputation to consider a series of questions to be sent to him in

writing in advance; and it deprecated criticism of the royal colleges for their role in the affair. After a meeting on 12 April, the BMA's questions and the minister's written replies were published.[9]

The minister said he had not yet worked out how to prevent a whole-time service being introduced by regulation, and would welcome the profession's help in doing so. The arrangements would be, however, that general practitioners would be paid entirely by capitation fee except for new entrants during their first three years; and hospital staff would be appointed on the basis of advertisement with special advisory machinery for consultants. Private hospital accommodation would continue as expressly provided in the Act, though its future distribution might change. No assurance could be given that 'disclaimed' hospitals would never be taken over, but this was not intended, and if acquired they would have to be purchased. He agreed that every hospital should have a medical advisory committee, but he could not compel the staff to appoint one; nor could he accept nomination of members to BGs or HMCs by any such committee, though he would consult them in making appointments. Assurances already given covered freedom of speech by doctors, including the right to criticise the administration. The security of hospital staff would be guaranteed by continuity of service at the appointed day, and thereafter by the appointments procedure; further machinery would be devised through a Whitley council.

A suggestion made for a special procedure for the approval of regulations was not clear. All regulations were scrutinised by a parliamentary committee to confirm their scope and to identify any unusual features. The regulation method of legislation was advantageous to the profession because of its flexibility, as experience under the NHI scheme had shown. Where annual payments were necessary, ECs would be consulted on their variation, and the minister would be ready to discuss with the profession the conditions for them. He was not prepared to postpone the MPC system, but to review it in (say) two years. He did not feel able to stipulate that the Lord Chancellor should appoint a High Court judge as chairman of the tribunal, but he would be a lawyer of high standing. After the abolition of the sale of practices, a doctor would still be free to practise anywhere except in an area closed by the MPC, to choose his partners and assistants (with the EC's agreement where the assistant's stay was for more than three months), to allocate duties within a partnership or group, and to have his views about a successor taken into account by the EC. Midwifery was not to be limited to doctors with special qualifications but to those included on a local list, compiled

as recommended by a committee on maternal care which had been established in agreement with the negotiating committee. The minister gave an assurance that consultant and specialist services would be available to general practitioners within the resources of the hospitals.

Finally, although he would, as required by the Act, consult the professional bodies in making appointments to boards and committees, and would want to take those acceptable to the bodies concerned, he could not agree to take only those on whom the bodies would agree. (Indeed, as he once remarked, why should the Minister of Health be the only person to be deprived of free choice of doctor?)

The BMA council came now to the conclusion that, in view of the changes the minister was ready to make, the profession must be consulted again; and on 19 April another plebiscite voting form was sent to every doctor, together with a statement by the council of the changes, and of its view that 'the freedoms of the profession are not sufficiently safeguarded'. It declared that the BMA would advise against entering the service if a majority of general practitioners, consultants and whole-time voluntary hospital staffs were opposed to doing so, and if that majority included 13 000 general practitioners. On 22 April, a meeting of London consultants, by a vote of 196 to 1, advised against entering into a contract until conditions of service had been agreed. If interpreted literally, this decision would have delayed the operation of the service for months, because it was not until 19 May that the Spens report on consultants' remuneration became available, and terms of service had to be negotiated after that.

This Spens report constituted another encouragement to the hospital consultants to support the service.[36] The salaries recommended for whole-time service were not ungenerous; and for three groups, making up in all 34 per cent of the numbers of consultants and specialists, three levels of higher remuneration were recommended, the recipients to be selected in confidence by a small central committee, mainly medical in composition. This was the much criticised (and praised) 'awards' system, designed at once to stimulate and reward good work and, by its confidentiality, to avoid any advertisement of the merits of the individuals concerned. It was the brainchild of Moran, who himself became the first chairman of the awards committee. But it was several months before the proposed scales could be applied and the terms of service settled, and interim arrangements had to be brought into operation from 5 July, on the understanding that the permanent terms would be retrospective to that date.

Towards the appointed day

By mid-May, when the BMA council met again, enough was known of the voting in the plebiscite for the result to be clear: 14 620 approved of the Act and 25 842 disapproved; but of the consultants, general practitioners and whole-time voluntary hospital staff, 12 799 were in favour of accepting service and 13 891 against, and of the latter only 8493 were general practitioners—well short of the 13 000 regarded by the council as the required minimum for refusal. The council therefore recommended the representative body to cooperate on the understanding that the minister would continue negotiations, and to accept his invitation to discuss an amending Act and other outstanding matters. The *BMJ* made a gallant attempt to list the concessions and changes ostensibly wrung from a succession of reluctant ministers,[123] most of which were items either never proposed by those ministers or changed on their own initiative. But the plain fact was that the BMA leadership had been defeated.

In a letter of 26 May, Douglas set out for Charles Hill the scope of the prospective amending Bill.[74] It would clarify the position of partnerships in the light of the legal committee's expected report, and would operate so far as practicable from 5 July. It would ensure that the introduction of a whole-time service for consultants as well as for general practitioners would require fresh legislation; it would provide for ECs to choose their own chairman, and to meet the cost of local medical committees where the local practitioners so desired; and it would lay down that the professional member of the tribunal should be not one person only but one drawn from a panel of suitable people. The minister also agreed to make the option of a basic salary available only on the recommendation of the appropriate EC, to pay doctors not on the local obstetric list to attend midwifery cases, but for a lower fee, and to guarantee freedom of publication for all doctors. This list of items shows clearly that the minister had also been defeated, in the sense that a number of his original proposals had been substantially modified. Perhaps the ultimate winner was that common sense for which Butler had asked in the debate on 9 February.

The SRM on 28 May accepted the inevitable. Dain made clear his deep disappointment with the result of the plebiscite, and Horder urged unwearying opposition to the service, but the council's recommendations were adopted as the only statesmanlike course.[123] The crowning argument was that the doctors were already voting with their feet. By

then, 26 per cent of English general practitioners, 37 per cent of Welsh and 36 per cent of Scottish had already joined the service and, in contrast to 1912, the leadership did not want to be frozen in hostility when the rank and file were accepting involvement. But the SRM went on to wash its hands of the effects it expected to flow from its decision, by resolving that the public be told that the inception of the new service could not be followed by all the improvements promised by the government, and that the profession would not hold itself responsible for those promises, though it would make every endeavour to work the scheme. Finally, a letter from Dain was published in *The Times* of 18 June giving an assurance that 'the profession will do its utmost to make the new service a resounding success . . . There will be no shortage of goodwill on the part of the profession . . . to make the new public service the best which is humanly possible under present circumstances.' And so, despite Dain's earlier protestations of its impossibility, the 'Appointed Day' did prove to be 5 July 1948.

It was left to *The Lancet* to have the last word. In a leader on 3 July, the editor summarised the position like this. 'The new arrangements confer a great benefit on medicine by lessening the commercial element in its practice. Now that everyone is entitled to full medical care the doctor can provide that care without thinking of his own profit or the patient's loss, and can allocate his efforts more according to medical priority . . . Given time, the rationalisation of the hospital services under State ownership would mean real progress in applied medicine, and anyone who has studied the membership of the boards and committees charged with their management must agree that our profession has been given a full opportunity for leadership. If we continue to think of the NHS as a State service it will fail; but if we recognise it as our own service we can make it a great and increasing success.'[91]

The last act

There was, of course, an epilogue to the drama—the National Health Service (Amendment) Act 1949. This finally reached the statute book on 16 December that year,[52] and duly carried out the promises given by Bevan in May 1948. Part I dealt with the very complicated changes recommended by the legal committee on the effects of the 1946 Act on partnership agreements, and Sections 10, 11 and 12 prohibited full-time salaried service for general practitioners, dentists and specialists (that is, specialists as a whole). The Act also covered such matters as the election

of EC chairmen and charges for day nursery care. And in Sections 16 and 17, it took powers which were to provoke continuing controversy, the first enabling regulations to be made imposing charges for pharmaceutical services (the drug bill was already causing anxiety), and the second similarly conferring a regulation-making power to charge for any services to those persons not resident in this country. Bevan later claimed that he never intended to use the first of these powers (which was probably true), though it has been frequently employed since. The second power has never been used, as it would create more administrative difficulty than it is worth.

