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Interest Groups and the National Health Service Act, 1946.

A study of the development of plans for the National Health Service Act, 1946, with particular reference to the part played by interest groups.

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SYNOPSIS

This is a case study of the development of plans for a piece of legislation and of the part played in that process by interest or pressure groups. It examines the wording of the National Health Service Act, 1946 and, in contrast, the health services of 1939. The main events of 1939 to 1946 are surveyed together with a review of the interest groups and their views.

The main evidence of the study shows the development of plans for a National Health Service from the first plan put forward by Mr. E. Brown as Minister of Health (the plan of his officials rather than himself) through the White Paper of 1944 and the Revised White Paper of 1945 (both prepared by Mr. H.U. Willink as Minister) to the final plan adopted in the Act of 1946. Studied section by section the plan adopted by Mr. Bevan is shown as a development of the previous plans, together with changes necessary by the arrival of a new and powerful interest group, the Labour Party, rather than any dogmatic expression of party views. This analysis brings out quite clearly the following pattern. In the first place an officials' plan (Brown Plan) was prepared as a necessary basis for discussion with the groups. (Mr. Brown discarded it and therefore was unable to make any definite progress). As a result of these discussions, another plan (the White Paper) was drawn up as a basis for more detailed discussion (or negotiation). Bit by bit a plan emerged from this further discussion which seemed to command general agreement among the main groups. This plan, the revised White Paper plan, was being translated into legislation when the general election of 1945 brought a change of government. Mr. Bevan, the new Minister, adopted the previous plan and applied to it, as far as he considered necessary to ensure his party's support, the views of the Labour Party. The result was the National Health Service Act, 1946.

In a final section some suggestions for a wider study on the role of interest groups in the drafting of legislation are made.

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PREFACE:

To list all those who have helped me in this study would be an impossible task. All the main groups, almost without exception, have helped by way of literature supplied and queries answered. Some have sent their only copies of valuable minutes for perusal, whilst others have welcomed me in discussions with their officials. Of individuals to whom I am indebted there are many - particularly to my tutor, Mr. H. Maddick, to Sir High Linstead, M.P., Sir Frederick Messer, M.P., Sir William Jameson (and other officials of King Edward's Hospital Fund for London), Dr. H. Guy Dain and many others. My dental surgeon (who must remain anonymous) helped by the loan of literature and by discussion on my subject during visits to his surgery. The staff of Birmingham Reference Library, too, deserve my thanks.

I owe much to all these and more, but the responsibility for what follows is, of course, mine alone. Much must remain supposition until some future day when historians gain access to the Ministry of Health's files.

A. J. W.
October, 1953.

PART I - Introductory.

Chapter 1 - Purpose and Plan of this Study.

2 - National Health Service Act, 1946.

3 - The Health Services in 1939.

4 - National Health Service Timetable (1939-46)

INTRODUCTORY PART

CHAPTER 1

Purpose and Plan of this Study

This study spans a period of four years from the date early in 1943 when the Government of the day accepted[1] the main provisions of the Beveridge Report including the provision of a comprehensive health service, to November 6th, 1946, when the National Health Service Act received the Royal Assent. The relationship of this Act to the tentative plans first drawn up by the Minister of Health, Mr. Ernest Brown in 1943 is the subject of this thesis. (It will be suggested in a later chapter that the first plan put forward came in all probability from the officials of the Ministry rather than from the Minister himself). This relationship is dependent in large measure on the views put forward by the interest or pressure groups most concerned with the health services, and it will be suggested in this study that from the first 'official' plan the various Ministers of Health moved outwards in an attempt to reach some sort of compromise with the various groups. The following pages bear out that assertion, that Mr. Bevan

(1) In a debate in the House of Commons 16-18 February, 1943 - see p. 39

sought, like his predecessors at the Ministry of Health, to face 'realities' i.e. the wishes of the groups, and did not seek to enact, as his Parliamentary majority would well have enabled him to do, an 'ideal' Labour Party plan. As Mr. Bevan himself said 'Many of those who have drawn up 'paper plans for the health services appear to have 'followed the dictates of abstract principles, and not the 'concrete requirements of the actual situation as it exists'. (1)

This then is a case study of a piece of social legislation which, in its shape and content, is largely the result of the Government's assessment of the value and strength of the many interest groups. Whilst it is important to differentiate between the value and the strength of the views, it is not always possible to say when the value of the views put forward have been accepted as the result of the rational acceptance of those views as the best method, and when a concession has been made to the strength of the group putting forward the views. From the point of view of this study, the results of both methods are equally noteworthy though in the latter case some may argue that the bowing of the Government before the pressure of a group is morally wrong. Be that as it may, the later pages offer examples of concessions of this type by both Mr. Willink and Mr. Bevan.

(1) House of Commons Official Report Vol.422 c43.

Some of the limits of this study must be mentioned. In the first place the study has been limited to the National Health Service for England and Wales thereby ignoring the National Health Service (Scotland) Act, 1947, which set up a service on somewhat similar lines for Scotland.[1] It has also been limited in the period covered to the four years 1943 to 1946. A fuller study might take this study beyond the passing of the Act through the period of regulation making up to the 'appointed day' on 5th July, 1948, or even further through the early years of the service and including the National Health Service (Amendment) Act, 1949 which, prima facie, seems a remarkable capitulation to the views of the main professional groups. One final limitation concerns constitutional practice which has made impossible access to the various non-published Government papers and as such leaves a gap in the available material. Approaches to the Minister of Health on this point were not successful, the Minister doubting if he, himself, could see these papers of a previous Government. The picture drawn in succeeding chapters seems, however, to be one whose general lines this material would not greatly alter, though detail might here

(1) In most of the discussions between the Government and the groups, the Secretary of State for Scotland was present or represented.

and there suffer.[1]

The original title to this thesis included the words 'pressure groups' but these words have now been deleted in favour of 'interest groups'. It is not my intention, in this study, to sit in judgement on the views presented by the various groups or on the government for accepting or rejecting those views. Instead an attempt has been made to present a purely factual survey (without any qualitative judgements) and, to this end, phrases such as 'pressure groups' or 'vested interests' were dropped on the grounds that they import emotional content and bitterness out of keeping with this attempt. To aid the impartiality of this study, therefore, 'vested interests' give way to 'interest groups' - i.e. groups representing special interests. An interest group is any organized group of people who put forward their common views in a manner likely to come to the notice of the Government. It is, of course, not suggested that these groups exist solely for expressing views to the Government and indeed many of them, for example the British Medical Association, the Royal College of Nursing have many other functions.

(1) It cannot be too strongly stressed, therefore, that this study is made from the 'outside' - with the aid of Government papers it would present a more thorough study and one whose value would be greatly strengthened.

It is, however, claimed that the two essentials of interest groups are firstly an organization and secondly views or interests held or shared in common. It must be added immediately to this second point that these views or interests must be considered sufficiently important to individuals for them to band together in these groups. There is no doubt that most people in this country at the time of the Act desired the best of medical services for himself or herself but such a desire was not sufficiently strong or definite to lead to any organization to represent the views of the potential consumer. Indeed one often gets the impression when reading through the debates and discussions on the National Health Service that little more than lip service is paid to the view of any potential consumer of the service.

In this study the only conclusions drawn are, as indeed they can only be, solely related to one piece of legislation, but a later chapter will suggest some possible lines of thought for any wider investigation of the problems of interest groups in the present political situation.(1)

The following pages set out, in similar pattern, the Act of 1946 and the services of 1939. The gap between 1939 and 1946 is briefly sketched in, and the views of the

(1) See p. 363.

various interest groups, as well as something about the groups, are also given. The main portion of the study is devoted to an examination, section by section, of the plan for a National Health Service Act - a process here studied for a period of four years, but one which may well have been much longer. As a final chapter, some conclusions are set forth.[1]

(1) cf. p. 346.

CHAPTER 2.

The National Health Service Act, 1946.

In discussing the National Health Service it is important to keep separate the actual wording of the Act and the oft-times expressed intentions of the Minister. As far as possible in this account the wording of the Act is relied on, although elsewhere notice may be taken of Ministerial assurances given to the interest groups on points not written into the Act.

The Act (1) provided for the establishment of a comprehensive health service in England and Wales available to all without limitation of any sort and with, three exceptions, (the repair of appliances negligently treated, certain types of domestic help and amenities in hospitals) was free of charge at the time of use, all persons, irrespective of age, income and insurance record, being entitled to use its services. Although those compulsorily insured under the National Insurance Act, 1946, would make some small contribution towards the cost of the service, those not so contributing were not to be disqualified from using the service. The cost of the service was to come mainly from rates and taxes. The service whilst available to all was not a compulsory service in that patients could seek and doctors provide the services privately. It was, therefore, a 100% service with the right to opt out of it

(1) 9 & 10 Geo.6. Chap.81.

but with no right thereby to exemption from contributing to its cost.

The first section of the Act laid a duty on the Minister of Health 'to promote the establishment in England and Wales of a comprehensive health service 'designed to secure improvement in the physical and mental 'health of the people .. and the prevention diagnosis and 'treatment of illness ..' He would be aided in this task by an advisory body, the Central Health Services Council, representative of the various interests concerned in the service, and appointed by him after consultations with those interests. The actual balance of representation was laid down in a schedule to the Act. (1)

The Council would be free to advise the Minister both on his request for advice and on its own initiative. It would report annually to the Minister who would lay the report before Parliament with his comments (unless the publication of the report of any part thereof were contrary to the public interest). The Minister would also appoint Standing Advisory Committees on special aspects of the service, such committees to have direct access to the Minister and the Council, the committees relationship with the Council being clarified by amendments to the Bill. The Committees were compelled to send to the Council copies of any advice they gave to the Minister, and the Council given the right to comment thereon. A duty was laid on

(1) The First Schedule - see also p. 156f

Minister to consult the Central Health Services Council before deciding that the publication of their report or any part of it was contrary to the public interest. No reference was made in the Act to any other change in the duties of the Minister of Health who, therefore, remained responsible for non-health duties whilst at the same time not gaining responsibility for all civilian health services.

Hospital and Specialist Services:

In providing the comprehensive health service, the Minister would use a tripartite organization, each part having a Part of the Act devoted to it. These parts were the hospitals and specialist services, the local health services, and the general medical services, each separately organized without much apparent linking.

The Act transferred all hospitals, voluntary and local authority alike, to the Minister together with their endowments, the only exception to this change being teaching hospitals whose endowments would be transferred to a Board of Governors set up for each such hospital. These Boards would be outside the Regional administration set up for other hospitals but it was the Minister's intention that they should work closely with the regions to which they were attached. To administer the rest of the hospitals ad hoc bodies, Regional Hospital Boards, appointed by the Minister would be set up for 'regional'

areas based on medical teaching hospitals. In these duties they would be assisted by ad hoc Hospital Management Committees appointed by the Boards for single hospitals or groups of hospitals - the Minister said the general aim was to achieve units of 1,000 hospital beds. The financing of the service would be mainly out of monies provided by Parliament. The hospital authorities would however be entitled to use the income from endowments to provide 'extras' for the patients, to be used as 'pocket money' as the Minister claimed. The Regional Hospital Boards and Hospital Management Committees would receive shares of the income of the Hospital Endowments Fund into which all endowments to non-teaching hospitals were to be paid on the appointed day. The Boards of Governors would, as stated earlier, retain control of their own endowments.

The hospitals services would be freely available to all but for those who desired to pay privately 'pay beds' would be available in some hospitals. 'Amenity' beds, where, for a payment towards the cost of the bed, a patient could receive extra amenities in the public service, would also be available.

Local Health Services:

The second part of the tripartite administrative system concerned the local authority services. These services were enumerated in the Act, section by section,

and included the maternity and child welfare services, midwifery, health visiting and home nursing. These duties would fall on local health authorities,[1] the counties and county boroughs, including in the London area the London County Council. In addition these authorities would, subject to Ministerial approval, provide and equip health centres for all types of medical services. It was hoped that all three services would meet here, the hospital boards sending specialists, the local authorities providing the health visitors and similar services and the local executive council providing general practitioner, dental and pharmaceutical services. Local health authorities would also provide, or contract with, a voluntary body to provide, an ambulance service for the whole health service - a service which would be used mainly on the recommendation of doctors and hospital authorities, neither amenable to local authority control. Local health authorities would be obliged to appoint statutory health committees with discretion to co-opt thereon non-members of local authorities, up to one less than half of the committee, and would receive from the central government grants towards the cost of the provision of these services.

(1) For a full list see p. 319

General Medical and Allied Services:

Four main services were dealt with in this part of the Act setting up the third leg of the tripartite organization, i.e. the medical general practitioner service, the dental service,[1] the pharmaceutical service and the supplementary opthalmic services. The first three were to be the responsibility of ad hoc[2] appointed bodies representative of the patients (per the local authorities) and the professions concerned. These bodies, Local Executive Councils would be set up for areas corresponding to those of the local health authorities on a general pattern following closely that of the National Health Insurance system. The Councils would prepare lists of practitioners willing to provide the services, all qualified persons having a right to be on such lists at the time of the service coming into force. The Local Executive Councils would be responsible for the remuneration of the doctors providing the service but no method of remuneration was provided.

(1) The dental service was to be provided in 2 parts - this part for the non priority patients. Priority groups (e.g. children and expectant and nursing mothers), would be provided for through local health services.

(2) These services were to be temporarily part of the duties of these local bodies, when the Minister deemed there were enough specialists in any area, the administration of the service would pass to the hospital authorities.

Local representative committees of the professions would have advisory and disciplinary functions, whilst the removal of any practitioners from the service would be by the Tribunal (with appeal to the Minister) such body deciding on the complaint of an Executive Council or any other person if the continued inclusion of the respondent in the service would be prejudicial to its efficiency.

The most contentious section of this Part proved to be the clauses which forbad the sale of medical practice and which made an offence of any future sale of goodwill open or concealed. Provision was made in the Act for compensating doctors for the loss of goodwill as the result of the change. By amendment the financial terms of an agreement on the amount of compensation between the Minister and the British Medical Association, were written into the Act.[1]

As originally worded the Bill suggested that a central body, the Medical Practices Committee would appoint each general practitioner to his practice, but, by amendment, it was made clear that this Committee would seek the advice of the Executive Council (it, in turn, having sought the advice of its Local Medical Committee - i.e. professional committee) before making any such appointment. The main purpose of the Medical Practices Committee was to prevent the entry of further doctors into areas considered over-

(1) See p. 267

doctored, in an attempt to achieve a better distribution of doctors.

The Opposition was strongly opposed to the rigour of the penal sections of this Part of the Act and succeeded in getting some alterations made. The Minister introduced an amendment whereby a doctor (or his representative) selling his house (wherein he had had his surgery) could obtain from the Medical Practices Committee a certificate that no sale of goodwill was involved. With this certificate the doctor was safe from prosecution, unless it could be shown that he had suppressed material information in seeking the certificate. The Minister also introduced an amendment making any change under these sections triable only on indictment giving persons thereby the benefit of jury. One other amendment which needs to be noted was the important insertion of the word 'knowingly' in the sentences setting out the charge of including goodwill in any sale of doctors' property.

Before leaving this Part, an amendment owing its initiative to Opposition peers can be noticed as one of the many which wrote the Minister's intention into the Act. It laid down that in making appointments to practices the Medical Practices Committee should have regard to the expressed desires on the part of the applicant to practice in a certain area or with certain other doctors, and have

special regard to these desires when the applicant or practising doctor was related to one another. The Lord Chancellor in accepting the amendment said that he had always expected the Committee to be sensible and act in that manner. The Opposition, however, preferred it in the Act.

This review has now included the tripartite organization and leaves some minor points in the remaining sections of the Act to be dealt with. The provisions concerning the mental health services were in the main a series of complicated sections (and amendments to previous legislation) to decant the previous system without a full review of the law concerning these services into the National Health Service, the institutional services passing to the hospital service, the other services to the local authorities and many of the duties of the Board of Control being passed to the Minister of Health. This 'decanting 'of institutions and care into the whole service' provided 'one of the most complicated pieces of legislation 'we have had for years' the Minister told the Standing Committee.(1)

A useful postscript to this outlining of the Bevan plan is a comment from the Lancet which might well be a text for this chapter and indeed for the whole study.

(1) Standing Committee C Official Report 3.7.46. c1009

'The Act, as it now emerges, is a much less revolutionary 'measure than it would have been if the original 'suggestions of Mr. Ernest Brown had been translated in 'law. It derives much more from the long discussions 'between the profession and the Ministry of Health than 'it does from any doctrinaire idea of the present 'Minister's political party'.(1) The succeeding chapters will, it is suggested, in large measure bear out the truth of that statement.

(1) Lancet 16.11.46.

CHAPTER 3.

The Health Services in 1939.

Having in the previous chapter briefly set out the end of the process considered in this study, the National Health Service Act, some general background must be sketched in as a starting point for the chapters which follow. The services in 1939 are outlined below and their principal defects noticed without any reference to the war-time changes, except where absolutely necessary. It is realised that, for example, in the hospital service, the Emergency Medical Service made a considerable difference to the pattern of the hospital services, but the situation was unique. It may well have acted as a spur to reform and indeed provided some necessary experience for any such reform, but it is in the services as they existed in 1939 that lies the root causes of a need for change - those services marked the real position reached in the advance to a National Health Service.

In describing the services as they existed in 1939, as far as possible the pattern of the chapters in Part III of this study is followed, beginning with the general coverage and financing of the services. The coverage of the 1939 services is hard to define broadly for it varied with each service, and it is therefore best left to the sections on the individual services. In theory, a comprehensive health service was perhaps available

to all, but, in fact, it was so available only to those able to pay for it. The financing of the service, too, varied from one part of the service to another.

The central administration of the service shows no major difference in form between 1939 and 1945 although the content has considerably widened. In 1939 the Minister was only responsible for those services publicly provided and not for the service as a whole; he was advised by a Central Advisory Committee, now replaced by a much more complicated advisory machinery which, it is to be hoped, is more effective than its predecessor.(1)

Hospital services were provided in two ways, either by voluntary bodies set up especially for that purpose, or by local authorities. The division between providing bodies spread throughout the service and was the cause of many of the difficulties encountered by the Ministers of Health when they attempted to plan a National Hospital Service. Some brief account of the two types of hospital can be given, but a cautionary word must be added, that whilst the co-ordination between the types of hospital was notoriously bad, co-ordination within the types was equally bad. A hospital system did not exist, for there were rather many bodies, local authority and voluntary providing hospitals.

(1) See p. 12.

Local authorities had had powers with regard to mental and isolation hospitals for many years, [1] but it was not until 1929 [2] that they entered the field of general hospital work, a field previously almost exclusively provided for by voluntary bodies. Under an Act of that year, in addition to being given powers to build and maintain general hospitals, local authorities were empowered to 'appropriate' Poor Law Infirmaries and turn them into general hospitals open, unlike the infirmaries, to all. [3]

Local authorities were slow to make use of their new powers and it was not until the late 1930's that they made any big contribution in the field of general hospital provision. By 1939, however, their preponderance over voluntary hospitals in isolation and infectious diseases beds became also a preponderance of general hospital beds. [4]

(1); Isolation & Hospital Acts 1893-1901.

(2) Local Government Act, 1929.

(3) These 'appropriated' hospitals usually became the responsibility of the local authority's Public Health Committee. The 'unappropriated' passed with all Poor Law duties to their 'Public Assistance Committee'. By 1936 only 46 local authorities (counties and county boroughs) had used their powers of 'appropriation' - By 1946 this had risen to 77.

(4) Local authorities provided 858 hospitals of all sorts with 143,494 beds, the comparative figures for voluntary hospitals being 988 hospitals and 71,956 beds. Stone 'Hospital Organization and Management' 3rd Ed. pp 12 and 13.

The administration of local authority hospitals tended to be very different from that of voluntary hospitals, the main differences of which need not concern one here. One point, however, must be made as having some bearing on the views expressed by the medical profession, In most local authorities, their hospitals were under the administrative control of a medical superintendent who often took some part in the clinical work of the hospitals. The profession objected to this system on the grounds that these superintendents could and did interfere in the clinical work of their junior doctors, a practice breaking down the essential medical doctrine of the doctor being individually responsible for the care and treatment of his patients. The profession, however, displayed some ambivalence on this point, calling for a medical body to control the health services, not realising until 1945 that perhaps after all lay control was better than that of 'five medical despots'. (1)

Little needs to be said here of the voluntary hospitals except to attempt some definition. The best, a negative one, is that taken from the Voluntary Hospitals (Paying Patients) Act, 1936, which defined a voluntary hospital as 'an institution', 'not being an institution which is carried on for profit or which is maintained wholly 'or mainly at the expense of the rates, which provides 'medical and surgical treatment for in-patients'. Of the

(1) See p. 153.

points which may be noted here about these hospitals, one must note that whilst their main aim was the treatment of those not able to afford payment, (or full payment) increasing provision had been made for the treatment of those patients able to pay the full cost. Their specialist staffs were usually non-resident and in most cases they received no remuneration for the services they gave to the hospitals.(1) One other point may be noted - the inter-war years are remarkable for the spectacular growth of contributory schemes and their great financial contribution to voluntary hospital finances.(2) The exact state of those finances set out in the following table discloses the great dependence of the voluntary hospitals on the two sources of income just mentioned, paying patients and contributory schemes, neither of which can strictly be termed voluntary sources of income.

Voluntary Hospitals Income - 1940 (3)

From philanthropic Sources	£6,843,000
" contributory schemes	£3,250,000
" payment for services	£6,607,000
TOTAL =	£16,700,000

(1) In 1932 a Committee of the British Hospitals Association and the British Medical Association agreed that the time had come to give consultants some share of the contributory scheme income of voluntary hospitals, but little had been done in this direction.
(2) See Page A.T. 'Pennies for Health' (1949)
(3) 'Eight Hundred Years of Service' British Hospitals Association (1943). A useful discussion of the differences between voluntary and local authority hospitals can be found in the Interim Report of Medical Planning Research - Lancet 21.11.42.

The nearest deliberate state plan for a national health service prior to 1946 was the National Health Insurance Act 1911 which provided for 'the prevention and 'care of sickness' amongst its aims. The Act established Local Insurance Committees representative of the Approved Societies,[1] and the professions concerned, to maintain lists of doctors willing to provide medical services under the Act, all doctors having the right to go on such a list should they so desire. The details of this service[2] are well-known, but one or two features of the service can be noted. In the first place the service was one linked with the insurance system - i.e. only those who contributed to the insurance system could obtain the benefits of the medical sergice. This meant an extremely limited coverage and never dovered the dependents of those who paid the contributions - in all, by 1942, some twenty one million people were covered.[3] Those covered were those employed on manual work on a contract of service, or if on non-manual work earning less than £420 per annum, this latter figure having risen gradually from the £160 in the original Act.

(1) i.e. the Societies set up to organize the payment of pecuniary benefits under the system.

(2) e.g. see 'National Health Insurance' - H. Levy (1944)

(3) White Paper 'A National Health Service' Cmd 6502 - 1944 - p.54

The National Health Insurance service suffered a further limitation - not only was its coverage limited, but also the amount of medical care given. Doctors were required to provide 'all proper and necessary medical 'services other than those involving the application of 'special skills and experience of a degree or kind which 'general practitioners as a class cannot be reasonably 'expected to possess'. (1)

Local Insurance Committees were responsible also for the provision of a pharmaceutical service which would dispense all proper drugs and medicines ordered by general practitioners for National Health Insurance patients. The general practitioner and pharmaceutical services were termed 'statutory benefits' guaranteed to all contributors in need of them. There were also 'additional benefits' for the dental and opthalmic services. Any contributor receiving treatment under these services would have part or all the cost paid by his Approved Society should it be in surplus i.e. have had a surplus of revenue from contributions over expenditure on benefits over the previous five year period. These additional benefits were, therefore, not dependent on the contributions directly but rather on the profit of a Society - a fact leading to great variations in benefits obtainable by members of different societies, all paying the same

(1) Clause 8 (1) of Part I of First Schedule to the Medical Benefits (Consolidated) Regulations 1924.

compulsory contributions. Of the twenty one million contributors only 13 million were entitled to dental benefits and ten million to the opthalmic benefits. (1)

Before leaving this service the method of remunerating the practitioners must be described. The general practitioner who signified his willingness to accept National Health Insurance patients had to provide a surgery open at regular hours for them. Any patients registered with the doctor, i.e. going on his list, became his responsibility for all their medical care within the definition outlined above. For each patient for whom such responsibility was accepted the doctor received a per capita fee from which he had to pay any expenses incurred in treating them. This system became known as the capitation system and was successfully defended by the medical profession against all variations in discussions with the government.

One paragraph must be devoted to the Highlands and Islands medical scheme which was sometimes put forward by members of the medical profession as the ideal way for a government to help in poorer areas. Under an Act of 1913 this remote area of Scotland was treated in a special way: a Government fund was established to make grants to doctors, nurses and other health workers to help them provide houses for themselves, buy their equipment, to

(1) White Paper op cit p.64-5.

help them in transport problems and generally to ease the burden of the heavy costs of such an area to the health workers. In return the doctors agreed to charge only nominal fees to those they visited. The Fund, almost as a wise and wealthy benefactor, set out to improve the lot of health workers, not in any sectional interest, but in the hope thereby of 'providing and improving means for 'the prevention, treatment and alleviation of illness and 'suffering'.(1) One doctor who knew the Highlands and Islands before and after 1913 has written that 'to compare 'medical work in the Hebrides in former times with what 'obtains today is like recollecting a terrible nightmare 'in the course of a good breakfast'.(2) Poverty and bad transport had largely been overcome with government help.

One of the main duties of local government in the field of health work has already been discussed, namely the hospital services. There were, however, many other services provided by local authorities under this heading including, for many people at least, the environmental health services. Of the others the main services provided were three, the maternity and child welfare services, the tuberculosis service and the school medical service. Little

(1) Public Administration Vol.IX 1931 p.161 - an address by A. Shearer on the Highlands and Islands Medical Scheme.

(2) Ibid

point would be served by any detailed description of the services provided, and one cannot do better than summarize the position and say, with Wilson, that there were 'very great variations in the adequacy and 'efficiency of the services provided ...' (1) This, as was pointed out, was not due entirely to variations in the drive and progressiveness of authorities but rather to the variations in the size, resources and powers of the different authorities.

One might have put the mental health services under the heading of the previous paragraph, but they deserve a separate mention if only because, in Part III, they are given a separate chapter. The law governing the fields of Lunacy and Mental Treatment was extremely complicated and in need of review. The duties, however, were fairly clear and all rested on Local Government with some exceptions for central government and the Board of Control, e.g. over the institutions of Rampton and Moss Side for dangerous defectives. Voluntary bodies, too, had made notable contributions in this field, though in total amount their effort was small.

(1) Municipal Health Services - N. Wilson (1946) p.167.

One further service must be mentioned, if only as an example of the 'bewildering variety of agencies' providing the services.[1] This is the ambulance service which before 1948 was provided by such bodies as the Public Health Departments of local authorities, voluntary hospitals, police, fire brigade, some industrial undertakings, the St. John Ambulance Brigade and the British Red Cross Society. Such a lack of system can only have resulted in waste and overlapping whilst at the same time leaving many needs unsatisfied.

Conclusions:

This brief review of the health services of 1939 has presented a picture 'complicated and somewhat inchoate'[2] Such services as existed were provided by a 'bewildering 'variety of agencies'; some agencies provided more than one service, e.g. local authorities, whilst others provided only one main service, e.g. local insurance committees. Reversing the picture one sees some services provided by many bodies, e.g. notoriously the ambulance service, and others provided by one body e.g. the National Health Insurance medical service. Above all this chaos, the Ministry of Health, despite its title was not in a position to prepare or maintain an overall health policy

(1) 'British Health Services' P.E.P. (1937)

(2) 'Medicine and the State' - Sir Arthur Newsholme (1932) p.71

for its control of the services was limited and patchy. Only in the realm of the general practitioner services, and to a lesser extent in the local authority services had it any form of control. A Ministry without a policy and a multitude of health bodies without linking or co-ordination stand as symbols of the major failure of the pre-war health services.

In such a situation the result could only be overlapping and waste of resources and at the same time many gaps. At a time when medical knowledge was outstripping the organization of the health service, the cost of medical treatment was becoming, for all but the wealthy few, too much for the private purse. A comprehensive health service was therefore only readily available to this fortunate few, and for the most part, people had to be satisfied with an incomplete service. Its double lack of comprehensiveness lay in its limited coverage and limited amount of medical care available.

If these were the major faults, and as such they were generally accepted by all the interest groups studied in this connection, there are other faults not always so readily accepted. The hospital surveys set in motion by Mr. Ernest Brown in 1941 (1) when published in 1945 showed a grim picture of the condition of the hospital services

(1) See p. 38.

of the country. The Nuffield Provincial Hospitals Trust summarized the results of the surveys in its 'Domesday Book of the Hospital Services'. It found the survey reports 'almost monotonously unanimous' on three points.(1) The major defects of the service were these - inadequate accommodation (some putting the existing accommodation as short by one third of the required amount), shortage and maldistribution of specialists, and the lack of co-ordination among hospitals. On this latter point the lack of co-ordination was not only between the two types of hospital but within the types as well. In the face of such a round condemnation of the situation some action was called for on the part of the Government.

The reports of the Ministry surveys of the hospital services were limited to the services themselves without regard to the providing bodies. If one widens the survey a little a fourth point can be added to the category of defaults of the 1939 system. This was the financial position of the voluntary hospitals which was becoming increasingly unsteady, despite the steady increase of contributory schemes. Indeed, but for their rapid growth, the voluntary hospital movement would probably have collapsed before 1939 or been forced to seek Government

(1) See p. 38.

assistance, as it had done before.[1] This is not the study in which to analyse in detail the causes or the results of this situation, but by way of a summary it can, I think, be fairly stated that in 1939 the voluntary hospital movement as a whole were able to maintain their existing services but completely unable to expand. A similar position was apparent in 1946 when expansion was even more urgently required.

Turning to the general practitioner service some faults can be mentioned. Doctors were coming increasingly to complain of overwork, of isolation from their professional colleagues and of inability to find time to keep abreast of developments in medical knowledge. The answer in such a situation seemed to the medical profession and the Government alike to lie in health centres - that the medical profession renounced what was largely its own brain child is discussed later.[2]

(1) See 'Pennies for Health' A.T. Page - the Interim Report of the Voluntary Hospitals Committee 1921 (Cmd 1206) recommended a government grant of £1m. to voluntary hospitals. The Government gave half of that sum but in 1925 the Voluntary Hospitals Commission (Amd.2486) reported ... "there is in most cases little prospect of essential extensions being undertaken within the next few years". p.14. They called for an increase of 22% in the number of beds.

(2) P. 232.

'The approved societies and the insurance 'committees administering medical benefits were the 'essence of the compromise'. Professor Levy is here referring to the 1911 Act which like the 1946 Act was the focal point of strong conflicting pressures. The role of the approved societies need not here concern one, but some account of the insurance committees can be given. The medical profession, in the discussions on the 1911 Act, were opposed to the control of the general practitioner service either by local authorities or by friendly societies. The reasons for these objections are hard to state categorically. In the case of local authorities, it seems almost to have been an automatic reaction to reject any form of local government control. Friendly societies had, on the other hand, gained a bad reputation with the profession for their harsh treatment of doctors and the small fees they had paid. In addition the medical profession called for a voice in the control of the service, and in the face of such demands and such pressures the Government settled on ad hoc machinery on which local government, the approved societies and the medical profession would be represented. Thus were born, as creatures of a compromise, the Local Insurance Committees. By 1936

their extinction had been recommended[1] but in 1946 one finds the Minister of Health returning to this creature of compromise as the only port in the stormy seas of two conflicting groups, the medical profession and local government.

These, then, were the services and their defects in the year 1939. For those who seek to examine the success of the National Health Service, it is against such a back ground as this, that they must make their measurements.

(1) Committee on Scottish Health Services (1933-36) Cmd 5204 p.309-1. For a full discussion of the National Health Insurance Act, 1911, see H. Levy 'National Health Insurance' (1944)

CHAPTER 4.

National Health Service Timetable (1939-1946)

The purpose of this chapter is to set out briefly the main dates of the period 1939 to 1946 and to relieve the chapters in the third Part of much repetitious material. The first part of this chapter, therefore, takes the story up to the beginning of 1943 and the second part gives the main dates for the period 1943 to 1946. As such, therefore, the first part of the chapter is part of these introductory chapters, whilst the second part if part of all the chapters in Part three.

1939-1943:

Only three events are worthy of record in this period, a period when Britain's eventual victory in war seemed far enough away to make post-war planning into wishful thinking. The first of these events was the setting up of the Emergency Medical Service, the history of which has been so graphically described by Professor Titmuss (1). This service which was established to deal with the great stream of casualties which were expected, did much to direct people's thoughts to the failures of the pre-war system and to the possibilities of a better hospital service at the end of the war.

(1) Problems of Social Policy - R.M. Titmuss (1950)

This was, no doubt, the reason behind the announcement made by Mr. Ernest Brown, the Minister of Health on 9th October, 1941, when he told the House of Commons (1) that it was 'the objective of the Government as soon as may be 'after the war to ensure that by means of a comprehensive 'hospital service appropriate treatment (would) be readily 'available to every person in need of it'. He outlined certain broad principles on which it would be organized speaking of wider local government areas and the continuance of voluntary hospitals. He also said that until such a service was organized, the Government could not think of the wider plan, a national health service. He announced that with the help of the Nuffield Provincial Hospitals Trust, a survey of hospital facilities throughout the country would be begun. (2)

In 1941 the Government had set up an Inter-Departmental Committee under the chairmanship of Sir William (now Lord) Beveridge 'to undertake, with special 'reference to the inter-relation of the schemes, a survey 'of the existing national schemes of social insurance and 'allied services, including workmen's compensation' (3)

(1) House of Commons Official Report Vol.374 c.1116 9.10.41.

(2) In all Ten Reports of these surveys were published by the Minister of Health in 1945-6 Nos.32-364-1 to 10.

(3) 'Social Insurance and Allied Services' Report by Sir Wm. Beveridge Cmd 6404 - November, 1942.

The history of this Report and its success as a best seller needs little telling here. Because of the matters of high policy involved Beveridge was given permission to sign the report alone, his civil servant colleagues acting as advisers only. His report, the main content of which lies outside the scope of this study, was based on three assumptions, one Assumption B reading: 'a national health service for the prevention 'and for the cure of disease and disability by medical 'treatment' and the 'rehabilitation and fitting for 'employment by treatment which will be both medical and 'post-medical'.(1)

The Report was debated for three days in the House of Commons (2) when some difference of opinion came to the fore, the main difference being over the date of the implementation of the Report rather than its contents - a certain section of the Commons calling for its total acceptance and immediate implementation. The majority, however, supported the Government's view that whilst the Report was acceptable some reservations must be made until fuller consideration could be given to it. There was, however, a wide measure of disappointment at the failure of the Government speakers to put the Government case clearly.

(1) Ibid p.158

(2) House of Commons Official Report Vol.386
16-18th February, 1943.

All three speakers, Sir John Anderson, Sir Kingsley Wood and Mr. Herbert Morrison (and especially the first two) devoted a large section of their speeches to cautioning and restraining those who wanted all the Report at once. The general theme was that the financial situation at the end of the war and the financial costs of the scheme would have to be carefully considered. For the moment the Government would begin earnest consideration of the details and would open 'consultations' with interested organizations - 'consultation', as Mr. Morrison put it 'a very blessed word in the administration of British 'democracy'. (1)

The Lord President of the Council, in his speech (Sir John Anderson - now Lord Waverley) welcomed the conception of a comprehensive health service. It would be a comprehensive service in two ways: 'it would cover 'all forms of treatment and it would extend throughout the 'community' (2) The basis of the new service would be one of co-operation between public and voluntary authorities but public health must be someone's responsibility. 'Experience (justified) putting this ultimate responsibility 'in any area on to the well tried local government machinery, 'working very often over larger areas perhaps and certainly

(1) House of Commons Official Report Vol.386 c2047

(2) Ibid c.1665

'working in consultation and collaboration with voluntary 'agencies'. Free choice of doctor, the least possible disturbance of the association between doctor and patient and scope for private practice for those who wanted it, would be principles of the new service. The voluntary hospitals would be safeguarded, and negotiations with interested bodies would begin at once but it was only fair to realise 'that negotiations with the medical professions 'would take a considerable time for it was essential 'when one is dealing with a great honourable 'profession such as the medical profession, that the 'matters which have to be settled between it and the 'Government, should be settled by negotiation and achieved 'with the utmost amount of good will' (1).

This Report, which must rank as one of the most important ever to come from the Government, provided the motive force for all that follows - but for that report it is extremely unlikely that much of what today is known as the Welfare State would have arrived so soon after the end of hostilities.

(1) Ibid c1832. Sir Kingsley Wood, Chancellor of the Exchequer.

1943-1946:

The events of the first half of this chapter lie outside the main period of this study, but those which follow are in backbone. They are, as has been said earlier, part of every chapter in the third part of this thesis.