The medical profession welcomed the 1949 Bill when it was first published with something less than warm enthusiasm. The *BMJ* recognised that the minister had carried out his undertakings, but it was more concerned to castigate his failure to discuss before introducing the Bill—'a breach of trust with a profession that has loyally collaborated with the government in operating a service full of imperfections'.[105] It was regrettable that nothing had been included to establish an automatic right for the doctor in 'open' (that is under-doctored) areas to choose partners or assistants; to give private patients the right to get drugs and appliances from the NHS (that is, at public expense); to recognise representative specialist staff committees; to enable BGs and HMCs to elect their own chairmen; to prevent the free treatment of foreign visitors (Section 17 of the Act (see above) was inserted during the passage of the Bill). This tone of critical appraisal was to become the normal attitude of the BMA towards a service which it both loved and hated according to the light in which it was viewed at any given time. Sometimes the BMA seemed to see the NHS as its own, and sometimes as a State strait-jacket. But, whichever it proved to be, with the royal assent to the 1949 Act, it could be said that the NHS at last came fully into existence.

7

The end of the beginning

After a gestation of some seven years, the birth of the National Health Service finally came calmly and almost imperceptibly, after the agitation of the preceding months. What was the nature of this newborn infant? What were its peculiar features? And who were its parents, or its midwives?

Characteristics of the new service

From very early on, the NHS has been criticised for not being what it was never intended to be; that is, an organisation responsible for every form of activity designed to promote health. As Willink pointed out in answer to the criticisms of the British Medical Association in 1944, environmental services, housing, nutrition—indeed all the principal preventive health measures—were outside its scope. It did, however, extend to specific preventive measures such as vaccination and immunisation, and won victories over such diseases as tuberculosis and poliomyelitis. But its main task was different, namely the organised delivery of medical care. Nor did it aim to change the basic patterns of medical practice (with the exception of the introduction of the health centre which, in the event, did not materialise on any appreciable scale for twenty years), or the sacred principles of free choice of doctor and patient, the clinical freedom of the practitioner, the right of publication, and so on. It was, first and foremost, machinery for ensuring that the appropriate medical care would be delivered to everybody when needed.

The first characteristic of the new service, then, was that it was comprehensive in scope; that is, it included health and allied services of every kind. This comprehensiveness was not a matter of course. At the beginning, it had been intended to exclude mental health services, until

the advantages of unification were seen to outweigh the difficulties of an unreformed lunacy law. At another stage, the possibilities of including dentistry seemed remote, until the Teviot committee urged boldness. In any case, industrial health and prison medical services continued as separate entities outside the NHS, in spite of the doctors' pressures, though services for war pensioners were fairly soon absorbed. As time went on, the meaning of comprehensiveness changed with the development of new techniques and the growth of medical knowledge, but the principle remained unaffected even if its operation was tempered by the introduction of some charges.

The second characteristic was availability for all, a principle which had to be won against the opposition of many doctors. It was, after all, a new principle, foreign to the practice of most other countries and to that of this country up to then, because the usual basis of public medical schemes was, and is, insurance, with medical care available only to the insured. But a restricted health service could not be married with a social insurance system aimed at covering everybody as Beveridge intended; and, as *The Lancet* had pointed out, a health insurance scheme would be a cumbersome and costly administrative top-hamper for the purpose of excluding, at most, 10 per cent of the population from medical benefit. Some doctors, particularly the surgeons, thought that private practice would perish if this were not done, but they proved to be mistaken. A continuing ground for criticism of the principle was that it allowed of the free treatment of foreigners in this country—hence the inclusion in the 1949 Act of the regulation-making power to charge them. But, in practice, it has been found that administrative measures can deal with flagrant abuse (the millionaire coming to this country expressly for free medical care), and that it is just not worth while to go to the lengths of introducing identity cards for everyone (as would be necessary to catch every foreigner) in order to make charges to the relatively small numbers involved.

The third characteristic was that the service should be provided free at the time of need. This is the principle that has been most frequently breached and even more frequently threatened for three main reasons: the first, to raise revenue; the second, to discourage abuse; and the third, to influence consumer choice. Prescription charges, and charges for some forms of dental care (for example, dentures) have been seen as fulfilling all three reasons; 'hotel' charges in hospital (above the deductions made from social security benefits of long-stay patients) have been seen as a source of income, charges for attendance by a doctor or at

his surgery have been regarded as both yielding revenue and deterring patients from making unnecessary calls on busy practitioners. What seems to be overlooked by most of those advocating charges is that their effect is to defeat the very object of the NHS. This, from the days of the 1944 White Paper, was proclaimed to be that the getting of necessary medical services 'shall not depend on whether [people] can pay for them, or on any other factor irrelevant to the real need . . . to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens'.[32] In other words, money should not be allowed to stand in the way of preventing advice, early diagnosis and speedy treatment, all of which would undoubtedly be hindered by some of the charges proposed from time to time, and some of which are now hindered by charges currently in force. Charges for some appliances, such as wigs or glasses, may be justifiable to encourage careful use and discourage abuse, but other charges simply contradict the original aims of the whole system.

The fourth characteristic, long contested, was the method of remuneration of the professions in the NHS. For dentists there was little choice. Numbers were too few for any kind of salaried service or capitation fee system to be possible, apart from a few salaried local authority officers to provide a service for specially vulnerable groups. Payment by item of service, subject to prior approval of estimates by a professional board, was the only practicable solution. For medical consultants and specialists, part-time or, if desired, whole-time, salary was the obvious answer, as this was the basis of service to which six years of war had accustomed them in the Emergency Hospital Service, and it was what they wanted. General practitioners clung to the capitation fee system which they had known for thirty years under the old National Health Insurance scheme, and fought even part payment by salary as being the cloven hoof of the satanic Bevan. Charles Hill claims in his autobiography that 'a whole-time salaried service did matter, and the profession had won on that'.[66] But this did not prevent the profession, in the widely acclaimed so-called 'general practitioners' charter' of 1965–66, from agreeing to basic salaries for all—now called 'practice allowances'—which it had so strenuously opposed since 1943.[1]

The fifth characteristic was the administration of services by appointed, not elected, bodies. Local authority services continued to be managed by elected bodies, but both the general practitioner and the hospital services had local appointed committees or councils in charge of them. For the first, the executive councils, half professional and half lay,

with two-thirds of the laymen appointed by the related local authority and one-third by the minister, replaced insurance committees which consisted, in part, of members elected by the approved societies. These councils were, in theory, independent but, in practice, they were administering detailed regulations and paying remuneration which had both been determined nationally by negotiation between the minister and the professions. By contrast, the regional hospital boards and hospital management committees were, in theory, subject to ministerial direction on any matter, however small, but, in practice, they enjoyed a very wide measure of independence for making decisions and taking action. It was, however, very difficult in this structure to find much evidence of the democratic control and public participation which had been so strongly emphasised as desirable in the early stages of planning the NHS. It could be, and was, argued that the hospital bodies were publicly accountable because they were appointed by, and were responsible to, a minister who was himself responsible to Parliament; and certainly it is true that, unlike the ministers responsible for the nationalised industries, the Minister of Health was answerable to Parliament for everything that went on in the hospitals, however detailed. But this was a somewhat long and tenuous chain of responsibility and, in relation to ECs, even that did not exist. The only public voice at the local level was that of the individual lay member of the HMC or like body.

What certainly did exist in the new structure, however, and was a new feature, was the sixth characteristic: that of expert participation in the administrative process. In a non-elective setting, it became possible to introduce professional elements into the managing bodies in a way which had always been strenuously resisted by local authorities dependent on elected party voting. As a result, not only did ECs have their quota of doctors, dentists and pharmacists, but also RHBs and HMCs included doctors, dentists, nurses and sometimes other professionals alongside university representatives, local authority members, and laymen drawn from a wide range of voluntary and other bodies such as trades unions. If the medical profession can be said to have won a victory in their long drawn out exchanges with successive ministers, surely this was it; that the doctors were henceforth fully involved in the process of making decisions. Indeed, so complete was this involvement that Eckstein, in his account of the NHS from an American viewpoint, saw some signs of domination by the doctors to the detriment of the laymen representing the patients.[24]

Controversial new features

The NHS, as it came into existence, embodied several new and distinctive features which have continued to cause controversy ever since. First, there was the administration of the services through three separate channels: hospital bodies, local authorities and ECs. This separation was regretted by all, and the reconstruction of the service in 1974 was designed to remedy it. But it is open to doubt how far the separation was detrimental to the service and, in any event, in the circumstances of 1948 no other solution would have been politically possible. Neither hospitals nor general practitioner services could have been entrusted to local authorities in the then climate of professional opinion; on the other hand, local government could not be denuded of all its personal health services as well as of its hospitals. Separate administration need not mean separation of services, as became apparent in some areas where cooperation flourished; and as a matter of practical working, unification of the delivery of care depended, and depends, much more on the professional and personal relationships of doctors, nurses, social workers and others close to the patients than on administrative unity. And it is ironic that the separate administration of the general practitioner services, which has been so long and so strongly attacked, has, in practice if not in theory, survived the reconstruction of 1974.

A second new and distinctive feature was, of course, the nationalisation of the hospitals. There is little doubt that only through the unification of ownership of both types of hospital—voluntary and local authority—could the fragmented services have been brought together in a single system. The EHS had dragooned them into a semblance of unity for a limited purpose and a limited time, but that provided no continuing basis for the reorganisation—physical, geographical and functional—which was essential to a rational long-term service. As the hospital surveys had clearly demonstrated, it would be necessary to group hospitals together regardless of ownership and of previous function, and to rebuild and develop along new lines. And at the time, only nationalisation offered the means of ensuring the fluidity needed for change and progress.

The third distinctive feature was the use of appointed voluntary bodies in the administration of the NHS. In the EHS, it had been in the hands of a centralised bureaucracy; in local government, in the hands of elected councils; in voluntary hospitals, in those of self-perpetuating

oligarchies. Here was an instrument of a new type, appointed not elected, including professionals as well as lay spokesmen, but made up entirely of volunteers serving without payment. One of the best founded criticisms levelled at Bevan's plan by the representatives of the voluntary hospitals was that of the danger of losing voluntary commitment and local involvement in the new hospital service, and here was the answer. Hospital boards and committees relied on the willing help of thousands of volunteers to man them, quite apart from the continuing place for voluntary help in the hospitals themselves, and in a very short time HMCs and their hospital groups evoked every bit as much local interest and commitment as ever the voluntary hospitals had done.

Fourthly, it was a distinctive feature of the new hospital structure that power was freely delegated down the line from the centre. Even after financial troubles began to surface in 1951, and additional controls were introduced, it remained true that the great bulk of decision-making rested with the boards and committees, and not with the minister in whose hands all power was formally concentrated. Indeed, very frequently the minister became the defender of the independence of hospital bodies against members of Parliament or others who pressed him to interfere with the hospital bodies' decisions in order to get what they wanted instead. There are those who would hold that successive ministers exercised not too much but too little control, and that greater progress would have been made if less reliance had been placed on the judgment and decisions, particularly those of the RHBs. However this may be, the NHS system of wide delegation of powers to local voluntary bodies was, and remains, a unique feature.

Finally, there should have been another distinctive feature—cooperative general practice from shared purpose-built premises, the concept of group practice in the health centre advanced by the Medical Planning Commission. But, in spite of ministerial enthusiasm for the idea (or perhaps because of it), medical support waned between 1942 and 1948, and building shortages came as a final blow to early development. Indeed, it took two decades and a new pattern of remuneration for general practitioners before the health centre really began to take root.

Shifts in opinion

Between the first planning for the NHS in 1941 and its emergence in 1948, some considerable shifts in opinion took place both within the

ministry and among the professional bodies; and to follow these shifts throws some light on the scheme which finally came into being.

When ministry officers began their thinking, it was assumed, almost without question, that the way forward was to concentrate administrative responsibilities for the whole service in the hands of the county and county borough councils. Local government provided the public participation which was seen as an essential feature of the administration of the service, and within local government the 'major' authorities (that is, the counties and county boroughs) were the obvious choice. They alone had sufficient size and resources (and not even all of them), and over the recent past they had been the recipients of major new duties, such as the administration of the reformed poor law. Accordingly, the first announcement of hospital policy, in October 1941, was in terms of a statutory duty on them to provide services, with the help of the voluntary hospitals, and perhaps with the advice of some kind of regional body, and through joint boards where they were too small to act on their own. Similarly, when thinking moved on to the future shape of the general practitioner service, it was in terms of a salaried corps of doctors employed by these authorities, but—with a view to meeting probable medical objections—assisted by a central medical board responsible for selecting entrants to the service and for dismissing them, for advising on remuneration and terms of service, arranging refresher courses and inspecting the service in operation.

These ideas were rapidly eroded when discussions began with the doctors and the voluntary hospitals. The former saw administrative responsibility as being in the hands of a new regional body with representatives of the profession on it, and rejected both employment by local authorities and a salaried service. The latter were reluctant to accept a statutory duty on counties and county boroughs to provide a hospital service, and would accept only if they had alongside them an advisory council, representative of both parties, which would see and comment on all hospital service plans. The upshot was the scheme proposed in the 1944 White Paper for joint boards to plan and administer the hospital service and to plan other services, which would be administered by the individual authorities, other than the general practitioner service in the hands of the CMB and its local committees.

Meanwhile, the doctors had also been changing their minds. In the first flush of reforming zeal, when the Medical Planning Commission reported in 1942, the BMA had been prepared to accept the ending of the sale of practices, the development of group practice from health

centres (but not the formation of groups by an outside authority) and a service available to the whole population, while opposing salaried employment even part-time, supporting continued payment by patients, and calling for central administration by a corporation, not a minister. By the end of 1943, the BMA wanted to reconsider the idea of availability to everyone and to introduce the scheme by stages, the first being the extension of NHI, in scope and availability. As discussion of the White Paper proceeded, the BMA moved further away from its original readiness for change. It began to oppose the ending of the sale of practices, to demand a prolonged experiment with health centres before they were adopted as policy, to attack the proposal for a CMB and to deplore the government's 'haste' for reform.

Discussion of the White Paper eroded the ministry's proposals also, with the result that the Willink plan of early 1945 abandoned several principles earlier regarding as cardinal. For example, the function of planning was wholly separated from that of execution, so that the area health authorities would be merely planning bodies, and even so would have alongside them a regional body advising on wider service needs, and a special group with equal membership from the voluntary and the local authority sides to draw up the hospital part of the area's plan. Health centres became an experiment only; the idea for a CMB and any attempt to improve the distribution of doctors were dropped (apart from inducement payments in unattractive areas), the sale of practices would continue subject to an enquiry later, and a 'clearing house' system would be set up through which voluntary hospitals would receive payment instead of from the local authority direct.