The Minister of Health began discussions with the various groups in March, 1943, and soon afterwards introduced, as a basis for discussion, his own plan. The detail of this plan is reserved for following chapters, and all that needs to be noticed here was that it was short-lived. The medical profession told the Minister that they regarded the proposals as unfruitful basis for discussion and called on him to appoint a Royal Commission. This he refused to do but he did agree to put his plan 'in the discard' and begin again from the ground.

This Brown plan is important in one respect - its possible authorship, The contents of the plan are such as to suggest that this plan was not the plan put forward, from his own experience, by Liberal National Mr. Brown, but was that of his officials. Several grounds for this can be adduced. In the first place the plan has little in it to suggest Liberal National political sympathies, in its author - if anything it would deserve the epithet 'socialist'. Secondly, on examination the plan is found

to bear striking resemblance to the plans produced by bodies of local government officials - e.g. that of the National Association of Local Government Officers (1) and the Society of Medical Officers of Health (2). These plans were produced by local government officials and it is not too much to expect central government officials to think on similar lines, especially as some of the medical staff of the Ministry of Health come from local government service, as, for example, the present Chief Medical Officer, Sir John Charles did. Private conversations I have had with people who have taken part in the discussions at the Ministry, bear out this supposition. Finally a plan by an ex-civil servant from the Ministry of Health could be quoted. This plan by R.W. Harris, sometime Assistant Secretary in the Ministry (3) shows a great similarity in broad outline and thought to that put forward by Mr. Brown. For these reasons it is asserted that Mr. Brown's plan was that of his officials and as such therefore represents the starting point from which the officials of the Ministry (together with their Minister) considered all other plans put before them. It is suggested that without some such preliminary plan on which to work the task of the Minister and his officials

(1) See p. 61f

(2) See p. 61f

(3) British Medical Journal (Supplement) 16.1.43.

would have been impossible. Indeed his abolition of this plan, may have led, as is suggested below, to Mr. Brown's inability to produce any plan at all.

Mr. Brown first began discussions on a National Health Service when on March 9th, 1943, he met representatives of the Medical profession. As he told them in a subsequent letter he had in mind the publication in a statement 'in general terms of the kind of measures which '(he) might have in mind to submit to Parliament'.(1) These discussions went on until the end of July, not only with the medical profession but with other interested groups. In April, 1943, he had promised a general statement in two or three months time(2). In June, he was speaking of the publication of this general statement as the next step.(3) By the early part of August the hope was expressed that it would appear when Parliament reassembled in the last days of September.(4) On the reassembly of Parliament he found himself 'not in a 'position to say when' it would appear.(5) Towards the

(1) Quoted from British Medical Journal 20.3.43.

(2) House of Commons Official Report Vol.388 c1401.

(3) Ibid Vol.390 c842-3

(4) Ibid Vol.391 c2108

(5) Ibid Vol.392 c376

end of the year Mr. Brown gave way to Mr. H.U. Willink at the Ministry of Health, and some causes for this change can be suggested, though perhaps the above recital provided ground enough for such a change. In the first place it may well have been that the parties in the coalition government could not agree on the proposals put forward by Mr. Brown, his original proposals being extremely 'socialistic'. Secondly it has been alleged that Mr. Brown failed to produce any workable plan at all,(1) being, it was suggested, unable to bring all the discussions he had had into focus and produce any coherent plan.(2) Whatever the reason for the change, one thing is certain - the change meant further delays.

In the King's Speech in November, 1943, the Government outlined its plans, the Gracious Speech reading

(1) See p. 44.

(2) Mr. Willink once said: "I sometimes feel that it must have been depressing for those with whom we have had conversations in various fields ... that in the first months when a project of this sort is under discussion, the Minister ... has nothing to give, no terms to make, no promises. I think that those who are experienced have understood that until a certain stage has been reached when we have an impression of the views of all concerned, we cannot begin to review the public mind as a whole, the views of (the various groups).. and reshape to the right extent the original proposal" - "Physiotherapy" Nov. 1944.
By abandoning his original proposals Mr. Brown made his task infinitely more difficult, It seems essential that a Minister, at least, have some sort of plan in mind when meeting the interest groups.

as follows: 'My Ministers will present to you their 'views and proposals regarding an enlarged and unified 'system of social insurance, a comprehensive health 'service ... and they will decide in the light of your 'discussions, what specific proposals for legislation 'on these matters can be brought forward at this stage'.[1] In the following month, the new Minister who had won war-time fame as Special Commission for London's Homeless reported that he was studying the problems and drawing up the White Paper.[2] Eventually on the 17th February, 1944, the White Paper 'a National Health Service' was presented to Parliament, and so fifteen months after the publication of the Beveridge Report, the first major step on the road to legislating for a National Health Service, had been taken.[3]

The White Paper set out to examine the subject generally and made proposals representing what the Government believed 'to be the best means of bringing the 'service into effective operation'.[4] The Government wanted its proposals to be freely examined and discussed

(1) White Papers on "Social Insurance" and "Workmen's Compensation" Cmd.6550 and 1 were issued in October 1944 - in each the 100% coverage was maintained.

(2) Ibid Vol. 395 c.9

(3) Ibid Vol. 395 c.1137

(4) White Paper Cmd 6502 p.5

and said it would welcome any constructive criticisms. The first part of the White Paper reviewed the existing services and the second summarized the government's view of a comprehensive service, which, they felt, could best be achieved by using and absorbing 'the experience of 'the past and the present, building it into the wider 'service', a method 'in accord with native preference in 'this country'. (1) The service would be doubly comprehensive covering everyone and all forms of treatment with temporary exceptions, due not to matters of principle but to shortage of dentists and opthalmologists.

As the Brown plan should have been to Mr. Brown, so the White Paper was the basis on which Mr. Willink discussed at great length the proposals for a national health service. After lengthy discussions a revised version of the White Paper was circulated to some of the groups - this version is here styled the revised White Paper of the revised Willink Plan. The exact date of this plan is hard to state categorically but for present purposes the early months of 1945 are accurate enough (2). Indeed, it is

(1) Ibid p.8

(2) Cf Municipal Review December 1951 - in a memorandum to Select Committee on Estimates there is a reference to a plan circulated by the Minister in a memorandum dated 1.3.45.

doubtful if these proposals were contained in any one document as were those of the White Paper. They probably evolved bit by bit after discussion with the various groups. The plan, here discussed as a separate plan, is therefore a symposium of several documents sent to different groups.

The revised Willink plan was reported by the British Medical Association as not being 'new proposals 'put forward by the Government in the place of the White 'Paper' but rather 'proposals which the Minister would be 'willing to put to his colleagues as soon as he(knew) 'whether they commended themselves to the medical 'profession'[1] Another account described them as 'possible alternatives .. which the Minister thought the 'Government would be prepared to consider on their merits'[2] Mr. Willink, whilst Minister, said that he had made no suggestions to the medical profession or to anybody else which could properly be described as his proposals.[3] In the face of these conflicting statements the actual

(1) Confidential British Medical Association Document.

(2) A similar document to pharmacists.

(3) House of Commons Official Report Vol.410 c160.

position of these proposals is hard to state. One is however forced to assume them to be Government proposals and one can bring as evidence for this point of view Mr. Willink himself when he had divested himself of the cares of Ministerial office. Describing the long negotiations, he went on to tell the House of Commons: 'in the result 'by the end of May we had reached a stage where ... a 'structure had emerged likely to command such general 'agreement that it was possible to begin .. drafting 'necessary legislation'. (1) An opportunity to study the Government papers of this period would prove or disprove the validity of these statements - it is perhaps needless to add that access to these papers was refused.

On the 23rd May, 1945, Mr. Churchill resigned his position as Prime Minister of the war-time coalition government, and resumed as Prime Minister of a caretaker government pending a general election in July, 1945. The result of this election swept Mr. Churchill and with him Mr. Willink out of office and replaced them by Mr. Atlee and Mr. Bevan. The long period of discussion and negotiation had been halted by Mr. Willink pending the result of the election and it was not until many months afterwards that Mr. Bevan made any move to resume them.

Towards the end of 1945 Mr. Bevan announced that he proposed to ask Parliament to abolish the custom of the

(1) House of Commons Official Report
Vol.413 - 21.8.45.

sale of medical practices, whilst at the same time paying full compensation to all doctors affected.(1)

The National Health Service Bill was introduced to Parliament on the 19th March, 1946, when it was given its formal first reading and ordered to be printed. Three days were devoted to the Second Reading, 30th April, 1st and 2nd May, 1946, after which, despite Opposition protests the Bill was committed to a Standing Committee of the House. In all this Committee spent some twenty days (spread over the period 14th May to 3rd July, 1946) discussing the Bill.(2) The Bill was then returned to the House and examined on recommittal and on Report, and on the 26th July was given its third reading and passed to the House of Lords. The Lords devoted some eight days to all stages of the Bill, a process which was completed on the 31st October. The Bill returned to the Commons who accepted all but two of the Lords amendments. The Upper House did not insist on these amendments(3) and the Bill received the Royal Assent on 6th November, 1946. With that date the study ends -

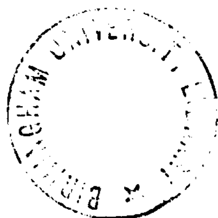
(1) House of Commons Official Report Vol.417 6.12.45.

(2) In the Appendix an account of the personnel of the Committee is given - p.371.

(3) One concerned the remuneration of doctors (see p.260) and the other the local health services in London (see p.334)

an end necessitated by considerations of time rather than interest. The period between 6th November, 1946 and the appointed day 5th July, 1948 would amply repay study on the lines of this thesis.

This First Part of the thesis is thus complete, the Act itself, the services in 1939 and the main dates of the period studied have all been reviewed. The next Part outlines the groups concerned and their views.



PART II THE INTEREST GROUPS

Chapter 1 - The Interest Groups and their views on a National Health Service in 1942.

CHAPTER 1.

The Interest Groups and their views on a National Health Service in 1942.

In the previous Part the starting and finishing points of this study have been outlined and the main dates and events of the intervening period filled in. Before turning to the detailed study of the development of plans for a National Health Service, and the part played in that process by interest groups, it is important to describe the groups taking part and the viewpoints they held when the dev.lopmental process began. It is to this task that this chapter and Part is devoted.

In the discussions with which this study is concerned there were a three main groups, the others paling into insignificance beside them. They were the medical profession, the local authorities and the voluntary hospitals and their importance was in the order here indicated. Undoubtedly the most important was the medical profession, its importance being measured in part at least by the great successes it achieved in its negotiations and discussions with the Government. One must, however, in speaking of the medical profession remember it was never a unified profession speaking with one voice and within its ranks it comprised several organizations. Of these, three main divisions may be discerned. In the first division, the general

organization of doctors of all types, comes the most important body, the British Medical Association which represented a majority of the profession. Organized on a federal system, its main organs were the formal policy making body, the Representative Body representative of all areas and branches of the Association, and the Council, in effect its executive committee.[1] According to its constitution the Council was bound, in major policy matters, to await the decision of its Representative Body, a fact which explains the sometimes apparent slowness of the Association in reaching a final statement of policy, e.g. as in 1944[2]. At the time of this study the membership of the Association was steadily increasing, including more than two-thirds of those on the medical register.

The second division of medical organizations was that based on a speciality or particular occupation. Of these there were many, of which the Royal Colleges in London and the Society of Medical Officers of Health may be quoted. The former, of which there were three, the Colleges of Surgeons, Physicians and Obstreticians and Gynaecologists, represented doctors with particular specializations whilst the latter represented doctors in a particular job, namely officials of local authorities.

(1) Also called the Representative Meeting.

(2) See p. 88 for the long delay in issue of the British Medical Association's policy on the White Paper.

Fitting also into this category would come the Medical Practitioners Union, a Trade Union of general practitioners.

The third division, of political medical bodies, has only one body which need concern this study, though others have been discovered. This was the Socialist Medical Association an association of doctors whose aim was a socialized health service. Unlike the other bodies it also included other health workers than doctors. Fitting uneasily into either category was the Medical Women's Federation which, except for its natural stress on equal pay and conditions for women doctors differed little from the British Medical Association.

All these groups mentioned, except the Medical Practitioners Union and the Socialist Medical Association were represented on Joint Committees set up to meet and discuss with the Minister of the day on the plans for a National Health Service. On these joint bodies the British Medical Association always had a majority and for the purposes of this study the views of the Association can be taken to represent the views of the joint Committees and, therefore, of the profession. Only where necessary are the views of the two dissident groups, only minority groups, mentioned. The Joint body went under different names - in 1942 it was the Medical Planning Commission set up by the British Medical Association to

'study war-time developments and their effects on the 'country's medical services both present and future'[1], in 1943 it was the Representative Committee set up to enter into non-committal discussions with the Government, and in 1944 it was the Negotiating Committee set up to negotiate with the Government. It is to these bodies, or their biggest constituent, the British Medical Association, that one is continually turning throughout this study.

Before passing on to discuss the local authority organizations, some general remarks on the medical profession must be added. In the first place, the tendency to increasing specialization in medicine must be noted, with a resultant clash of interests within the profession. It may well be that this clash of interests led to the vagueness of much of the so-called 'principles' drawn up by the profession - to maintain unity within its ranks the medical leaders had to produce 'principles' which, like a political platform, read as everything to every man. One may quote the maternity service as one of the examples of the clash within the profession - the general practitioner maintaining that this service came within his province whilst the gynaecologists and

(1) The Commission published an Interim Report in 1942 - British Medical Journal 20.6.42 but never any final report. It disbanded on 16.3.44 to avoid any confusion with its successor - the Representative Committee.

obstreticians claimed that every woman should have the benefit of their specialized services. Not only was there this clash within the profession, but there was also a clash with kindred professions, notably the opticians and dentists. The medical profession wanted to take under its direct control all eye-testing and treatment, a system strongly and vociferously opposed by lay opticians who had worked, in large measure, the 'additional benefit' service of the National Health Insurance scheme. They claimed that, as qualified opticians, they were able to perform almost all eye-testing and dispensing of glasses, leaving only those cases where eye-disease was present for the medical specialist. The medical profession, too, one suspects adopted a similar attitude towards dentists. The dental profession, in their turn, always behaved as if the medical profession had such an attitude towards them. These then are the broad clashes of interest within and without the medical profession and must be taken as present, even not explicitly stated, in all medical statements.

The second of the big three groups mentioned above were the local government organizations. Unlike the medical profession and the voluntary hospitals whose main and indeed only aims lay within the fields of the health services local authorities had wide interests including health services but ranging from fire brigades to municipal

restaurants. Their reactions to the government plans for a national health service tend therefore to be less emotional for, to them, the prospective National Health Service Bill, was little more than another piece of Government legislation on which they felt bound to make representations. Their reactions are therefore hidden away in the dull minutes of local authority association meetings and not spread far and wide by press conference and other publicity device. Their aim lay rather in the field of reforming local government, and as will be shown (1) it was sometime before they would accept the Government's intention to plan the services of local government before planning the reform of local government itself. Throughout all the discussions therefore one may say that any agreement wrung from local authority associations was, in their eyes, only a temporary one pending the reform of local government.

The bodies to which reference have been made include the Association of Municipal Corporations, representing county boroughs and non-county boroughs, interests which often conflicted, the County Councils Association, the London County Council and the Metropolitan Boroughs Standing Joint Committee. Of these the first three form the bodies regularly consulted by the Ministers when they wished to hear the views of local government. It

(1) See p. 319f

will be noted, at once, that the third of these bodies is a single authority and therefore spoke always with the voice of its controlling political party, the Labour Party. The other two Associations, however, were largely non-political in their pronouncements. The stresses and strains, the clash of interests and the varied points of view within the conglomeration called local government are well known and it is therefore very doubtful just how far one can take the views of the three bodies as representative of local government views.

The picture of the third main interest group is superficially clear. The British Hospitals Association spoke as the representative body for the thousand or more voluntary hospitals whilst the Kind Edward's Hospital Fund for London spoke for those of them within the London area. Voluntary hospitals, however, were notoriously local units and attempts at co-ordination among them had not been very successful. It has not been possible to see the minutes of the British Hospital Association or to survey the views of its members but one gets the feeling throughout that the Council of the Association was always very hesitant in proposing regional schemes because of the strong local feelings of its members. This fact may well have been a weakness in their negotiations with the various Ministers of Health.

The three major groups have now been surveyed and it remains but to glance at a few of the minor groups. The number of these groups is surprisingly large, but for the purposes of this study only those which seemed of any real importance were studied. Of these undoubtedly the dental organizations deserve pride of place in importance. Three main organizations spoke for the dental profession, the British Dental Association, the Incorporated Dental Society and the Public Dental Service Association and of these the British Dental Association was the most important. For the purposes of the discussions with the Government they joined with the other organizations in a Joint Committee, on the initiative of the Minister of Health, and this Committee seems to have expressed views little different from that of the British Dental Association. The views of this body have, therefore, been taken to represent the views of the dental profession, a profession which, as mentioned earlier, felt themselves to be too much under medical control.

To speak for the nursing profession, the Royal College of Nursing has been used, whilst in the pharmaceutical profession, this role has been filled by the Pharmaceutical Society of Great Britain, the main but not the only such body. It has been thought necessary to have the views of the bodies who represented the compromise of 1911, namely the Insurance Committees, and for them

their National Association has, throughout the period studied, commented on the various Governmental plans. To complete the picture the views of bodies not directly concerned with the health services have been studied, namely the Trades Union Congress and the main political parties.

The Views of the Groups towards the end of 1942:

In the next part of this thesis the main evidence is examined section by section, dividing the National Health Service for this purpose into several separate headings. For ease of presentation it has been proved necessary to adopt a similar pattern in this section. The views of the various groups towards the end of 1942, i.e. just before the Beveridge Report appeared and the Government committed itself to a National Health Service, are examined, where available, section by section, thus, as it were giving a balance sheet of the pros and cons of pressures which any Minister would have to face.

The first sections concern the general reactions to the idea of a National Health Service, and to the more particular points of coverage and financing. No group has been discovered publicly stating that it did not want a national health service, although some groups, e.g. the dentists had at this time published no views at all and may therefore not have wished for such a service. It is,

however, I think, charitable and fair to say that all the groups thought in terms of a national health service, or at least paid lip service to the idea. On the financing of the service little or no comment is available - it is perhaps too much to expect an altruistic plan for a National Health Service to more than touch on the sordid details of finance.

As is pointed out later (1) several alternative plans for coverage were available for the Minister about to plan the service. These plans, for the present purpose, can be reduced to two, the 100% coverage with the right to seek private treatment outside the scheme, and the 90% coverage i.e. all those persons earning less than £420 per annum together with their dependents. The chief protagonist of the 90% coverage was the medical profession: in their 1938 plan (2) the British Medical Association had spoken of the extension of the existing service to cover all health services, and to cover roughly 90% of the population. The Interim Report of the Medical Planning Commission (3) in 1942 found general agreement among the profession on the need for a family doctor

(1) See p. 112f

(2) 'A General Medical Service' - British Medical Association, 1938. - British Medical Journal Supplement 30.4.38.

(3) See p. 56.

service for all, but it did not thereby imply that the state should provide such a service freely to all. The Nursing profession was even more cautious feeling that the benefits of the National Health Insurance system could 'eventually' be extended to the dependents of insured contributors (1), i.e. an 'eventual' acceptance of the 90% idea. The National Association of Insurance Committees, too, joined in the call for the 90% coverage of the population by the new service. (2)

On the other side of the fence favouring the 100% coverage were the Trades Union Congress who called for a comprehensive health service 'made available to everybody 'in the state'. (3) The Labour Party, too, favoured this total coverage although it was not until early in 1943 that they propounded their detailed views on the topic. (4) No other group made public their views on this topic but it can be assumed that some at least would have joined with

(1) Memorandum to the Beveridge Committee - Nursing Times 25.5.43.

(2) Memorandum to the Beveridge Committee - National Insurance Gazette 11, 18 and 25 June, 1942.

(3) Memorandum to the Beveridge Committee - 'Labour' Sep.'42

(4) 'A National Service for Health' - Labour Party 1943. As early as in 1932 Conference the Party had talked of a State Medical Service. No evidence of any Conservative Party plan have been discovered.

those favouring the 100% service. Almost all the groups however in their published statements, spoke of a comprehensive health service in the sense of all forms of medical treatment being available to the contributors to the service.

From the coverage of the service one must turn to the central administrative and advisory machinery and attempt some description of the views of the groups on this point. The choice for the central administrative body lay between a government department or some other body outside the normal governmental structure. The Medical Planning Commission favoured a central body exclusively concerned with health matters, but expressed no preference between a government department advised by a central medical advisory committee, and a separate Board, a central medical services board. Both the Medical Practitioners Union (1) and the Socialist Medical Association (2) came out in favour of a government department exclusively concerned with all civilian health services. On the other hand, however, the Report of Medical Planning Research (3) favoured a Board which it termed a National Health Corporation

(1) Medical World 11.6.43.

(2) See p. 43.

(3) A symposion of drafts voluntarily submitted by a group of doctors mainly under 45 years of age. see Lancet 21.11.42.

completely outside the departmental machine. Beyond these expressions of opinion, however, one cannot go for no other group had publicly commented on this point before the appearance of the Beveridge Report.

On the central advisory machinery even fewer opinions are available. Except for the reference to the need for the central department to be advised by a medical committee in the alternative favoured by the Medical Planning Commission, no one seems to have commented directly on this problem.

On the next problem, the hospital service, some more comments are available. In its Report the Medical Planning Commission spoke of four points on which it found complete agreement within the profession and of these the final point was the need for some form of unified hospital system on a regional basis. It must, however, be added that the word 'unified' as used here does not seem to imply a change of ownership of hospitals as would be implied by the 'unification' referred to throughout this study. It is nevertheless worth reiterating that the proposed hospital system was to be on a regional system - regionalism was favoured, throughout, by the medical profession for all health services. The Medical Planning Commission envisaged the unification of all health services under ad hoc regional bodies representative of local government and the various

professions concerned in the health service. The Socialist Medical Association, on the other hand, thought in terms of regional local authorities for this purpose, a view shared by the Society of Medical Officers of Health (1) and the National Association of Local Government Officers - (2) both these latter groups including the reform of the health services in the wider context of the reform of local government.

It seems clear that the National Association of Local Government Officers thought in terms of some change of ownership of voluntary hospitals, but in the other plans this is not sufficiently clear to state dogmatically that this was intended. Voluntary hospital organizations, on the other hand, spoke in terms of their own continued existence and of the need for an active partnership between the two types of hospital. Despite this, there seems to have been no strong expression of feeling one way or other on the future of the hospital system before the Beveridge Report appeared.

The views of the groups on the general practitioner service were sharply divided. There were those who

(1) Municipal Journal 12.2.43.

(2) Local Government Service - Feb. 1943.

thought in terms of a full-time salaried service as part of the local government service, either in its present areas or over wider areas, and those who thought on lines of continuing the National Health Insurance system with perhaps some slight modifications. Speaking for the former point of view of a full-time salaried government service organized from health centres were such groups as the Socialist Medical Association, the Society of Medical Officers of Health and the National Association of Local Government Officers. Adopting a middle position Medical Planning Research spoke of a basic salary element introduced into the existing system, the ending of the sale of practices and the appointment of doctors to practices. Taking up the other extreme was the majority of the medical profession, who according to the Medical Planning Commission's Report, was opposed to a full-time salaried service as part of the government service, and favoured instead a regional service, organized on traditional lines for remuneration. From this brief review of such sharp division of opinion, one can well see how this part of the service became the most contentious part to plan.

For the other services little can be said - the medical profession, with its ad hoc regional system, and the local government officials with their plans for regional local government, all envisaged sweeping these

services together as part of the duties of a regional health authority. Of the groups intimately concerned, the dentists, the pharmacists, the opticians and the nurses little was heard. Only one group, the National Association of Insurance Committees vouchsafed an opinion and that was a very timid one - their own continuance as administrative bodies for the general practitioner and allied services.

Such then were the views of the main groups when the publication of the Beveridge Committee's Report towards the end of 1942 transformed the scene and every group began to think out its own ideas on a national health service in the light of its proposals. One can, I think, safely say that all groups were agreed on the need for change and on the need for such a change to be an improvement. On the content of such change differences appear, differences which were not always great at first but which subsequently tended to harden. The hardening process went hand in hand with the gradual detailing of plans for a National Health Service. In 1942 the fundamental differences were there, e.g. between local government and the medical profession, but the pious abstractions of that year tended rather to obscure them. Not until the discussions for a service got under way did the differences really appear and the groups take up sides - usually the medical profession and the voluntary hospitals joining forces against the local authorities.

This survey, then, has shown the broad patterns of thought on the problems of a National Health Service and given the background for the following chapters, but it must always be remembered that the brave phrases of this time were made before the Government accepted the idea of a National Health Service - e.g. it was easy for the medical profession to talk in general terms, of health centres, but when the Government began to plan for the administrative control of these centres, the profession realized some of the pitfalls and its enthusiasm waned somewhat.

PART III - DEVELOPMENT OF PLANS FOR THE NATIONAL HEALTH SERVICE ACT, 1946:

Chapter 1 - A General Section

" 2 - The Financing of the Service and its Population Coverage

" 3 - Central Administrative and Advisory Machinery

" 4 - Hospitals and Specialist Services

" 5 - General Practitioner Medical Service

" 6 - Other General Practitioner Services

" 7 - Local Authority Health Services

" 8 - Mental Health Services

CHAPTER 1.

A General Section

The purpose of this chapter is to examine the general responses of the various interest groups to the plans put forward by the Ministers of Health over the years 1943 to 1946. In so doing it ignores all detailed issues and some groups whose reactions to the various plans were entirely linked to that part of the plan most directly affecting them. Reactions of this latter type are dealt with in succeeding chapters when, adopting the same pattern in each chapter, the development of the plans for a National Health Service are examined section by section. This pattern is a chronological one taking the development of each section of the plans through the years 1943 to 1946. It means some loss of the overall picture but on the other hand this can adequately be obtained by reading the same portions of each chapter to give the full picture at any point in the period reviewed. The general timetable of events of this period has already been given.(1)

(A) Some Alternatives:

In each succeeding chapter this first section will deal with some of the problems facing the Ministers of Health and set out the possible alternatives open to them under the

(1) See p. 37f

heading of the chapter. It is assumed throughout the study that some sort of reform of the health services was inevitable - an assumption based on the prevailing climate of public opinion for a better Britain when the war should end. No evidence has been collected in support of this claim, but general reading and personal recollection suggests it to be a valid one.

The nature of this present chapter is such that no alternative plans or problems fall to be discussed here once the assumption that reform was inevitable has been accepted.

(B) Mr. E. Brown's Plan, 1943:

In each chapter this section will, set out such detail of the plan as is appropriate to the chapter in question and examine the reactions of the interest groups to that detail. The detail available is regrettably small and, in many cases, the interest groups were not in a position to comment on it because of such lack of detail.

Mr. Brown's plan was shortlived for the Representative Committee (1) of the medical profession who discussed

(1) At a meeting with representatives of various medical bodies early in March, 1943, Mr. Brown had asked for a representative medical committee to begin discussions "not on the basis of any preconceived plan but from the ground". He intended, when these discussions ended, to publish a statement giving "in general terms the kind of measures which (he) would have in mind to submit to Parliament" - Letter from the Ministry of Health to the British Medical Association British Medical Journal 20.3.43

it with him decided it provided an unfruitful basis for discussion. Dr. Charles Hill, their spokesman, suggested[1] that the Government were hurrying forward with this part of the Beveridge Report alone because they wanted to control the medical profession and, through them, the issue of medical certificates upon which any payments for sickness benefit would be made. He claimed that the proposals had no comprehensiveness, left the central organization unreformed, local authorities unaltered and said nothing of the mental health services. It meant a rush into untried health centres and the turning of a free profession into a branch of the local government service.

On the 17th May, 1943, less than two months after discussions had begun, the Representative Committee of the profession therefore informed the Minister of their decision and asked for a Royal Commission saying the matter was one on which the general public should be consulted.[2] The

(1) British Medical Journal (Supplement) 22.5.43.

(2) This request for the public to be consulted is unique. Throughout one reads of the interest groups views of the 'public interest' but there is little evidence on which to assess their contentions. In a survey of the general public however the B.I.P.O. found 50% in favour of a publicly run Nat. Health Service. 69% favoured health centres even if further away than doctors surgery. On voluntary hospitals 42% wanted them taken on by public authorities, 21% favoured part-public part-private like the White Paper and 21% wanted them to remain entirely voluntary. 35% believed a drawing up of a new service was a matter for the public and the govt. 32% the joint concern of public and doctors and 25% the doctors should have most to say in its creation. See B.I.P.O. pamphlet 'The Nation's Health'. Asked who would put the point of view of the general public Mr. Brown replied that 'the point of view ... is fully appreciated by all taking part in the discussions'. House of Commons Official Report Vol. 388 c830 8.4.43.

Minister refused the request for a Royal Commission, but agreed to regard his original proposals as 'in the discard', insisting that his only commitment was to plan a national health service and that he was not, thereby, committed to any one method of achieving that aim. He repeated that discussions would be non-committal for the participants and, on that condition, the medical profession's representatives agreed to resume discussions - discussions which were resumed 'in a very helpful spirit'.(1)

The Council of the British Medical Association had earlier(2) recommended the Association to co-operate in the preparation of plans for a National Health Service on two conditions, firstly that 'the character terms and 'conditions of the medical service (were) determined by 'negotiation and agreement with the medical profession'(3) and secondly that provisions were made for those not wanting to avail themselves of the National Health Service to make private arrangements for their medical treatment. For later chapters it is interesting to wonder if the character of the service, to which reference is made, can be taken to include the administrative structure to which later the medical profession were to attach pre-eminent importance,

(1)Mr. E. Brown - House of Commons Official Report Vol.389 c1586.

(2)3.2.43.

(3)British Medical Journal (Supplement) 13.2.43.

The Medical Practitioners Union, on the other hand, felt unable to trust a Minister who professed willingness to begin discussions from the ground upwards, but who already had a plan of his own and was speaking in public of entrusting to local authorities new duties in the field of health services. They felt themselves to be 'fighting tooth and nail for (their) liberties in the national sphere'.(1) They turned their attention instead to fourteen general principles set out in a report of the British Medical Association. These they found to be 'vague and unsatis-'factory to the most extraordinary extent'. They were one third platitude and the rest vague 'except in (their) 'insistence on maintaining competitive and private practice 'to the utmost extent which the State will allow'.(2)

A solitary medical welcome to the Brown plan came from the Socialist Medical Association who accused the British Medical Association of seeking to prevent a unified health service. In many ways, this plan was the nearest approach to their aims of a socialized medical service ever to come from a Minister of Health.

The local authority associations, too, had begin discussions with the Minister. The proposals of the Brown plan caused the County Councils Association and the

(1) Medical World 23.3.43.

(2) Ibid 20.8.43.

Association of Municipal Corporations to hold a joint meeting and to issue thereafter a joint statement. They mentioned that they were 'seriously perturbed[1] by the 'drastic changes made or sought to be made in the local 'government service and by the methods by which such 'changes (were) proposed to be brought about'. They accepted the necessity for a change and were anxious to assist in this matter, but they were convinced that the problem was being approached on entirely the wrong lines. The method used was 'destroying a system of accepted 'worth instead of improving it, wherever and whenever 'required'. They were convinced that a reform of the machinery of local government should precede any reform of the services of local government.

In this joint statement unity prevailed on the need for reform but the subsequent failure of local authorities, as a whole, to agree any detailed plan of local government reform made such unity of little value, especially in this present context. This difference over the content of the changes made local government reform or reorganization a politically dangerous and lengthy business. The broaching of such a controversial matter in Parliament in war-time was not to be expected of a Coalition Government, and to delay reform of local government until the end of the war and the reform of the services of local

(1), County Councils Association Official Gazette - August, 1943.

government beyond that was, in the prevailing mood of public opinion, even more politically dangerous. The local government associations had therefore achieved but a fleeting unity in terms so broad as to mean very little.

The main fears of the dental profession at this time were that the doctors would represent them in talks with the Minister (who at this point had only called for a representative committee of doctors but made no similar invitation to dentists) and that he would not thereby recognize the special problems inherent in any dental service of the future. These fears were largely set at rest, however, by the appointment of the Teviot Committee,(1) which was welcomed by the profession who recognized that any decisions on a future dental service would be postponed until the committee had reported. The profession, therefore, contented itself, at this stage, by preparing a memorandum of evidence for submission to this Committee.

Such then are the general reactions to the Brown plan. With the sole exception of the Socialist Medical Association not a voice was raised in approval and the speedy passing of the plan was not generally mourned. As is however suggested elsewhere(2) the failure of Mr. Brown to produce any plan at all may, in part, be due to his discarding this plan altogether. Such a plan, as a basis for discussions, seems an essential if any speedy and successful outcome is to be expected.

(1) See pp. 279 (2) See pp. 348.

(C) The White Paper, 1944:[1]

This section in each chapter sets out the part of the White Paper, which appeared in February 1944, appropriate to the chapter and records the reactions of the groups thereto. In this case, the general reactions as far as ascertainable of the groups to the proposals in the White Paper are examined.

The British Medical Journal, the official journal of the British Medical Association, which was tireless in its endeavoured to explain the White Paper to its readers, welcomed it as a 'well written and for the most part un-'ambiguous report' with throughout a 'clear recognition of 'the realities of the present situation'[2] It found temporary relief for those who feared a state-salaried service but warned that it was 'important to recognize in 'the White Paper the unmistakable direction in which the 'mind of the government (was) moving and that it (was) 'towards the institution of a whole-time salaried medical 'service, with the provision that private practice (should) 'not be denied to those who want it and that doctors in the 'public service (might) provide it.'

The Medical World, the journal of the Medical

(1) 'A National Health Service' February 1944. Cmd 6502.

(2) British Medical Journal 26.2.44.

Practitioners Union, after quoting the views of other journals (1) felt bound to express its fear that the White Paper system would mean the general practitioner being worse off than before. The Union welcomed the aim of the White Paper but claimed it meant little more than an extension of the existing service. They regretted the many compromises which made improvement in the quality of the service difficult, and symbolized their feelings on the White Paper in a later pamphlet on it entitled 'Mr. Willink's Lost Opportunity'.

On the other hand the Socialist Medical Association warmly welcomed the White Paper as a step forward to a socialized medical service and called it a 'pivotal point 'in the history of British medicine'. (2) They had some regrets however and urged the Government not 'to allow itself 'to be weakened by pressures from any quarter or vested 'interest'.

The British Medical Association's Council reported on the White Paper in a spirit, it was claimed, of constructive criticism. Remarking that the White Paper presented a 'medical' rather than a 'health' service, the Report claimed that the Government knew of the profession's continual pressure for a service available to all. (3) It regretted

(1) Perhaps the neatest of these was one from the Lancet: the White Paper 'apprpaches the millenium somewhat 'indirectly''.
(2) Socialist Medical Assen. Statement on the White Paper - Socialist Medical Assen. Bulletin May-June, 1944.
(3) The Assen. always spoke in terms of a national health service available to all, but at no time did they mean thereby a service freely available to all. They always thought of an upper ~~tenth~~ being outside the free public servic

the raising of a controversial matter in time of war and went on '.. it is idle to suggest that the recasting of the 'form of health services cannot wait until there is time and 'opportunity to give them the care and thought they merit 'and until our colleagues in the Forces are back in our counsels and their practices. There is suspicion, not 'without basis, that these proposals found their first 'inspiration in a desire to control an independent 'profession in order to control medical certification and 'so the outgoings of a Social Security Fund.' (1)

The Council proposed a Negotiating Committee to represent the profession as a whole in negotiation with the Minister of Health. The committee was to contain 30 members in all, 16 being representatives of the British Medical Association, three each from the Royal Colleges of Surgeons and Physicians, two each from the Royal College of Obstretricians and Gynaecologists and the Society of Medical Officers of Health, one from the Medical Women's Federation and the remainder representing Scottish medical organizations.

(1) British Medical Journal 13.5.44. The profession often recalled the Prime Ministers statement of Oct.13,1942, 'that no controversial legislation would be introduced unless essential to the production of the war.' When questioned on this pledge and the White Paper, the Prime Minister replied 'The assumption that these proposals are controversial in the sense of seriously dividing the forces now united for winning the war can best be tested by obtaining the sense of the House upon them...' House of Commons Official Report Vol.397 c1759 3.3.44.

This constitution gave the British Medical Association the majority vote, and, in effect, meant that the Committee could not be set up or begin negotiations until the recommendation of the Council had been accepted by the Representative Body of the Association, and in other words, until the end of 1944.

A survey of the views of the medical profession showed some variation of opinion on the proposals, a variation which became more apparent when the results of a questionnaire on the White Paper prepared by the British Institute of Public Opinion for the British Medical Association are examined.[1] Of all the questionnaires sent out to persons on the medical register whether members of the Association or not, some 48% were returned[2]. Most of the answers showed the profession somewhat evenly divided and indeed in some cases, e.g. 57% of all doctors (and 51% of general practitioners) regarded one of the powers of direction of the Central Medical Board as reasonable, the results

(1) With the questionnaire went a copy of the White Paper to all doctors. These White Papers were supplied by the Minister at a cost to the Government of approx. £950. Was ever an interest group's views more carefully sought?