With the advent of the Labour government, ministerial thinking and the views of the profession drew further apart than ever. Opposing views led to suspicion and mistrust on both sides, not helped by the increasingly sharp tone of the exchanges between them. Bevan was liable to say in discussion things which were wrongly taken up—as Michael Foot says, 'a witticism designed to smooth might hurt instead'.[25] An example was his remark in the course of discussion of the differences within the profession: 'I have my spies', a light-hearted quip which aroused the deepest suspicion in the minds of the doctors present. On other occasions, he did not realise the impact his words would have; a striking example is his notorious reference to the Tories as being 'lower than vermin' in a speech on the eve of the operation of the NHS. On the medical side, Dain and Hill were never backward in expressing their hostility which, in Dain's case, became increasingly emotional, however

genuine his belief that he was fighting in defence of the future of a great profession.

Bevan's proposals, of course, brought together again the planning and executive functions in relation to the hospital service, but they did not provide for any effective local coordination of that and other services. They also involved the abolition of the sale of practices, some control of the distribution of doctors and, most important of all, the effective unification of the hospitals. To the BMA, these were blemishes, not improvements. It could, and did, justifiably criticise the divided local responsibilities for services (though, of course, it approved of a separate administration for the general practitioner service); but there was less cause to denounce the nationalisation of hospitals, the abolition of the sale of practices and the 'negative direction' powers of the MPC. Still less was there any ground to claim, as did the *BMJ*, that takeover of the hospitals meant they would be run by civil servants, and their medical staffs would become State employees working under civil service direction, when not only the assurances of the minister but the drafting of the Bill itself precluded either result. These hostile noises evoked a corresponding belligerence from the minister. Small wonder, then, that opposition to the Act persisted until the end of May 1948. By then, however, it was clear that the NHS would indeed come into existence on 5 July because large numbers of doctors were joining it, and the BMA leadership had to execute a rapid *volte face*, and to promise to do its utmost to make 'a resounding success' of the service which up to that point it had so consistently and so bitterly denounced. In so doing, it repeated the story of early 1913, but in a slightly revised version; for in 1913 the BMA's leaders had pursued their opposition to the NHI scheme even after it had come into operation.

The makers of the NHS

The NHS had at last won through. To whom belongs the credit for its successful creation? The answer is, of course, that it must be widely shared. There is no doubt that, whatever may have been his attitude to the proposals of the war years, Dawson must be given much of the credit because of the report of his consultative council in 1920. This contained a number of seminal ideas which others cultivated and developed to meet a different set of circumstances, such as health centres (though Dawson's centres included beds and consultant clinics as links between

hospital and general practice). Many of those ideas were embodied almost unchanged in the services which finally emerged—notably the broad hospital pattern (which more recently has been even more closely paralleled with the growth of the notion of the 'community hospital').

Credit must certainly be given, not so much for ideas as for their practice, to the voluntary hospitals and the local authorities. The former contributed their internal structure of 'tripartite' administration by doctor, matron and lay administrator with a medical advisory committee of consultants alongside the governing body. This, and not the hierarchical medical superintendent system current in the local government hospitals, was the pattern followed in the new national service. But the local authorities had demonstrated that personal health services of good quality could be provided by elected bodies responsible to the community, notably antenatal and postnatal care, child welfare and treatment of tuberculosis; and at least a few of them had shown, contrary to the expectations of the Cave committee a generation before, that public authorities could indeed run general hospitals of good quality with caring staff.

Other contributions came from a variety of sources. One was the BMA itself. By its plans for a general medical service for the nation in 1930 and 1938 it kept alive in the public eye the need for reform and development—just as the PEP report of 1937 highlighted the many gaps and deficiencies in the services. And through the work of its Medical Planning Commission the BMA stimulated post-war reform, however much it later regretted having done so.

War-time experience contributed through the EHS, which exerted considerable influence in many ways: bringing voluntary and local authority hospitals into a single framework, developing national standards of performance from plastic surgery to catering, distributing consultants much more widely through the country, creating a regional pattern of special centres and consultant advisers, organising a national blood transfusion service, introducing national scales of remuneration for doctors and nurses and others.

The contribution of Beveridge, through his report, was not a plan for service but an impetus to its creation. His proposals for social security aimed at covering the whole population required the support of equally available medical care, and the momentum provided by his report instilled reality and urgency into the planning of the service needed to provide it. Then, from mid-1945 onwards, came stimulation from

another source—the publication of the hospital survey reports, with their analysis of deficiencies and their proposals for future coordination, which had a wide effect on both medical and lay opinion.

Another major contributor was undoubtedly Moran. He was the leading professional advocate of a regional hospital pattern, and a strong opponent of local authority control (though, at one time, he feared it might have to be swallowed). Bevan's nationalisation of hospitals was, therefore, for him an admirable solution, and though he might have doubts about the ministry's receptiveness to medical advisory committees, or about the desirability of a salaried general practitioner service, he threw his weight in favour of the scheme and against the BMA leadership. This made possible his effective interventions in January 1947, and again in April 1948, when deadlock seemed to have been reached. (It is interesting to speculate what would have happened if Horder and not Moran had won the RCP presidential election in March 1948; but the answer is that it would probably have made little difference, because the individual practitioners demonstrated, by enrolling in the service, that they did not share the attitude of unyielding hostility adopted by Horder and his supporters.) Moran made a further contribution through the 'awards' system of higher remuneration for consultants which he thought up, and later applied with considerable skill and acceptability.

Three ministers played a part, and to each of them a share of credit must be given. Ernest Brown was responsible for the first tentative plans and opened the discussions with the doctors, the voluntary hospitals and the local authorities. The White Paper of 1944 was put together largely under his direction, though it appeared under the auspices of his successor, Henry Willink. He, in his turn, conducted protracted negotiations on the White Paper's proposals, making every effort (and some unwise concessions) to find an agreed solution to the difficulties raised by the doctors and the voluntary hospitals, only failing at the last fence of the July 1945 election. Aneurin Bevan brought a new perspective and a new dynamism to the work of planning, and succeeded in persuading first his colleagues and then the House of Commons—and ultimately even the medical profession—that his rather more radical reforms were sound and practical.

But ministers necessarily depend a good deal on their senior civil servants for ideas and advice, and these three ministers were no exception. The part played by civil servants is normally veiled in anonymity, as is only proper when it is the minister who must accept

public responsibility for the product. But after thirty years it is permissible to look more closely at the personalities involved in the planning and building of the NHS and to assess the roles they played.

First must come Sir John Maude, permanent secretary of the ministry from 1940 to 1945. He went over to the administrative side from the legal branch, where his experience with the NHI scheme had made him very conscious of its deficiencies. The earliest outline papers in the ministry on post-war policy came from his pen, and his was the perhaps somewhat theoretical concept of a whole-time salaried general practitioner service available to the whole population. As time went on, he played a less personal part in the elaboration of the NHS; but his involvement did not end, even with his retirement in 1945, for he was a member of the Guillebaud committee on the cost of the service, which produced a reassuring report in 1956.[57]

Sir John Wrigley, the deputy secretary, was another early contributor who dropped out after a while under the pressure of his responsibilities for war-time evacuation, housing and other problems. He was a strong supporter of local government as the most suitable instrument for managing the service, emphasising, as he did, the importance of public participation and local interest. He, therefore, saw the NHS as being administered by the counties and county boroughs on whom (jointly in some areas) should rest the statutory duty to provide it; and if a regional body were needed to plan on a wider basis, he saw that as small, expert and advisory only.

A third officer who played a leading part was Sir Arthur Rucker, a deputy secretary of the ministry from 1942 to 1947 when he moved to international relief work. He was prominent in the discussions on the 1944 White Paper, presided over innumerable meetings with the professions and others, and was indefatigable in seeking compromises which would provide the basis for an agreed scheme. Sir William Douglas, permanent secretary of the ministry from 1945 to 1951, was also active in the many negotiations necessary over those years, but was for the most part content to leave matters to his deputies and to the chief medical officer.