(2) 25,435 of 53,728 returned. See British Institute of Public Opinion's booklet 'The Nations Health' claimed as a world record for a postal survey.

were contrary to the official recommendations of the British Medical Association's Council. The nearest approaches to unanimity came over the safeguarding of the doctor's political rights in the new service, the right of the Central Health Services Council to initiate advice and to publish its own Reports, when 90% or more voted in favour of these points. Of twenty four questions which gave the opportunity for a choice of two answers, twelve received answers where the majority view was shared by 50-59% of doctors and only in seven cases were votes of more than 70% recorded. In addition to those already mentioned these included statements that the local arrangements proposed in the White Paper were unsatisfactory and infringed one of the principles held by the profession (i.e. no local government control of the medical profession), that the health service patient should be free to seek private treatment from other doctors than his own service doctor, and that it is undesirable that doctors in municipal hospitals be clinically subordinate to medical superintendents. In such circumstances one can hardly claim that the medical profession was undivided on the great issues of the National Health Service.

The results in three questions concerning general reactions to the White Paper are of immediate importance. The final question on the questionnaire asked if the doctor's reactions to the White Paper as a whole were favourable or

unfavourable, and the results showed 53% recording unfavourable reactions to 39% with favourable ones. The appropriate figures for general practitioners alone were 62% to 31%(1) Perhaps the most revealing general question was one which asked the doctor if he considered that medicine under the White Paper's National Health Service would be regarded by him as an attractive profession for his child. Of all doctors 51% regarded the profession as unattractive to their offspring, whilst 33% regarded it as attractive. In the case of general practitioners alone 60% regarded the profession as unattractice to only 25% returning the opposite answer.(2) 44% of all doctors felt the quality of the country's medical service would suffer by the introduction of a

(1) These figures taken from the B.I.P.O. pamphlet 'The Nations Health' were reprinted in the British Medical Journal Supplement 5.8.44. In the above account those answering 'don't know' are ignored the %ages therefore not totalling exactly 100%

(2) It would be interesting to know if the proportions of doctors' children following in their father's profession has diminished or increased since the introduction of the service in 1948.

national health service whilst 32% felt it would be enhanced and again general practitioners felt more strongly against a National Health Service, 52% of them answering that the quality of the service would suffer, only 24% giving the opposite reply. These three answers show the majority of doctors against the White Paper in general, though whether the assumptions of the British Medical Journal below are thereby justified is difficult to say.

The Journal devoted an article to making sense of these results. The negative replies to the general questions outlined above led them to claim that 'this 'generally adverse reaction to the White Paper as a whole '(was) to be borne in mind throughout any consideration of 'the replies to the remaining questions. Put briefly, over '50% of the profession prefix to each of their further 'replies a reservation that the answer (was) given subject 'to their expression of disapproval of the White Paper as a 'whole'(1) Prima facie, this assumption seems questionable, but of importance here, is the implication in these sentences of the anxiety on the part of the profession's leaders who had hoped for a triumphant expression of a profession united behind its leaders. This claim could hardly be sustained in the face of these results, results which it must however be remembered came only from just

(1) British Medical Journal Supplement 16.9.44.

under half of the profession.

The Lancet on the other hand found that the questionnaire results showed that the Government could command substantial support on a number of main issues. 'Their general effect (was) to weaken intransigence and 'to strengthen those of our leaders who (saw) the possible 'advantages of large changes and (believed) that the best 'results could be secured only by whole-hearted and 'friendly co-operation'. (1)

This would seem to be the appropriate place in which to make some mention of a division of opinion in the medical profession over the questionnaire itself. It is perhaps unnecessary to say that for such a document to be of value in ascertaining the views of the profession, it must have been unbiasedly presented. With this aim in mind, the majority of the British Medical Association Council had been in agreement with the questionnaire when first discussed, but there was a section which believed the Council should give a lead and seek to 're-educate' any potential floating vote. For them, convinced of the general support of all members of the Association, the questionnaire was to be the means of displaying the unity of the profession. On what might well be termed the 'lunatic fringe' of this group there were those who felt the questions should have been worded on these lines - 'are

(1) Lancet 12.8.44.

'you in favour of a policy which will ruin the voluntary 'hospitals' 'Will you vote blindly for health centres 'knowing nothing about them?' and so on. These questions contained in a letter after the results of the questionnaire had been published.[(1)] are to a degree symptomatic of the disappointment of those who, consciously or unconsciously, expected of the results a triumphant and unified acceptance of the views of the Council. Their feeling was well expressed at the Annual Meeting in November 1944, of the Local Medical and Panel Committees (i.e. the representative local professional committees of the National Health Insurance service) when a motion was accepted, ungrateful in the extreme to the British Institute of Public Opinion, 'that the recent questionary was so constructed that it did 'not reflect the opinion of the profession and no valid 'conclusions can be based on it'. One might almost call this the typical response of the elected representative to an unfavourable public opinion poll. It is not the aim of this study to measure the efficiency of the representational system of the British Medical Association, but it is a fair inference from the results of this survey that, at this particular moment at least, the leaders of the profession were out of touch with their members on several important issued.

(1) British Medical Journal Supplement 23.9.44.

When asked in July, 1944, for progress in this matter with the medical profession, the Minister, Mr. Willink, referred to the non-commital discussions before the issue of the White Paper and to the series of questions from the medical profession which he had answered since that date. He explained the discussions had had to be deferred pending the Annual Meeting of the British Medical Association. He went on: 'Meanwhile I have studied 'with interest the draft statement of policy recently 'issued by the Council of the British Medical Association 'and there are many detailed points in it on which I should 'welcome some elucidation. In particular, for instance, I 'should be glad to have further explanation of the Council's 'views upon the proposed administrative and consultative 'machinery, both central and local. I am, therefore, 'inviting the Council to send representatives to discuss 'these and other points with me and my officers, in order 'that the ground may be cleared for the general discussions 'which will be opened when the Representative Meeting has 'been held'.[1] Reporting on these meetings to a meeting of the British Medical Association's Council, Dr. Dain, the Chairman, said that during these meetings he had told the Minister he considered it likely that the Representative Body would instruct the Negotiating Committee not to negotiate on anything unless satisfied with the

(1) House of Commons Official Report Vol.401 c1888-9 13.7.44.

administrative structure.[1]

The bar imposed by the Government on travel in the summer of 1944 meant the postponement of any meetings, including the Annual Meeting of the Representative Body until the end of the year. When, at last, they did meet they agreed to set up a Negotiating Committee on the lines proposed in their Committee's Report. The profession were, therefore, then ready to begin negotiations.

Of the other motions carried at this meeting further mention will be made in appropriate chapters, but for the present no better summary of the main spirit of four hectic days in conference can be found than the Chairman, Dr. H.G. Dain's closing remarks. Amid loud cheers he said 'We have 'expressed ourselves in favour of developement of the service. 'We have disapproved of the White Paper as it stands. We 'have decided to negotiate. We have appointed our share 'of the negotiating body. We prefer the service to proceed 'by evolution from the National Health Insurance by first 'the development of the hospital system and then the 'extension of the general practitioner services. We have

(1) Cf. Chadwicke and Lord Morpeth's experience on Public Health Bill, 1848. 'The Lancet welcomed the Bill provided that medical men administered it, but when Morpeth refused to give this assurance, became bitterly hostile. (S.E. Finer "The Life and Time of Sir Edward Chadwicke" p.319 quoting evidence from Lancet Vol.i pp.216 and 269.

'stated emphatically that we do not wish to be employed 'by local authorities, that there should be no civil 'direction, that there should be no whole-time salaried 'service for general practice and that we shall have no 'clinical control. We have instructed our negotiators 'that their first action shall be to try to agree with the 'Government the form of the administrative structure and that 'no action shall be taken in the matter of negotiations 'until the administrative proposals have been agreed'. (1)

To present the other side of the picture the Times newspaper can be quoted 'The British Medical Association 'conference has shown clearly that doctors know very well that they do not want, and that on many matters of administration 'their objections are well founded. But it has not 'revealed at all what doctors do want, except to be left 'alone. From an impressive mass of negative resolutions 'it emerges that only the conference has willed almost all 'the ends and rejected almost all the means'. (2)

It is not fair to the medical profession to say that continued study of the White Paper increased their dislike of and opposition to the White Paper. Showing many changes favourable to their ideas from Mr. Brown's plan, they still found much to criticize and object to in the White Paper.

(1) British Medical Journal 16.12.44.

(2) The Times 9.12.44.

Turning now to consider local authority associations one finds the White Paper doing much to bring home to them the determination of the Government to press on with its plans for a National Health Service, without waiting for an agreed, or, indeed, attempting to impose a plan of reform of local government. The Municipal Journal welcomed the White Paper's proposals as those for a machinery of co-ordination rather than integration of the health services. It felt that local government personnel could have devised better and simpler machinery but it was comforted by the thought that this better structure would come about under the pressure of experience. The Local Government Chronicle was not, on the other hand, quite so content about the White Paper and its proposed National Health Service. In the protestations in the White Paper of the government's wish to 'interfere as little as possible 'with the shape of representative local government' the Chronicle detected a guilty ring. It felt the White Paper to be an attempt to set up regional authorities (anathema to all local authorities) to deal with the medical services and this, it felt was not 'local government nor the 'autunomous administration of local affairs'.

Although, at its meeting on the 29th March, 1944, the Executive Council of the County Councils Association reiterated their belief that the government were going about the matter in the wrong order and that local

government reform should precede the reforms of the White Paper, they were not prepared to recommend opposition to the point of refusing to consider the Government's proposals. After some detailed comments they stated that then a general measure of reform of local government should be agreed these services now to be transferred from them should be returned. Throughout the whole of the four years here considered local authority associations were continually pressing for the reform of local government and when, at this time and again in 1946, it became apparent that this reform was not to come, they refused to consider the schemes for a National Health Services as more than temporary ones pending the reform of local government.

A report of the committees of the Council of the Association of Municipal Corporations on the other hand welcomed the White Paper referring especially to its aims. On some of the methods for achieving those aims the Association withheld its agreement, however, going into some detail, detail which is properly discussed in later chapters.

On the whole one finds the local authority organizations concerning themselves solely with the services they had or were going to have. The few exceptions to this rule include one at this time, when the County Councils Association in its first meeting on the White Paper (1)

(1) 29th March, 1944.

declared that it felt that those able to do so should be required to contribute to the cost of the more expensive appliances, or at least to their replacement or repair. At a later meeting however they amended this opinion saying that payment should be required when replacement or repair of an appliance was due to misuse or negligence on the part of the patient.[1] No reason for this change of view, or indeed, for the original excursion outside strictly local authority matters, has been given.

The latter half of 1944 and the early months of 1945 were, for the Association of Municipal Corporations months of 'arduous and protracted discussions on the National Health Service'[2] but unlike their sister organization, the County Councils Association they have not disclosed the contents or results of those discussions and therefore the remainder of this section, and in parts of later chapters, reference is made to the rural organization alone.

(1) Accepted at a Joint Meeting of the Emergency and Public Health Committees of the Executive Council of the County Councils Ass. on 13.6.44. This motion was never formally accepted by the Council as, at its meeting on 25.10.44, it had read to it a letter from the Ministry of Health offering to discuss alternative proposals (i.e. the revised Willink plan). In the face of this letter the Council decided not to adopt this and other motions on the White Paper.

(2) Annual Report of Council of the Association for 1944.

The appearance of the White Paper was soon followed by the provisional comments thereon of the British Hospitals Association. It subscribed wholeheartedly to the aim of a hospital service available to all regardless of income, as this had already been accepted by the Association as part of its own post-war policy. It felt, however, that the emphasis on a free service might be misleading and that equal prominence should be given to voluntary hospitals and their finances. '.. To ensure that the voluntary hospitals (could) go on 'with their work of treating patients and combining their 'research, the active interest and support of the people 'freely given (would) be more than ever needed'. At a subsequent meeting[(1)] representatives of the Association recorded their full sympathy with the aim of the White Paper and their appreciation of the references therein to the value of the voluntary hospitals but 'viewed with grave 'concern the proposals with regard to administration and 'finance'.[(2)] The financial proposals were inconsistent and unacceptable as affording only part payment towards services rendered and leaving the gap to be filled by voluntary effort, whilst at the same time offering a free service thus discouraging the incentive to contribute to the hospitals. The meeting called on the Government to

(1) Meeting of the British Hospitals Association 7.3.44.

(2) Report of this meeting in 'The Hospital' April 1944.

reconsider its views on these proposals.

After this meeting the Association issued a statement setting out their criticisms of the White Paper and making their own counter proposals. They repeated their criticism of the financial dilemma in which the White Paper placed them; they regarded the effect on contributory and provident schemes as serious, and claimed that the suggested central government payments, took no account of the rising income from such schemes. They added that any proposals for financial help in capital developments must not be such as to place the voluntary hospitals under the direction of local authorities.

Recalling the misleading title to the service, 'free' and the record of the service provided by voluntary hospitals, their statement continued ... 'the voluntary 'hospitals are genuinely anxious to do everything possible 'for the benefit of the patient and to participate in any 'comprehensive health plan designed to this end, provided 'only that the conditions are such as they can accept without detriment to their very existence'.

A word or two here can be devoted to the contributory schemes for whom the White Paper appeared to deal a death blow. Speaking in April, 1944, the President of the British Hospitals Contributory Schemes Association (Sir Bertram Ford) said that to oppose the Government schemes

would be 'futile, undignified and against the interests of 'the country' and went on that what was left for them to do was to see that schemes continued to work well up to the beginning of the new service and then to discover new channels of service beyond that day. This speech did not please delegates at the Association's annual meeting who demanded a special committee with the British Hospitals Association and the British Medical Association to consider constructive proposals for and publicity about their continuance. However, neither of these two organizations felt justified in establishing another committee at that stage, and instead the Association was forced to return to an old theme emphasised many times before. If the contributory schemes were to provide a worthwhile alternative to the Government's plan they must seek the closest cohesion, uniformity of management and complete reciprocity among schemes. Like the voluntary hospitals the contributory schemes tended to be extremely individualistic and local in outlook and their continuance as a possible alternative to the Government's proposals was unlikely without a change of heart.[1]

(1) See A.T. Page 'Pennies for Health' 1949. The story of the British Hospitals Contributory Schemes Association.

The dental, nursing and pharmaceutical organizations had little to say on the subject matter of this section and chapter. Their main interest, quite naturally, was still with 'domestic' problems and in each case lack of information in the White Paper made their task of commenting thereon difficult. The National Association of Local Insurance Committees, on the other hand, welcomed in general terms the White Paper, at the same time regretting their own disappearance. Conclusions of a general nature are hard to find here. Such general reactions to the White Paper as have been quoted all speak of welcoming the aim of the White Paper. Their reactions, beyond that, became at once tinged with their feelings on particular parts of the Paper. It is, however, fair to say that the White Paper was widely welcomed, even if, on occasions, the welcome was spoken with tongue in cheek.

(D) <u>The Revised White Paper (or Willink) Plan, 1945</u>:

This section in each chapter, like its predecessors, will deal similarly with the proposals here headed the revised White Paper plan of the early months of 1945. This plan was a confidential one and the general reactions of the interest groups to it are hard to find.

No public comment is available from the British Medical Association but a confidential document shows the Association welcomed many of the fundamental changes in the plan and they seemed prepared to accept in the main, its

proposals. The Association still, however, had some complaints as will be seen from later chapters.

No views on this Plan were published at the time by the local authority associations but some evidence of their feelings is available. In a memorandum (1) some seven years later they spoke of their preference for this plan and in the discussions with the Minister of the National Health Service Bill both the Association of Municipal Corporations and the County Councils Association expressed a preference (2) for the revised Willink Plan.

The Representative Board of the British Dental Association discussed the plan but its detailed decisions have not been made available. Their Journal was, however, able to make some comments. 'The expressed desire of the 'Minister to compress within a period of a few weeks 'discussion on a matter of such vital importance was (3) 'unanimously deplored, a view which was, indeed, almost 'inevitable when it is remembered that even a year has

(1) See p. 47n.

(2) See p. 210.

(3) The first meeting took place on 14.2.45 and the Board meeting at which this complaint was raised took place on 28.4.45., some ten weeks later.

'has proved inadequate for the complete consideration of 'the medical service proposals. Moreover the unwillingness 'or inability of the Minister to allay the proper 'apprehension of the profession as to its future under a 'scheme which appears calculated to nationalize not only 'dentistry but medicine and nursing did little to create 'the atmosphere of trust and goodwill' essential to fruitful discussion. The Journal, therefore, called on its members to approach all prospective candidates for Parliament with a standardized letter - in all some 1646 dentists obeyed this call.

The general reactions of the interest groups to the political left were unfavourable to the revised White Paper plan. At their 77th Annual Congress Trade Unions called upon the Government 'to stand firm for the full 'operation of the proposals for a National Health Service 'as visualized in the recent White Paper and further to 'extend the proposals by the inclusion of an industrial 'health service.' (1) The Socialist Medical Association summoned a meeting to hear of the 'White Paper in danger'. It pledged its support for the Government if it would implement the White Paper and nothing less. The Labour Party, too, regretted the Minister's contemplation of 'radical alterations in the scheme violating democratic 'principles and sacrificing the health of the people to the 'vested interests of the medical profession' (2) and called

(1) Report of 77th Annual Trades Union Congress at Blackpool 10-14 Sept.1945.

(2) Report of Annual Conference of Labour Party Blackpool 21-25.5.45.

on the Government to implement by legislation 'nothing less 'than the proposals of the White Paper'. At the general election a few months later the Labour Party's Speaker's Handbook reminded election speakers that the party stood for a service comprehensive and complete and available, voluntarily, to all. In his election address Mr. Churchill, om behalf of the Conservative Party also spoke of a comprehensive health service freely available to all.

With the exception therefore of the medical profession and the local authority association the views noted here are generally unfavourable to the revised Willink plan. It should be noted however that many groups, for example the voluntary hospitals have had to be omitted for lack of information.

(E) The National Health Service Bill and Act, 1946:

Chapter by chapter this section will examine the appropriate sections of the National Health Service Bill and Act and any major amendments made to the Bill during its passage through the Parliamentary machine. The views of the groups on the Bill, together with, where known, the amendments they sought will also be given.

The main change to be noted at the beginning of this section was the advent of a new and powerful interest group, the Labour Party. Unlike the parties which had backed the Coalition Government in its attempts to plan a

National Health Service, the Government supporters now had decided views on a service and were committed to a document outlining their views. In such circumstances changes were inevitable, if Mr. Bevan was to carry his supporters with him - but he had also to carry with him as far as possible the other interest groups. Therefore the balance was altered but not completely shattered.

Towards the end of 1945 the ominous silence on the future national health service, led the British Medical Association to remind Mr. Bevan of the existence and purpose of the profession's Negotiating Committee. He, in reply, expressed a willingness to meet this Committee as soon as he was in a position to do so, and meanwhile the Committee felt the need to set out the profession's point of view and once again resorted to a statement of principles, principles which the Medical Practitioners Union dismissed as the 'seven futile clauses' and the Socialist Medical Association described as completely 'unprincipled'. (1)

Meetings between the Minister and the various groups

(1) These principles may be quoted in full:- '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 (2) the medical profession should remain free to exercise the art and science of medicine according to its traditions, standards and knowledge, the individual doctor retaining full responsibility for the care of the patient and freedom of judgment, action, speech and publication

(continued over leaf)...

took place during the early months of 1946. At them the Minister outlined his plan and listened to the views and answered the questions of the various groups. The medical profession were not alone in complaining that the Minister did not negotiate, but only listened. He gave them his proposals but made no attempt to make alterations to meet their point of view. Mr. Bevan, answering these criticisms, said that he or his officials had attended thirty three conferences with various groups on his proposals. (1)

(Footnote continued from previous page) without interference, in his professional work (3) the citizen should be free to choose or change his or her family doctor, to choose, in consultation with his family doctor, the hospital at which he should be treated and free to decide whether he avails himself of the public service or obtains independently the medical treatment he needs: (4) doctors like other workers, should be free to choose the form place and type of work they prefer without governmental or other direction: (5) every registered medical practitioner should be entitled as a right to participate in the public service (6) the hospital service should be planned over natural hospital areas centred on universities in order that these centres of education and research may influence the whole service (7) there should be adequate representation of the medical profession on all administrative bodies associated with the new service in order that doctore may make their contribution to the effiency of the service.' British Medical Journal 15.12.45.

(1) House of Commons Official Report Vol.422c 60ff

He had been ready to consult the various groups, as he indeed had done, but he had not been willing to negotiate with them. 'If there is one thing that will spell the 'death of the House of Commons it is for a Minister to 'negotiate Bills before they are presented to the House'. To do so, he alleged, the Minister must resist amendments in the House if he were to play fair with the groups. Ending, he said, 'the House of Commons is supreme, and the 'House of Commons must assert its supremacy, and not allow 'itself to be dictated to by any body, no matter how 'powerful and how strong it may be'. (1) In this interesting thesis Mr. Bevan suggested no method of distinguishing negotiation from discussion and consultation, a vital weakness in his case if negotiation is to be condemned as such a reprehensible activity.

The National Health Service Bill was introduced to Parliament on March 19th, 1946, and in its next issue the British Medical Journal devoted a leading article to a review of the Bill. (2) It commended to the profession the need

(1) House of Commons Official Report Vol.422 cs 60-1.

(2) Just before the Bill appeared the British Medical Journal of 9.3.46 announced the setting up of an Emergency Guarantee Fund for use should the profession decide not to work in the service. It was said that patients would be treated privately, the Fund being used to support doctors in their work. This Fund seems to deserve the name given it by one paper "crude pressure group stuff" - it was never used however.

for quick clear thinking directing the profession's attention to the all important administrative structure of the new service. Generally the tone of the article was apprehensive rather than condemnatory a feeling which, despite all the brave words, seems to have lasted throughout the period of the Bill's course in Parliament. On the change of ownership of the hospitals the Journal argued that 'it was the first blow that counts and once 'the blow of ownership (was) delivered it would be 'surprising if it were not followed by others, delivered 'at the principle of private and personal responsibility 'for the conduct of professional life'. This first reaction contains the key to all the future reactions of the profession to the Bill - a fear not so much of the contents of the Bill but the possibilities which lay beyond it at some future date - not so much, as quoted above, for the change of ownership, though this was bitterly enough contested, but at what lay beyond it - a state hospital service intruding into professional life. (1)

A later and stronger article complained of misrepresentation of the views of the medical profession in the lay press, and included among the guilty newspapers the Times. Rather plaintively the Journal put forward the

(1) British Medical Journal 30.3.46.

thesis that 'democracy is discussion, and the medical profession wants to discuss these matters before the Bill becomes an Act under the terms of which it will work with reluctance and dissent'. (1)

A letter in the Journal at this time urged that doctors convince themselves that they would fight if necessary. This is, it is suggested, significant of a feeling in the profession at this time, if one can judge from a general reading of the correspondence columns of the British Medical Journal, a feeling that the profession would split or that some part of it would desert and not fight. Two reasons for this feeling may be essayed. In the first place it must be accounted, in some measure, due to the historical fear dating from the passing of the National Health Insurance Act, 1911, when threatened resistance collapsed. The second reason, the main one, was the patent failure to achieve unity on the main issues involved. It is realised that the voting figures of the meetings of the Association appear to gainsay this, but the results of the earlier questionnaire and the tone of many letters in the medical press, not to mention the dissentient medical organizations suggests a large minority with a considerable measure of disagreement over the policy of the leaders of the profession. One must be careful not to attach undue weight to this point, but it is worth some

(1) British Medical Journal 20.4.46.

weight when considering the causes for the failure of the medical profession to affect any real changes in the Bill, for Mr. Bevan seems to have aimed at splitting the profession, hoping thereby to defeat them.(1)

The Special Representative Meeting of the British Medical Association called to consider the Bill, agreed to oppose the Bill not only as unacceptable to the profession but also as constituting strong reasons for advising the public against its acceptance. Dr. Dain, the Chairman of the meeting, said he intended to tell the Minister 'you 'want a good service, we want a good service; you want 'the doctors, we <u>have</u> the doctors'.(2) This ultimatum, howeverm had no apparent effect on the Minister for at a subsequent meeting Dr. Dain predicted that a conflict was inevitable. The Bill's proposals were at odds with the professions point of view on four major points:- no control of doctors with regard to areas in which they practise; no state ownership of hospitals; the continuation of the method of remuneration (i.e. by fixed capitation fee). The administration of the service had largely followed that proposed by Mr. Willink, which the profession had largely accepted.

(1) See pp. 206f

(2) British Medical Journal (Supplement) 11.5.46.

Summing up the position as the Bill left the Commons Dr. Dain said 'The matter is entirely in our own hands. There are no other doctors who are qualified. We 'are in the strongest possible position for ensuring that 'what we think is best for the public will be carried out' (1) Indeed in theory one must accord the professional an ideal position - without their labour and skill the service could not work. The significance of this position is reserved for a later discussion.

This is, perhaps the best point to note a dilemma facing the medical profession and, one imagines, all other groups, too. They had to decide whether to stand completely aloof in an attempt to get all the main points of their case accepted, or, while still heading to these aims, attempt to get the best possible version of the Bill - i.e. by amendment. The profession, if one, may decide by the result of a questionnaire, decided to stand aloof and await the Minister's capitulation. (2) This capitulation, they succeeded in getting, but only on one of the four points outlined above - the remuneration of doctors. It may be that their power of or threat to withhold their skill affected only this point - for the

(1) British Medical Journal (Supplement) 3.8.46.

(2) On the question whether or not to enter into negotiation on the Regulations to be made under the Act 54.5% of those replying favoured not negotiating - a rejection of the service. British Medical Journal 21.12.46.

rest the public would not have sided with them. But these are points beyond the span of this study and must be left to subsequent researches.

The Medical Practitioners Union, found the Bill 'frankly disappointing from the point of view of the 'general practitioner', (1) whilst on the other hand the Socialist Medical Association warmly welcomed the Bill though even here there were some regrets - e.g. at the exclusion of an industrial health service, a regret shared by many groups. (2)

The local authority organizations and voluntary hospitals reacted against the Bill mainly on account of the provisions of the Bill discussed in later chapter. The Association of Municipal Corporations and the County Councils Association expressed a preference for the revised Willink Plan, but the London County Council were prepared

(1) Medical World 29.3.46.

(2) Report submitted to T.U.C. October, 1946.
In a meeting with the Trade Union Congress the Minister announced his intention to tackle an industrial health service as soon as he could, explaining that he had excluded it at that stage for reasons of time and complexity alone.

to accept the Bill. In its welcome to the Bill, the British Dental Journal could not resist a pat on the back for the dental profession who ever since it came into existence had been pressing for the extension of the dental services. 'Almost inch by inch the battle 'against inertia, short-sightedness and false economy 'has been won and it is largely due to the unwearied 'insistence of the profession itself that dental treatment 'has been available for many who were unable to afford 'the ordinary fees of private practitioners'. (1) If one may continue the metaphor, the battle against inertia turned suddenly into a battle against a momentum which threatened to sweep them beyond their objective and into unpleasant realms. The Journal claimed the Bill showed little evidence of the government; recognition of the special position and problems of dentistry - a sentiment shared by all groups if their own profession be inserted in place of 'dentistry' in this sentence.

The Royal College of Nursing welcomed the Bill in an editorial headed 'Your very good health', (2) its whole-hearted welcome was being tinged with but two minor complaints. Pharmacists, on the other hand, were not so

(1) British Dental Journal 5.4.46.

(2) Nursing Times 30.3.46.

enthusiastic, their first major reaction recorded in the editorial columns of the Pharmaceutical Journal[1] being one of regret at the lack of a positive approach to health and to the prevention of disease displayed in the Bill. They went on to make detailed criticisms of parts of the Bill.

As may be expected the Labour Party welcomed the Bill, doing so, however, with some voices raised in criticism. It may well have been that Mr. Bevan had to face even stronger criticism of his proposals in the private party meetings than he did in public parliamentary debate; a review of which shows some of the points on which he was criticized. On the second reading debate Mr. Messer regarded the plan as going too far and Miss Alice Bacon, as not going far enough. Dr. Clitherow opposed the Minister demanding the right of appeal for a convicted doctor to the Courts and not to the Minister. In this, he was supported by Dr. H.B. Morgan one of the Labour members who, in Committee, crossed the floor and voted against the Government on this issue.[2] There were Labour members who opposed private practice, part-private and part-public practice, pay beds in hospitals and the localization

(1) Pharmaceutical Journal 30.3.46.

(2) See p. 371. Appendix on Standing Committee shows the Labour M.Ps. voting against the Government.

of the ambulance service. These were some of the points on which the Government were criticized by their own members, members who, in almost all cases, had special interests in or knowledge of the health service. The 'lay' member, if he can be so called, mainly accepted the Minister's proposals with, perhaps here and there, a regretful glance at the Labour Party's Plan of 1943.

The official reaction of the Conservative Party must be taken to be the amendments moved in the House of Commons rejecting the Bill. That moved on the second reading welcomed the idea of a comprehensive health service, rejecting the methods adopted which '(prejudiced) the 'patient's right to an independent family doctor, which '(retarded) the development of the hospital services by 'destroying local ownership and gravely (menaced) all 'charitable foundations by diverting to purposes other than 'those intended by the donors the trust funds of the 'voluntary hospitals: and which (weakened) the 'responsibility of local authorities without planning the 'health services as a whole'.(1) The party's speakers tended to favour the proposals outlined in the revised Willink Plan, but how far this represented long held views is hard to say. It is indeed interesting to note that at no time does the Conservative Party appear to have published any detailed plam for a National Health Service as did both the Labour and Liberal Parties.(2)

(1) House of Commons Official Report Vol.422 c222.
(2) 'National Service for Health' - Labour Party 1943.
'Health for the People' - " " 1942

Research into Conservative literature of pre-war days shows them proud of the early service but making no mention of any needs for improvement. It may be that they only adopted the idea of a National Health Service when they realised the temper of the electorate or the reason may rather lie in their empirical approach to the problems of Government, an approach opposed to the more dogmatic approach of the Labour Party.

The general reactions to the Bill were, therefore, very varied but on the whole tended to be unfavourable. All paid homage to the aim of the Bill whilst dissenting in many cases from the methods it proposed. The views of the interest groups on these methods is discussed in later chapters.

(F) Conclusions:

The conclusions from this chapter are not of importance. Indeed the general reactions of the groups to any plan as a whole was generally so coloured by its reactions to the parts most intimately affecting them that conclusions are better left to succeeding chapters.

CHAPTER 2.

The Financing of the Service and the Population Coverage.

This and succeeding chapters outline the changes taking place between the Brown and Bevan plans, taking each section of the national health service in turn, attention being paid in this chapter to the proposed population coverage of the new service, and the financing of the service together with the reactions of the groups on these points.

(A) Some Alternatives:

Two main problems had to be solved under the heading of this chapter, both fundamental ones having considerable bearing on the other parts of the service. In the first place the Minister of Health decided the population to be covered freely by the new service. Two separate questions arise here, the date and the extent of any increase in coverage. The Minister had to decide whether changes could be made immediately in the middle of 'total war', or would have to be deferred to a date after the end of the war with, perhaps, a proviso to that date 'when conditions permit'. This particular problem had raised some political controversey when the Beveridge Report was debated in the House of Commons in February 1943 (1) when some members of the House called for its immediate

(1) See pp 31.

implementation. The majority, however, supported the more cautious view of the Government that such a scheme should be implemented as soon as possible after the end of the war. The Minister of Health, thus, had part of his main question solved for him in favour of the implementation of the service after the end of the war, a solution giving him more time to consider the main question, how many people should be able to obtain freely the benefits of the service. There does not seem to have been much doubt that the service should be by and large a free one (1) but there were rather more doubts over who should so benefit by the service. The alternatives before the Minister were theoretically unlimited in number but general agreement limited them to three of four possible choices. The first, never accepted, or, as far as is known, considered by any Minister involved the compulsory coverage of all people, - thereby denying anyone the right to seek treatment outside the scheme. The second alternative again involved total coverage but this time with the right for those who so desired to seek private treatment outside the service, whilst the third would give to those having private treatment the right to be exempt from contributing to the national service, or, of contributing and having a financial grant-in-aid in return for not using

(1) Free, that is, at the time of use

the service. (Any such scheme would have needed a grant in aid system because at no time did the Government announce anything but a total population coverage for the National Insurance benefits and, as a corollary, compulsory contributions from all). The final alternative open to the Government was much canvassed by some groups, notably the medical profession. Known as the 90% scheme, it involved extending the coverage of the National Health Insurance scheme to include the dependents of insured contributors, together with those of like economic status to the insured contributors (i.e. those not insured because they were not employed on a contract of service) and their dependents bringing the total population thereby covered to approximately 90%.[1] The remaining upper-tenth would have to seek private treatment and would be excluded from the benefits of the national health service. Of the groups studied almost all favoured either 100% coverage with a right to private practice or the 90% coverage though it should be noted that the Royal College of Nursing, in a memorandum to the Beveridge Committee[2] had some hesitation over the extension of benefits to the dependents to contributors, a hesitation limited to the timing of such extension.

(1) The upper income limits for the National Health Insurance Service were, at that time, £420 p.a. - see National Health Insurance Act, 1942.
(2) Nursing Times 25.5.43.

A second great question facing the Minister of Health was the financing of a national health service. Five possible sources of income were available, national taxes, local rates, voluntary hospital endowments, contributory schemes (national insurance or voluntary) and the fees of the paying patients and of these taxes, rates and contributions were the most important. All these sources were dependent on decisions covering other parts of the service. If, for example, local government were to play a part, local rates would have to bear some part of the cost subsidized by grants from national taxes. Again, if the voluntary hospitals were to be allowed to continue, a source of income would be their endowments together with the income of voluntary hospital contributory schemes, if allowed to continue. But, if the service were to be linked in some way, however slight, with National Insurance contributions, then all would be entitled to the services of hospitals. (The Government's plans for a comprehensive service, always involved types of treatment) and no apparent place would be left for the contributory schemes. Further combination of these sources of income could be attempted but enough has been said to show that to cut out any one source was to have repercussions in other ways in the service, and vice versa, to make a 100% compulsory service, for example, cut out a source of

income, the paying patients. Whatever decision the Minister took on the financing of the service it was, at once, dependent on and influencing other sections of the plan.

(B) Mr. E. Brown's Plan, 1943:

It was in the first stage of the developmental process that Mr. Brown introduced his plan. The Minister claimed that his plan was put forward only as a basis for discussion, but the little information available on it is not very helpful to the matters studied in this chapter. It proposed a comprehensive health service, which in one service at least, the family doctor service, would be freely available to all. That Mr. Brown envisaged a service open to all with the right to seek private treatment outside the service seems clear from references to the continuance of private practice. He intended to use national taxes, local rates, some contribution from the insurance services although in what proportion is not known. These proposals concerning coverage and finance seem moderate alongside his 'revolutionary' proposals (1) for the general practitioner service.

The general reaction of the medical profession to the plan has been noted in the previous chapter. The Council of the British Medical Association had earlier (2)

(1) See pp 234f
(2) British Medical Journal Supplement 13.2.43.

given a great deal of attention to the problem of the population to be covered by the new service, and had given a hesitant acceptance to the principle of 100% coverage enunciated in the Beveridge Report, recalling at the same time the preference of the Medical Planning Commission[1] for a 90% coverage. They had recommended the Association to co-operate in preparing for the National Health Service on two conditions, firstly that 'the character terms and conditions of the medical service determined by negotiation and agreement with the medical profession' and secondly that provisions were made for those not wanting to avail themselves of the National Health Service to make private arrangements for their medical treatment. Discussing the problem of 100% coverage the British Medical Journal remarked that this was a matter for Parliamentary decision and that it 'would be undemocratic, not to say foolish, for the medical profession to run counter to the rest of the community at a time when it needs all its sympathy and support in what is the gist of the matter namely the determination of the conditions and terms of service"[2]

(1) See pp 62.

(2) British Medical Journal 13.2.43.

At the end of this period of resumed discussion in July 1943 (i.e. after the Brown plan had been discarded)[1] the Representative Committee of the profession felt the need for a statement of fundamental principles. The Council of the British Medical Association, therefore, agreed to recommend to its members fourteen general principles[2] of which one is of immediate importance at this point. This recommended a service freely available to all providing also arrangement was made to enable those who did not wish to accept the free service to seek their treatment privately. In accordance with their normal procedure these recommendations were submitted to the Representative Body of the Association at its Annual Meeting on the 21st, 22nd and 23rd September, 1943. At this meeting, despite the Council's recommendation on the Beveridge Report[3] a motion was carried 'that a comprehensive medical service should be available for all who need it, but it is unnecessary for the State to provide it for those who are willing and able to provide it themselves' - a version of the 90% coverage. The Chairman of the meeting speaking to the motion, said that their 'axiom that a first class medical

(1) The Medical Practitioners Union were unable to draw a line between discussion and negotiation and therefore termed the activities of the profession's Representative Committee 'discussiation'. Medical World 18.6.43.

(2) British Medical Journal 7.8.43.

(3) See pp 117.