Another major contributor, both before and after he joined the ministry, was Sir John Charles, who succeeded Sir Wilson Jameson as chief medical officer from 1950 to 1960. He came to the ministry to be deputy chief medical officer in 1944, and brought with him not only mature wisdom but also the deep experience of health and hospital

services he had gained as MOH of Newcastle upon Tyne. He also enjoyed the advantage of the respect of the RCP and of the consultants in general.

There is no doubt, however, that the main credit for the emergence of a viable and, indeed, successful service must rest with two other officers of the ministry: Sir Wilson Jameson, chief medical officer from 1940 to 1950, and Sir John Hawton, deputy secretary from 1947 to 1951 and permanent secretary thereafter until his retirement through ill-health in 1960. Jameson was a very able and distinguished professor of public health when he came to the ministry, but his interests ranged much more widely than that. He it was who first promoted in this country a campaign for immunisation against diphtheria, and who first broadcast on the unmentionable subject of venereal disease. But more relevant to the NHS, he had for some time been revolving ideas for post-war medical reforms. Early in 1939, he arranged for a small informal group (the 'Gasbag Committee') to meet at the London School of Hygiene where he was dean, in order to discuss the future pattern of the health services. He played a leading part in the plans of the Nuffield Provincial Hospitals Trust and was a member of its medical advisory committee which, during the war years, became a sounding board for enlightened and objective medical opinion about future developments. His was the unenviable task, which inevitably falls to the lot of all chief medical officers of the ministry, of trying to be at one and the same time a loyal civil servant and someone who is *persona grata* with the medical profession. This role Jameson could fulfil because he was trusted and, indeed, liked by both; and however strongly the doctors fought the NHS proposals which it was his duty to defend, most of them felt that his judgment would be objective. He was therefore able to act as honest broker in many of the exchanges of those years, and to moderate at least some of the bitterness felt by the scheme's most violent opponents.

In his biography of Jameson, Goodman gave him the title of 'architect of national health', by which he was referring to the greater issue of the nation's health rather than to the NHS.[28] But in a very real sense, Jameson was an architect of the NHS, though other designers and draughtsmen were at work as well. He shared in the formulation of the wide-ranging reforms recommended by the Goodenough committee on medical schools, of which he was a member and the true creator; and with Bevan he was able to build up a relationship of mutual respect and trust, recognising that both were essentially pragmatists seeking the same ends. In the debate in the Commons on the tenth anniversary of

the NHS, on 30 July 1958, Bevan paid him, and Sir William Douglas, a personal tribute.

If Jameson was an architect of the NHS, Hawton was both architect and builder. He came into the planning of the service from experience of the administration of the EHS, and therefore knew at first hand many of the problems of managing a national medical service. His first task was to lick into shape the proposals emerging from Ernest Brown's discussions, and this he did in what became the White Paper of 1944. That paper—apart from some of the supplementary material in the appendices—was entirely his own work, which accounts for its very readable style and its homogeneity, the subject of much favourable comment at the time. But this set of proposals rapidly began to crumble in the discussions which followed publication, and it became necessary to put together a revised scheme and to try to secure a commitment to that scheme from the Conservative caretaker government before the 1945 election. After prolonged and wearisome labour, a revised scheme was duly produced; but publication was refused, and no public indication was given by the Conservative Party of any details of the NHS promised in its manifesto.

With the arrival of Aneurin Bevan, Hawton had to begin again, more or less from scratch. It was agreed that the scheme patched together by Willink would not do for the new government. But what should be put in its place? Drawing on his EHS experience, and looking to proposals for nationalisation of various kinds then being made, Hawton suggested—and Bevan readily agreed—that the Gordian knot of the hospital service might be cut by taking over ownership of all the hospitals but entrusting their administration to new, *ad hoc,* appointed voluntary bodies endowed with wide powers delegated to them by the minister. At one stroke, this solved the main problem which had defeated previous attempts: namely, how to provide a single, unified hospital service and at the same time ensure effective local interest and responsible administration. Once this had been dealt with, the rest of the planning presented no particular difficulty. Sale of practices must go—Labour opinion would not tolerate its continuance—and some control of the distribution of general practitioners must be arranged; health centres would be the foundation of the general practitioner services, and all would receive a basic salary. For the rest, apart from a few details, the 1944 White Paper proposals would meet the case.

In the battles which followed, in Cabinet, in the Commons and the Lords, and with the medical profession, Hawton provided much of the

ammunition which Bevan fired, though it was amply supplied also from Bevan's own store. Neither was in any doubt that in the end the profession would join the service, as it had done in 1912, but both recognised that at the right tactical moment some concessions would have to be made to encourage it to do so. The problem was to know when that moment would arrive. Meanwhile, the work of construction had to go on, so with one hand Hawton was engaged in fending off the assaults of the doctors and with the other he was building up the framework to operate from the appointed day. There was, of course, the added complication that every bit of building was liable to be seen by the doctors as a deliberate provocation by Bevan and his officers, when in fact it was a struggle—and sometimes, it appeared, a losing battle—to produce a novel form of administrative structure within the space of eighteen months. If both struggles were won—that against the doctors and that for the creation of the NHS—much is due to the leadership and untiring labours of Hawton from 1946 onwards.

Envoi

With the advantage of hindsight, after thirty years, it now seems that quite unnecessary strife and bitterness were generated over the birth of the service. There were genuine misunderstandings. The doctors frequently failed to grasp the essentials of the machinery of government or of administrative problems, and ministers and their officers often failed to appreciate the strength and genuineness of the apprehensions of the doctors for the future of their profession. But from time to time it does look as though one side or both were spoiling for a fight. The leaders of the BMA, with Hill as 'saboteur in chief', as Bevan called him in the 1958 debate, whether they were inflaming the rank and file or being inflamed by them, pursued some distinctly foolish courses; and Bevan on his side was a great deal more abrasive than necessary, thus adding fuel to the fire. A little more statesmanship from both sides might have produced the result sought by the editor of *The Lancet,* that the profession should recognise the NHS from the outset as its own service, and go on to make it a great success. After all, it was, and remains, a remarkable achievement, which reflects credit on a very wide range of contributors, and one which might well win the approval of some of the earliest health service planners of all—Dawson, Morant and that sternest of critics, Beatrice Webb.

8

Assessments

In the light of the experience of the National Health Service since 1948, certain questions—four, in particular—may well be asked about decisions reached during the formative stages. Were the scope and content of the NHS rightly defined? Was the consultative process adequate? Was the administrative structure satisfactory? Was the finance of the service properly based?

Scope and content

The scope and content of the NHS were determined by the purpose it was designed to serve; namely, the delivery of appropriate medical care to everyone needing it. It is true that the 1944 White Paper spoke in terms of prevention as well as of care and cure, and that the 1946 Act put on the Minister of Health a responsibility to promote health as well as to provide treatment; and one of the longest and loudest criticisms of the NHS has been that prevention has been neglected. This accusation is not wholly fair, though it is not without foundation. Preventive medicine, in the form of vaccination and immunisation, has been actively promoted within the NHS, with considerable effect on poliomyelitis, diphtheria, whooping cough, tuberculosis, measles and so on. But other, similar, action has not been taken, for a variety of reasons—the timidity of successive governments about, for example, the fluoridation of water supplies, or about the economic consequences of health education. Again, in defence of the NHS, it must be said that many of the most effective forms of health promotion lie outside the scope of health services, the most obvious example being adequate housing. Then there are all those measures vitally important to health which raise wide-ranging issues and are the concern of other departments of government,

such as discouraging smoking in order to reduce lung cancer and other diseases, stricter control of alcohol consumption to check alcoholism, compulsory wearing of seat-belts to minimise the effect of traffic accidents.