'... service should be obtainable by every individual (had been) expanded ...that no one is to pay' - i.e. they had long desired a first class service for all, but not a service freely available to all.(1)

By way of a general conclusion, one finds all except the medical profession who were stung to a rapid and violent reaction, interested still in their own special problems and utilizing the time to formulate their own ideas on a national health service. The reaction of the voluntary hospitals is unknown, but one can be sure that they strongly were opposed to any suggestion of local authority control of their hospitals. The dentists were worrying about their subordinate position, the pharmacists about their future professional status, and the local authorities were speaking in general terms of the need for the reform of local government whilst at the same time not reaching any agreement on the content of such reform. Thus all except the medical profession, and possibly the voluntary hospitals were still concerned with what one may

(1) In a letter printed in the British Medical Journal Supplement 15.1.44 the action of the British Medical Association on the appearance of the White Paper was explained. The Paper would be considered by the Council whose report would be studied by all branches and divisions of the Association before a Special Representative Meeting would be called to consider the Association's policy thereon. A questionnaire on the Paper would be sent to all Doctors. After all this, the negotiations would begin.

with what one may term their domestic problems.

(C) <u>The White Paper (1944)</u>:

The paper spoke of a comprehensive service freely available to all, but it was 'not the wish of the Government to debar anyone who prefers not to avail himself of the public service from obtaining treatment privately ..."(1) The financing of the service would be mainly from rates and taxes, and indeed with the continuation of voluntary hospitals under the same ownership the fees received from paying patients would not directly benefit the National Health Service as in the service which came into being in 1948. In addition a contribution from Insurance funds would be made towards the cost of the service, a sum which Beveridge had recommended should be £40 m. per annum.(2) According to the Appendix E of the White Paper, a rough estimate of the relative shares of the cost of the service to be borne by the various sources, showed the social insurance scheme contributing 27% of the cost, the tax-payer 36.6% and the ratepayer 36.4%(3). It is interesting to compare the figures given in the Appendix for the

(1) Ibid p.34
(2) This figure was included in subsequent plans
(3) According to Lafitte 'Finance Problems' p.98 (The Health Services - Problems I.P.A.(1951)) these percentages in 1948-50 were approximately 4% from the ratepayer, 10% from contributions, 86% from the tax-payer.

public medical services of 1938-9 which show 20% coming from contributions, 6% from the taxpayer and 74% from the ratepayer. Relatively speaking then the burden was to be shifted from the ratepayer to the taxpayer, and from the locality to the nation. On one final point concerning the financial proposals, the Government followed Beveridge in his recommendations that there should be no linking between the Insurance and health schemes - the payment of a lump sum by the Insurance Fund towards the cost of the health service implied no dependence by the individual on his contributions as qualification for the benefit of the health service.

Such were the proposals of the White Paper pertinent to this chapter, and early in May the British Medical Association drew up a Report on them for the next meeting of the Association's Representative Body.(1) It based its decisions on the fullest study of the White Paper and on a series of questions submitted by the profession's Representative Committee to the Minister on doubtful points in the White Paper and the Minister's replies thereto.(2) The questioners sought an assurance

(1) This meeting was planned for July but had to be postponed as had many other meetings at this time, because of a ban on travel imposed by the Government. This Report, therefore, remained only as recommended policy until accepted by the meeting in December 1944.

(2) British Medical Journal 13.5.44.

that the principle of 100% coverage for the health service was dependent on a similar coverage for the insurance services. The Minister gave this assurance adding in his reply that in the event of changes being made in the coverage of the insurance services, the coverage of the health service would be reconsidered. (1)

'In examining or promulgating any plans for a comprehensive medical service the medical profession will resist any control by the state, whether political or administrative, which is inconsistent with their intellectual and professional freedom'. The Council, therefore, refused to accept the principle of 100% coverage until further information should be available on the social security provisions. It was stated that the 100% plan would mean less private practice to the doctors, more of their income from government sources and therefore more government control of the profession, a matter, to them, of some considerable concern.

In the results of the questionnaire, however, 60% of all the doctors answering, approved the principle in the White Paper of a 100% coverage with the right for those who so desired to seek private treatment outside the scheme. At the postponed Annual Meeting of the Representative Body of the Association, despite this result on the questionnaire a motion was carried

(1); In these services the Government accepted 100% coverage - see footnote p. 46.

expressing preference for the 90% coverage. Speaking on another occasion,[1] as if in justification of this refusal to accept the majority view, Dr. Dain, the Chairman of the Association had said that the policy of the Association was made by the Representative Body and not the questionnaire.

The local authority associations, whilst welcoming the White Paper in varying degrees, vouchsafed no comment on this part of the Paper. The British Hospitals Association, on the other hand, welcomed a service available to all regardless of income, claiming that this had been adopted as part of their own post war policy. As already seen they expressed some doubts about the financing of the hospitals, a matter which can best be discussed in a later chapter.[2]

The National Association of Insurance Committees welcomed the White Paper but expressed a preference for the gradual evolution of a National Health Service. They thought the first step should be the extension of the existing service to 90% of the population.

The political parties whilst expressing varying welcomes to the White Paper, accorded a general agreement on the coverage and the major financial proposals

(1) Annual Conference of Local Medical and Panel Committees - Nov. 2nd and 3rd, 1944.

(2) See p. 164.

of the White Paper. The Trades Union Congress, too, accepted this part of the White Paper but insisted that those paying privately for treatment should not thereby be exempt from contributing in the same way as those who participated in the service.

Almost all the groups studied, therefore, have explicitly or implicitly (by default) accepted the ideas here discussed, namely the 100% coverage with a right to seek private treatment outside the service, and the financing of the service mainly from rates, taxes and insurance contributions. The medical profession and the Local Insurance Committees, alone, expressed a public preference for a 90% coverage, although in the case of the medical profession the results of the questionnaire suggest[1] that the leaders of the profession misinterpreted the feelings of their members. This general acceptance (with the two exceptions mentioned) of these points is reflected in the succeeding plans which make no major change on these two important items of a National Health Service.

(D) The Revised White Paper (or Willink) Plan, 1945:

All the changes proposed in this plan fall under the headings of subsequent chapters, and here it but remains to reiterate the proposals of the White Paper

(1) See p. 81f.

carried over into the new plan - i.e. a 100% coverage with the right to seek private treatment outside the servife whilst not thereby gaining exemption from contributing towards the cost of the national service, and the method of financing the service from rates, taxes and insurance contributions.

Amid the many other changes in the plan, the coverage and financing of the service received little attention from the interest groups. The medical profession, however, as a result of their negotiations with the Minister of Health came to realise that it would be 'illogical to try and exclude one tenth of the population',(1) from the benefits of the service. They maintained, at the same time, the importance of private practice arguing that the doctor who received some of his income from private sources was a freer man than one who received all his income from governmental sources. For the medical profession the doctor under government control ceased to serve the patient only and hence ceased to be a good doctor and therefore the doctor with private practice would be a better doctor than his government colleague. They therefore announced that, 'regarding the 100% issue as one for Parliament to decide'

(1) British Medical Journal 12.5.45.

they were 'willing to negotiate terms and conditions for such a 100% service, if such be decided upon, provided that ample safeguards (were) introduced to ensure that any member of the community, whatever his income, should be enabled to obtain his medical services, in part or in whole, privately, as for exampke by grant-in-aid provisions'.[1] Giving way very cautiously on the 100% issue (which had long since been implicitly if not explicitly accepted by Parliament), they now suggested a completely new plan - private treatment made available to all by a method involving an exemption from contributions or a return of contributions paid. The profession had therefore turned away from the upper tenth of the population compelled to seek private treatment to a potentially wider field able to demand private treatment. This repeated stress on private practice laid the profession open to many charges of seeking to preserve selfish money interests and however sincere their motives, undoubtedly did them harm in the public eye.

(1) A resolution recommended by the British Medical Association Council to its Representative Body at its meeting considering the revised Willink Plan. At this meeting this resolution was accepted after an amendment calling for an income limit to the service (the old 90% version) was defeated by 162 to 64.

At the general election a few months later the Labour Party's Speakers Handbook reminded election speakers that the party stood for a service comprehensive and complete and available (voluntarily) to all. In his election address Mr. Churchill on behalf of the Conservative Party, also spoke of a comprehensive health service available to all and towards the cost of which all would contribute. He spoke too of scope for private medical practice, thereby dispelling any notion of a compulsory 100% coverage.

Except for the medical change of heart and the public acceptance by both main parties of the 100% coverage with the right to seek private practice, little can be said in this section. These proposals had been largely agreed in discussions on the White Paper there was little purpose in changing them. The change in medical opinion was, perhaps, due to a realization that a 100% coverage had come to stay, and that therefore a new method of preserving private practice had to be discovered. In such a situation the new medical proposal seems, therefore, the natural one.

(E) The National Health Service Bill and Act, 1946:

Proof that the agreement on the proposals concerning coverage and financing the service, was general is born out, it is suggested, by the fact that they were taken over entirely by Mr. A. Bevan, the Labour Minister of

Health. He followed closely those of his predecessors on the points here studied. The service was to be a comprehensive one freely available to all with the right to seek private treatment outside the scheme but without thereby being excluded from contributing to the cost of the national service. A grant from the Insurance funds together with rates and taxes would provide the finance for the service.

Views on this part of the service are scarce - it was so largely an agreed subject that no groups made any comments thereon. A move to get the British Medical Association to revert to 90% coverage was rejected, and the profession, therefore, accepted the 100% idea calling, at the same time, for a grant-in-aid system. (1)

(F) Conclusions:

The one major conclusion of this chapter is the remarkable degree of agreement on the proposals for financing the service and for the population to be covered, proposals taken in large measure directly from the Beveridge Report. In the face of such general agreement the medical profession could hardly hope to achieve only a 90% coverage and, as already noted, continued emphasis on this point may well have lost them public favour.

(1) See p. 125.

If one may return to the questions posed at the beginning of this chapter, one finds the answer to the question when to increase the population covered, to be always as soon as possible after the war. On the coverage to be afforded, it appears that at no time did any Minister of Health favour other than a 100% coverage with the right to seek private treatment but no right to be exempt from contributing to the national service. On the question, too, of financing the combination of rates, taxes and insurance contributions was always accepted, although the early plan envisaged some contribution from voluntary sources through voluntary hospitals, and Mr. Bevan, some contribution from paying patients in the State's hospitals. But these differences were minor ones in a field of broad agreement.

One is loathe to elevate any part of the National Health Service Act to the status of an end rather than a means to an end. Undoubtedly its main end was the good health of the community as a whole without regard to economic facts, and as such the proposals here discussed, particularly that regarding the population covered, come almost into the category of ends. It may be that this fact accounts for the large measure of agreement thereon, a measure of agreement found in almost no other part of the Service.

CHAPTER 3.

The Central Administration and Advisory Machinery.

In this chapter, using as far as possible the pattern of previous chapters, the development of the central administrative and advisory machinery is considered.

(A) Some Alternatives:

Once again there was, in theory at least, an unlimited number of possible plans which the Government might have adopted for the central administration of the service and for the advisory machinery. Again, however, these alternatives can be limited to a few practical possibilities which can best be discussed under three headings, the degree of central control, the type of central body exercising such control and the advisory machinery to assist that central body, all headings concerning matters of considerable importance to most of the interest groups, though perhaps the most important being the last, the advisory machinery.

The degree of central control can be discussed from two angles - how much power was to be given to the central body over local units and for how much of the civilian health services the central body was to be responsible. By common consent the military, naval and air force medical services were exempted from any such discussions,

this general acceptance being signified in the regular use of the phrase 'civilian health services'. To discuss the second part of the main question first, the contention of many groups (especially the medical profession) was that the central body should have exclusive control of (or be exclusively responsible for) all civilian health services. In 1939 many other government departments had had responsibility for special health services, e.g. the Ministry of Education and the School Medical Service, and the Ministry of Health had had other duties than health services, notably housing and local government matters. Indeed, even in 1946 when the Bill was before Parliament the Conservative member for Pudsey and Otley (Colonel Stoddart Scott) could claim that 17 Government Departments still had their own health schemes and that the Bill made no attempt to co-ordinate them.(1) The Government had therefore to decide whether or not to co-ordinate all these civilian health services under one Ministry, and Colonel Stoddart-Scott's claim shows that by 1946 no attempt had been made in that direction. In fact at no time did the Government attempt a Ministry of Health exclusively concerned with all civilian health services. Mr. Willink (speaking, one feels, for all the Ministries) told the

(1) House of Commons Official Report Vol.422 c 357 - also cf. ibid Vol.390 c 1481-2 - a Ministerial answer setting out the medical staffs of government departments.

medical profession that he would regret any move to limit the duties of his Ministry to civilian health services.(1) This part of the main question was therefore answered in favour of the status quo and was not re-opened in any Government plan despite the views of many of the groups.

The problem of how much power should be given to the central department had a vast range of possible solutions from the extreme of absolute central control to the other extreme of little or no central control. The exact position adopted by any Minister in this wide scale is impossible to plot accurately, and therefore this question must go without detailed answer. Indeed this question is largely ignored as, in no plan, were details given, nor could a satisfactory answer be given but from the experience of the working of the Service.

This question of the degree of central control may have been the first, of those in this chapter, requiring decision or it may have waited upon a decision on the second question - the type of central body. The possible types of central body included a central department on traditional lines with a Minister responsible to Parliament, an idea backed by such groups as the Socialist Medical

(1) British Medical Association document on the revised White Paper plan.

Association and the Society of Medical Officers of Health, a public corporation(1) outside the departmental machine (and here the University Grants Committee and the British Broadcasting Corporation were mentioned as possible models), an idea favoured mainly by the British Medical Association and finally a splintering of such a public corporation into several professional bodies administering separate parts of the health services. On this latter point, one finds almost all the professions favouring separate professional organizations, sometimes as executive bodies and sometimes as advisory bodies. The dental profession spoke of a dental organization, the pharmacists of a pharmaceutical organization and the medical profession of a medical organization though in the latter case they did not favour splintering but sought medical control of all the health services. This repeated claim for separate professional organizations is of particular interest and, it is suggested, is symptomatic of a fairly general professional dislike of 'lay' administration, each profession in turn claiming that the problems of administering its own part of the service could only be understood by a professional as opposed to a lay administrator.

(1) The relation of such a body to local authorities if they were to continue to provide health services does not seem to have been considered by those who proposed such a body.

Such syndicalist or technocratic plans had little hope of success, a fact realised if not admitted by many leaders of the profession, who therefore turned their attention to the advisory machinery.(1) The failure of the advisory machinery of the pre-war Ministry of Health had been established(2) leaving the groups, particularly the medical profession, determined to prevent a recurrence of such failure. The Ministers, with the exception of Mr. Brown, on the other hand, seemed reluctant to strengthen the advisory machinery and many of the concessions seemed to have been wrung from them after much discussion. It may be that the Ministers felt their own professional staff competent to advice them and these officials were jealous of any outside advice reaching the Minister.(3)

Besides deciding on the strength of the advisory machinery, a major problem for the Ministers to solve was the method of obtaining members for these bodies. It was,

(1) There were some 'concessions' - e.g. the Central Medical Board of the White Paper, though exercising powers not pleasing to the profession, was a purely medical body - similarly the Medical Practices Committee of the Bevan Plan.

(2) Advisory Bodies 1919-1939 edited by R.V. Vernon and N. Mansbergh (1940) Chapter by R.N. Spann.

(3) It is interesting to note that the Medical Practitioners Union attributed the disappearance of the Central Medical Board in the revised White Paper plan to the scheming of civil servants against bringing outsiders in. Medical World 4.5.45.

with the apparent exception of Mr. Brown, always the Government's view that the members of these bodies should be experts in their own right rather than representatives of various interests. On this ground, they contended that appointment by the Government was much more likely to secure the best persons than nomination or election by the various groups themselves. For the groups, however, the advisory machinery represented their concession on a desire for separate professional administration and they therefore tended to look on this machinery as a method of maintaining their interests. They were therefore in favour of election or nomination and any move which increased the power of the advisory bodies vis à vis the Government.

(B) Mr. E. Brown's Plan, 1943:

This first Government plan was vague in many respects particularly on the matters pertinent to this chapter. It envisaged responsibility for a comprehensive health service resting on a Ministry of Health responsible through its Minister to Parliament, but it is safe to infer from what is known of the plan that the Minister leaned more towards local autonomy than central control in his new service. The Ministry would be advised on its duties by a predominantly medical body, the Central Medical Services Council; three quarters of this body (which would have the right to issue its own reports) being nominated by the

profession and the remainder by the Minister. In three respects the plans for this body proved unique in that they were never repeated by subsequent Ministers. In the first place a body containing three quarters of its membership in doctors, in the second place the nomination of those members by the profession and finally the right to issue its own Reports: all these matters, in the main acceptable to the groups, were not repeated, later Ministers arguing for an expert advisory body rather than a representative body.(1)

It is perhaps unfortunate that the rest of Mr. Brown's plan caught the eye of the groups, and the medical profession in particular to such a degree that it left them no time to comment on this part of the plan, for their detailed views would have been valuable. In his strong attack on Mr. Brown's plan Dr. Charles Hill(1) made several criticisms among them one against the unreformed central organization of the service. There

(1) The details of Mr. Brown's plan seem to contradict the suggestion made that the Minister's officials were opposed to outside advice. It should, however, be noticed that, all this is put forward only as a suggestion (no definite statement can be made), secondly these 'concessions' might have been deliberate in view of the known antipathy of the medical profession to a salaried service and finally one has only Dr. Charles Hill's word for these points - and indeed it is surprising that these points are not mentioned again by the profession.

(2) British Medical Association Assistant Secretary - speech reported in British Medical Journal 22.5.43.

was to be no bringing together of all civilian health services under one Ministry exclusively concerned with them, as was necessary in a National Health Service. Following this up the British Medical Association's Council laid it down as a general principle that the comprehensive health service should be administered, centrally, by a government department exclusively responsible for all civilian health services, and advised, on medical matters, by a medical committee. This general principle however proved unacceptable to the Association's Annual Meeting which substituted for a central department, a corporate body including, and advised by, representatives of the medical profession. It also added that any such administrative arrangements in the Government plans were to have the approval of the profession before their representatives discussed any other part of the service with the Minister. The profession had come finally and firmly to the paramount importance of an agreed administrative structure.

The British Hospitals Association, representing voluntary hospitals, emphasized the importance of the administrative structure at their Annual Meeting in July, 1943. The Chairman, Sir Bernard Docker said the Association favoured a Central Hospitals Board consisting of equal representation of local authority and voluntary hospitals with a few seats for doctors, the Board's duty

being to advise the Minister on planning and policy, the approval of local schemes and on the allocation of central monies. This Board should have to be consulted by the Minister and should have the right to initiate advice and publish reports. This claim therefore for a separate administration was, at this stage, limited to a central advisory body, albeit a powerful one.

At this meeting Sir Bernard Docker was followed by the Minister of Health, Mr. E. Brown, who spoke of the great history of the voluntary hospitals and of the Government's policy to make full use of them. He claimed that his early meetings with the various groups had only been in the nature of 'thinking aloud in one another's company' and he warned against seeking to safeguard 'particular interests' to such an extent as to render impossible the efficient working of the service. The final success of any plan must depend, he claimed, on the spirit of willing co-operation of all who would work it.

The pharmaceutical organizations[1] spoke of a pharmaceutical service immediately controlled by bodies predominantly pharmaceutical in composition. A Pharmacy Commission should be set up under the Minister of Health,

(1) A memorandum submitted by pharmaceutical organization to the Minister of Health - repeated in Pharmaceutical Journal 17.7.43.

composed of pharmaceutical and medical representatives, with a duty to ensure that an adequate service was available in all areas controlling new entrants by permitting them only to work in areas where there was a real need for their services. Once again the separate professional organization was claimed, although this time the new power of controlling new entrants to the service and the area in which they should practice was added - a power strongly opposed by the medical profession when suggested for doctors.

At about this time, the spring of 1943, the Labour Party issued its plan for a national health service.[1] It envisaged inter alia a central authority, the Ministry of Health, responsible for all civilian health services including the industrial and school medical services. Thus in the light of this plan Mr. Brown did not go far enough, but nor, it may be noted, did Mr. Bevan.

(C) The White Paper, 1944:

In February, 1944 the White Paper outlined a plan for the central administration and advisory machinery having much in common with Mr. Brown's plan. Central

(1) 'A National Service for Health' - Labour Party 1943. The title is an interesting change of the normal wording, bringing out the main aims, a national service for the Health of the people.

responsibility for the proposed service would lie with the Minister of Health responsible in the normal way to Parliament. He would be advised by a statutory body, the Central Health Services Council [1] which whilst primarily medical in composition would include representatives of the hospitals, and the other professions concerned. It would be appointed by the Minister after consultations with those interest groups represented on it, would choose its own Chairman and would be free not only to advise the Minister on his request but also to initiate advice. The Minister would provide it with a secretariat and would report annually to Parliament on its work. It would have the right to appoint specialized sub-committees and co-opt thereto, but all advice would come from and in the name of the Council primarily a medical body.

As remarked earlier in this chapter three points of the Brown plan were unique, three-quarters of a Council as doctors, the nomination of members by the interest groups and the right to publish its own reports. None of these appeared in the Willink White Paper for reasons one

(1) The White Paper also proposed an advisory body at local levels - the Local Health Services Council - see footnote p. 324.

can only assume. As suggested earlier Mr. Willink must have held to the view of these bodies as expert rather than representative bodies, and it may also have been impressed upon him the political dangers of a too powerful advisory body. Whatever the reasons the results were plain enough - the displeasure of the interest groups particularly the medical profession.

Sometime after its issue every doctor received from the British Medical Association a copy of the White Paper,(1) the Association's Council's report thereon, a list of questions submitted by the profession to the Minister on the White Paper and his replies thereto, and a questionnaire. Among the questions to the Minister were ones seeking his reasons for preference of a Government department to a public corporation as the central body and on his views on the Central Health Services Council. The Minister expressed a willingness to discuss election to that Council, publication of its annual report and the appointment of independent secretaries to it (i.e. not members of the Minister's staff). The profession however viewed the existing situation as one for negotiation not discussion, but as the largest organization of the profession, the British

(1) In answer to a Parliamentary question the Minister explained that the cost of these copies of the White Paper (approx. £950) would be borne by the Government. House of Commons Official Report Vol. 399, c 43-4 18.4.44.

Medical Association, had not given power to its representatives to negotiate, the profession had to wait until such power was given.(1)

In its Report on the White Paper the Council of the British Medical Association criticized the continued dispersal of health responsibilities among many Ministries and the continued responsibility of the Ministry of Health for such controversial post war matters as housing. Remarking that advisory bodies were often only facades concealing the true working of an organization, the Council could not accept a Central Health Services Council appointed by the Minister and reporting only through him. It wanted an altogether stronger advisory body.

From criticisms the Report turned to 'Some Positive proposals'; no preference was stated for any type of central body but certain conditions were laid down as constructive proposals for forming such a body. It should be concerned exclusively with all civilian medical functions and advised by a body predominantly medical in composition. This statutory advisory body should play a prominent part, should be elected by the medical profession, and should advise and report on all regulations referred to it. This latter would be affected by a statutory duty laid on the Minister to submit all regulations(2) except those

(1) See p. 88. The British Medical Association meeting had to be postponed until the end of 1944.
(2) cf. National Insurance Act, 1946.

governing the terms and conditions of service of medical practitioners, to the Council. It should be able to initiate advice, publish its own reports, obtain such information from the Minister as it required, have power to appoint committees and co-opt thereto and it should have the power to appoint its own Chairman and independent secretariat. Excluded from its terms of reference would be the terms and conditions of service of medical practitioners which should be agreed by permanent machinery linking the profession and the Ministry for that purpose.

The Medical Practitioners Union, also, felt that the Central Health Services Council should be elected, up to two thirds of its membership, by the Local Health Services Councils which in turn would be elected, up to two thirds of its membership, by the medical profession.

Examining the views of the profession as expressed by its leaders and those expressed by the rank and file through the questionnaire referred to earlier[1] one finds, on the issues of this chapter, a complete sympathy of views, 51% of all doctors felt the central administrative structure of the White Paper to be unsatisfactory to only 35% on the other side, and of those answering 'unsatisfactory' some three fifths favoured, as an alternative, some form of professional control through

(1) See pp 81f

ad hoc boards or committees. In answer to the questions whether the Central Health Services Council should have the right to publish its own annual report and its own advice more than 90% of the profession answered in the affirmative, a striking confirmation of the policy of the profession's leaders.

The postponed meeting of the Annual Conference of Local Medical and Panel Committees (i.e. the professional committees of the National Health Insurance system) in November, 1944, had before it a motion that the profession was 'willing to discuss the White Paper provided' that it was 'assured of an adequate share in the organization and control of the medical service". (1) This was significantly amended to substitute the word 'predominant' for 'adequate': the conference wanted the profession to have the largest voice in the control of the new service. It also agreed that the acceptance of the administrative structure must precede any discussion on the rest of the service - this, it was hoped, would prove a 'big stick' with which to intimidate any Government. A few weeks later the Representative Body of the British Medical Association followed suit: 'that without prejudice to other issues the consideration of the administrative structure, central and local, should precede consideration of all other questions and that agreement on this subject is an essential

(1) British Medical Journal Supplement 11.11.44.

' ...prerequisite to discussion on other subjects'[1].
The Representative Body also called for elected medical representatives at all levels of administration, seeking thereby to ensure that the medical point of view be put at all levels of administration by those whom the profession wanted as spokesmen.

The Lancet was cautious in its appraisal of the motions accepted by this Body, suggesting, that the claim for a predominant share in the organization and control of the new service was, at its face value, open to public ridicule. Such comments, however, did not deter the Association in its policy for it immediately began, through the profession's negotiating committee, to negotiate with the Minister on the administrative structure aiming at a corporate body instead of a Ministry and a much more powerful version of the advisory machinery.

As is shown in a later chapter the local authority organizations on the other hand kept mainly to the local government proposals of the White Paper, only one resolution on the matter of this chapter being passed.
In this[2] the County Councils Association accepted without

(1) British Medical Journal Supplement 16.12.44.

(2) County Councils Association Gazette August 1944 - a meeting of Committees of the Executive Council 13.6.44.

any suggested alterations the proposed advisory machinery, but beyond that it did not go.

In a statement on the White Paper the British Hospitals Association spoke of three fundamental principles in any comprehensive service (1) and of these the second claimed that the administrative structure must afford a real and effective share at each level for voluntary hospitals in the planning of the hospitals services. The Association went on to complain, in company with other groups, of the negligible representation afforded them on the Central Health Services Council. They argued that the White Paper inadequately recognized the complexity of hospital administration and called for the setting up of a Central Hospitals Advisory Board with lay and medical representatives of local authority and voluntary hospitals and with representatives of the ancillary interests, all representatives nominated by the bodies concerned. This Board should be linked with the other central bodies of the service and should be free to publish its own Report. In a later report, towards the end of 1944, the British Hospitals Association came out in favour of a Central Hospital Board, with regional and local counterparts to administerrather than advise on, the hospital services, though no change of ownership was implied in this plan.

(1) British Medical Journal Supplement 26.8.44.

At the same time the King Edwards Hospital Fund for London[1] presented a similar plan with a Central Hospital Board, a consultative and executive body on the lines of the University Grants Committee, which would distribute, by way of block grants, central government monies for the hospital service. These block grants would go to Regional Hospital Councils equally representative of voluntary and local authority hospitals. In both these plans the voluntary hospitals had swing across to the idea of a separate 'professional' administration - a process which in their case took in the intermediate stage of a specialised advisory body.

Turning to the dental organizations, one finds the British Dental Association discussing dental problems and the White Paper in a memorandum to the Teviot Committee.[2] The Association accepted the idea of the Central Health Services Council provided there were directly elected representatives of the dental profession thereon and on a sub-committee which should be set up entirely of elected dentists to consider dental matters. Like the other groups here noted they called for the Council to have the right to publish its own reports. The Association asserted that the administration of the dental services should be in the hands of a Central Dental Board with a series of local

(1) Representing voluntary hospitals in London.

(2) See p. 279.

committees, all of which should be mainly composed of mmembers of the dental profession (a term seemingly preferred in the dental press to the term 'dentists'). In so doing they followed their sister professions in calling for a stronger Central Health Services Council and a separate professional administration. It is interesting to observe the Teviot Committee in its Interim Report largely backing up the British Dental Association's case saying that full use should be made of dental advice in planning and administration of the service and adding that dentists should be under contract to a dental body.

The Royal College of Nursing joined in the crusade for separate advisory machinery calling for an Advisory Council on Nursing and Midwifery with representation on the Central Health Services Council. This suggestion was contained in a memorandum (1) on the White Paper which the Royal College submitted to the Minister. Before doing so it was discussed at a meeting of members of the Royal College, where the suggestion that members of the Council elect was rejected. It was pointed out in the discussion that such a system would result in most of the nursing representatives being assistant or trainee nurses, the largest section of the profession. A second reason was given following on from this, that therefore election did not necessarily secure the best type of person for the job. Such a viewpoint was unique among the interest groups at

(1) Nursing Times 11.11.44.

this time.

Once again one finds another profession calling for a separate organization for its part of the service but this time with a difference. Pharmaceutical organizations claimed that the grounds used by the Government in justifying a Central Medical Board for controlling the distribution of doctors were similar to those for a Central Pharmacy Board which the Government had rejected. They called for a Board to control the distribution of pharmacists to prevent areas becoming so full of pharmacists that it became impossible for any individual pharmacist to be employed full-time on pharmaceutical duties. It was pointed out that such a situation existed under the pre-war system and pharmacists were forced to keep chemists shops and act as little more than specialised shop keepers, a fact damaging to their claims of professional status.

At the risk of dull repetition one further profession must be added to the list of those opting for separate organizations. This time it is the opticians who, in comments on the White Paper, called for the setting up of a Central Optical Board, an executive body responsible of the Minister of Health. Opticians followed pharmacists in desiring of the central body some form of control of the distribution of practitioners and in this case also the

maintenance of a register of duly qualified opticians. This Board should be represented on the Central Health Services Council. It should perhaps be added that opticians lacked any state register of properly qualified persons and were therefore seeking this step as one on the road to full professional status.

One hardly dares to repeat the main claims of the groups at this time. In no other part of the health services were the claims so insistent and so similar - a stronger advisory machinery and separate professional organizations. Undue concessions on the latter point would have split the administration of the health service into a series of vertical watertight units and all hopes of a co-ordinated service would have gone. On the other point, the advisory machinery, the Minister could, however, if he wished, make concessions without materially affecting the outcome of his plans. Mr. Willink's attempts in this direction must now be reviewed.

(D) The Revised White Paper (or Willink) Plan 1945:

After many months of negotiation (or discussion) a confidential plan (1) was discussed by several of the groups with the Minister. In this plan several changes were made in the White Paper proposals for the advisory machinery, (2)

(1) See pp 47f

(2) The local advisory machinery is discussed on pp. 140.

the central administrative body remaining as the Minister of Health responsible in the normal constitutional way to Parliament. He would be advised by a statutory body, the Central Health Services Council whose duty it would be to provide expert advice and, where appropriate, to initiate advice. It would be representative of the main professional viewpoints, with a majority being members of the medical profession.(1) To assist the Council in this work, a number of Standing Advisory Committees would be appointed, two statutorily, and the rest after consultation between the Minister and the Council. The two statutory committees would be one on medical matters and one on hospitals. All advice given by these standing advisory committees would be sent to the Central Health Services Council as well as to the Minister, to whom the Committees would have direct access. The Council would be empowered to inform the Minister of a desire to review any such advice and the action proposed on such advice would be postponed pending the receipt by the Minister of the Council's views thereon. The Council and its Committees

(1) The proposed membership of the Council was 37: Medical 19 (including 6 ex-officio - a means of allowing certain members to be nominated by the profession) Voluntary hospitals 5; Local authorities 5; Nursing 2; Dentists 3; Midwives 1 and pharmacists 2. Under the 1946 Act the total was increased to 41 by the addition of 2 medical representatives and 2 lay representatives of the mental health services - except that the vol. hospitals representatives became hospital representatives no other change was made.

would be appointed by the Minister after consultation with representative bodies and a statutory enactment would give six ex-officio seats on the Council to the Presidents of the Royal Colleges and other medical bodies. The Council would be free to appoint its own chairman and would appoint one of two joint secretaries, the other being appointed by the Minister. The Minister would be required to consult the Council in framing all regulations under a National Health Service Act.(1) The Council would be under a statutory duty to report annually to the Minister who would, in turn, be under a similar duty to lay it before Parliament with his comments, unless publication of the report or any part of it were not in the public interest.

Mr. Willink had thus done much to strengthen the advisory machinery and by the introduction of the semi-independent Standing Advisory Committees had compromised with many of the groups' calls for separate professional organizations. It should be noted, however, that the Council, with its medical majority, had a strong position, vis a vis the Committees: the Council had the power of holding up, if not of vetoing, the advice of the Committees. The Minister had evolved a compromise between the medical demands for a predominant part and the other professions desire to be separate. The plan appeared only shortly before the general election in the

(1) cf. s77 of National Insurance Act, 1946.

summer of 1945 and little time was left the groups to comment on it and, in fact, detailed comments on it are hard to find owing to this time factor and to the secrecy which surrounded the whole episode - a secrecy which it has been impossible to disperse completely.

The British Medical Association's Representative Body was summoned to a special meeting on 3rd and 4th May, 1945, to discuss these proposals and welcomed, along the 'fundamental changes', the proposals concerning the Central Health Services Council. They were not however completely satisfied: the Ministry of Health must be exclusively concerned with all civilian health services. A move to insert a call for a corporate body in place of the central ministry was successfully resisted by Dr.Dain (Chairman) on the grounds that the profession was in a much stronger position in relation to the Minister and the Government than it would be if 'five medical despots' were in control. Numerous minor amendments sought to limit the powers of the Standing Advisory Committees and bring them under the control of the Council, (with its medical majority) by, in particular, claiming that the personnel, terms of reference and right to report directly to the Minister of the Committees should all depend on the Council. In other words they still demanded full control of the advisory machinery which the compromises of this plan suggested they might be in some danger of losing.

Dr. Dain resisted attempts to seek election to the Central Health Services Council saying that they had been told by the General Council of the Trade Unions Congress(1) that the present method was as far as any Minister could be expected to go and that they (the General Council) had found this method worked alright. On the right of the Central Health Services Council to publish its Reports, Dr. Dain said the new proposals were a great advance and all that could be hoped for.

Dental organizations seemed prepared to accept most of Mr. Willink's proposals enumerated in this section. They did, however, call for a Statutory Standing Advisory Committee on Dentistry and for increased representation on the Central Health Services Council. Pharmacists, too, asked for increased representation on the Council, one member claiming that they should be accorded equality with the medical profession i.e. 19 seats. Replying to this suggestion, Mr. (now Sir Hugh) Linstead, Secretary of the Pharmaceutical Society of Great Britain, said that the most they could hope for was 3 members - it seemed natural to balance pharmacists with dentists(2). At the same meeting

(1) Dr. Dain has told me that representatives of The British Medical Association met with the General Council of the Trades Union Congress on several occasions. No reference to these meetings has been found in the medical press.

(2) One wonders why it should seem natural to balance dentists and pharmacists.

the Chairman when moving a resolution accepting a Standing Advisory Committee on Pharmacy told the assembled pharmacists that the Minister had asked them not to press for a Pharmacy Board, and that the Committee was the Minister's attempt to replace it. The Committee would have a majority of pharmacists on it and would be appointed, the Chairman explaining that he agreed election did not always get the best men for this type of position.

The General Council of the Trade Unions Congress on the other hand could not accept the proposed Central Health Services Council which would have a medical majority whilst at the same time there was to be a Standing Medical Advisory Committee. They felt that doctors should have fewer representatives on the Council and that their places should be taken by other grades of health workers.

What is most interesting in this section is the general acceptance of the main outlines (1) and many of the details. None of the objections discussed above can be called major ones the main bone of contention being the exact representation to be afforded to each group. In such a situation it appears that the Minister had reached a satisfactory balance between the various interest groups.

(1) It is known that the British Hospitals Association accepted the administrative proposals in general at a Council Meeting in March, 1945.

(E) The National Health Service Bill and Act, 1946:

The National Health Service Act, 1946, takes over almost exactly the proposals of Mr. Willink just examined, except that the balance of power was tilted away from the Council towards the Committees.

The Bill set out that the Minister would be advised, in his duties to promote the establishment of a comprehensive health service, by a Central Health Services Council representative of the various professions concerned. It would be appointed by the Minister after consultation with the groups, it would be free to advise the Minister both on his request and on its own initiative,(1) and it would report annually to the Minister who would lay the report before Parliament with his comments (unless publication of the report or any part of it were contrary to the public interest). The Minister was empowered to appoint Standing Advisory Committees on special aspects of the service, such committees, none of which were statutorily defined, would have direct access to the Minister and to the Council. Amendments to the Bill accepted in Parliament had the effect of compelling the Standing Advisory Committees to submit copies of their reports to the Minister to the

(1) The power, suggested by Mr. Willink, to advise on all regulations was dropped - a decision due, perhaps, to a realization of the contentiousness of many of those regulations which would have to be previously discussed with the groups - e.g. on doctor's remuneration.