If the NHS had taken the form first proposed by Ernest Brown, and had been administered by local government, at least housing and some other important environmental health responsibilities would have been in the same hands as the treatment services, and there might have been a greater stimulus to take preventive measures—the point made by Morant when he deprecated separate health authorities. But any such combination of responsibilities was ruled out in the formative stages of the NHS by medical and other hostility to local government control, and inevitably a gap opened up between preventive and treatment services.

The consultative process

The question of the adequacy of the consultative process raises some interesting issues. In the past, various patterns of preparation have preceded important legislation, a common one being to appoint a royal commission or a committee of enquiry to sift the available evidence and recommend the form legislation should take. This is what happened, for example, in relation to the law of mental health in the 1950s, the royal commission of 1953–56 being followed by the Act of 1959; and it is what the medical representatives suggested to Ernest Brown in 1943 in relation to a comprehensive health service—perhaps seriously, perhaps as a delaying tactic. Certainly, it was the expectation of delay which led to the rejection of the idea by ministers (after all, the main recommendations of the Royal Commission on the Poor Laws took twenty-one years to reach the Statute Book, quite apart from the three years consumed by the commission itself). In 1943, ministers saw the need as being to work out urgent solutions to the post-war problems of the voluntary hospitals and of the doctors returning from the forces to civilian life; and they accordingly ruled out any form of enquiry, which would necessarily be time-consuming. They opted for the 'Green Paper' form of consultation (though the name was not then used), followed also in 1968 and 1970; that is, the publication of official proposals without commitment so that full public discussion could take place before the content of legislation was finally settled.

But there was a significant difference between the procedure adopted by Brown and Willink and that by Aneurin Bevan. The former both

engaged in confidential discussion and modification of proposals preparatory to the publication of a scheme for general debate; the latter circulated his outline proposals confidentially and listened to comment, but declined to enter into discussions, and published his final proposals in the form of a Bill. This difference in procedure meant that Brown's and Willink's schemes were already compromises when they were finalised, the first in the 1944 White Paper, the second in the document confidentially circulated to the medical profession in 1945. It also meant that the controversies on those schemes took place in private, for the most part anyway. Bevan's scheme, on the other hand, was not a compromise when it was published, and any modification took place in public—as did the controversy it aroused. It must be a matter for individual judgment which procedure was preferable. The former led to a scheme acceptable to the parties concerned (or so they claimed afterwards), but one of formidable complexity which would probably have been unworkable. The latter produced a viable solution, but at the cost of a long and bitter struggle. What degree of consultation is desirable is open to debate. No doubt confidential discussion with the parties concerned, in advance of legislation, ensures a measure of agreement and smooths the path of the subsequent Bill through Parliament. But advance consultation carries with it the danger of commitments which have to be honoured in public debate, whether they have merit or not; and it also restricts Parliament's ability to amend draft legislation, however desirable such amendment may be. Briefly, consultation can operate contrary to open discussion and to the public good.

The administrative structure

Was the administrative structure embodied in the Bevan scheme a satisfactory one? As the structure was refashioned in 1974, and again in 1981, the answer would appear to be No. On the other hand—and allowing for the fact that, given a sufficiently devoted staff, any structure, however defective, can be made to work—the pattern laid down in 1946 survived in good order for over twenty-five years, compared with six years for the 1974 version. But the 1946 pattern was not the idea envisaged in the original thinking on the NHS. This was for administration by joint authorities (combinations of counties and county boroughs) with a minimum population of perhaps 100 000 to 200 000. These authorities would prepare a scheme for their services, with the

participation of medical and voluntary hospital members of a statutory committee and the guidance of a regional advisory council, and the scheme would be submitted to the minister for approval or modification. The scheme would cover all services, including use of the voluntary hospitals on terms agreed between them and the joint authority, and including also a salaried general practitioner service. On this basis, the integration of services sought in 1974 would have existed from the outset, and there would have been participation in their administration by elected representatives of the community. But, as rapidly became apparent, this pattern had no chance of adoption. It broke down irreparably on the opposition of the doctors to any form of administration by elected local government and to any version of salaried general practice. An alternative would have been to concentrate administration of all the services, not in the hands of elected local authorities but in those of appointed regional boards and local committees. But this option was not open in the circumstances of 1946.

Bevan's hospital proposals, depriving local authorities of their services, constituted a serious blow to them which, on political grounds, somehow had to be softened—and this had to be done by leaving them with a number of community services to run. Equally, the doctors clung tenaciously to administration of the general practitioner service by separate bodies of the insurance committee type. Hence, the tripartite administrative structure, so long and so heavily criticised, was unavoidable. As Bismarck rightly averred, politics is the art of the possible, not an exact science; and in 1946, possibilities did not extend to a unified structure. Nor did they admit of democratic control by elected representatives, except in relation to the services provided by the local authorities.

NHS finance

Finally, was the finance of the NHS properly based? 'Properly' here may mean 'adequately' or 'rationally'. If it is taken to mean 'adequately', the almost unanimous answer to the question would be No. It is the constant and universal complaint, both inside and outside the NHS, that it has not enough money to provide every service that ought to be provided in the quantity, or of the quality, desirable. But, of course, the position is that the NHS never will, or can, have all the finance it ideally requires, any more than can education, social welfare or any other service. It may be true that other countries devote a higher proportion of

their national income to health services, but that may simply mean that their services are wasteful while ours are more cost-effective. It is certainly true that the main task of the NHS administration is not to demand more and more money, but to put to the most effective use the resources which society can make available—in other words, to work out and apply the right priorities.

Whether the NHS is 'rationally' financed is a matter for argument. There are those who put their faith in charges, others who favour an insurance basis, or state lotteries, or more voluntary contributions (though the two last could, at best, provide only a minute proportion of the revenue required). At present, in broad terms, 88 per cent of the total cost of some £8500 millions is met by the Exchequer, 10 per cent by NI contributions, and 2 per cent by charges. It is argued that this is unsound because the man in the street wholly fails to realise how very expensive the NHS is, because the cost is lost in the general pool of taxation. All he knows is that the services are almost wholly free when he needs them. Steps should therefore be taken, it is argued, to bring the cost home to him, for example by making widespread charges or by requiring a weekly insurance contribution of some magnitude.

At the outset of the discussions of the shape of the NHS, the only charges contemplated were those hinted at by Beveridge in his report; that is, a 'hotel' charge to hospital inpatients equivalent to the cost saved by the patient's household (ten shillings a week was the amount suggested), and a quasi-fine for damage or breakage of appliances. The 'hotel' charge was dropped in the course of the Cabinet committee discussions in 1943, being regarded as incompatible with a universal insurance contribution on Beveridge lines. The charge for repair or replacement of appliances survived, and continues. At the time, charges for general practitioner services, such as a prescription charge or a consultation fee, were considered indefensible because those services had been provided without charge for insured persons since 1912. In any case, charges of this sort, which could be financial obstacles to early diagnosis and effective treatment, were precisely what the NHS was intended to get rid of.