Central Health Services Council who would have the right to comment thereon to the Minister; and the Minister was put under an obligation to consult the Council before he decided that the publication of their report or any part of it was not in the public interest. The central administrative machinery remained unaltered - a central department, the Ministry of Health, responsible through its Minister to Parliament for the promotion of a National Health Service but not exclusively for all civilian health services. The refusal of successive Ministers to accept these latter ideas may in some measure have been due to the dreams of political glory awaiting the energetic solver of the housing problems.

The seven 'principles' which the negotiating committee of the medical profession laid down have already been noted, but one, the seventh, may be repeated here. It read 'there should be adequate representation of the medical profession on all administrative bodies associated with the new service, in order that doctors may make their contribution to the efficiency of the service'.(1) In the light of this principle the medical profession turned to examine the relevant proposals of the Bill.

The British Medical Association's Council, reporting on the Bill, recommended two changes in the advisory machinery: firstly that the medical members of the Central

(1) See pp 100-1n.

Health Services Council, in addition to the ex-officio members, should be appointed only if acceptable to the profession and the Minister and secondly that the Council should have the power to appoint and determine the terms of reference of the Standing Advisory Committees which should report to it directly and only in special cases to the Minister. Once again the profession# used the two pronged attack to get the 'right' people on the Council and to maintain the medical control. Undoubtedly Mr. Bevan's Bill gave less power to the Council over the Committees than had been done in the previous plan though the amendments mentioned above helped to redress the balance slightly. (The other groups had, in this matter, been successful in the face of medical opposition). On the other hand, compared with other parts of the Bill, this part must have seemed 'just what the doctors ordered'.

For the other groups the main reactions can be summarized under two headings. The first of these were some expressions of regret at the disappearance (or rather non-acceptance) of separate professional organizations. Just before the Bill appeared the British Dental Association put forward a new plan for a separate dental administration under a Central Dental Board - a last minute attempt to sway the Minister's decision. About the same time, also, the British Hospitals Association brought out a plan, the main content of which is reserved for the next

chapter, suggesting an executive Central Hospitals Board to organize the hospital services. This latter plan shows obvious signs of attempting to compromise with Mr. Bevan's ideas which representatives of the Association had heard in confidential discussions earlier in the year. Both bodies had a final fling to get separate administrations and had, at last, to admit defeat. The Pharmaceutical Society abandoned with regret its ideas of a controlling body for the pharmaceutical service after discussing the matter with the Minister. Too many pharmacists was not a matter calling for central control to protect the patient in the same way as too few, or too badly distributed doctors were.

The second main reaction to this part of the Bill was that of seeking increased representation on the Central Health Services Council and statutory authority for Standing Advisory Committees. Attempts were made in Parliament to secure additions to the numbers of ex-officio seats for the Chairman of the Dental Board[1], the President of the Pharmaceutical Society[2], the Chairman of the Association of Municipal Corporations and of the County Councils Association[3] as well as some attempts

(1) Captain Baird - Standing Committee Official Report 2.7.46 c.952f also raised in the House of Lords by Lord Teviot.

(2) Ibid

(3) Ibid

to increase the representation e.g. the pharmacists claimed equality with the dentists.(1)

Throughout all the discussion on the Bill the Minister refused to alter the balance of representation, begging the Standing Committee not to allow 'auctioning of seats on this Council'. The only changes he did accept were ones moved by the Opposition making it impossible for the ten members representing local authorities and hospitals to be doctors. It was remarked that it should be impossible for the medical majority to be further increased through these categories.

Mr. Bevan, like Mr. Willink, had reached a balance which he refused to alter - a balance very like that of Mr. Willink's. The reasons for the exact choice of numbers are hard to find; there are, however, two clues. The first, to the medical majority, shows Mr. Bevan explaining this majority in these terms: 'considering the doctor in the abstract, he is the person who, in himself, sums up all the various health services, and therefore he has a different relationship to the health services as a whole'.(2) The other clue has already been noted - the shortage of dentists and the relative abundance of pharmacists was given as the excuse for giving more seats to the former

(1) Ibid 3.7.46 c.1006 When asked why he had agreed to three dentists being on executive councils and only two pharmacists, the Minister replied 'We are more short of dentists than we are of pharmacists"

(2) Standing Committee Official Report 2.7.46. c955

than to the latter [1], a concession in terms of the power of the applicants.

The other amendments to the Bill on the matter of this chapter have already been noted, but it is interesting to see how far these amendments were in accord with the wishes of the groups. They have the common aim of strengthening Council in relation to the Committees and the Minister. Undoubtedly all groups welcomed the amendment compelling the Minister to consult the Council before deciding not to publish its Report or any part of it, as it strengthened their position very slightly. The other amendment which gave the Council the right to receive and comment on the reports of the Committees to the Minister can not have been so well received in the smaller groups as it was in the medical profession. No group, except the Trade Unions Congress [2] publicly complained at the medical majority on the Council but it seems fair to assume that some of them, e.g. the dentists and opticians, might have felt nervous about it. The Standing Advisory Committees were the escape from the medical majority and if they were to be brought under the Council's control that escape had gone. [3] That escape was kept open

(1) See p. 160n.
(2) See pp 155.
(3) It is interesting to observe that on the topic of Executive Councils where dental representatives were three out of twenty-five, the profession asked the individual dentists 'Is it likely your voice will be heard in this cacophony' B.D.J. 2.8.46. How much smaller the dental voice in the Central Health Services Council when only three out of 41.

though the amendments tended towards shutting it off.

(F) Conclusions:

As stated at the beginning of this chapter the question of the degree of central control envisaged has had to go largely unanswered for lack of evidence. Such evidence as is available shows all the Ministers taking up a position between the extremes of central control and local autonomy. The final position adopted by Mr. Bevan can only be safely stated by an examination of the Service in action, a task which is outside the scope of this study. From a study of the Act alone, Mr. Bevan's exact position is hard to find - so much detail is left to his regulations that one could argue, as did the Opposition, of a highly centralized service, or of a decentralized service as Mr. Bevan himself claimed as his intentions.

The question of what kind of central body should be used was never in doubt - the Government plans throughout the period spoke only of a government department, the Ministry of Health. Nor too were there ever any suggestions of a Ministry exclusively concerned with all civilians health services, for no doubt all Ministers felt with Mr. Willink when he said he would regret any attempt to limit the powers of the Ministry.[1]

(1) See p. 132.

Of the three questions set out at the beginning of this chapter only one proved a ground for discussion and compromise. The compromise was one which took in the second question mentioned above - i.e. the compromises on the advisory machinery were in lieu of any compromise on separate professional administrative structures. It is, then, in the realms of advisory machinery, that one sees the various Ministers seeking to balance the various interests, using one suspects, the promises of strong and effective machinery as a consolation prize to the groups unsuccessful in other ways. One is therefore left with the interesting problem of the consolation prize, was it a prize of real value or was it once again the sham of the pre-war years, a problem to which only a serious study of the Service would provide an answer.

CHAPTER 4.

The Hospital and Specialist Services

Leaving altogether the central administrative arrangements, the next task is to survey the development of plans for the hospital and specialist services, plans which, unlike those so far considered, bring in the element of a new national service with no previous structure or experience on which to build except the war time emergency medical service. The fact of a new service offers at once, more scope for experimenting and for difference of opinion, for none could claim the experience of a well tried system that had worked well before.

(A) Some Alternatives:

Undoubtedly the major weakness of the National Health Insurance system was the exclusion of hospital and specialist treatment from its benefits, but setting that on one side and turning to the hospital services themselves one must reiterate the three main weaknesses found by the hospital surveys.[1] These were the lack of, or maldistribution of hospital beds, the maldistribution of doctors and the lack of co-ordination both within and between the two types of hospital. Any national hospital service must, therefore, seek to increase and/or

(1) See pp 33 & 38.

redistribute hospital beds and doctors and to achieve co-ordination among the various hospitals.

The first two problems of increasing the numbers of beds and doctors are not specifically dealt with in the Act; both were problems for solution by other than legislative means. Two main problems faced the Government once it had been decided in 1941 to affect some reorganisation of the hospital services (1) and once it had decided in 1943 to accept the Beveridge Report and his Assumption of a comprehensive health service. (2)

The first main problem facing the Government was whether to aim for a co-ordinated or a unified hospital service, in other words, a continuance of the dual provision of hospitals or some change of ownership. If the former aim was adopted, the main problem became to achieve a suitable measure of co-ordination between the two types of hospital, voluntary and local authority, to

(1) House of Commons Official Report Vol.374 c.1116-1120 9.10.41. In the course of his statement Mr. Brown, the Minister of Health, said a reorganisation of the hospital service must precede any wider scheme of a national health service.

(2) Such a service was to include a hospital and specialist service available for all and therefore the Government had to be in a position to guarantee this service to those who needed it.

ensure adequate provision of all types of treatment without wasteful duplication. To do this several further problems had to be solved and of these perhaps the most delicate was the composition of the co-ordinating body. It could perhaps be based on a system of proportional representation in relation to the number of beds provided by the two types: this would mean, in most areas, a large majority for local authority hospital representatives and would be strongly attacked by the voluntary hospitals. Another alternative, the equal representation of the two types was not favoured by the local authorities particularly when suggestions were made for also including medical representatives who, generally speaking, favoured voluntary hospitals to local authority hospitals(1). It was recognized, too, that local authority and voluntary hospitals would need government financial assistance and Ministers were faced with the problem of how best to administer such assistance. Grants could be paid on a work done basis or on some other basis, e.g. beds kept ready and staffed for the national service - a problem mainly technical in its aspects and subordinate to the method of paying these grants. They could be paid directly from the central government to the hospital authorities or via the local authorities, the co-ordinating body or a central version

(1) Most of doctors had, of course, received their training in voluntary hospitals.

of the University Grants Committee. Whatever method was adopted the Government could be certain of voluntary hospital opposition if there was the slightest suggestion of local authority control over these grants.

These then were some of the problems facing the co-ordinator, problems which largely disappeared in a unified service (i.e. involving a change of ownership of one or both types of hospital). These problems, therefore, were very real for Mr. Brown and Mr. Willink, but largely disappeared for Mr. Bevan once he decided on a unified service.

The second main problem facing the planner of a national hospital service was common to the would-be co-ordinator and the would-be unifier though infinitely more difficult for the former. This problem concerned the best area for the administration of the service - local, regional or central. Some authorities on hospital reorganization (e.g. Nuffield Provincial Hospitals Trust) had long favoured regionalization of the hospital system based on 'natural hospital areas' with teaching hospitals as the focus of each region.[1] It was felt that in this way the benefits of the research and the specialized staff

(1) In his original statement on hospitals on October 9th, 1941, Mr. Brown had spoken of wider areas than those of existing local authorities.

of the teaching hospital would be made available over wider areas than before, raising the general level of hospital provision and benefitting ordinary and teaching hospitals alike.[1] In a unified service such a solution was relatively easy to achieve but in a co-ordinated service a great obstacle stood in the way; the local government structure did not easily admit of regionalization and pending a reform of that system, some special structure would have to be erected on the existing structure to attain the generally accepted benefits of organization over wider areas than those of existing local authorities. It was on this problem that Mr. Willink found some of his greatest difficulties.

One other solution was theoretically open to any Minister - to leave things as they were, but in the face of strong pressure for improvement, and in the face of the damning evidence of the hospital surveys, no Minister would have dared to adopt that course, and indeed by the time this study opens the Government were already pledged to a national hospital service.[2]

(1) The term 'teaching hospitals' is used throughout to mean hospitals whose main function was the training of medical students, and as such they were, in most cases, linked with University Medical Schools.

(2) See p. 38.

(B) Mr. E. Brown's Plan, 1943:

This plan went into little detail setting out the barest outline of a structure, the hospital and specialist services part of the plan being no exception. Mr. Brown envisaged the establishment of Joint Health Boards with precepting powers on constituent local authorities to achieve the linking of personal, environmental and institutional services. In so doing he brought forward the only government plan to link all health services in an area under one body. Conflicting interests were to make such a solution untenable for later Ministers and Mr. Brown's attempt at a unified local health administration stands as a relic of the incompatibility of administrative tidiness and the views of the various interest groups. Mr. Willink endeavoured to maintain the idea of unification through an area plan administered by different bodies, but Mr. Bevan seems to have abandoned any attempt at all at unification setting up three completely separate administrative structures for the three parts of the service.

Mr. Brown's Joint Boards were acknowledged to be temporary expedients pending the reform of local government when, no doubt he visualized a new type of local authority being responsible, inter alia, for all the local health services. At a meeting of the County Councils Association Mr. Brown said that it 'was because of their

'... recognition of this principle (i.e. that as a public service, the national health service should be subject to public control) ... that the Government (looked) to local government to take up this new duty'[1] Voluntary hospitals were to be allowed to continue though no evidence is available of the conditions of their survival or participation in the national service; Mr. Brown had spoken of the great history of the voluntary hospitals and of their great service, adding that the Government intended to make full use of them.[2] All that is known therefore of this plan is the salient features, a form of local authority over wider areas with joint boards,[3] pending the necessary reform of local government, and the continuance of the voluntary hospitals, or, in other words, a co-ordinated hospital service over regional areas.

The medical profession rejected outright the Brown plan as providing an unfruitful basis for discussion[4]. Their views on the proposals for the hospital service are,

(1) Annual Meeting of the County Councils Association 14.4.43 reported in the County Councils Association Official Gazette May, 1943.

(2) Annual Meeting of the British Hospitals Association 22.7.43 reported in 'the Hospital' August 1943.

(3) Mr. Brown was reported to be considering professional representation on this Board.

(4) See pp. 42.

however, not known in detail, for one can only assume that they were so perturbed at the proposals for a salaried medical service included in the plan that they were unable to discuss the other parts of the plan.

For local authority organizations the material of this chapter came very near home and they soon expressed their views on the Government's proposals, the secrecy of which they regarded as unlikely to facilitate any real progress. At a meeting of representatives of County Councils the 'customary' resolution calling for local government reform first and then the reform of the services of local government, was followed by one which, in its preamble recognized the need for areas wider than existing local authorities to run hospital services and went on that they were 'prepared to accept, in cases of proved need, the establishment of joint committees of county and county borough councils with precepting powers'. They could not, however, agree to counties and county boroughs being deprived of their domiciliary services, although they recognised the need for effective liaison between institutional and domiciliary health services. This acceptance of joint committees was conditional upon these committees 'being required to submit to the appointing councils an annual report of their proceedings and also triennial estimates of their capital and revenue expenditure for approval, with provision for the settlement

'... of any financial disputes by the Minister of Health, and also to arrangements being made for such committees to be staffed by the chief officers of the councils concerned'[(1)] The County Councils Association were joined by their urban colleagues of the Association of Municipal Corporations in their protest against the government's refusal to reform local government first. The latter Association, however, vouchsafed no comment on the details of the plan itself.

Like the local authority organizations, the voluntary hospitals were vitally affected by this part of the plan, however vague it might have seemed. No evidence is available of what comments were contained in a confidential memorandum submitted by the British Hospitals Association to the Minister on his proposals, but one can guess much of its content from the remarks of the Association's Chairman, Sir Bernard Docker, at the Annual Meeting of the Association in July, 1943. He summed up the general principles which had guided the Association's Council in meetings with the Minister, saying: 'Voluntary hospitals in the public interest, we suggest, must be 'preserved as an essential factor in the planning of a 'national health and hospital service. To this end 'individual hospitals must retain their freedom and 'flexibility in the administration of their own affairs 'and the appointment of their own staffs. The patient

(1) Municipal Journal 27.8.43.

'... must be free to choose not only his doctor, but to 'choose also, his hospital subject only to the adequacy 'and availability of the service at the hospital of his 'choice. Lastly, we attach the highest importance to 'the nature of the payments and the methods by which 'such payments should be made, in respect of any services 'rendered by the voluntary hospitals either to the 'Government or to the local authorities in the carrying 'out of the plan ...' [1] He, Sir Bernard, did not dispute that local authorities might have to have the duty of seeing that facilities were available but he could not agree to them having the duty to <u>provide</u> all the facilities. [2] Machinery should be set up to enable voluntary hospitals to take a proper share in the formulation of policy and to make available to local authorities the practical experience of voluntary hospitals. To advise local health authorities, local versions of the Central Hospitals Board [3] would be required with a right of appeal to the Central Board in cases of dispute with the local health authority. The finance of the scheme must be

(3) See pp. 146 for discussion of administrative proposals of the Association.

(2) British Hospitals Association Council on 23.3.43 had agreed 'that in the event of the Minister of Health's proposals involving the handing over of the control of the .... hospital services of the county to local authorities, this Association will be definitely opposed to such proposals ...' quoted in House of Lords Debate Vol.127 1.6.43.

(1) 'The Hospital' August 1943.

such as not to discourage private charity and should be to voluntary and local authority hospitals alike, a payment for services rendered.

The voluntary hospitals had, therefore, implicitly rejected Mr. Brown's proposals and put forward their own involving separate advisory machinery for the hospital services. In the autumn of 1943 the British Hospitals Association reiterated its views in a pamphlet entitled 'Eight Hundred years of Service'. It examined in glowing terms the long history of this great humanitarian movement, and told of the growth of contributory schemes, whose aims were 'to encourage a sense of civic responsibility and to 'fill a gap in the income of voluntary hospitals'.

The future of the hospitals service lay, according to this pamphlet, in the partnership of local authority and voluntary hospitals. The voluntary hospitals could 'see the best results coming from their collaboration as 'active members, in all plans for improved hospital services 'which preserve that free development which has been the 'mainspring of their service to the community'. The Association was anxious to see existing hospital services made more freely available to all regardless of income, a comprehensive health and hospital service in all areas and the 'increase or better geographical distribution of hospital beds'. They felt prevention of disease called for even closer co-operation between the hospitals and the

local health services. Medical research needed more organization and refresher courses should be made available to all qualified doctors. The patient must have, subject to the limits of availability and adequacy, the choice of hospital and this must include greater facilities for rehabilitative treatment. 'The Voluntary hospitals ... '(looked) ... not only to the continuance of their 'existance and the preservation of their standards and 'ideals but to an extension of their services'. In these terms the British Hospitals Association rejected the Brown plan and set forth its views as it awaited the next stage, the White Paper.

The Labour Party, in a plan issued shortly after the appearance of the Brown Plan, favoured the administrative unification of all health services under democratically elected regional authorities. {Voluntary hospitals would 'be brought into the national scheme, on 'terms which will satisfy the nation's sense of equity'}. They would receive financial assistance from local authorities and would therefore have to accept representatives of these authorities on their governing bodies. 'The 'effect of this scheme would be to ensure that before long 'the voluntary hospitals (would) come under the control 'of local authorities' (1) and so a unified hospital system would be achieved. It is not uninteresting to note that a whole-time salaried medical service, elected regional

(1) Labour Party 1943 'A National Service for Health'

authorities and the eventual control of voluntary hospitals by local government were the major points of the programme accepted by the Labour Party at its conference in 1943. It is a commentary on the relative strengths of the three major interest groups, the medical profession, the local authorities and the voluntary hospitals, to observe that only one of these three points, the control of voluntary hospitals, were in Mr. Bevan's Bill. In this case, too, the control was very different from that envisaged in the party's proposals of 1943. On the other two points, wisdom or pressure or both, compelled considerable compromises. The whole-time salaried medical service which was, by 1946, sliding out of the vocabulary of the Minister of Health, was buried with full Parliamentary ritual by the same gentlemen in 1949.(1) The other point, the elected regional authorities, never again saw the light of day - the word elected was dropped for appointed and adhoc bodies took the stage as the Minister's solution to the problems of the hospital service. In short little remained of the main points of the Labour Party's plan except perhaps for the aim of a national hospital service.

(1) National Health Service (Amendment) Act 1949 s.10 made impossible the introduction of a whole-time salaried service without further legislation.

Once again in a summary one must remark on the absence of reaction (or evidence of reaction) to the Brown plan, except for the local authority organizations and the voluntary hospitals. Their views, as set out, seem to suggest that the Minister's attempts at a locally unified health service was doomed, from the start. His attempts at a unified health service did not, however, include a unified hospital service, for here he intended some form of co-ordination under the Joint Health Boards using areas wider than those of existing local authorities. The exact form of such co-ordination, it has been noted, is not known nor do the reactions of the groups enable one to guess at it. It was left to the next plan to fill in these details.

(C) The White Paper, 1944:

Under these proposals the local organization of the national health service would devolve on local authorities, county and county borough councils, either singly or where necessary, in combination as Joint Authorities. In the case of the hospital service, joint authorities would almost always be necessary, and they would be advised by local counterparts of the Central Health Services Council, (1)

(1) Mr. Willink told, in the White Paper, of the Government's acceptance of the view that professional representation on Joint Authorities would be an impairment of the doctrine of public responsibility. Instead, therefore, he proposed these Local Health Service Councils - a concession at a local level to professional demands for separate professional organisations, as the County Health Service Council was at the control level.

the exact division of powers between the Joint Authorities and the constituent authorities being a matter to be decided in the plans for the area which the Joint authorities would be called upon to prepare. The hospital and consultant services would be the responsibility of the joint authorities who would take over and run all local authority hospitals. Those voluntary hospitals willing to participate in the scheme, would have to accept the area plan drawn up by the Joint Authority after consultation with the Local Health Services Council and approval by the Minister. Hospitals would be inspected to see that they maintained certain national standards but there would be no interference in the day to day administration of the voluntary hospitals by the Joint Authorities. The voluntary hospitals would receive grants from the Joint Authorities towards the cost of the services provided; total payments would not be made for they would dry up the voluntary income on which the hospitals depended for their autunomy.

The main features of the plan therefore were, firstly the continuance of two types of hospitals, with the change of ownership of local authority hospitals, the right of voluntary hospitals to participate or not in the scheme and the part-payment of voluntary hospitals by Joint Authorities for services provided. Inspection of voluntary hospitals was envisaged, Mr. Willink outlining the conditions

expected of voluntary hospitals in receipt of grants. These 'reasonable conditions' may be summarized: the hospital would be expected to comply with the area plan in the services it provided, to observe national standards regarding rates and conditions of their staffs, to appoint senior medical staff in accordance with national conditions, to be always open for inspection and to secure reasonable uniformity in accounts and auditing. (1)

As the first published proposals from the Government the White Paper merited and received careful attention from most of the groups. Alone of all the medical groups the Socialist Medical Association went on record as regretting the continuance of the dual hospitals system - local authority and voluntary hospitals. For the rest of the profession they welcomed this fact, or rather the continuance of the voluntary hospitals.

Criticizing the hospital proposals, the British Medical Association' Council claimed that voluntary hospitals would be gradually submerged despite the Government's claims of their continuance, and co-operation would be achieved by putting them under the control of local authorities. 'These proposals would appear to 'illustrate once more the urge to control even a form of 'voluntary organization which, while uncontrolled, has 'achieved a magnificent standard of service to the community' (2)

(1) White Paper Cmd 6502 p.23.
(2) From Council's report on White Paper published in British Medical Journal 13.5.44.

The Council suggested regional areas for the hospital and medical services; the regional bodies should consist of representatives appointed by local authorities, the medical profession and voluntary hospitals and their functions should be the planning of schemes and the disbursement of central government monies. Pro tem, local authorities should continue to administer their own hospitals under the regional plan[(1)] and each local authority should have a statutory duty laid on it to have medical advisory committees, representatives of whom would be co-opted on to its health committee. Referring to voluntary hospitals, the Council felt that 'the 'financial arrangements should secure that it is reasonably 'practicable for these hospitals, with such help as may be 'available from voluntary sources, to maintain their 'existing services and to embark upon necessary extensions'. The Association were undoubtedly concerned at the problems of the hospital proposals but even more concerned at this stage, at least, with the proposals affecting the general medical services.[(2)]

(1) The medical profession had long favoured a regional co-ordination of the hospital services.

(2) The British Medical Association's questionnaire shows 63% of doctors favouring joint boards over large areas but 78% regarding as unsatisfactory the constitution of these boards as solely local authority membership.

Obviously, on the other hand, the proposals of the White Paper, with the prospective loss of their hospitals, were of vital importance to the local authority organizations. First in the field were the County Councils Association who concluded that, having regard to 'the admitted need for hospital re-organization on a wider 'basis than can be provided by existing administrative 'arrangements', they could not recommend opposition to the point of refusing to consider the Government's proposals. They repeated their earlier resolution calling for joint authorities to submit triennial estimates and annual reports to the constituent councils, and disagreed with 'the 'proposals that bed grants should be made direct by the 'Government to the authorities of such voluntary hospitals 'as participate in the scheme, and they (considered) that an 'arrangement of this kind would be wholly inconsistent with 'administrative and financial responsibility proposed to be 'placed upon the county and county borough councils or the 'joint authorities ..." They recommended instead that such grants be paid through the councils or authorities concerned thereby illustrating a fundamental part of opposition to the voluntary hospitals who rejected any scheme at all suggestive of local government control.

The Association of Municipal Corporations, in their turn, considered the White Paper and in a report welcomed the aims of the Paper but dissented from much of the method

to be employed. It agreed with the proposal that joint authorities should be planning authorities but could not accept that they be administrative bodies. This, the Association regarded as a retrograde step and adduced several reasons to support this view. It separated, administratively, many services which it was essential to keep together, e.g. the various services under the general heading of maternity and child welfare services. Further, local authorities' hospitals were of such a standard as to show no cause for their partial removal from local authority control entailing thereby that public money would be spent by non-elected members not directly accountable to the electors. For these reasons the Association felt that the functions of the Joint Authorities should be limited to planning, general policy and supervision and the co-ordination of the various health services in their areas, the day to day control of the hospitals remaining in the hands of local authorities subject to the general powers given to the joint authorities.

In due course and after further reflection another report from the appropriate Committees of the County Councils Association appeared. They came into line with the proposals of the Association of Municipal Corporations that the proposed joint authorities 'should be charged 'with the duties of preparing and keeping under general

'...review a scheme for a comprehensive health service, 'should not have administrative functions, except in cases 'of local authority default, and should be able to precept 'the cost of all the services in the plan.' The administration of these services should remain with the constituent local authorities, to whom the joint authority should have to submit annual reports of its proceedings and triennial estimates of expenditure, any such estimates being subject to the approval of the constituent local authorities. They considered that the payment of public money to voluntary hospitals should be followed by public representation on the boards of these hospitals. Consultation with voluntary hospitals should be conditional upon such hospitals undertaking to participate in the scheme for five years, subsequent withdrawal from the scheme to be only after twelve months notice, and those hospitals remaining outside the scheme should not be permitted, by extensions, to destroy the balance of the joint authority's plans. The Association had, therefore, changed its mind somewhat and accepted the view of the Association of Municipal Corporations. Their final resolutions concerning voluntary hospitals sprang from what can only be termed a jealousy of voluntary hospitals who always seemed to get the better of them.

On 14th June, 1944, the day following the meeting, at which this Report was prepared, representatives of the

County Councils Associations began a series of meetings with the Ministry of Health at which a difference of outlook became apparent on the local administration of the health services. The Ministry favoured the administration of the hospital and specialist services by the Joint Authorities whilst the Association favoured making these bodies solely planning and advisory bodies. The Ministry felt it too early to attempt to settle areas of the joint authorities but mentioned that they contemplated about forty such areas with minimum populations of half a million.

The results of these meetings with the Minister were discussed at a Joint meeting of the Committees of the Council, and a considerable change of opinion is apparent in the motions accepted after 'prolonged debate'. Having carefully considered the views of the Ministry of Health on the administration of the hospital and specialist services, the Committees resolved not to pursue their previous resolution calling for the administration of these services by the constituent local authorities. Instead they reached the conclusion that areas even larger than joint authority areas were necessary for the planning of the hospital and specialist services. They, therefore, proposed twelve or thirteen planning authorities be established for England and Wales, such bodies to consist of representatives of the administering authorities, the

medical profession, the universities, the voluntary hospitals and other bodies concerned. Available data does not make it possible to account accurately for this change of opinion and to state where these proposals first emanated. The similarity of the following resolutions of the Joint Committees with those later submitted by Mr. Willink, the Minister, as his alternative proposals, is striking. These resolutions are quoted verbatim. 'That these planning authorities 'should be charged with the preparation of schemes for 'their respective areas, ascertainment of the views of 'the administering authorities thereon, and the eventual 'submission of the schemes, with such amendment as the 'planning authorities may consider necessary, to the 'Minister of Health for approval. The schemes should also 'be sent simultaneously to the administering authorities, 'who should have the right to make representations thereon 'directly to the Minister." 'That the planning 'authorities should thereafter remain in existence for the 'purpose of keeping the execution of the schemes under 'review, of making representations to the Minister in the 'event of delay or default on the part of the administering 'authorities and of amending, subject to the same procedure '(as above) the scheme from time to time to such an extent 'as may be deemed necessary'. As if to emphasise that these proposals were limited to the hospital and specialist

services the Committees opined that the planning of the local health services should be left with the administering county and county boroughs councils.

These resolutions of the Committees of the County Councils Association are interesting in that they propose regional bodies with some sort of executive power over local authorities. After all the bitter complaints of local authorities about regionalization, one cannot help but wonder at this apparent change of heart. It may well have been that they saw, from discussion at the Ministry, the direction of official thoughts. It is not unlikely that, despite their resolution dropping the claim for local authorities to administer the hospital services, they hoped that by this method it would be possible to do away with joint authorities as administering bodies. It is perhaps not coincidental that all,references in the two resolutions quoted on the previous page are to 'administering authorities' - a vague term.

Little happened for several months until on the 24th November, 1944, the Committees of the County Councils Association held another joint meeting, this time to consider a letter from the Ministry of Health asking them to meet the Ministry to give careful scrutiny to possible alternatives to the White Paper proposals. The letter expressed a desire that these proposals be considered by the Association before further actions were taken. In the

light of this letter, the meeting resolved to ask the Executive Council of the Association to be allowed not to move the reports of its two previous meetings outlined earlier in this section. This resolution was accepted by the Executive Council of the Association, and therefore the resolutions which have been outlined never officially became the policy of the Association, though there is little doubt that they would have been so accepted had the need arisen.
(1)

This curious flirtation with the idea of a regional body is hard to explain, and lack of evidence makes it impossible to suggest how the Association of Municipal Corporations felt about it. It should be repeated however that the regional idea was never formally adopted by the council of the County Councils Association, as the November offer of the Minister, to discuss alternatives, caused them to ignore all previous resolutions.

The voluntary hospitals soon had their views on the White Paper in print. In a provisional statement the British Hospitals Association said that the powers given to the proposed Joint authorities would need careful consideration because it was vital 'that the plan should be established on 'a basis of true partnership, free co-operation and co-ordination in the strictest sense of these

(1) See p. 92. re absence of comment on Association of Municipal Corporations.

'words' At a subsequent meeting of the representatives of the Association[(1)] early in March, 1944, several resolutions were unanimously adopted: the administrative proposals did not afford the opportunity for that partnership aimed at in, and indeed essential for, an efficient service; and the financial proposals were inconsistent and unacceptable as affording only part payment towards services rendered thus leaving the gap to be filled by voluntary effort, whilst at the same time offering a free service thereby discouraging the incentive to contribute to voluntary hospitals.

Shortly after this meeting a small leaflet was published setting out the considered views of the Association. This document reasserted that the voluntary hospitals were anxious to co-operate in any scheme on the basis of equal partnership and it listed the conditions proposed in the White Paper which rendered co-operation impossible. The first of these must be mentioned here; the Joint Authorities were to be the owners of the local authority hospitals which would mean the first interest of the joint authority would be with their own hospitals and the position of the voluntary hospitals, particularly in regard to expansion of services, would be gravely prejudiced. On the proposals for the inspection of hospitals (they preferred the term 'visits') the voluntary hospitals had two main complaints: firstly that the proposals that the

(1) 'Hospital' March, 1944.

'visitors' should only be doctors neglected the role of the lay administrators and secondly the suggestion that a Joint Authority would have powers to inspect voluntary hospitals was in-equitable and totally unacceptable for voluntary hospitals, they exclaimed (petulantly one feels) would not be able to inspect local authority hospitals.

The statement noted the absence of any true attempt to utilize the experience of the voluntary hospitals for 'the proposals .. (placed) complete control of the 'assessment of need, the whole of local planning and the 'administration of the service in the hands of bodies to be 'known as Joint Authorities, which would be composed wholly 'of local authority members'. 'We should agree the 'constitutional convenience of local government having an 'ultimate responsibility for the adequacy of the area 'service .. but the absence of any provision for a statutory 'joint advisory hospital board precluded the voluntary 'hospital from any voice in the planning, maintaining and 'improving of the hospital services ... and deprives them 'of the right to enter the scheme as partners, to which, 'by reason of their high standard and record of service, 'they are entitled'.

The British Hospitals Association went on to propose two ways of contact between the two types of hospital at local level. The first method involved the establishment of a statutory and autunomous local hospitals board,

primarily composed of equal representatives of local authority and voluntary hospitals whose functions would be to advise the Joint Authority. The second and complementary method provided that representatives of voluntary hospitals should be at the meetings of the Joint Authorities, not necessarily as co-optees or with the power to vote. As a justification for their criticisms of the local administrative proposals and for their own suggestions, the statement claimed that it was 'not in the 'interest of the patient that the local authorities should 'be given such complete power to plan and control the 'hospital services'. They, the voluntary hospitals claimed that their subservience to local authorities, who they alleged had not as a general rule justified the hospital powers conferred upon them, would be an impediment to medical progress.

Towards the end of 1944 the British Hospitals Association issued another statement which largely repeated the criticisms and proposals of the earlier statement. The most interesting addition in this plan is that of regional bodies. Earlier the Association had made no reference to a regional level although the idea of the region was favoured by some voluntary hospital organizations (e.g. Nuffield Provincial Hospitals Trust). At about the same time as this latest British Hospital Association statement appeared, another body in the

voluntary hospital movement, the King Edwards Hospital Fund for London, made its views known. It suggested a central statutory body, the division of the country into twelve or thirteen regions based on university medical centres and the appointment of Regional Hospital Councils in each, equally representative of local authority and voluntary hospitals, each council having medical advisory committees. The Fund did not favour the contract method proposed in the White Paper and felt that the system it put forward would obviate the voluntary hospitals coming under the domination of the local authorities. The aim should be to give 'solid 'grounds for confidence' for the future to voluntary hospitals 'so that their representatives (could) sit down 'with the representatives of local authorities free from 'the sense that it (would be) within the power of the 'local authorities ... so to develope their own services 'to the ultimate supersession of the voluntary hospitals."

The reaction, therefore, of the voluntary hospitals at first mild became stronger as time wore on and the possible results of the proposals of the White Paper were better understood. Except for the Trades Union Congress which expressed a preference for a unified hospital system, but which was not prepared to oppose in the circumstances, the continuance of the dual system, all was silence from the other groups on these proposals of the White Paper.

The White Paper proposals aroused little interest outside the voluntary hospitals and local authorities and to a lesser extent the medical profession. Any changes that were to be made in the plan were not to meet the wishes of all the groups but of these three groups. Mr. Willink had followed Mr. Brown in aiming at a co-ordinated service over areas wider than existing Local Authority areas, and in so doing had run contrary to the views of all three groups most concerned, the medical profession, the voluntary hospitals and the local authorities.

(D) <u>The Revised White Paper (or Willink) Plan, 1945</u>:

Many changes in the White Paper plan were proposed by this plan; the Joint Authorities of the White Paper were abandoned in favour of county and county borough councils as executive units for their own hospitals and other health services. Regional and area planning machinery was proposed to provide a two-tier system of planning: the regional councils would be about ten or so in England and Wales, and, as expert advisory, bodies based on the areas of influence of the university medical schools, whilst areas of the Area Planning Councils would roughly correspond with the joint authority areas of the White Paper, both types of councils playing an integral part in the planning machinery. 'Generally the interest and concern 'of the Regional Councils would be mainly in the more 'specialized services and in the hospital and consultant

'.. arrangements over their wider areas, but it would be 'perfectly open to them to criticize and advise on any 'other aspects of the health services'.[1] There would be about 30-35 Area Planning Councils in England and Wales charged with the formal duty of preparing a plan for all the health services of the area[2]. Alongside these Councils would be Hospital Planning Groups, equally representative of local authority and voluntary hospitals, with some medical members, charged with the duty of preparing in collaboration with the Regional Planning Council, for the hospital and specialist services in the area. This plan would then be submitted to the Area Planning Council who would incorporate it in their general plan. If it made any changes in the hospital plan in this process the Hospital Planning Group and the Regional Planning Council would have the right of appeal to the Minister. When prepared the Area plan would go simultaneously to the Minister and to the Regional Planning

(1) British Medical Association Document.

(2) Suggested membership as follows:
Regional Councils - Chairman plus 2 from university medical school, 4 from medical profession and 4 each from local authority and voluntary hospitals:
Area Planning Council - Chairman appointed by Minister, 18 local authority members, 6 doctors, 3 voluntary hospital members, 1 dentist, 1 nurse and 1 midwife, all nominated by groups.

Council who would have the right to comment thereon to the Minister. When approved by the Minister the plan would be binding on all, any amendments to the plan having to follow a similar procedure. In the London area it was suggested that a committee representative of the London Councy Council and the medical profession, be a Pkanning Council and one of representatives of the County Council and the voluntary hospitals be the Hospital Planning Group.

Once again one must regret the absence of detailed views on these proposals, particularly in the case of the voluntary hospitals. The medical profession, in a meeting on the plan, called for the plans to go from the Area Planning Councils first to the Regional Planning Councils and thence to the Minister, and for the Regional Planning Councils to have some executive power to be able to recommend to the Minister the with-holding of grants in the cases of inadequate service. There should be further medical representation on the Regional Planning Councils, whose areas should be 'natural medical areas'. Area Planning Councils too should have more medical representatives and bodies similar to the Hospital Planning Groups should be set up for the general practitioner service. They had long favoured regionalism and were determined to maintain if possible as much regional power as possible. On the problem of the London area the

meeting rejected the 'conception of London as a single 'planning area covered by a single executive authority; 'held that in any plan for consultant and specialist 'services London and the home Counties (should) be con-'sidered together; that London and the Home Counties 'together (should) be divided into regions; that each 'region (should) be based on a regional council similar 'to those in the rest of the country'. During the debate it was mentioned that the voluntary hospitals of London had accepted a similar motion.(1)

The County Councils Association seems to have accepted the plans put forward in this form and, although no record of the Association of Municipal Corporations view at this time exists, at later dates they looked back with favour on this plan.(2) They had accepted a regional system but without any real executive power being given to those bodies, and it was on this point that the local authority associations clashed with the British Medical Association at a joint meeting in April, 1945.(3)

(1) See pp 319f The proposals for the London area brought the medical profession and the voluntary hospitals into very close contact with the local authority - a contact which they regard as too close.

(2) e.g. memorandum of Evidence submitted by the Association of Municipal Corporations to the Select Committee an Estimate on 7.6.51 - see Municipal Review (Supplement) Dec. 1951.

(3) County Councils Association Gazette - July, 1945.

The meeting was held at the instigation of the British Medical Association who wanted to see the Regional Councils put in a much stronger position than in the proposals of the Minister of Health. Their points were four: that regional councils should sketch plans for an area, the Joint Planning Authority filling in the details and returning the plan to the Regional councils; that these councils should advise the Minister as to the money needed and its allocation; that these councils should be responsible for the maintenance of a satisfactory standard of service; and that these councils should recommend to hospital authorities about staffing.

As such the British Medical Association showed itself determined to get away as far as possible from local administration and to put all the power in the hands of regional bodies. The local authority account of the meeting said that 'some of their (i.e. British Medical 'Associations) representatives were prepared to make a 'concession to the local authorities in this respect (the 'constitution of the Regional Councils) if their proposals 'were accepted'. The local authorities however declined this bait, 'their unanimous opinion being that, whilst the 'advice of the Regional Councils would be welcomed by the 'area planning authorities, the latter must be made 'statutorily responsible for the preparation of plans in 'the light of local conditions, the plans must be on an

'area basis save as regard certain specialist services, 'and they must go direct from the area authorities to the Minister ...' with copies going simultaneously to the regional councils. They therefore rejected the first three points of the medical case and were only prepared to accord a conditional acceptance of the fourth.

No better example could be given of the main grounds of conflict between the medical profession and local government. The medical profession disliking local authorities as masters and believing (perhaps, therefore, believing) in regional areas, endeavouring to get as much power as possible away from the local authorities and thereby strengthening the regional bodies, ran head on into the local authorities, who wanted to keep administration and planning as near home as possible. They had succeeded in getting back their rights as executive units while losing their planning rights, and these they wanted kept near anough at hand in joint planning authorities which with their local authority majorities would keep the matter fairly firmly under control.

It is particularly regrettable that no published evidence is available of the voluntary hospitals reactions to these plans and no inkling can be obtained of how they felt. It is only possible to go so far as to say that

they must have regarded the revised plan as an improvement on the White Paper plan, having much less suggestion of local authority control and introducing a special hospital advisory machinery. But if further evidence were available one might[1] find them, like the medical profession, an Oliver Twist asking for more.

The reaction of one other group remains - the Trade Union Congress. In a Report of the General Council, it was stated that they could not accept the equal representation of voluntary and local authority hospitals on the Hospital Planning Group in view of the higher number of beds provided by the local authorities. The Council felt that the Regional Councils, too, would be overweighted with voluntary hospital representatives.

It is hard to find any satisfactory conclusion to this section when the views of the voluntary hospitals are unknown. The best summary is to draw attention again to the see-saw introduced by the regional planning councils. The doctors wanted regionalization and therefore increased power for these councils - the local authorities (and one suspects the British Hospitals Association whose beliefs in regionalism never rang completely sincere amongst the highly individualistic voluntary hospitals) favoured a more local administration and endeavoured to keep the balance of power with the locality. That local authorities

(1) It is known that they accepted the administration proposals in general terms.

agreed at all to a regional council is perhaps the most remarkable part of the plan. As suggested at the beginning of this chapter, the ways of the co-ordinator were indeed hard, as the complicated machinery proposed by Mr. Willink bears witness. He had sought simultaneously to provide a unified health service at Regional level to meet medical views, a special advisory machinery for hospitals to suit the voluntary hospitals and executive power for local authorities.

(E) National Health Service Bill and Act, 1946:

With the publication of the National Health Service Bill the days of co-ordinating two types of hospitals were over: 'unification' became the key word and from thence on many of the problems which faced the other Ministers disappeared. The Minister, unable to provide a reformed local government and desiring a unified service on a regional basis, had no option it is suggested but to nationalize the hospitals.(1) The Act transferred all hospitals(2), local authority and voluntary together with

(1) It is interesting to see Mr. H. Morrison when Secretary of State for Home Affairs in the Coalition Government saying '...the view of the Minister of Health was that it would not be right to take the hospitals over into a national concern. I know that is quite right...' House of Commons Official Report Vol.408 c512 15.2.45.

(2) Or, more correctly, gave the Minister power to acquire all hospitals. Some by reason of their special nature or religious backing have not been taken over - there are some 200 such hospitals including Royal Masonic Hospital and the Manor House Hospital owned by the Trade Union Congress.

their endowments to the Minister, the only exception to this being hospitals designated as Teaching Hospitals for whom special arrangements were made. All the endowments were amalgamated into a Hospital Endowment Fund the income from which is divided among the administrative bodies of the hospital service.

The new hospital and specialist services would be administered by ad hoc bodies, regional hospital boards appointed by the Minister except in the case of teaching hospitals which would be administered by Boards of Governors not subject to control by the regions, but linked with the universities of which they formed part. The day to day administration would be entrusted by the Boards to ad hoc Hospital Management Committees appointed by the Boards and responsible for one or more hospitals. Some specialist services (e.g. blood transfusion and medical research) however would be the direct responsibility of the Minister. He would, according to the Bill finance the hospital service from monies provided by Parliament, except that both types of Boards could use their endowments or share of the Fund as they pleased to provide extra amenities, research or in any other way not covered by the central grants.

Some lengthy accounts must be given of the amendments to the Part (Part II) of the Bill dealing with hospital and specialist services which are of some importance. The right to treat patients in pay beds was limited[1] in the Bill to specialists but amendments extended that right to cover all doctors whether on the hospital staff in an honorary or paid capacity, an extension, covering in certain circumstances, general practitioners.

The section covering the taking over of endowments etc. was strongly contested and four changes of some importance[2] were accepted. As originally worded Hospital Management Committees were not to share in the income of the endowment fund, or if so only at second hand from the Regional Hospital Boards. An amendment put these Committees on a par with the Boards insharing this money, the uses for which were altered to specifically include medical research. A relatively important change saw the Minister concede the right to Hospital Management Committees to keep the endowments given to them or to the hospitals in their charge during the period between the date of the Bill becoming law and

(1) The section four bed or amenity bed is a bed on the public side of the hospital with some special amenities (for example in a separate room) for which payment must be made if not required on purely medical grounds. The section five or pay bed is one for which the whole cost and a section of the overheads is made.
(2) S.7.

the appointed day when the service should come into being. But for this these endowments like all others at the appointed day would have passed to the Hospital Endowment Fund. Finally the section was amended to secure as far as reasonably practicable that the wishes of the donors of the objects of the endowments were not prejudiced by the Act.

In the division the amendments made were mainly directed towards two ends, the increasing of Parliamentary surveillance of the Minister's activities under the Act, and the increasing of the powers of the Hospital Management Committees. The designation of Regional Hospital Boards, of their personnel and of certain hospitals as teaching hospitals was according to the Bill to be done separately and by order, and under a later section of the Bill all orders were to be subject to negative resolution procedure - i.e. to lie on the table of the House and become law in due course unless negatived.(1) By amendment orders concerning Regional Hospital Board areas were to be subject to a more direct control - i.e. they had to obtain the affirmative resolution of the House before coming into force. Thus in a limited way the House sought to tie down the Minister in his use of regulations.

(1) S.75

The division of powers[1] between the Regional Hospital Boards and their Hospital Management Committees came in for a lot of criticism in the House of Lords where considerable changes were made, some against the wishes of the Government. The original wording was such as to suggest that Committees were entirely dependent on the Boards for what powers they were to have. By amendment it was enacted that the duty of these Committees was to control and manage the hospitals in their group subject to the regulations and direction of the Minister and the Boards. It is not one's purpose here, to criticise the Act, but it must be noted that the final wording still left plenty of room for central and regional control - 'to preserve our chain of 'aithority' was the reason given by the Lord Chancellor[2], (Lord Jowitt). On the subject of legal status of Management Committees the Government suffered a defeat which it took no steps to reverse. They had not written in the Bill any legal status for these Committees - all actions by or against these bogies would be through their Regional Hospital Boards, the Committees being but agents. The Bill had given a legal status to the Regional

(1) S.12

(2) House of Lords Hansard Vol.143 c757 28.10.46.

Hospital Boards notwithstanding their agency relationship to the Minister and by Opposition amendment in the House of Lords a similar provision was extended to Hospital Management Committees giving them the right to be sued or to sue.

To summarize the amendments discussed here, they are limiting, even if only in a small way, the power of the Minister, by rewording particularly wide phrases and by making certain actions subject to some sort of Parliamentary control, and also seeking to write into the Bill the claims of the Minister for a decentralized service. For the Minister many of these amendments may have given the impression of tieing him down, for he wanted the Bill to be a flexible instrument, but yet it can, with some safety, be asserted that these changes have proved little defence against the centralizing tendencies shown in the later working of the service.

The motives behind these amendments were two-fold. Firstly a genuine desire, on both sides of the House, to see a large measure of decentralization. Secondly, and as a corollary of this, it was felt that if Hospital Management Committee's were to attract the right sort of people to make the hospital service a success, they must be given a worthwhile job to do and not be little more than rubber stamps for a distant Regional Hospital Board. Local interest in the hospitals could only be preserved

if local people felt it worth their while to give up time to sit on these Committees. Similar motives lay behind the amendments to the plan for the endowments of the voluntary hospitals - to decentralize and personalize as far as possible the Government proposals.

Turning from the amendments to the reactions to the Bill, one finds its appearance the subject of a report by the British Medical Association's Council. They expressed a desire for a co-ordinated hospital service and emphasized the importance, in the Ministerial plan, of the membership of the Regional Hospital Boards. The exact constitution of these Boards, which should not include a majority of local authority representatives, should be written into the Act. Each hospital should have a governing committee with close liaison with, and having representatives of, the medical committees of hospital doctors. The Council claimed that the change in the ownership of the hospitals was an unnecessary step to achieve the right hospital service adding that it would make possible the squeezing out of private consulting practice. 'In the public interest the 'conditions imposed should not be such as would lead or 'compel consultants or their patients to use nursing 'home or similar accommodation dissociated from the 'hospitals for private consultation and treatment'.

To this response can be added one from those rather secretive bodies, the Royal Colleges. The Royal College of Physicians approved the principles of the proposals to reorganize the hospital services declaring that much would depend on the membership of the administrative bodies of this service. These persons should be chosen entirely on grounds of personal fitness to do the work. Believing in the importance of local interest and initiative, the hospitals should be allowed as much independence as compatible with regional plans and account should be taken of the wishes of the donors of endowments. This meeting was reported in the Lancet under the heading of 'The Turning Point', the Royal College being the first major medical organization to support the Bill.

This importance is heightened for this study by several pieces of evidence which suggest, to put it no higher, that the Minister of Health sought to split the medical profession. It is, therefore, suggested that he sought the favour of the consultants hoping that by splitting the profession the abandoned general practitioner would be bound to accept the proposals of the Bill. One may outline several points in the Bill which suggest Ministerial wooing of consultants; firstly the special position accorded to teaching hospitals (1)

(1) One has heard that this position was in large measure due to the intercessions of Lord Moran, President of the Royal College of Physicians.

outside the regional machinery with the power, alone of all hospitals, to keep all their endowments; secondly the absence of disciplinary machinery for consultants whilst general practitioners were to be subject to a strong[1] disciplinary machinery; the permitting of private patients in state hospitals (contrary to Labour Party beliefs) with the right given to the consultants to charge these patients fees: and the amendments accepted in Parliament to strengthen the local committees of the service and to afford some protection to the wishes of the donors of endowments, in line with the proposals of the Royal College of Physicians. All this suggests the thesis stated above, and a further study of the period 1946 to 1948 would add further weight when one observes the favourable conditions afforded to consultants and perhaps most important of all the Presidents of the Royal Colleges acting as intermediaries between the warring British Medical Association and the Minister.

How far the medical profession itself sponsored amendments in the Houses of Parliament is hard to say, but some attempt can be made to study the amendments to the pertinent part of the Bill in the light of known medical views. The power given to hospitals to provide beds for paying patients was widened by amendments in both Houses to make possible the use of such beds by more

(1) Cf. Standing Committee Official Report c.444.

doctors than originally envisaged, including in certain cases general practitioners. This must have pleased the profession though it is rather more doubtful if the many amendments which increased the powers of the Hospital Management Committees were so pleasing to the professions with their preferences for regionalization.

Of the four points on which Dr. Dain claimed they were at odds with the Minister, the one relevant to this chapter, no state ownership of hospitals, is a witness to the failure of the profession to affect any real change in the Bill. Despite then the regionalization of the hospital service the profession found little comfort in this Part of the Bill.

The Executive Council of the County Councils Association, in its first report on the Bill, complained that the scheme was not in accordance with democratic principles giving two grounds for this complaint, firstly that appointed committees controlling the hospitals were no substitute for locally elected bodies and secondly that the scheme was calculated to diminish, if not wholly eliminate 'the local interest upon which the efficiency 'of the service (would) largely depend'. The scheme separated curative and preventive services, divorced hospital and domiciliary services and therefore would involve a loss of efficiency. The Report stated that

the Minister had proved 'obdurate' when presented with local government proposals and it drew attention to the variance between the Bill and the White Paper of 1944 to which, in the debate on the King' Speech in 1945, the Government were said to be going to return (1) The report concluded that the 'interests of the public (would 'be best served by) a return to the position reached in 'consequence of the protracted negotiations' which had followed the issue of that White Paper, in other words to the revised Willink Plan. Reporting discussions with other local authority organizations it asked for power to continue discussions in an endeavour to 'safeguard to the 'fullest extent the interests of the county councils and 'the ratepayers they represent', this original wording being subsequently amended to read 'to secure the 'establishment of a comprehensive and 'efficient health 'service' - a belated recognition of the true purpose of 'the discussions'.

A day later the Executive Council of the Association of Municipal Corporations followed suit and issued its report on the Bill. Like the report of the County Councils Association it contained a historical introduction and then went on to point out that the confidential discussion which representatives of the Council had had with Mr. Bevan before the issue of the

(1)House of Commons Hansard Vol.413 c258 17.8.45.

Bill committed them to nothing. They had put points of view before him and had expressed their preference for the proposals agreed with Mr. Willink, a preference which the report noted was shared by the County Councils Association but not by the London County Council. The Association told the Minister that they considered that the administrative bodies of the hospital service should include direct representatives of local authorities including non-county boroughs - the frequent inclusion of non-county boroughs was due to the dual nature of the Association which represented county and non-county boroughs.

As far as can be seen, political party affiliations did not cause great differences within the two main associations of local authorities, the third body consulted, the London County Council, spoke in the voice of its controlling party, the Labour Party. It welcomed the Bill, regretting losing its hospitals confident however that it was thereby doing the right thing. Its acceptance of this change of ownership was dependent on the Government retracting none of its proposals for transferring voluntary hospitals and on its own municipal teaching hospitals (the Maudsley and Hammersmith) being treated in the same way as voluntary teaching hospitals. This mild reaction is all the more surprising when viewed alongside the report of the Hospitals and Medical Services

Committee of the Council on February 19th, 1943, which gave details of the plans for their hospitals - plans divided into short-term and long-term plans including in the latter provision of two new hospitals and twenty new out-patient departments[1]. Of a 'deal' between the Council and the Minister, which the Opposition alleged, more will be said in a later chapter[2] when the whole question of the London area is discussed.

One can therefore say, putting on one side the peculiar case of the London County Council, that the local authority organizations were opposed to the main proposals of the Bill concerning the hospital services. The amendments sought by one of the two Associations, the Association of Municipal Corporations have been published, and a survey of these must stand for the detailed reaction of local government to the proposals of the Bill. The success of the amendments can now be examined.

An amendment proposed to the section[3] which provided for special accommodation in hospitals on part payment sought to d lete the phrase 'on medical grounds' this being given in the section as the reason for the free

(1) British Medical Journal 2.3.46.

(2) See p. 319 f

(3) S.4

use at other times of such part paid accommodation. The Association feared, and their spokesman in Committee, Mr. Messer, emphasized that such condition might be such as to make the section worthless as everyone was in hospital on medical grounds. The Minister, in reply, said that he was advised that the phrase in question was capable of extremely wide definition and that his intention was that such rooms should be available to non-paying patients when, for their health or the health of their fellow patients, it was considered medically necessary to put them into this accommodation - usually a small room at the end of a large ward.

The Ministry was approached about property temporarily in use as hospital accommodation and was asked if such property would be included in the transfer to the Minister. They were assured that it would not, and the Government moved an amendment, in Standing Committee to ensure this (Section 9 (4)). Whilst the Committee was discussing this amendment, a question was raised about the future ownership of land adjoining hospitals bought not for hospital buildings but solely as a barrier against undesirable buildings next to the hospital. The Parliamentary Secretary to the Minister of Health said that this land would not be transferred to the Minister but that if such transfer should become necessary the Minister would use his powers of compulsory purchase. In

further discussions with the Ministry on this section the local authority representatives sought to obtain an assurance that any local authority property taken over by the Ministry and not made use of by them should be returned to the local authority. The Ministry was loathe to agree to this but promised to look at the matter again claiming that the Minister had power in the Bill to dispose of any property taken over.

The section concerning the setting up of Regional Hospital Boards, Hospital Management Committee and Boards of Governors of teaching hospitals, received the detailed attention of the Association's representatives. They felt that a duty should be laid on Regional Hospital Boards to produce schemes for co-ordinating the service in their areas and that local authorities should have a right to object and make representations thereon to the Minister. In discussions at the Ministry, the officials were not prepared to agree to this request, whilst in the House of Lords a general reply stated local authorities would be represented on the Boards and would thereby know what was going on, and presumably able to make their views known. The problem of co-ordinating the hospital services was raised in a general manner in Standing Committee when in reply it was stated that the Minister would almost certainly appoint a Standing Advisory Committee on hospital matters. Another matter raised by the Association and discussed on Standing Committee was the

question whether the delineation of areas of regional hospital boards should be the subject of separate orders under Parliamentary control. This matter was accepted by the Government who moved the necessary amendments to this section and the seventy third section. Orders setting out the areas of the Regional Hospital Boards were therefore separated from those setting up the Boards, both being subject to Parliamentary control. The Association's final amendment to this section concerned the duty of the Boards to lay before the Minister schemes for the setting up of Hospital Management Committees. The Association's representatives considered that these schemes should be published and served on local authorities who should have the right to object to the Minister. No proposer for it could be found in the Commons, but in the Lords it was discussed when the general reply concerning local authority representatives on the Boards, mentioned above, was given.

In the next section, the twelfth, which sets out the functions of the Boards and Committees, the Hospital Management Committees were given the duty of administering the hospital specialist services in their area. The Association felt that the word 'in' might have a limiting effect and should be substituted by the word 'for' to cover facilities for an area but not geographically within it. The amendment was raised in slightly different form in

Standing Committee by Mr. Somerville Hastings and after the Minister had assured him that this amendment was unnecessary the amendment was withdrawn. The Ministry agreed with the representatives of the Association that although the Boards appointed specialists the Hospital Management Committees would have day to day control of their duties. The Association seeking an assurance that Boards of Governors of teaching hospitals would use their beds in accordance with the Regional Plan were told that although no overall scheme would be drawn up the Boards of Governors would work in close contact with the Regional Hospital Boards to achieve the same results.

On the legal status of Regional Boards the representatives of the Association raised with the Minister the problems of Crown prerogatives if they covered the Regional Boards. It was stated in reply that the Boards could be sued for acts and omissions but on further representations it was agreed to look into the matter further. The Association thought it cumbersome that Hospital Management Committees should be denied legal status and that all actions would lie against the Regional Hospital Boards. It was pointed out to the Standing Committee that the proposal to let the Committees accept legacies and the like meant that they should have legal status. The Minister promised to look into the matter which was subsequently raised in the Lords, when

an amendment to this effect was carried.

On this second part of the Bill therefore one may note that the Association of Municipal Corporations sought no major changes despite its known views. Many of the amendments sought were to protect local authority interests but it must also be said that some were of the nature of suggestions for improving the Bill's wording from experienced administrators of past legislation, showing that the Association's representatives had given the Bill careful and detailed consideration.

As such the Association performed a very valuable function in assisting in the detailed examination of the Bill.

Voluntary hospitals, like the medical profession, still preferred their own proposals and on March 18th, the day before the National Health Service Bill was presented to Parliament published their plan for providing 'on a 'secure financial basis a comprehensive service free to 'the citizen, combining the resources of the State with 'all that is best in the existing services, including the 'voluntary hospitals with their pioneering spirit, 'tradition and experience'. The statement was in the form of six brief paragraphs. The first laid it down that the Minister of Health would assume general

responsibility for the direction and financing of the hospital service, and the second that, subject to his own veto, he should delegate the major duties and responsibilities including the framing of a national policy, to a Central Hospitals Board. This board would be appointed by the Minister after consultations with, and be representative of, the various interests concerned in this service. Regional Hospital Boards would be appointed for areas having at least one medical centre associated with it, these Boards to plan and extend the hospital service over the whole of the area so that a complete hospital service be provided in each Region while leaving the patient the freedom to choose his hospital. These Boards would decide the role of each hospital and have the necessary powers to ensure this role being carried out. The Boards, like the Central Board, would be wholly or mainly representative and would be appointed after consultation with the appropriate bodies. Under this system the individual hospital management would continue to be responsible for the day to day administration of its hospital but would have to provide the service called for by the Regional Board. This would mean no change of ownership. So far as the voluntary hospital would be concerned it would receive payment from the State for services 'required and rendered' but would remain free to attract voluntary gifts and personal support for activities

outside the scope of the plan and for the general improvement of the services provided. This plan, although not explicitly stated as such, must have been prepared by those members of the Association who had heard from Mr. Bevan his plan in confidential meetings with him. It shows some moving away from previous ideas and a move towards Mr. Bevan's own plan, no doubt in the hope that thereby compromise would prove easier. Perhaps its most interesting change, is the power given to the Regional Hospital Boards which make them approximate rather more closely than before to the powers given to such boards under Mr. Bevan's plan. The Accosiation's plam with its emphasis on planning at the higher levels and administration remaining with the individual hospitals formed a basis of much of the criticism of the Bill and contributed towards the loosening up of the apparently more rigid Bevan plan.

Representatives of the voluntary hospitals in London met in May to consider their reply to the Bill and agreed on the following resolution 'That the voluntary 'hospitals of London while welcoming a National Health 'Service designed to co-ordinate the hospital services of 'the country, urge the Minister to incorporate such 'amendments in the Bill as at present drafted as will 'ensure the retention by the voluntary hospitals of their 'property and management, their entities and their tradition

'..since only thus, in their view, can the best interests 'of the community be served.'

From this point, when Mr. Bevan persisted in his refusal to alter his plan for change of ownership, there was little left for the Association to do (1). The ground had slipped from under its feet and amendments seeking to restore the status quo were resisted by the Minister. All that was left was to secure as far as possible that the Bill conform to their ideas of planning at the top and administration at the periphery, a view which the Minister shared to a large degree.

The major changes in this part of the Bill were in two directions - the strengthening of the powers of the Hospital Management Committees vis à vis the Regional Hospital Boards and the changes in the proposals concerning endowments. Voluntary hospitals had always maintained that the advantages of their system lay in the local interest in 'our hospital', the freedom of initiative and the use of moneys without strict attaching conditions or control and in the course of its passage through Parliament, the Bill was altered in these directions. The Hospital Management Committees were, by amendment, given definite

(1) In the Times of 26.3.46 some remarks of Sir B. Docker, Chairman of the British Hospitals Association are quoted - the plan was a 'mass of mechanism in which the patient will get caught and mangled'. It was 'mass murder of the hospitals', etc.

powers of day to day control, were given legal rights to sue or be sued, were generally strengthened in the hope of attracting the interest of the best people.

In the endowments system, Committees were to be allowed to keep those endowments made between the Royal Assent and the appointed day, and after that date would be free to accept, though not to solicit, gifts. On paper, at least, the amendments to the Bill had succeeded in introducing a large element of decentralization thus seeking to preserve the main advantages of the voluntary hospital system whilst at the same time abolishing the voluntary hospital system. (1)

On the schedules to the Bill, only one change of some importance need be noted. By amendments the original Hospital Management Committees and Boards of Governors of Teaching Hospitals were only to be appointed after consultations with the governing bodies of any voluntary hospitals coming under these bodies. As originally worded this consultation suggested voluntary hospitals in general

(1) In a letter to the Times (6.4.46) Sir Wm.Goodenough (Chairman of Nuffield Provincial Hospitals Trust) called for the following powers to be given to Hospital Management Committees: (1) to accept gifts as legacies, (2) to sue or be sued, (3) to receive a share of Hospital Endowment Fund with freedom to spend it as desired and (4) subject to Regional Hospital Board, to generally manage and control the hospitals. All these points, supported in letters by the Kind Edward Hospital Fund for London and the British Hospitals Association, were largely met by amendments to the Bill.

rather than in particular as the new wording had it.

There is little more to add to this survey of the position from the point of view of the voluntary hospitals. They had lost the day and their property, but for the rest they were quite successful in achieving some 'paper' loosening up of the proposed services.

No direct comment on this Part of the Bill came from the dental organizations who were too concerned with their own part to direct much attention to it. One can however note moves by Captain Baird in the Commons and Lord Wolverton (on behalf of Lord Teviot) in the Lords to obtain dental representation on the Regional Hospital Boards. In each case the Government speaker replied that where necessary and where the right type of person was available, a dentist might be appointed to a Board, but they could not make the Boards representative of any or all of the interests involved. A similar move on behalf of the pharmacists received a similar reply.(1)

The Royal College of Nursing had only one point of complaint which they took up with the Minister. They complained that the affect of the Bill appeared to be that nurses would be employed by the Regional Hospital Boards rather than an individual hospital and therefore would be liable to be moved about the region from one hospital to another. The Minister assured them this was not intended

(1) See p.

and repeated his assurance in Standing Committee. (1)

Within the Labour Party there was some criticism of Mr. Bevan's 'concessions' to the specialists regarding pay and amenity beds. The matter was discussed in some detail in Standing Committee when Mr. F. (now Sir Frederick) Messer asked the Minister for an assurance that he was aiming eventually at a full socialized service with equality of service. He did however realise, what some of his Labour colleagues apparently didn't that the Minister 'wouldbe able quite easily to ignore the opposition of 'the rest of the medical profession if he could carry with 'him the higher ranks of specialists and consultants' (2) This statement from one of the acknowledged experts of the party on the health services, adds to the weight of evidence for the contention advanced earlier in this section of the Minister's attempts to split the profession.

The Conservative's opposition to this part of the Bill can be said to have worked in two directions. In the first place they were opposed to the change of ownership and the transference of endowments. They spoke at length and with apparent feeling against these proposals of Mr. Bevan, but they were not successful and concentrated on seeking to write into the Bill as much decentralization as

(1) Standing Committee Official Report C.4.6.46. c 420

(2) Standing Committee Official Report C.21.5.46 c 153.

possible. Local interest and a job worth doing were needed if the right sort of people were to be encouraged to serve on the Hospital Management Committees. Almost all the amendments concerning the definite strengthening of these Committees, the definite setting out of their powers, their legal status, their direct share in the income from the Hospital Endowments Fund and their right to keep endowments made to them or hospitals under their control between the day the Bill received the Royal Assent and the appointed day of the new service (i.e. between November 6, 1946 and July 5, 1948) were due to the initiative and pressure of the opposition. The Minister often claimed these points as his 'intentions' but the Opposition preferred to have them in writing in the Act. In so doing they affected more changes in this part of the Bill than in any other part.

Mr. Bevan had, thus, decided against continuing the attempt to co-ordinate the two types of hospital and in favour of unification. In so doing he removed the hospitals from their previous owners and cut the ground from under the feet of the voluntary hospitals and the local authorities - with their ownership gone they had nothing with which to bargain.

(F) Conclusions:

The conclusions from this chapter are of some importance. The major one is that the sole new feature

of this part of the Bill and indeed of the Bill as a whole, due to Mr. Bevan, was the nationalization of the hospitals. It was a move which was almost inevitable although not contained in the published plans of the Labour Party. The 'manifold and great' difficulties confronting Mr. Willink in his attempts at co-ordinating two types of hospitals, never before co-ordinated, made further attempts on these lines unlikely; the Labour Party's own firm ideas of a regional local government system had, temporarily at least, also to be abandoned. If he was therefore to achieve regionalization of the hospital system, a point accepted by the Labour Party, the Minister had but one alternative left him - the nationalization of the hospitals and the establishment of ad hoc machinery. It is, therefore, suggested that nationalization entered into the plans for a National Hospital Service rather as a last resort than as any expression of a political dogma. The opposition of the various conflicting interests made any other solution impossible.

The other major conclusion from this chapter, born out by the preceding paragraph, is the essential thread of development throughout the period. Mr. Brown had tried to unify the health services under local government by co-ordinating the two types of hospital and had failed.

Mr. Willink, seeing the opposition of the voluntary hospitals and medical profession sought to modify this whilst maintaining a measure of local government control - i.e. one body ultimately responsible for all the hospital services, and the other health services. Further opposition caused him to move the hospital services outside the other services, suggesting complicated machinery for maintaining a modicum of local responsibility with unification of all health services to be achieved through area and regional plans. Mr. Bevan went one step further - he removed the hospital service altogether from any other health service and at the same time from conflicting interests. His plans, in essence, were a logical outcome of what had gone before with the addition of one new factor, the strong belief in regionalism held by the Minister and his party.

The National Health Service Act, in regard to the hospital and specialist services, is the result of at least four years of negotiation and discussion, although in so saying one must not detract from the great credit which should go to Mr. Bevan in succeeding in legislating where his predecessors had failed. As such he deservedly stands out above his predecessors, but their role in the development of plans for the service must not be overlooked.

CHAPTER 5.

The General Practitioner Medical Service.

The two most contentious sections of the plan for a National Health Service seemed always to be the hospital services and the general practitioner medical service; each government plan aroused opposition to its proposals under these headings. This chapter, then, follows the previous one in the contentious matter of the National Health Service.

(A) Some Alternatives:

Unlike the plans for a hospital service the plans for a general practitioner service had a basis of experience on which to build, i.e. the National Health Insurance system which has already been described.[1] The key points of this service were the right of every doctor to enter the scheme when and where he wanted, the right of the patient to choose his own doctor, the maintenance of the intimate doctor-patient relationship without third party interference, the capitation method of payment, the right of doctors in the public service to provide private treatment, and the right of the doctor to sell his practice, or the goodwill thereof, without government interference.

Around each of these points arose the main problems

(1) See p. 16.

of the general practitioner service. One, the population to be covered, has already been discussed in an earlier chapter (1) where it was noted that throughout the period surveyed the various Ministers of Health always favoured the 100% coverage with the right to any individual to seek private treatment outside the scheme if he so desired but without thereby escaping his obligations to contribute, through insurance contributions, rates and taxes, to the cost of the national service.

The first problem facing the Government here was whether or not the patient should retain the right of free choice of doctor - a decision to abandon this right might have produced an entirely different plan for the service. There were those who said that it was essential to the peculiar relationship of doctor and patient. On the other side there were those who said that the reasons for choice of a doctor were totally irrelevant to the ability of the doctor, (e.g. his surgery's accessibility, his bedside manner, etc.) and that the freedom of choice of doctor was unnecessary, if not, harmful. Throughout the period under discussion, however, this right to a free choice of doctor and the contingent right of the maintenance of the intimacy of the doctor-patient relationship unharmed by third party interference, was accepted by the Ministers as their aim even if, at times, some groups

(1) pp. 112f.

claimed that the methods envisaged made impossible the attainment of these aims.

Under the National Health Insurance medical service, there was a right extended to all general practitioners to practise where they wished and to enter the scheme if and when they desired. No reference at all was made to the need for their services; the sole criterion was the economic one of whether or not the doctor felt able to earn a sufficient income in the area of his choice. The problem in this connection facing successive Ministers of Health was the almost generally accepted need for a better distribution of doctors: two possible courses of action therefore, seemed open to them - compulsion or attraction. The Minister could, by differential rates of remuneration and perhaps other methods, seek to encourage doctors to leave the over-doctored areas like Bath, Bromley and Hastings and move to the under-doctored areas of South Shields, Dartford and Swindon.[1] Or, on the other hand, he could direct doctors to the under-doctored areas, or rather less drastically refuse them permission to practise in over-doctored areas; in these circumstances the right to enter the public service wherever they desired would have to be withdrawn from doctors. The terms 'over' and 'under-doctored' are here used loosely and relatively - it is

(1) House of Commons Official Report Vol.422 c53. Mr.Bevan mentioned these places in his speech introducing the second reading debate.

realized, of course, that a straightforward correlation of population against doctors in the area shows a distorted picture requiring many refinements (e.g. the number of assistant doctors, doctors reaching retiring age, the population structure, etc.)

The problem of remuneration of doctors was one of the most contentious issues in the whole national health service. To some it seemed that the capitation system (i.e. a fixed fee per patient accepted) had faults; (1) it made life very difficult for a doctor starting a new practice, it encouraged the doctor to take on more patients than he could properly care for in the search for higher income; it increased the dependence of the doctor on his patient in that doctors were less able to resist the type of patient (reputed to be all too common) who suggested their own medicine and, if refused, were apt to change to another doctor, (2) and finally it reduced the doctor-patient relationship to an economic one. These critics favoured a full-time salaried service or some modification of it, e.g. a basic salary together with

(1) It is doubtful whether even now, some 7 years later, a final solution has been reached.

(2) One doctor, when discussing this problem with me, said I was understating the issue - a dissatisfied patient not only removed himself but also all his relatives and even his friends.

reduced capitation fees. The defenders of the capitation fee claimed it as an incentive to good doctoring, for it meant the doctor must serve his patient well if he hoped to encourage more to join his list, the doctor could regulate his load to his abilities, his relationship with his patient was not broken by any state interference and finally the doctor was master in his own field and not subject to control on clinical matters. Whatever may be the merits of these points of view, the final decision was not reached until after the service had commenced in 1948, a decision in favour of the continuance of the capitation fees system.

In a salaried service it was assumed that private practice would be forbidden to doctors in the service, but under the capitation fee system it was always a burning question whether doctors in receipt of these fees should be allowed to provide private treatment for other patients. The opponents cried that it meant two standards of service, one for the public and another for the private patient. The doctor they said faced his dilemma of getting money from sick people with the resultant temptation to keep them sick or to delay their recovery. The defenders praised the mixture as giving the doctor a private source of income and therefore a stronger position vis a vis the state (to be a civil servant always forced to obey was anethema to most of the medical profession).

But these were not the only problems facing the Minister setting out to plan a general practitioner service. The National Health Insurance system had allowed the continuance of the custom of buying and selling of public medical practices. Some argued that it was not proper that a right to a public income should be bought and sold, nor that the public patients could be bought and sold in the medical market place. On the other side it was declared that no patient was bought or sold for he could always change his doctor is he did not like the new occupant of his surgery, whilst the sale of the goodwill of these practices was the just reward for the doctor's hard and conscientious work. This problem was linked closely with the method of remuneration to be adopted and more particularly with the distribution of doctors. If a Minister were going to direct doctors to certain areas and forbid them from others, the right to buy and sell practices was endangered. So, too, if a full-time salaried service had been adopted, but at no time was there any question that if this right were endangered compensation should be paid to those affected, or to all general practitioners.