If charges are unhelpful as a source of revenue, what of insurance? The present NI contribution derives from Beveridge's suggestion that NI should, as it were, pay the NHS for backing up the NI scheme through its provision of medical services; that is, for keeping the incidence of sickness down, for shortening sickness spells by prompt treatment and for providing medical certification. In other words, the

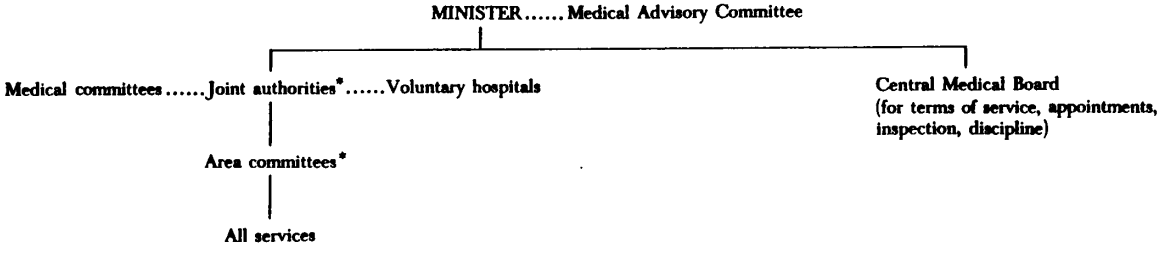
NI contribution is a token payment of an arbitrary size. Insurance of a genuine kind figured large in the doctors' case at various stages of the negotiations about the NHS, as their basic approach was that of extending the NHI scheme to cover dependants as well as insured persons themselves, and to include hospital and specialist services as well as family doctoring. Some of them saw an insurance basis for the NHS as a bulwark against the disappearance of private practice, by not allowing the better-off to have free service. But this concept was incompatible with an NI scheme covering the whole population and, as *The Lancet* declared, an extension of the NHI scheme would be 'an extraordinarily elaborate mechanism for excluding about ten per cent of the population'. It would also be an expensive alternative to taxation if the NHS were to be restricted to eligible insured persons, since a whole new administration would be needed to keep track of eligibility. Yet, to substitute universal compulsory health insurance for the present general taxation as the way of raising the necessary revenue would simply be to replace a progressive tax basis by a regressive poll-tax. Nor does there appear to be much validity in the argument that a separate health insurance payment would impress on people the cost of the NHS and, thus, lead to more economical use. In practice, the regular payment of an identifiable sum of this kind tends to encourage people not to be economical in their demands but to take good care to see that they get value for their money. If the objective is to discourage unnecessary demands on the NHS, it seems unlikely that an insurance scheme is the way to achieve it. Certainly, the inclusion of a health service element in the weekly NI contribution has led to a widespread belief that it covers the cost of the NHS and thus justifies any demand the contributor may make on the service as a patient.

The answer to all the four questions about decisions taken in the formative stages of the NHS seems to be that, however imperfect the result, the makers of the NHS did the best that was possible in the context of the 1940s. They worked out a pattern and an organisation of services which appeared likely to be efficient and, in all the subsequent exchanges, they sought to approximate as nearly as possible to the original concepts. The other parties involved, notably the medical profession, had the weight and political strength to compel some modifications, but the main objectives remained secure. The keynote of the whole process might be described as evolutionary pragmatism—pragmatism because the ideal was continually being adjusted to practicalities, and evolutionary because the whole content and structure were

rooted in the experience of the past and the circumstances of the period. There were voices, again notably medical, calling for lesser and more gradual change—for example, as a first step, the extension of NHI and the regionalisation of hospital services—but the makers of the NHS saw that, if the opportunity of war-time flexibility were not seized to introduce a comprehensive service, the goal might be missed for many years. Fortunately, the opportunity was seized, and the NHS came into being, to the great advantage of the British people.

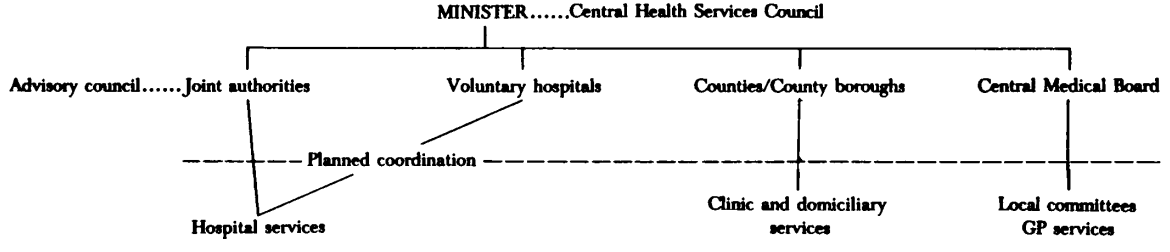
Appendix: Proposed administrative structures

1943 — Ernest Brown's original scheme

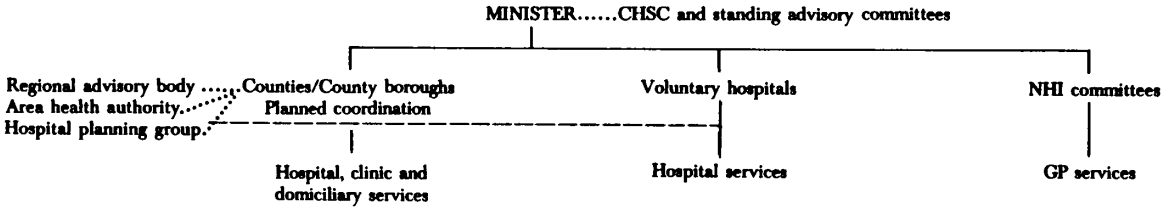


* including medical and voluntary hospital members

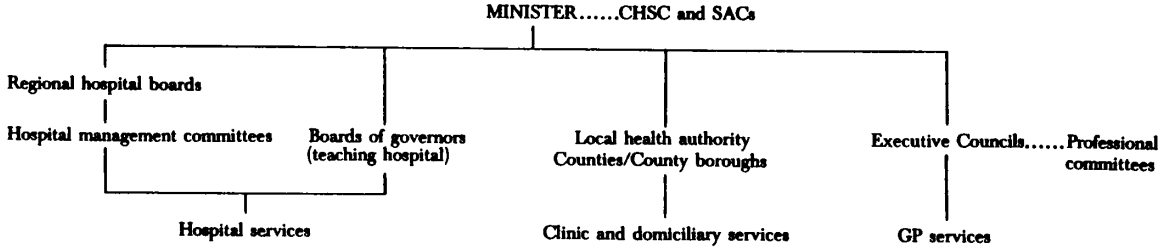
1944 — White Paper plan



1945—Willink's plan



1946–48—Bevan's scheme



———— lines of executive responsibility
..... advisory relationships
— — — — planning for coordination of services

Abbreviations

AMC	Association of Municipal Corporations
ARM	annual representative meeting (of the BMA)
BG	board of governors (of teaching hospitals)
BHA	British Hospitals Association
BIPO	British Institute of Public Opinion
BMA	British Medical Association
BMJ	*British Medical Journal*
CAB	Cabinet
CCA	County Councils Association
CDB	Central Dental Board
CHSC	Central Health Services Council
CMB	Central Medical Board
CP	Cabinet Paper
DEB	Dental Estimates Board
DHSS	Department of Health and Social Security
EC	Executive Council
EHS	Emergency Hospital Scheme
EMS	Emergency Medical Service
GMC	General Medical Council
GP	general practitioner
HC	House of Commons
HCSA	Hospitals Contributory Schemes Association
HL	House of Lords
HMC	hospital management committee
LCC	London County Council
LHA	local health authority
MH	Ministry of Health
MO	medical officer

MOH	medical officer of health
MP	Member of Parliament
MPC	Medical Practices Committee
MRC	Medical Research Council
NHI	National Health Insurance
NHS	National Health Service
NI	National Insurance
PAC	Public Assistance Committee
PEP	Political and Economic Planning
PRO	Public Record Office
Rcn	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians (of London)
RCS	Royal College of Surgeons (of England)
RHB	regional hospital board
RSM	Royal Society of Medicine
SAC	standing advisory committee
SAMO	senior administrative medical officer
SMA	Socialist Medical Association
SMO	senior medical officer
SRM	special representative meeting (of the BMA)
TUC	Trades Union Congress
UGC	University Grants Committee