One other main problem remains - the type of practice to be encouraged, grouped or single. One of the complaints of the National Health Insurance, often voiced by the medical profession itself, was the isolation of the

individual general practitioner. Working alone for long hours he had no hopes of keeping up with the current advances in knowledge or discussing problems with his colleagues; one frequent feature of the doctor's home was the unopened pile of medical journals put aside for the spare time which rarely seemed to come or leave the doctor the energy to tackle them. The solution seemed easy - grouped practices especially in health centres where a group of doctors would work together having at their disposal diagnostic and curative equipment not otherwise possible, with the medical auxiliaries beyond the command of the individual general practitioner. Here each general practitioner could be assured of regular time off, time for keeping abreast of medical knowledge, time for discussion with his colleagues and with doctors in other services (e.g. the local authority services) centred at the health centre and time, too, to indulge in some minor specialization according to his interests. In all this, the standard of the general practitioner service would be improved. The problems here were the remuneration of health centre doctors and the control of the centres. The latter is discussed in the next paragraphs, whilst the problem of remuneration always seemed, to the Government at least, to be to avoid undesirable competition among such doctors for patients. The Government invariably fell back on the idea of salaries or similar alternatives

- this automatic response of successive Ministers helped to turn the medical profession against the health centre idea that it had so much to do with in proposing originally.

Having discussed at some length the problems of the general practitioner service in itself, there, alas for any Minister of Health, remained the equally important problems of the administration of the service. He had, in theory, the choice of national, regional or local administration. If he sought to unify all the health services it must obviously follow that general medical practice must fit in with the general pattern, but after Mr. Brown, however, this idea was never strongly forced. The medical profession's strong feelings against local authority control almost automatically ruled our local authority administration of the general practitioner service leaving only ad hoc machinery as an alternative.

The administrative control of health centres posed problems which proved very difficult of solution. If they were to be regarded as outposts of the specialist services then they should come under the hospital administration, or if they were local services, they should be linked with the other local authority services which would use the centres. Three alternatives presented themselves to the Government: to control the

health centres through the hospital administration, the general practitioner service administration or local authority administration.

This survey has shown that any Minister moving into planning the general practitioner services was moving into a territory beset on all sides by pitfalls and traps. Any false move, any false statement and even any concession would bring the interest groups into strong action, and yet changes had to be made in what was termed the 'frontline service' for no national health service would be complete without a good general practitioner or family doctor service.(1)

(B) Mr. E. Brown's Plan, 1943:

According to Mr. Brown the 'front-line service' would be provided by family doctors and would be available to all, free of charge, with the right given to all to choose his own doctor. In urban areas, at least, the family doctor service would work from grouped practices

(1) The terms 'General practitioner' and 'family doctor' are used inter-changeably in the literature on the National Health Service. The latter was, perhaps, more popular with the medical profession - maybe because it recalls visions of the faithful friend of the family attending all their troubles, advising them in times of birth and death and generally acting as a confidante to the family.

in health centres, which would also be the centre of the personal health services of the local authorities. The remuneration suggested for general practitioners was, following a period of duty as a house doctor in hospital, three years spent as an assistant in general practice at £400 per annum. As a principal a doctor would then earn £650 per annum rising by annual increment, over 18 years to £1,200, all these figures being net incomes, expenses being paid above these figures (1). Doctors already in general practice at the time of the inauguration of the new service would have the option of joining the service in a whole-time or part-time capacity whilst new doctors after that date would have the choice between whole-time salaried public service or whole-time private practice. Doctors wishing to join the new service would make application to the Central Medical Board (2) and if accepted by them then to the Local Health Authority for

(1) It is interesting to compare these figures with those given in the Inter-Departmental Committee on the Remuneration of General Practitioners Cmd 6810 May 1946 - figures given in 1939 money values net of expenses of G.Ps (aged 40-9) 7% should be earning under £700 p.a., 20% £700-£1000) 24% £1000-&1300, 24% £1300-£1600, 16% £1600-£2000 and 9% over £2000.

(2) No description of the role of this Board was given.

the area in which they wished to practice. This authority would make the appointment which would be terminable on three months notice by either party.

The plan was for a full-time salaried medical service controlled by local government with some few concessions to the present generation of doctors in respect of private practice. All was to be simply and clearly administered as part of the total unification of all health services. Mr. Brown appears to have implied at least, the ending of the custom of the buying and selling of medical practices.(1)

Previous chapters describe the medical profession's outright rejection of the Brown plan and the two grounds sufficient in the medical view for this rejection are in this part of the plan - the whole time salaried medical service and the control of that service by local government. In reply the British Medical Association set forth the principles by which the profession stood. The state's invasion of personal freedom could only be justified to co-ordinate or augment the existing services and remove

(1) Sir Wilson Jameson, it was reported at a British Medical Association meeting on 31.3.43 had told them the Government accepted the principle of compensation for the loss of capital value of practices.

economic barriers. There should be free choice of doctor, who, in the public interest, should not be a salaried servant of central or local government. The state should not invade the sanctity of the doctor-patient relationship, should remunerate the doctor on the basis of work done or patients for whom responsibility was accepted and should leave room for private practice for all doctors. These principles were the medical profession's reply to the proposals of Mr. Brown.

Their general response of rejecting the plan was so speedy that all but one group had no time to comment thereon. The only group who succeeded in commenting on this part of the plan was the National Association of Insurance Committees who expressed concern at the Government's intention to transfer the general medical service to local authorities for they adhered to the view that the best method of achieving a comprehensive health service was by an extension of the existing National Health Insurance medical system. The administration of the health services should be entrusted to ad hoc bodies, although they recognised special circumstances might alter it in the case of the hospital services. The Association favoured the principle of the patient's right to a free choice of doctor and the maintenance of the doctor-patient relationship, and were not in favour of a whole-time salaried medical service.(1)

(1) National Insurance Gazette 10.6.43.

(C) The White Paper, 1944:

The White Paper set out five principles to be observed in planning a new health service. The first four of these are, in themselves, interesting but their interest grows when it is noticed that the medical profession, whilst accepting their validity claimed the White Paper plan contravened them. The four points were the freedom of the doctor and patient to use the service or not, with the contingent right to seek private treatment if desired, freedom of choice of doctor for the patient, freedom for the doctor to pursue his own professional methods without outside clinical interference and finally the preservation of the peculiar intimacy of the doctor-patient relationship.

Turning to the proposals, a special executive body would be set up, composed mainly of medical members, acting under the direction of the Minister and known as the Central Medical Board. The general practitioner would enter into contract with this body and if employed in a health centre, the local authority would be joined in the contract. The local duties of the Board would be exercised through local committees (including representatives of local authorities) which would supercede the Insurance Committees of the National Health Insurance system.

The pivotal point of the national health service would be the family doctor service available to all, the

general administrative responsibility for this service resting on the Central Medical Board and its local committees, although joint authorities would be expected to make some reference to the needs for the service in the preparation of their area plans. The family doctor service would be provided either through grouped practices or single practices, whichever appeared most suitable to local conditions. Doctors participating in the scheme from single practices would be remunerated, normally, on a capitation basis, whilst those in grouped practices in health centres by salary or other similar alternative to avoid undesirable competition among centre doctors for patients. A doctor in the public service would be permitted to engage in private practice in addition to his public work, and new practitioners or practitioners changing areas, would have to seek the approval of the Central Medical Board before taking up the new public practice, the aim of the Board being the gradual redistribution of doctors in such a manner as to relate the number of the doctors to the needs of each area. (1)

(1) The White Paper (p.33) pointed out that to give doctors the right to practice anywhere would make it impossible for the Government to assure all of a general practitioner service.

Newly qualified practitioners, if desiring public practice in certain areas, might be required by the Board to provide full-time public practice in the area for a number of years. The Board would not be able to prevent these doctors providing full-time practice in those areas or applying to go elsewhere - the only prohibition would be on part-public part-private practice in certain areas. The question of the sale of public medical practices was left over for discussion, the Government stating its acceptance for the principle of compensation for those doctors whose practices were swallowed up in the wider practice of a health centre, or those practices which had to close as the result of the Central Medical Board refusing to sanction a successor.

Health centres would be provided and maintained by local authorities (county and county borough councils) who would use the centres for their own personal health services, such as maternity and child welfare services and health visiting. The exact role of the local authority in the health centre was not defined beyond this general statement.

Mr. Willink in his plan had thus rejected the full-time salaried service and local government control, although he favoured remuneration by 'salary or similar alternative' in health centres. There was also the suggestion in the

White Paper that the general practitioner service though controlled by ad hoc bodies would be part of the plan drawn up by joint authorities, a remnant of the idea of unification of all health services under local government. Prima facie then one might expect the White Paper to be more favourabby received by the medical profession than the previous government plan.

As already observed one of the first actions of the profession's representative committee was to question the Minister on some points in the White Paper[(1)] and in particular on the proposed powers of the Central Medical Board. In a lengthy reply the Minister claimed that, as proposed, it was predominantly a medical body with whom doctors would enter into contract. Its powers were twofold; firstly there must be the power to refuse doctors entrance to the public service where they were not needed and therefore all doctors must seek the consent of this body before starting in public practice; and secondly the Board must have power to compel young doctors wishing to enter the public service in certain areas to practice full-time ib the public service. This power was limited in that the young doctor could apply to go elsewhere or if he felt so inclined set up in the area in private practice. The Minister was also asked what would constitute over and under doctored areas and he replied

(1) British Medical Journal 13.5.44.

that this was a point on which he would welcome the co-operation of the profession.

On the general practitioner service itself, the representative committee's first question found the Minister hoping the profession would join in discussions with him on the problems of compensation for the loss of capital value of medical practices. He refused to agree that Health Centres would more properly come under the Joint Hospital Authorities than the local authorities, and, in reply to a question whether or not he proposed to make experimental health centres, the Minister said that whilst he intended to experiment 'the wish of the local doctors 'to bring their work into the centres must obviously be a 'big factor in decisions to provide centres". No arrangements had yet been made, he said, in regard to the internal working of these centres, and referring his questioners to the White Paper on a question concerning remuneration in the centres, the Minister added as a suitable alternative to salary for such doctors, a basic salary together with a pooling of capitation fees for all the doctors at the centre.

In these questions and answers the main points of the medical case against the White Paper is already apparent - the administration of health centres, the remuneration of doctors therein and the powers of the Central Medical Board. In its report on the White Paper

the Council of the British Medical Association accepted as valid the four principles outlined at the beginning of this section but warned its members that their application was equally important. The opinion of the Council on the proposed Central Medical Board was brief and pointed, objecting to the Board because of its two powers of direction, be they used by doctors or laymen. 'Errors of distribution of medical practitioners' the Report went on 'should be corrected by the process of 'attraction rather than that of compulsion'. (1) The local organization of the White Paper was also strongly criticized as more chaotic than the central organization aiming at 'fragmentation, not unification of medical 'services'.

The report criticized the proposals for health centres as containing no proper basis for experiment. Taking this fact with the powers of the Central Medical Board, the payment of salaries to doctors working in health centres, the White Paper looked, to the Council at least, like the thin end of the wedge of the state salaried service.

Turning from these vigorous criticisms of the White Paper the Council made 'Some Positive Proposals'. Under the heading of General Medical Practice, the Council proposed that terms of remuneration for doctors should be

(1) British Medical Journal 13.5.44.

centrally negotiated and should be related to work done or responsibility accepted irrespective of whether or not the doctor worked in a health centre. The only difference in remuneration between doctors inside and outside a health centre should be the scale of expenses paid. General practitioners should enter into contract through local committees with the Central Medical Board, divested of all compulsive powers, as they were 'unwilling to enter into 'contractual relationship with local authorities' - a mild understatement of medical feelings. It was further proposed that health centres should only be established, in the first place, on an experimental basis in a few areas.

Claiming that the establishment of health centres would adversely affect the capital value of all practices, the Report proposed that compensation for loss of value should be on an all-or-none basis; in no circumstances would they accept compensation only in the cases where a doctor's practice was swallowed up in a health centre. This proposal presupposed, the report went on, the establishment of health centres of a particular type, i.e. where grouped general medical practices would be sited. A centre for diagnostic and specialist investigation only, often called a health centre, would not have any effect on the value of practices.

Special consideration, the Council of the British Medical Association felt, should be given to the remuneration

of general practitioners in rural areas and in those areas there would be need for an extended cottage hospital system. The general practitioner should have the right, as far as practicable, of free choice of consultant whose terms and conditions of service should be centrally negotiated. Finally, the Council's Report suggested that private practice be maintained for those who wanted it, the Council reserving its final opinion on private practice until such time as fuller information on the Social Security plans should be available.

Amongst the other medical bodies the Socialist Medical Association, at its Annual Meeting, deplored 'the report' issued by the Council of the British Medical Association', i.e. the document reviewed in the foregoing paragraphs. It felt the British Medical Association was fighting for sectional interests against a scheme approved by all the political parties for all the community.

The Report of the British Medical Association was described as 'hesitating and obscure', 'nebulous and incomplete'[(1)] by the Medical Practitioners Union who set out their views on the White Paper in a memorandum which appeared at the end of June, 1944. Claiming to represent the progressive general practitioners the Union restricted its suggestions to such amendments as might prevent the future service being hampered 'by the obloquy and bitterness

(1) Medical World 26.5.44.

which so greatly diminished the usefulness of the 'Panel system'[1]. They felt that professional freedom should be safeguarded in the Act with a right of appeal for doctors to the Courts of law against any penalties imposed by the Minister, but they were not opposed to 'such 'direction as the service may require'. The Central Medical Board should be an elected body responsible for the quality of the general practitioner service and it should provide equip and maintain health centres where doctors would be paid on a salary basis. Whole-time general practitioners should be paid by salary and part-time ones on a capitation fee basis, both methods to include allowances for length of service and special qualification. The report ended with a long section on matters concerning the payment of compensation and of pensions.

Once again some attempt can be made to correlate the views of bodies of the medical profession with those expressed by the profession as a whole in the questionnaire sent to all doctors in the spring of 1944. Many of the questions and answers are pertinent to this chapter, the first being one which asked if the White Paper infringed a principle earlier accepted by the profession: 'The 'profession rejects any proposal for the control of the 'future medical service by local authorities as at present 'constituted'. 80% of all doctors and 84% of general

(1) Ibid 30.6.44.

practitioners felt that the White Paper infringed this principle, whilst 55% of all doctors agreed that general practitioners should be under contract to the Central Medical Board as stated in the White Paper. Another principle, '.. no administrative structure should be 'approved which does not both permit and encourage free (choice as between doctor and patient' was set against the White Paper, 58% of all doctors and 64% of general practitioners agreeing the principle had been infringed by the proposals of the White Paper.

Two questions sought the views of the profession on the powers of the proposed Central Medical Board. 57% of all doctors (51% general practitioners) regarded as reasonable the power of the Board to require all doctors to seek its consent before entering the public service in a new area, whilst 66% regarded the second power concerning young doctors as unreasonable. In this part the questionnaire supports the professions leaders on the second half but reverses their policy on the first - a point never acknowledged by any change of policy on this issue.
(1)

Of all doctors 68% approved of the principle of health centres, 53% disagreed with the proposal to link local authorities with the Central Medical Board on

(1) Cf. p. 122. At no time did the profession change its policy because of the results of the questionnaire.

contracts for centre doctors, whilst on the subject of remuneration 34% of doctors favoured a small basic salary plus capitation fees for centre doctors. On this point general practitioners differed from their (1) colleagues the highest percentage (31%) voting for capitation fees. The highest percentage for all doctors and for general practitioners as a group (44% and 55% respectively) favoured capitation fees as the method of payment for doctors in single practices.

Asked whether the sale and purchase of public medical practices should continue general practitioners were equally divided 44% favouring continuance and 44% its cessation. For all doctors the figures were 52% in favour of the ending of the sale of these practices, a figure which rose to 56% when the question was widened to include all general medical practices. General practitioners (53%), too, favoured the ending of sales providing compensation was paid to all. In this again one finds the questionnaire results in conflict with the policy of the profession, and once again no change in policy was made.

(1) The profession voted against the White Paper idea of a health centre which they said was merely a grouped practice - 42% preferred health centres where preventative and curative services met.

These results, in the main, support the general policy put forward by the leaders of the profession, though with the two important exceptions on the power of the Central Medical Board and the sale of medical practices. Only once though did the support for the Council reach a figure high enough to justify any claims of a united profession and this on the question of local authority control - a question on which the profession had for long been united. The questionnaire, therefore, was little more than a weak support for the leaders of the profession in their task of negotiating with the Minister.

At its postponed annual meeting in December, 1944, the Representative Body of the British Medical Association accepted the report of its Council outlined above[1] going on to add four 'principles' as a basis for negotiations. (The continued use of 'principles' by the medical profession is confusing to the student of their literature). These were, firstly the freedom of choice for both doctor and patient, secondly non-intervention in professional matters in the doctor-patient relationship by any third party, thirdly medical representation at all levels of administration by election by the profession and finally the evolution of a National Health Service by stages governed by the availability of medical personnel. The

(1) See p. 243 f

latter point, no doubt, took account of the fact of the absence of many of the profession in the fighting services and sought to prevent a full service until these had returned. One is bound to comment on the grandiose vagueness[1] of these principles, a vagueness which seems to pervade all statements of 'principle' by the profession.

Only two other groups commented on this section of the White Paper, the National Association of Insurance Committees and the Trades Union Congress. The former regretted the Government's decision to abandon the well-tried system of insurance committees, and called for ad hoc machinery representative of all the interests concerned to administer the general practitioner service. They repeated their disfavour of the idea of a full-time salaried service for general practitioners. Mainly, one may summarize, this, therefore, as the cry of committees soon to be disbanded.

The Trades Union Congress did not press for a state medical salaried service, as it might have been expected to, nor was it opposed to private practice, but it strongly opposed part-public part-private practice as retaining two standards of service. The co-operation of

(1) Cf.p. 56. where it is suggested that this vagueness was the price paid for conflicting interests within the Association.

the doctors, they added, was essential to the success of the schemes. This supports, to a degree, the suggestion made to me in private conversation (1) that one of the main reasons for the dropping of the idea of a full-time salaried service was due to the views expressed by the Trades Union Congress on the importance of the co-operation of doctors.

As at the end of the previous section one is left with the views of the medical profession alone to summarize. The profession opposed the Brown plan with success, and now they opposed the White Paper, also with some faint degree of success, as the next section shows.

(D) The Revised White Paper (or Willink) Plan, 1945:

The two powers of compulsion of the Central Medical Board of the White Paper plan were dropped, in this new plan, in favour of a provision on the lines of section 37 of the National Health Insurance Act, 1936, (1) and, indeed,

(1) With a leader of the British Medical Association.

(2) This provided that where a service was inadequate the Minister could authorise the Insurance Committee to make other arrangements and pay to contributors a sum in lieu of medical benefit - according to the White Paper (p.33) this power had never been invoked.

its whole existence was left to the decision of the profession. It would continue as an employer body for general practitioners or would be scrapped altogether in which case this function would revert to a revised form of National Health Local Insurance Committees.

The general objective of the revised local administration of the general practitioner service would be to 'keep as closely as possible to the tested and 'familiar methods of National Health Insurance adapting 'the machinery only so far as was necessary to fit the 'wider scope of the new service'. (1) A statutory committee for each county or county borough area, nominated by the various interests, would replace the National Health Insurance Committee, and a local practitioner committee would replace the existing local medical and panel committees but, for the rest, little change would be made. Local authorities would provide health centres subject to centrally controlled experiments on the advice of the Central Health Services Council. Doctors in Health Centres would be on similar contract to other general practitioners (i.e. with the Central Medical Board of local alternative) but a solution would be needed to bring local authorities into the contract; the suggested method meant the local authorities contracting with the local committees of the general practitioner service to provide the necessary services at the centre, and the

(1) British Medical Association document.

committees, in turn, contracting with the individual general practitioners. The thorny topic of the remuneration of general practitioners was left open pending the report of the Spens Committee. According to the version circulated by the British Medical[1] Association the Government's views were as follows:- 'methods of remuneration in separate general practice 'to be by capitation, but the views of the profession's 'representatives would be welcome on the desirability of 'having some basic part-salary over and above which the 'rest of the remuneration would be by capitation. This 'might facilitate a system of differential basic salaries 'in different areas as added inducements to new 'practitioners going into unpopular or difficult areas. 'It would also help to secure reasonable minimum 'remuneration for young doctors in the early years of 'practice". Similarly in health centres doctors would be remunerated[2] on a basic salary with a share of the aggregate capitation fees for all patients attending the Health centre.

(1) See p. 235a.

(2) This might almost be Mr. Bevan. - cf. House of Commons Official Report Vol.422 c55 - Mr. Bevan in the Second Reading debate.

On the subject of the sale of public medical practices the statement repeated the announcement of the Minister in the House of Commons. In this he said,[1] that the Government recognized that a case could be made out for the abolition of the custom of buying and selling of practices, but that such abolition was not necessary to the initiation of the new service, as it would cause great difficulties. The Government, therefore, proposed to make no change in the custom for the time being but would hold an impartial enquiry into the problem after the service had had time to settle down. If, after this, it was decided to abolish the custom, compensation would be paid to all doctors affected.

With this plan the wheel had completely turned, the administration of the general practitioner service reverted to ad hoc bodies separate from the other health services. Remuneration was left to be decided at a later date, the powers of compulsion and direction were abandoned and health centres dropped from the important role assigned them in the White Paper to being an experiment.

The British Medical Association welcomed the fundamental changes in the plan, the dropping of the powers of direction of the Central Medical Board and the offer to drop the Board completely; the acceptance of the proposals that general practitioners should not be in contract with

(1) Ibid Vol.410 c160 3.5.45.

with local authorities and that all general practitioners, health centre and separate, should be in contract with the same body; the promise that health centres should be the subject of centrally controlled experiment and the recognition by the Government that the custom of buying and selling can properly continue with the promise that if and when it be abolished all doctors would receive proper compensation. Indeed a recital of another major triumph for the medical profession second only to their victory over Mr. Brown.

A Special Representative Meeting of the Association rejected the Central Medical Board saying that local administration of the general practitioner service should be in the hands of a statutory committee representative of the various professions, but predominantly medical in composition. The meeting favoured leaving comments on health centres until the results of the experiments be known. Having arrived at a largely agreed administrative structure the meeting set forth a further series of points to be approved by them before accepting any plan as a whole. No plan must split the profession rigidly into sections, no agreement until more was known on the disciplinary machinery, proposals for the control of certification and proposals for the safeguarding of private practice; and no final decision until the profession knew its remuneration, and if necessary its

compensation.

Although the medical profession were still far from completely satisfied, it is safe to say that this plan came very near indeed to satisfying them and they had no major criticisms to make of it in regard to general practice. If the British Medical Association thought this way, the Medical Practitioners Union could only think of the sacrifice of the White Paper and the betrayal of the public welfare. It summarized the plan with the motto 'as little progress as possible'. The Socialist Medical Association, too, felt alarmed sounding a call 'The White Paper in Danger'. At a hastily summoned meeting, a resolution was carried calling on the Government to implement the White Paper, and nothing less, by legislation in the present session of Parliament. It urged the Government not to be influenced by those opposed to social progress and promised all possible help in overcoming powerful reactionary opposition.

To round off the survey of reactions to the revised plan the views of the Labour Party as set out in their Speakers Handbook for 1945 can be mentioned. They aimed at a better distribution of doctors with a right for patients of free choice of doctor up to a maximum number of patients per doctor. Health centres

would be set up as the pivotal point in the front line of the medical services. 'Salaried doctors in the National Health Service would be prevented from accepting 'private fees, in order that they should devote their whole time 'to their health centre patients'. The selling of public medical practices would be prohibited but the conditions of service of doctors would be improved. In the light of these remarks, the views of the Party on Mr. Willink's concessions can be imagined.

Despite its brief appearance on the political stage, the Willink Plan, in this respect, achieved considerable acceptance among the groups (or more correctly, with the main group, the medical profession), with the exception of the groups of the political left. It was the addition of these groups as a force to be reckoned with, after the general election in 1945, which upset the balance so laboriously achieved by Mr. Willink.

(E) National Health Service Bill and Act, 1946:

The pattern adopted for the general medical services had much in common with Mr. Willink's revised plan and with the National Health Insurance system. Ad hoc bodies representative of patients and the professions would be set up to provide this service (and pharmaceutical, dental and opthalmic services) in areas corresponding to those of county and county boroughs. General medical practice would be carried on, in the main, from health centres

provided and maintained by county and county borough councils., The sale of medical practices would be discontinued and provision would be made for the payment of compensation to doctors for their loss in this matter. The future sale of goodwill of these general medical practices would, therefore, be disallowed. The duty of the ad hoc bodies to be established,[1] Local Executive Councils would include the preparation of lists of practitioners willing to provide the general medical service. After the opening months of the service any doctor wishing to join the public service would have to apply to a Medical Practitioners Committee (a central body of doctors) who would grant permission only if they decided the area in question had need of the doctor's services. They would refuse him entrance in the public service in over-doctored areas. Local representative committees of doctors, dentists and pharmacists would be set up for advisory and disciplinary purposes. The removal of any practitioner from the service could only be ordered by the Tribunal (with appeal to the Minister), a central

(1) Mr. A. Bevan had announced the Governments intention to discontinue the sale of practices some months earlier - House of Commons Official Report 6.12.45.

body including professional representatives, which decision could be taken on the complaint of a Local Executive Council or any other person, that the continued inclusion of a practitioner in the service would be prejudicial to the efficiency of the service.(1)

In cases where the service was inadequate the Minister would have powers to 'make other arrangements', The Minister could provide, through regulation, for changes for the issue and repair of appliances more expensive than those prescribed and for the repair or replacement of appliances where such repair or replacement was due to negligence on the part of the owner. Refresher courses would be provided, together with payment of expenses for attending such courses, for medical and dental practitioners.

Thus Mr. Bevan had followed Mr. Willink in setting up ad hoc machinery for this service, revived the idea of negative direction without the power to compel young doctors to th full-time service,(2) permitted the continuance

(1) The Minister already possessed a similar power under S.36 of the National Health Insurance Act, 1936. "If the Minister, after such inquiry as may be prescribed, is satisfied that the continued inclusion in the list of any medical practitioners would be prejudicial to the efficiency of the medical service of the insured, the Minister may remove his name from the list.

(2) See pp.247 It may be no more than coincidence that the power retained by the central body, renamed the Medical Practices Committee was one deemed reasonable by the majority of doctors in the 1944 questionnaire.

of part-public part-private practice, decided to end the sale of medical practices, a decision which Mr. Willink had postponed, restored health centres to the forefront of the service and set up the disciplinary machinery, on which Mr. Willink had reached no decision. Of these main points of his plan, all but the last, the disciplinary machinery, come from one or other of Mr. Willink's plans, either as a continuance of his last plan or a revival from his first, the White Paper. Mr. Bevan included in his Bill no mention of remuneration and refused to write any method of remuneration into it. He spoke of favouring a basic salary together with capitation fees and he said he was not in favour of a full-time salaried service. He did not believe the medical profession was 'ripe for it',(1) using reasons quoted earlier from Mr. Willink's revised plan to justify his ideas regarding the basic salary element in the remuneration of doctors.(2)

Some study of the amendments to this section of the plan must be attempted, turning first to an unsuccessful amendment. Of two amendments carried against the Government(3)

(1), House of Commons Official Report Vol.422 c55.

(2) See pp. 253.

(3) The other amendment to S.19 sought to enforce the agreement between the London County Council and the Metropolitan Boroughs Standing Joint Committee re local health services - see p.

in the House of Lords and rejected by the House of Commons, one concerned the remuneration of doctors. It sought to limit the remuneration of general practitioners, except in exceptional circumstances, to the capitation method, a fee for each patient for whom the doctor accepts responsibility. It had been moved unsuccessfully in the Commons, and when the House met to consider the Lords amendments it decided to reject it on the grounds that it 'was inexpedient that the method of remunerating 'doctors providing general medical services should be laid 'down in the Statute'. This failure makes all the more remarkable the amending Act of 1949 introduced by the same Minister making illegal the introduction of one type of remuneration, the salaried service, by regulation. In the intervening years the medical profession had secured another victory.

The amendments accepted to the Part, Part IV of the Act setting out the general medical service, are not as important as those accepted to the Part on the hospital services, but a few are worthy of mention. The sections, concerning the distribution of general practitioners, as originally worded, appeared to enact that the Medical Practices Committee, the central body, would actually choose the doctor for each post. This wording was strongly criticized and the Minister introduced an amendment to meet the criticisms ensuring that before making an

appointment the Committee would consult the Local Executive Council (and it the Local Medical Committee, the professional representative committee) of the area concerned, Mr. Bevan adding that, in the majority of cases, it would merely confirm the recommendation of the Local Executive Council. The position does not seem much clearer on the face of the Act as a result of the amendment, but it was the intention of the Minister that the Medical Practices Committee would only decide on the question whether mpre doctors were needed in any area and not on the ability of an individual doctor to fill the appointment. The section was further amended in the Lords, by the Opposition, by binding the Committee, in making appointments, to have regard to expressed desires on the part of applicants to practice in a certain area or with certain people and to have special regard to these desires when the medical practitioner in question was related to another in the area.

The sections forbidding the sale of practices seem to the layman, as they did to the learned Lord, Viscount Maugham, 'quite unintelligible'. These sections were amended in three ways. In the first place the insertion of the word 'Knowingly' to the clause setting out a new offence imported to the offence the need for the prosecution to prove a 'mens rea'. Secondly the Minister agreed that charges under this section should only be chargeable on

indictment, the original wording giving the alternative of petty sessional trial. The third, and perhaps the most important of the amendments made it possible for a doctor or his representative selling a doctor's house to obtain from the Medical Practices Committee, on a statement of the facts, a certificate stating the transaction to be free of any sale of goodwill, and therefore legal. This certificate, unless obtained on false information, would be a bar to all prosecutions under this section.

This survey of the amendments to the pertinent part of the Bill ends, as it began, with reference to an unsuccessful amendment. The disciplinary machinery, as set out in the Bill, gave the practitioner the right of appeal to the Minister of Health against the decision of the Tribunal. A long discussion took place in Standing Committee on an amendment to substitute a right of appeal to the High Court. The Minister claimed that, to give the right to doctors to appeal to the Courts when they had been dismissed for being 'bad servants of the public', would make it impossible to deny such a right to miners, railwayment and others and that that 'would be real judicial 'sabotage of the socialized services'.(1) Following normal Parliamentary procedure the amendment was moved in two parts, the first question being to leave in the appeal to the

(1) Standing Committee Official Report c774 26.6.48.

Minister, the question being defeated by 19 votes to 17. When, however, the second part of the question, to insert the new wording, was put the Government was successful it being defeated by 17 votes to 16, the Bill thus being left without any right of appeal. The Government as might be expected used its majority on the Report Stage to reinsert the appeal to the Minister. ,Of the 46 members (excluding the chairman) who attended the Standing Committee on that day only 36 voted and of these three crossed the floor in the first vote and abstained in the second. These were Drs. R. Clitherow and H.B. Morgan, (Labour) and Mr. P. Piratin (Communist). Of the ten members not voting, eight were supporters of the Government and including health service specialists Dr. Comyns and Mr. Messer. Whether their abstention was deliberate or unintentional is not known. (1)

Leaving the amendments to the Bill and turning to the reactions to the Bill, one turns first to the British Medical Association and its Council's report on the Bill. It pointed out the three compartments into which the national health service was being divided and went on that 'effective functional integration can be secured only by 'concentrating local responsibility, administrative financial 'and others, at one level and in the Association's view the 'appropriate level is the one selected for the hospital

(1), See Appendix for note of Labour M.Ps. voting against the Government.

'services, the regional level. This regional integration 'is essential not only to efficient administration but in 'the interests of the public'. (1)

Under the heading of 'family practitioner service' the Report stated that a few Health Centres should be established on an experimental basis before committing them as the basis of the new service. The degree of choice of doctor would be somewhat limited by Health Centre provided by local authorities, if they were limited to patients living in the area of the providing authority. Finding no mention in the Bill of assistants to general practitioners, the Report claimed the abolition of goodwill would discourage partnerships and assistantships. It asserted that better distribution of doctors by control, the Government's aim, was undesirable and unnecessary (this latter point was a new claim by the profession) (2) The figures of ratio of population served to doctors in an area did not present a complete or true picture, taking no account of the age

(1) This antithesis between efficient administration and the public interest is interesting. It has always appeared to me that administration, be it of the health service or of the coal industry, must help towards their aim - the public welfare or interest.

(2) Cf. p. 243.

record and qualifications of the doctors concerned. The 100% service would further the more even distribution of doctors noticeable under the partial coverage of the National Health Insurance scheme. Special inducements should be used for this purpose and to overcome the problems of providing a general practitioner service in sparsely populated rural areas. From these sentences the Report deduced that if control was not necessary then neither was the abolition of sale of practices. It found that the abolition of goodwill, the use of a part-salary basis to remuneration (not actually in the Bill) and the powers of control took the profession much nearer to a whole-time salaried service. The profession was opposed to the idea of a basic salary on the grounds that if it were paid only when a certain number of patients are achieved, it would be unnecessary and if it were paid irrespective of the number of patients then it would be extravagant. With this argument, apparently considered to be unanswerable, the Report turned to discuss compensation.

A letter from Dr. C. Hill the Secretary to the Minister was quoted outlining the fact that although the Association was opposed to the parts of the Bill which made compensation necessary, it agreed to enter into discussions on the amount of compensation payable without prejudice to its views on the necessity therefore. The letter went on

that 'the sum of £66 m. which the Government ... now offer 'may, on the evidence available, be taken to represent the 'aggregate capital loss involved in respect of the goodwill 'of general practices'. This sum was based on (a) the government's estimate that 17,900 principals would enter the service, (b) that figure as a maximum even if more than that number of doctors enter the service, and (c) the figure being reduced by one/17,900th of £66 m. for each principal under 17,700 in the number of doctors entering the service. (This agreement was later written into the Act on the initiative of the Opposition).

The Report said that the civil rights of doctors in the service should be safeguarded in the Act, and claimed that the exclusion of the Industrial Medical Service could not be justified. It regretted the absence of new proposals for greatly expanded medical research.

This Report of the British Medical Association's Council ended by comparing the Bill against the seven principles set out by the Negotiating Committee.[1] Three of these were important in that they were explicitly or implicitly violated by the proposals of the Bill. The plan would lead to doctors becoming full-time salaried servants of government, either central or local, thus contravening the first principle. The fourth principle (one almost feels compelled to grant these principles a

(1) pp. 100 -1n.

capital letter 'Principles') concerning a doctor's freedom to choose the place, form and type of work was in conflict with the proposals of the Government. No right was given to all doctors to participate in the scheme thus compromising the fifth principle.

When the Representative Body of the Association met to consider the Report, which it accepted in large measure, it added some motions of its own. It claimed that the right to buy and sell medical practices was essential to the freedom of the patient and the profession, it objected to any central control over where doctors should practice and firmly rejected all forms of remuneration other than a fixed capitation fee.(1) The importance of the adjective 'fixed' ought to be explained: the National Health Insurance system (which, in all these resolutions, was favoured by the medical profession who thirty years before had resisted its introduction) involved a set free for each patient, but some people had suggested, as a means of cutting down doctors' lists, that a sliding scale of such

(1) This insistence on a fixed capitation fee seemed hardly to balance with their insistence on attracting doctors by some method to the poorer areas.

fees be introduced whereby full rates would only be paid for the first, say thousand, patients whilst patients beyond that number would attract a progressively smaller fee. It was this idea that the Meeting was firmly rejecting. It urged the right of appeal from the disciplinary Tribunal to the Courts of law, viewing with 'apprehension the penal powers vested in the Minister'.

The Medical Practitioners Union in their Journal found the Bill 'frankly disappointing from the point of view of the general practitioner'. His status would be debased, his chance of teamwork in a health centre negatived and his right to treat patients in hospital gone. The Union noted that the penal procedure for the general practitioner would not apply to the specialist and insisted on the right of appeal to the Courts of law. Remuneration should be fair and personal freedom interfered with as little as possible. Doctors in health centres chould be paid by salaries and all general practitioners should work in close co-operation with the hospital and public health services. All medical services should be under regional control, (an interesting point of agreement with the British Medical Association) and all administrative officers concerned with the general practitioner service should be general practitioners of at least five years experience.

In May, the Annual General Meeting of the Socialist Medical Association, alone of the medical groups studied here, warmly welcomed the National Health Service Bill. The Association recommended the interim adoption of the administrative proposals pending a reform of local government when it suggested that all health services be under the control of regional authorities, democratically elected. The remuneration of general practitioners fell short of the aims of the Labour Party, and the Association felt that, at least, remuneration for doctors in health centres should be by salary to secure the proper team work, and, that all doctors should have the right to opt for remuneration by salary. The Association had realized one of its major aims, a National Health Service Bill, and felt that it was now their job to ease the passage of the Bill and explain the new service to the general public. Their aim, of a fully socialized medical service, still stands unattained.