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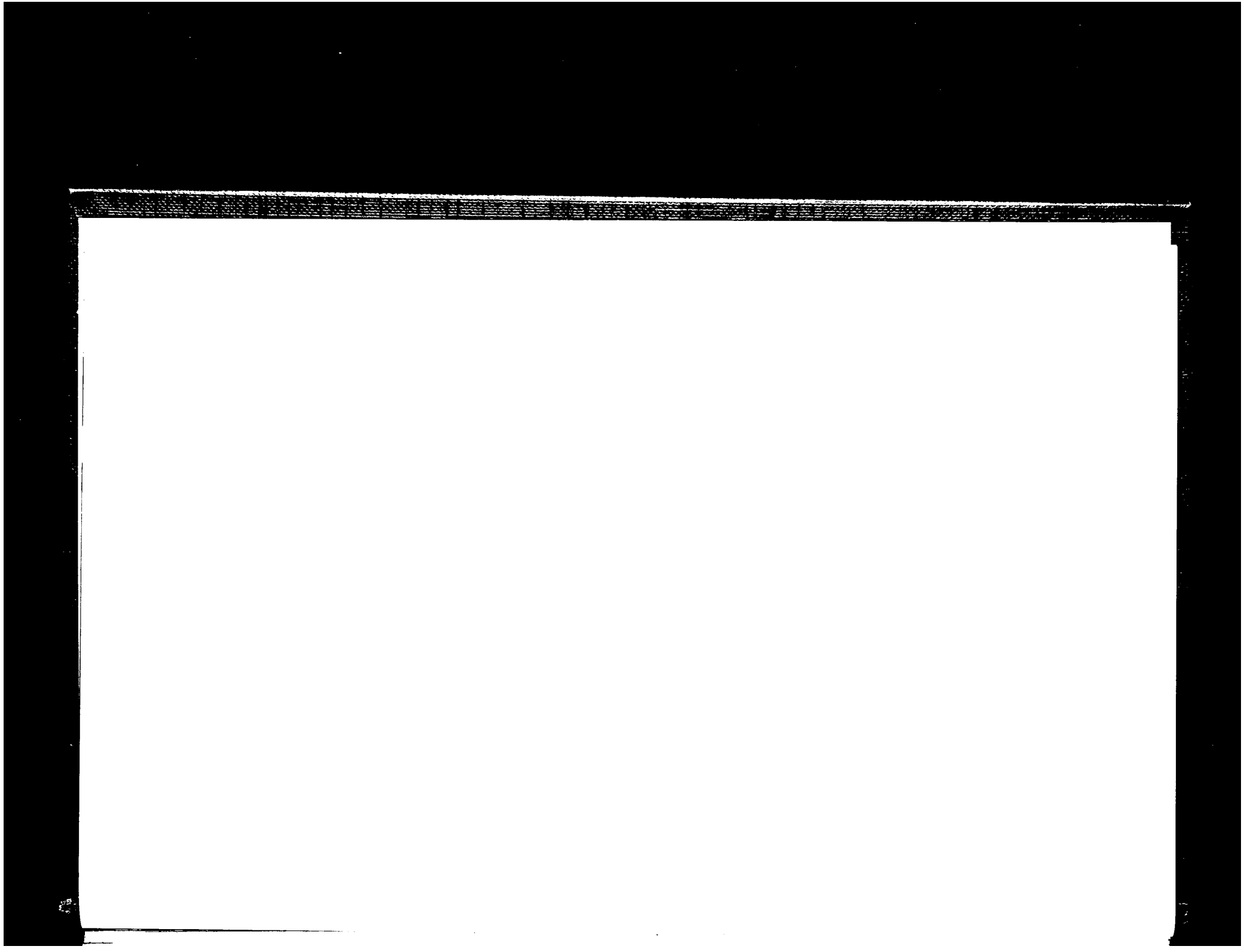

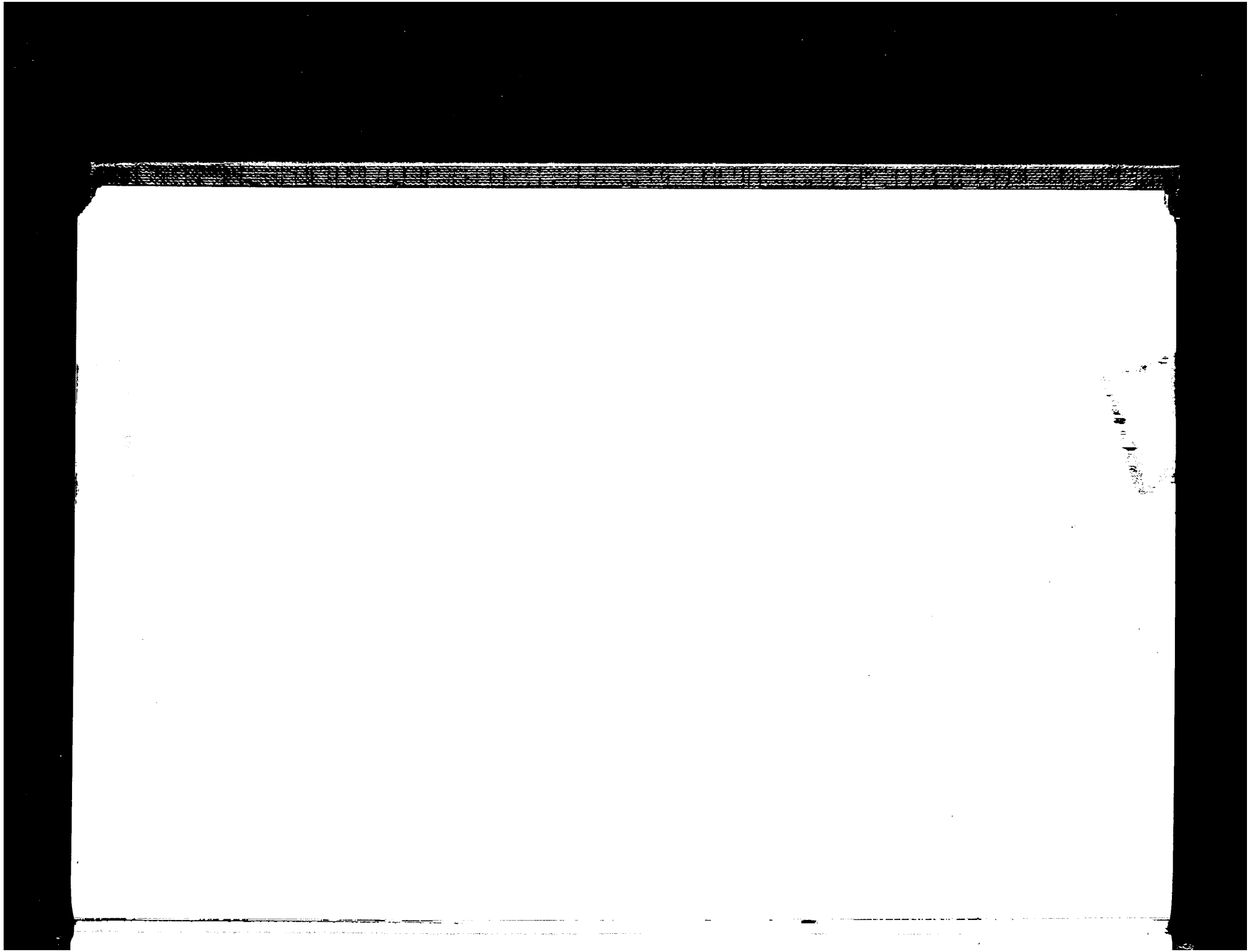


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John Pater CB MA began his civil service career in the Ministry of Health in 1933 and ended as under-secretary, a post he held from 1947-1973. He was educated at King Edward VI School, Retford, and was a foundation scholar of Queen's College, Cambridge. He is married and has a son and two daughters.

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