The medical view on the amendments made to the Bill can be suggested if not firmly stated as no list of amendments sought by the profession is available. Undoubtedly they must have welcomed the amendments noted earlier concerning the duties of the Medical Practices Committee, although the amendments did not meet their claim for the ending of direction. The Amendments to the clauses ending the sale of practices, and making an offence

of the sale of goodwill, though minor ones to a profession opposed to the principle of the clauses, must have been some small comfort as it improved the lot of the doctor and removed the dangers of falling, unknowingly, into an offence. The writing into the Bill of the actual details of the agreement on the payment of compensation[1] was again a small consolation for the profession, but in no case were the amendments more than that. The principles behind the clauses concerning direction, the abolition of the sale of practices and the disciplinary machinery, all principles rejected by the profession, remained unchanged.

Before taking leave of the medical profession, this is perhaps the best point to note a defiant gesture by the profession soon after the Act had received the Royal Assent. This move is mentioned here as it was on the proposals for the general medical service that the profession were most at odds with the Minister of Health. Soon after the Bill received Royal Assent a referendum of all doctors was organized by the British Medical Association on the question 'Do you desire the Negotiating Committee to enter into 'discussions with the Minister on regulations authorised by 'the National Health Service Act?' Over 80% of the profession replied to this question and of the replies 54.5% rejected discussions on the regulations. The profession had refused to accept the fait accompli of the Act and intended to await some concessions from the Minister

(1) Section 36.

before going any further. The result of this action lies outside the period here studied, but a glance at the National Health Service (Amendment) Act, 1949, shows that the gesture had, from the point of view of the profession, a reasonably successful outcome.

To come back, however, to the Bill, one turns to the local authority organizations one of whom, the Association of Municipal Corporations broke the silence on this part of the service to comment on health centres. They sought to have the responsibility of these centres transferred from local authorities to the Regional Hospital Boards in view of the high cost and little responsibility which would fall on them. In this complaint they were opposed by the County Councils Association and by the Minister who refused to make the change or to increase the powers of local authorities saying that he had agreed that doctors in health centres should not be servants of local authorities.(1) The peculiar role of local authorities in health centres was criticized but it is apparent that Mr. Bevan hoped to secure some sort of co-ordination between the different branches of the national health service in the common

(1) Cf. p. 364. One might almost say the Minister was refusing an amendment because of a 'concession' to an interest group.

meeting ground, the health centre. To bring the medical profession in, he had to refuse to extend local authority power over them, and what might to him have seemed like an important new service for local government to atone for the loss of the hospital services, seemed to the Municipal Corporations, at least, an unwanted burden.

To meet his view of health centres, the Minister had put in the Bill a proviso exempting the doctors working in health centres from local authority employment. Dentists were afforded a similar protection, but a move by the pharmacists to extend the protection to themselves was not successful, the Minister refusing to accept such an extension.

The National Association of Insurance Committees welcomed the return to ad hoc machinery for the general practitioner service. They sought to ensure seats on the new bodies for some members of the existing system, but the Minister refused to include an amendment to that effect. Mr. C. Key, the Parliamentary Secretary to the Minister of Health told the Association's Annual meeting in October however that the Minister intended to use their experience in the new service, whereupon they promised him their help in the difficult period of transition to the new service.

On the proposals of this Part the Conservative Party opposed the Government on the major principles, they opposed the abolition of the sale of practices, the direction of doctors, the disciplinary machinery especially in its absence of an appeal to the Court, the basic salary idea and the Minister's unwillingness to write into the Act a method of remuneration and the important role assigned to health centres. How much of this opposition sprang from previous beliefs is hard to gauge as no published plan of the Conservative Party exists. All these major points (except the disciplinary machinery and the immediate abolition of the sale of practices) had been included in the White Paper of 1944 drawn up by Mr. Willink who now led the Conservative Opposition on the Bill. He had come to the conclusion that these things 'were not worth the candle'.

Within the Labour Party, too, there were criticisms of the Government's proposals, but all of these criticisms were complaining that the Government had not gone far enough and had compromised too much. Points on which the opposition centred were the continuance of the part-public and part-private practice and the continuation, in a limited form admittedly, of the capitation fee method of remuneration. The critics wanted doctors to be in the public service on a whole-time basis and to be remunerated by salary. One criticism falling outside this general

heading has been noted earlier - the criticism of some few Labour members against the refusal of the Minister to concede a right of appeal against the decisions of the Tribunal to the High Court.

(F) Conclusions:

Mr. Brown envisaged a general practitioner service, the front line of any successful national health service, on a full-time salaried basis as part of local government services. His successor Mr. Willink gradually moved further and further away from this idea in his endeavour to meet the doctors until he finished with a system resembling the existing national Health Insurance system with experimental health centres and perhaps some change in doctor's remumeration. When Mr. Bevan came to the Ministry of Health he had another big group to meet, his own supporters who had determined views on a full-time salaried service working in health centres. He, therefore, re-introduced two of Mr. Willink's original ideas - the important role for health centres and the direction of doctors. He took over from Mr. Willink's last plan the basic salary idea, and, in fact, he added nothing new merely borrowing ideas from past government plans. Many of these ideas had, it's true, vanished to meet the medical profession's views but now another group had arisen calling for their return. Mr. Bevan had, therefore, to go part way to meet them as he went part way to meet many

groups - in so doing he upset the balance achieved by Mr. Willink.

This chapter has shown, as clearly as any other in this study, the importance of the interest groups, and the importance of the entrance onto the stage of a new powerful group - the Labour Party, in the development of plans for a National Health Service.

CHAPTER 6.

Other General Practitioner Services - Dentistry, Pharmacy and Opthalmics.

These services are grouped together and given the same administrative machinery. They are, therefore, studied together here.

(A) Some Alternatives:

The problems in this section were fewer and less explosive in content than those of the previous chapter. All the services were available as a public service to limited sections of the population, but it seemed logical that if the general practitioner medical service was to be made available to all, these services must similarly be made available to all. This presented no difficulties in the case of the pharmaceutical service, but there were problems in the other two services. In the case of the dental services it was constantly stated that a service freely available to all would increase the demand beyond the ability of existing dentists to meet it. A real problem was posed therefore, whether the service should be a total one or should be limited to some definite classes of the population (e.g. children and adolescents, nursing and expectant mothers) until the number of dentists could be increased.

In the opthalmic services a similar problem was complicated by the long standing dispute between medical

and lay opticians. The main points of the dispute have been outlined (1) the medical profession claiming that all eye testing be done by them leaving only the dispensing of spectacles to the lay opticians, whilst the latter claimed to be able to perform successfully the bulk of the testing of eyes (i.e. testing for errors of refraction) together with the dispensing of spectacles. If the medical view was accepted obviously there would be a great shortage of trained doctors to undertake the work, but if the lay case was successful, then there were probably enough practitioners to work a full service.

The problems of administering these services were similar to those of the general practitioner medical service. The alternatives were the same, regional bodies, local authorities or local ad hoc bodies, and the dislike by these professions of lay control, especially local government control, was as strong as that of the medical profession.

(B) Mr. E. Brown's Plan, 1943:

Throughout the early part of this chapter these services are shown as relegated to the more detailed arrangements of a national health service, and it is not, therefore, until the later plans that real discussions on these services took place. One point, however, about the Brown plan must be made. No specific proposals were made

(1) See p. 57.

but the appointment of the Teviot Inter-Departmental Committee showed the Government's awareness of the problems of one of these services, dentistry. Its terms of reference bring this out: 'To consider and 'report upon (a) the progressive stages by which, having 'regard to the number of practising dentists, provision 'for an adequate and satisfactory dental serbice should 'be made available for the population; (b) the measures 'to be taken to secure an adequate number of entrants to 'the dental profession; (c) existing legislation dealing 'with the practice of dentistry and the government of the 'dental profession: (d) measures for the encouragement 'and co-ordination of research into the causation, 'prevention and treatment of dantal diseases'.[1] These terms of reference suggest the Government accepted the claims of a shortage of dentists in a full service and had intentions of introducing such a service by stages.

The main preoccupation of the dental profession was that doctors would be called on to represent them in discussions on the National Health Service but the appointment of the Teviot Committee largely set those fears at rest. The British Dental Association therefore devoted its energies to drawing up a memorandum which it submitted to the Committee. In a general long view policy the

(1) Its Interim Report was published in November, 1944 Amd. 6565 and its Final Report in February, 1946, Cmd. 6727.

Association recommended methods to make the profession more independent. It recommended a reconstituted Dental Board removed from the control of the General Medical Council, stricter control of the practice of dentistry and of the work of dental mechanics, better facilities for dental education, and a dental administration free of any medical control. It stated that a salaried service, either as part of the functions of the local government service or the central departments, was not in the public interest. 'In the view of the 'Association it is essential for the well-being of the 'dental profession and hence of the public, that private 'practice should be maintained to the fullest possible 'degree'[1] The backbone of any profession, it claimed, was the individual member, the private practitioner. The plan suggested in the memorandum divided the population into two groups - the priority and non-priority classes. The priority groups would include all children, nursing and expectant mothers and adolescents up to the age of eighteen. These groups would be treated at dental health centres (with a right to seek private treatment elsewhere) by a salaried staff under the general control of the Ministry of Health, the administrative officers of this service being dentists. For the non-priority classes[2]

(1) Memo to Inter-Dept. Committee - Nov. 1943 p.20.

(2) These would be existing contributors together with adult dependents. No free service would be available to all, but it was suggested that as persons left the priority groups they might qualify - see next para.

there would be the private practitioner service presumably on a system somewhat like the National Health Insurance system. These latter plans were put forward as a transitional method of firstly tiding over the period of shortage of dentists and secondly building up for each individual a dental service which would maintain dental fitness from childhood onwards.

Remuneration of dentists would vary according to the part of the service in which they worked. Those in dental health centres would be paid by salary whilst the private practitioner would get his income in three ways. In the first place he would, of course, be able to charge fees to private patients. For those patients coming to him under the service (i.e. those of the non-priority classes) he would be remunerated in one of two ways. For those over a certain age, say 11, at the time of the scheme starting, he would be remunerated by a scale of fees in respect of work done. When the scheme had been in operation for some time those over 18 (or for a while a lower age) would have passed through the priority service and would be dentally fit and for these the dentist would be paid a percapita fee for each patient on his list.[1] It was assumed that once a person had been made dentally fit by the priority service the amount of treatment needed per annum would be an easily calculated average. In this

(1) Similar system to that used in the Medical General Practitioner Service.

case the per capita fee was much the easier method of payment, whilst for those at present leaving or having left these classes dentally unfit it would only be fair to continue a scale of charges system. The editorial of the Journal said of the scheme that it offered 'the 'public the possibility of securing complete dental 'treatment for everyone in need of it. Progress towards 'that end must necessarily be gradual and it (was) one 'of the principal merits of the proposals that their 'adoption would render easy the transition' (1)

Pharmacists:

The reaction of pharmacists to the Brown plan which contained no specific reference to pharmacy seemed, if one can judge from the columns of the Pharmaceutical Journal to be centred mainly on the provision of health centres. An editorial (2) criticized those who wanted to set up pharmacies in all such centres. It was opposed to 'hole and corner' affairs and yet felt the essential pharmacy was not really necessary in a health centre for several reasons. A memorandum prepared by a joint committee of the Pharmaceutical Society of Great Britain, the National Pharmaceutical Union and Scottish bodies and presented by the committee to the Minister (3) set out the reasons, believing it possible

(1) British Dental Journal 17.12.43.

(2) Pharmaceutical Journal 24. 7.43.

(3) Pharmaceutical Journal 17. 7.43.

'by expanding and developing existing facilities to provide 'a complete pharmaceutical service'. The reasons were five - firstly convenience to the patient; secondly the saving of state expense in building new pharmacies in Health Centres; thirdly the existence of a satisfactorily working system; fourthly the availability through existing services of ancillary medical and surgical supplies and finally the avoidance of disturbance on the opening of the new service. The enlarged service should aim at three things: units suitably equipped and readily accessible to patients; a service available at all hours of the day and night and the delivery of drugs where necessary. To do this the service must be based on national conditions of service for all pharmacists, be a Ministerial responsibility of the Minister of Health, be immediately controlled by bodies predominantly pharmaceutical in composition and make provision for the maintenance of pharmacies in rural areas.

To provide a service to meet these conditions the Joint Committee proposed a Pharmacy Commission under the Ministry of Health, composed of representatives of pharmacists (employer and employee) doctors and others. Its duty would be to ensure an adequate service by using existing services and only adding to them where necessary. It would also be responsible for dispensing by local authorities, hospitals and clinics, and would act as the

liaison body between the pharmaceutical services and the other services of the National Health Services. There should be representatives of pharmacists on all the administrative and advisory bodies of the service.

This document is of particular interest in one recommendation, the setting up of a pharmacy commission which brought the pharmacists into line with the other professions. It went further than many of the proposed Boards or Commission for sister professions in that the proposed body for the pharmaceutical services would have the power to control new entrance to the service in a way not sought by the other bodies, and indeed, anxiously avoided by the medical profession.

In January, 1944, the optical profession issued a report 'The Place of the Optical Profession in the Health Services of the Nation', (1) in which the profession expressed its hopes of finding its rightful place in such a service. 'There is good reason to know, however, that 'the just expectations of the optical profession in this, 'or, indeed in any other direction will be most bitterly 'opposed, as they have always been, by organized medicine, 'which has for many years sought - unsuccessfully despite

(1) In discussing the opthalmic services one is apt to run into difficulties over terminology - in this study 'optician' refers to a lay practitioner, i.e. one without medical qualifications.

'its power - to establish a monopoly of the nation's sight 'testing work'. (1) The report reviewed the history of these services here and in overseas countries and attempted to show that optical practitioners should, in the public interest, continue as a separate and independent profession, claiming that their co-operation was essential in achieving the best possible service. 'This, in turn, 'calls for state regulation of the profession at the 'earliest possible moment, together with the provision of 'suitable liaison arrangements with the medical profession 'within the general organization of the comprehensive 'health service'. In other words they demanded a state registration scheme as a step to securing professional status.

The main function of the Brown plan to these three groups can best be summarized by saying that it served as a force to drive them to think out for themselves what they wished ot their own parts of the health service. It served, too, to remind these three groups of their professional aspiration - the dental profession seeking to launch forth as a fully fledged profession away from medical surveillance, the pharmacists seeking to raise pharmacy to a profession instead of, as so often it was, merely a specialized form of shop-keeping, and the optician engaged in a desperate struggle for recognition, a struggle in which their adversary was the medical profession.

(1) 'The Place of the Optical Profession in the Health Service of the Nation' Page 3.

(C) <u>The White Paper, 1944:</u>

The White Paper in its plan for a comprehensive health service spoke of two temporary exceptions to comprehensiveness - firstly dentistry for the whole population, the proper aim, was impossible immediately, and instead the service would concentrate on certain priority groups, the Government, however, deferring its final decisions pending the report of the Teviot Committee. The White Paper suggested that similar difficulties might arise in the opthalmic service but made no further reference to detailed plans for the service. With pharmacy too the reference was only a brief one, and speaking of the relative success of the National Health Insurance scheme, the White Paper remarked that improvements and any problems, e.g. pharmacies in health centres, could be discussed with the pharmaceutical organizations. The White Paper, also, posed but did not solve the problem of what charges if any should be made for medical appliances. These three services, generally speaking, still remained therefore in the realm of detail into which the White Paper did not seek to venture, saying nothing of the proposed administrative machinery for these services.

Beyond welcoming the White Paper and setting up a Committee to examine it in detail, there was little for the Representative Board of the British Dental Association to do.

Not until June did the British Dental Journal devote a leader to the Paper, noting the freedom mentioned therein for the doctor from clinical interference and stating that this freedom was equally important for dentists. Was this freedom, it asked, to include the freedom to do one's best for a patient even to the extent of using more expensive treatment when cheaper might do? It noted how such questions had been decided in the past on economic grounds, a fact which it deplored. For the future three types of dentists were envisaged, those fully engaged in the public practice, or in private practice and those doing part-time in each. For these latter dentists an important point in the arrangements for the dental service would be the means of distinguishing between public and private patients and whether or not patients would be able to have treatment, part publicly and part privately.

The summer months of 1944 were the quiet season with regard to the National Health Service. Meetings of dentists and of the Teviot Committee itself were postponed until the strain on the transport system should have eased. Towards the end of the year however meetings were resumed and in October the Representative Board studied a draft additional memorandum drawn up by the Teviot and White Paper Committee for submission to the Teviot Committee. It set out the views of the Association on the problem being considered by the Teviot Committee as a result of the

proposals of the White Paper. This memorandum re-iterated that the Association felt that the arguments in favour of a comprehensive dental service restricted to those of limited income outweighed those against such a scheme, presumably a version of the 90% coverage. The Association was, as always, firmly opposed to dilution of the profession looking upon it as dangerous and likely to make the profession less attractive and thereby slowly down recruitment.

The memorandum claimed that to limit dentistry under the scheme to the basic and routine treatment and to exclude thereby the 'aesthetic elements' would detrimentally affect the standard of service and further discourage recruits to the profession. The Association were therefore 'convinced that the inclusion of dental treatment in a com-'prehensive health service must envisage the right of the 'patient to obtain treatment additional to that which may 'be essential for basic health reasons without invalidating 'his right to benefit under the scheme'. (1)

The Association's memorandum re-iterated that the priority classes, i.e. those entitled to treatment at health centres, should have the right to choose private practitioners should they so desire. The Association assured the Teviot Committee that they would fight with all the means in their

(1) The memorandum was reprinted in the British Dental Journal 15.12.44.

power any attempt to plan anything but the best dental service and that they were willing to discuss remuneration (and compensation) at a later stage provided the 'free 'play of competition' ensured that 'outstanding ability 'brings outstanding reward.

The Association asserted that the administration of the dental service should be in the hands of a Central Dental Board with local committees, all mainly dental in composition. Joint Authorities should be responsible for the local health services (including dental priority services), and there should be dental representation on these bodies and on the Local Health Service Councils. The non-priority service should be administered by predominantly dental committees of the Central Dental Board. The picture the dentists had in mind was of this dental service being administered completely separately from the other services, but in similar areas. They voiced no objection to the school dental and other priority services being administered by the joint authorities who should appoint Dental Officers of Health. The Association ended by expressing their determination to resist direction either positive or negative, as the better distribution of dentists could be achieved in other ways.

In November the Teviot Committee, at the request of the Minister of Health, produced an Interim Report to serve

as a guide for him in his discussions on the National Health Service. This Report (1) urged the immediate acceptance of the principle of a comprehensive service. The aim should be a family dentist service on the lines of the family doctor service. Dental surgeries should be set up in health centres where suitable, maintaining at all times freedom for the dentists and patient to participate or not in the service. Full use should be made of dental advice in the planning and administration of the service and dentists should be in contract with a dental body. Local authorities should provide for the priority classes, i.e. children, expectant mothers and adolescents.

On receipt of this Report the Government asked for a Committee representative of the three main dental organizations with which to commence discussions - the British Dental Journal emphasized that this committee would not have plenipotentary powers - the bodies co-operating to form this Committee, were the British Dental Association, the Public Dental Service Association and the Incorporated Dental Society. The committee first met the Minister in February, 1945, and discussions continued for some time with results to be reviewed later.

(1) Interim Report of the Inter-Departmental Committee on Dentistry - November, 1944 Cmd 6565.

The Dental profession had, at last, arrived at the stage of being able to discussntheir service in detail. The appearance of the report of the Teviot Committee had made this possible.

The Pharmaceutical Journal devoted two editorials to a general discussion 'Pharmacy and the White Paper'.(1) A general welcome, it was felt, would be extended to the proposal to continue the supply of drugs for the domicliary medical service by the existing system of chemists shops. This, the editor claimed, would allay the fears that chemists shops would be superceded by another system. 'Moreover', it continued, 'although they were entitled to 'expect no less it will be a matter of gratification to 'pharmacists that the White Paper represents a large 'instalment of progress towards the attainment of what 'has always been the main political objective of pharma-'cists, namely, full recognition of the pharmacist in 'principle and in practice as the only person competent 'to have responsibility for pharmaceutical matters'.

The editorial voiced disappointment at the lack of inclusion of pharmacy's proposals and claimed that if the government visualized only minor changes to the National Health Insurance system then the pharmaceutical organizations must vigourously oppose them. The

(1) 26.2.44 and 4.3.44.

editorial said the government had failed to show any realization of the aspirations and problems of the pharmacists, and that it had failed to make concrete proposals about health centre and hospital pharmacies.

The Journal returned to the same major topics in its editorial of the following week. Its main complaint was that the Central Medical Board had much in common with and was justified on the same grounds as the proposed Pharmaceutical Commission, and yet the Government were not prepared to accept this latter proposal. It felt, moreover, that there was room for suitable representative pharmacists on all administrative bodies of the proposed Health Service. Thus, if we take the Journal as expressing through its editorial the official policy of the Pharmaceutical Society, it can be said that the Society gave a limited welcome to the White Paper for it met one point in their plan but fell a long way short of the rest.

Towards the end of April, 1944, the Joint Committee of three Pharmaceutical organizations (1) issued, for discussion among their members, a memorandum on the White Paper. This showed a general measure of agreement on most

(1) The Pharmaceutical Society of Great Britain, the National Pharmaceutical Union and the Company Chemists Association.

of the administrative proposals of the White Paper with the exception of pressing for a separate Board or Commission for the Pharmaceutical Services and for representation of pharmacists on all administrative bodies of the new service. The Committee complained of lack of information on pharmacies in Health Centres and opposed such pharmacies as likely to affect detrimentally pharmacists' shops. The memorandum reiterated the claim for a pharmaceutical administration organized in three levels, central, area and local to coincide with the levels of administration of the proposed medical and hospital services. The central body should be the executive body with the area bodies as its agents. The local bodies would act as advisory bodies at that level of administration. Such a system was based, as any satisfactory system needed to be, on two principles: firstly, that 'wherever 'pharmaceutical questions are involved, both in planning 'and in administration, the scheme should provide for 'effective pharmaceutical advice and direction being 'available', and secondly that 'the experience of 'pharmaceutical administration during the thirty years 'working of the National Health Insurance Acts should be 'utilized in the service and the machinery of that 'administration adapted as far as applicable to the needs 'of the service'.

This memorandum was submitted for discussion by the

constituent bodies of the Joint Committee. The Pharmaceutical Society had, however, to postpone its meeting of branch representatives from the summer until November, 1944, when the memorandum and the White Paper was discussed. Introducing the memorandum to the meeting the President remarked on the absence of reference to remuneration saying that they had worked on the principle of the continuance of contractual arrangements rather than a salaried service, but had made no point of this because they considered remuneration was a matter to be decided when the framework of the service had been agreed. The White Paper meant the end of the Local Insurance Committees and posed therefore the problem of what body would be the contracting body for the pharmacists. They favoured contract with a Central Board, for 'We do not want' the President said, 'to see pharmacy directly regulated from 'Whitehall'. 'Nor do we want to be caught in the cross-currents of local politics or be subject to the varying whims of different authorities'. Outlining the proposals for the Central Pharmacy Board with its area and local board, the President said its duties should include the protection of the pharmacist from undue competition. The aim must be, as far as possible, to provide enough dispensing per pharmacist, to provide him with a full-time job of dispensing. 'The task of the pharmaceutical 'organizations', he concluded 'is to ensure that the retail

'pharmacist has his place in the scheme, security from unjust competition, proper remuneration and freedom from 'undue lay interference' (1). After his earlier remarks the order of the last two conditions is perhaps unfortunate. Having earlier laid stress on the need to secure the proper framework first, at the end of his speech, the President made this interesting transposition.

The optical profession, like the pharmacists, replied to the White Paper in a memorandum which it submitted to the Minister. They claimed four principles for an optical service: firstly, that the public should be able to choose the national service or pay privately, secondly, that freedom be given to practitioners in their professional work, thirdly, that private practice continue and fourthly and finally that the practitioner have the choice of working in the service, in private practice or in both. They also made proposals concerning administration in which they wanted a separate system of administration (2) for the optical services.

All these groups reacted to the White Paper, which provided little information on these services, as groups whose professional status was most insecure or even non-existant. The dentists still felt under the medical thumb,

(1) Pharmaceutical Journal 4.11.44.

(2) See pp. 149.

the pharmacist felt himself to be regarded as little more than the salesman of toilet preparations, and the optician felt his position most insecure beset as he was by the medical profession and realized the lack of any nationally accepted standard of qualifications. One of these groups, the dental profession, was to compensate for its feeling of insecurity by an attack of unique vigour, suspicion and 'purple patches' on the National Health Service Bill in 1946. For the rest it was mostly a case of wait and see until the details of these services were published.

(D) <u>The Revised White Paper (or Willink) Plan, 1945</u>:

Generally speaking, the pattern adopted by this plan for these services was to adapt the National Health Insurance system as far as necessary to meet the new needs. The pharmaceutical service would be run on lines similar to that of the existing system, administration being the responsibility of local ad hoc machinery on which the pharmacists would be represented. This machinery was that referred to in the general practitioner medical service, the two services maintaining their close links of the existing service. The dental service was to be divided into two parts, a priority service and a non-priority service. The priority service for children, nursing and expectant mothers and possibly adolescents would be organized with the local authority services as an extension

of the school dental service. The non-priority general practitioner service would be organized locally by the same machinery as already mentioned above for the pharmaceutical service, dentists being represented on the local body. Representative committees of the two professions would be established for advisory and disciplinary purposes and a Central Dental Board would be set up to examine and approve dental estimates and to pay dentists for work done. The dental letter system of the existing service whereby the approved society gave approval for meeting all or part of the cost of treatment would end, and this duty of deciding what treatment should be met on the national charge would fall to the Board.

When this confidential plan was discussed by local meetings of dentists the broad outlines seemed generally acceptable. The meetings called for a dental version of the Spens Committee (1) an offer which the Government had made as part of its proposals, accepted the Central Dental Board but called for more dental representation on the Central Health Services Council. The call for a Spens Committee deferred discussions on terms and conditions of service until such a Committee should report. At a meeting soon afterwards in June, 1945, however, the

(1) i.e. the Committee appointed to report on the remuneration of general practitioners - see p. 235 n.

Representative Board of the British Dental Association agreed that discussion of conditions of service which necessarily must be taken to 'include the method and 'order of remuneration of a nature such as will produce 'a National Dental Health Service acceptable to public 'and profession alike, should logically precede discussion 'of ways and means to give effect thereto, that is to say, 'administration'. The dental profession had come out, therefore, despite the general agreement which it seemed to be prepared to give to the broad outlines of the administrative structure of the revised White Paper plan, in favour of deciding on remuneration first. Such a motion which went on to reserve the right to oppose any legislation until agreement on remuneration had been reached, must have had an adverse effect on public sympathy for the dentists. Whatever may have been the underlying aims of the other groups no other group had so blatantly put remuneration first.

About the time when the revised Willink plan was being discussed the Joint Committee of Pharmaceutical Organizations submitted to the Minister a general memorandum on the National Health Service. The main burden of this memorandum can be summarized in one sentence from it: 'There is need for a fundamentally new approach 'to the pharmaceutical service concerned not only with 'every aspect of the provision of medicine and allied

'requirements, and the full utilization of the knowledge 'and skill of pharmacists under the service, but alsowith 'aspects external to the service such as self-medication and proprietary medicine advertising'. This latter point seemingly important to a National Health Service was never considered by the various Government plans despite some attempts by the Pharmaceutical organizations to get some control of proprietary medicines and their advertising. (1)

At a meeting to discuss the revised Willink Plan, pharmacists accepted the proposals, in the plan, that they should be represented as of right on the local committees to administer the general medical and allied services, but felt that the representation accorded them was insufficient. Speaking to a motion calling for pharmaceutical advice to be made available in the experimenting with health centres, the Secretary of the Pharmaceutical Society, Mr. H.N. (now Sir Hugh) Linstead, M.P. claimed that the position concerning these centres showed great improvements. They were now to be experimental, pharmacists were to have charge of any pharmacies therein

(1) Mr. H. Linstead M.P. introduced a new clause to the National Health Service Bill in Standing Committee to give power to the Minister to set up a Committee to review all pharmaceutical preparations and list those which doctors would not be recommended to prescribe and those the public advised not to use. Mr. Bevan welcomed the intention of the clause but regretted it was altogether too wide a topic to add onto the Bill. He added, however, that he regarded legislation in this matter as of some urgency.

and centre pharmacies would not be given a monopoly of local dispensing. This met their claims that pharmacies should always be under pharmacists, and that patients visiting health centres should have the right to choose to go to a chemist's shop rather than the health centre pharmacy, though it did not go as far as some would have liked in banning pharmacies from health centres altogether.

Perhaps the best summary of the pharmacist's position in the summer of 1945 comes from a speech from their Chairman (W.J. Tristram) at Edinburgh in 1946.[1] He told of three long meetings they had had with Sir Arthur Rucker, (Deputy Secretary at the Ministry of Health) at which three main points had been discussed. Firstly, they had claimed that there should be pharmaceutical advice at all levels of the administrative machine and this Sir Arther had accepted for all but one level, presumably the regional level; secondly, their claim that pharmaceutical work should be done only by pharmacists was categorically accepted, and finally they had sought to safeguard the position of the chemist shop, and had received a positive assurance that the patient would have freedom of choice between the health centre pharmacies and the chemists' shops.

From what is known therefore[2] it would appear that

(1) Reported in Pharmaceutical Journal 23.3.46.

(2) It is regretted that neither Mr. Willink's proposals for the opthalmic services nor the optical professions views thereon, have been discovered. It is indeed very likely that Mr. Willink had not reached a decision on this service.

Mr. Willink by abandoning earlier ideas of great changes and reverting in large measure to the machinery of the National Health Insurance system, had succeeded in securing the approval of these groups, subject, of course, to the dental claim to agree remuneration first. The changes from the National Health Insurance are those due to the increase in the population to be covered, the disappearance of the Approved Societies and additional benefits, and the acceptance of the claim of the pharmacist to be exclusively responsible for pharmaceutical work, thereby affecting the doctor who did his own dispensing.

(E) <u>The National Health Service Bill and Act, 1946:</u>

Once again one finds Mr. Bevan following, in large measure, the agreed position reached by Mr. Willink. Local Executive Councils were to be established for each county and county borough area, representative of the professions and the potential consumer. These Councils would be responsible for the general practitioner medical service, general practitioner dental service, pharmaceutical service and to a lesser degree the supplementary opthalmic service. Local representative committees of these professions would be established for advisory and disciplinary purposes, the disciplinary machinery being that outlined in the previous chapter for the general practitioner medical service.

The dental service was to be in two parts, the priority classes being provided for through the local

authority dental services, and the non-priority classes through the dental service organized by the Local Executive Councils. A Dental Estimates Board would be appointed to consider dentists estimates for more experienced forms of treatment. The Minister considered the eventual position of the opthalmic service on the other hand to lie with the hospital and specialist services division, when sufficient opthalmic specialists were available, but in the meantime a temporary arrangement was made setting up Supplementary Opthalmic Services Committees to organize the service at local level in co-operation with the Local Executive Councils. Thus the two exceptions to comprehensiveness of the White Paper of 1944 were still receiving special treatment.

The sections of the Bill setting out the services here discussed were not materially amended during their passage through Parliament. Two amendments are worthy of note, one at this point and one later in this chapter. The first of these concerns the clause setting out the power of the Minister to provide refresher courses. As originally worded it was limited to medical and dental practitioners, but by a series of amendments it came eventually to include under this provision all those providing services under the Act, thereby extending the right to refresher courses to pharmacists and opticians, as well as many other groups of health workers. The

second amendment concerning the definition of the persons providing the optical services is discussed below.[1]

The Minister of Health having opened confidential discussions with the dental profession on January 14, 1946, the burden of these discussions was no doubt before the Representative Board of the British Dental Association when, towards the end of January, they considered a report entitled 'Proposals for a dental health service' in which they set out for the confidential consideration of their members, their idea of a dental health service. These proposals, set out in great detail, therefore, represent the views of the profession modified in part at least as a result of their discussions with the Minister of Health. Once again they called for a separate dental organization to organize a non-priority service, and in this plan, to administer the priority dental service, no longer to be a local authority service. This plan shows a considerable change from their earlier ones which had not suggested removing the priority service from local authorities. Remuneration for dentists giving non-priority service would be based on a points system. A system of points would be drawn up for each type of treatment, and central monies made available to the dental organization would be used to remunerate dentists on a fixed scale in relation to the points value of the treatment given. Any charge

(1) p. 317a.

above this sum would have to be met by the patient - a version of the scheme whereby the more expensive forms of treatment would be charged in part to the patient.

In a later statement the profession condemned the secrecy concerning the discussions with the Minister. They alleged that the Minister was willing to discuss but not to negotiate with them, but that he had made one offer (or more correctly renewed the offer of the previous Minister) which they had accepted, namely the appointment of a dental Spens Committee.(1)

The British Dental Journal, announcing the appearance of the Bill carried a call to all dentists from the Representative Board of the Association - it might almost be termed a crusade. The document outlined the history of dentistry, a history of a profession which had advanced from a method of practice 'largely influenced by semi-'commercialism to one governed by high ethical standards', a history which was not truly appreciated by the Government or indeed by the Teviot Committee. The profession resented the attitude of the Minister at his conference with them and his proposals to take over the profession, and would resist the danger of passively accepting these proposals. 'If 'the profession is to surmount this danger we must resist 'and the time to make plain that we do not intend to be 'dominated by any Minister or any Government is now'. The

(1) See p. 297.

policy of the profession must be, the statement continued, to make clear where they stood and then if the Act passed was not acceptable they were no longer wrong in resisting it (A novel doctrine fortunately not widely accepted). There would be no strike but all patients would be treated as private patients, such a step soon causing the Minister to reopen negotiations. 'If we are strong we shall retain 'the proper measure of control and independence to which we 'are morally entitled'. The Board ended with a call on all members to attend Branch meetings to discuss this policy and affirm that no scheme would be worked which did not conform to the principles of the profession.

The Journal also contained a copy of the Press statement on behalf of the Board made soon after the Bill was published. It was a direct statement to the general public and re-iterated in more general terms the points outlined above. It ended thus - 'We fear that the result 'of the Bill may well be that you will virtually be forced 'to have such treatment as some official 'Dental Estimates Board' may think you ought to have and that you may find 'yourself forced to have such treatment, if at all, in the impersonal and public atmosphere of a dental centre'. The Addociation, obviously, had a firm belief in the importance of creating a favourable public opinion for its own case, and in this respect was probably the best organized of the minor groups observed in this study. In the weeks that

followed it printed a series of short statements entitled 'You and the Health Bill' giving the evangelizing dentist the necessary ammunition when meeting his Member of Parliament, his patients and the general public. The success of such a scheme cannot be measured in amendments secured or in regulations made to suit the wishes of the profession. At most it can have created an added awareness of the role of dentists in the health service, and even an added critical response to the claims of the profession.

At meetings up and down the country dentists had before them a resolution approving the principle of a National Health Service but condemning the proposals of the Bill as contrary to the public interests and therefore inimical to the profession. The resolution called on the dentists to pledge themselves to secure amendments such as to make a service completely acceptable to the public and the profession, No attempt can be made at statistical accuracy but it is interesting to note that the Journal records 19 such meetings in twelve of which the support of the motion is recorded as unanimous whilst in only two are any dissentient votes recorded. Prima facie it would appear that the motion commanded the overwhelming support of the members of the British Dental Association.

One may summarize by saying that the National Health Service Bill left the dental profession more vehement and

more outspoken than their medical colleagues. It may be as suggested later that a feeling of fundamental weakness pervaded the profession - that they were but a medical ancillary service. One has heard doctors say that as the cardiologist is a specialist doctor dealing with one part of the body, why should the person dealing with another part, the mouth, claim to be a separate profession. In its vehemence the Association was seeking to compensate for this feeling of insecurity.

In July, 1946, the British Dental Journal reviewed the Bill after it had left the Standing Committee of the House of Commons and could find little therein to be cheerful about. Although none of the proposed dental amendments had, at that stage, been accepted the main complaint was with a member of the Opposition. 'The most 'disquieting feature of the discussion ... was ... the 'irresponsible and uninformed suggestions put forward by 'Mr. Willink as to the possible dilution of the profession 'by persons who have received no recognized training'. For his indiscretions he was written to and visited by representatives of the profession. This reaction can only have been the reaction of a group extremely nervous about its professional status.

A list of eighteen amendments was circulated to all members of the profession as the changes which the Dental Consultative Committee were seeking on their behalf and it

the fate of some of these amendments which must now be noted. In the first of these amendments, to section 21 setting out the provisions concerning health centres, the profession sought to limit it in such a way as to make it impossible for local health authorities to provide separate dental health centres, i.e. the profession wanted to have their surgeries in medical health centres or not at all. In discussion the Minister assured them that no separate dental health centres would be built and he told Captain Baird who raised the matter in Standing Committee that he did not want any centres built solely for dental purposes.

The second amendment concerned what the profession liked to call the priority classes i.e. nursing and expectant mothers and children. The profession wanted to include in this category all adolescents and Captain Baird moved an amendment to this effect. In reply the Minister claimed that what was limiting the scope of the service was not the wording of the Bill but the number of dentists. 'As soon as we have the necessary facilities, 'the next priority class is that of the adolescents' he said, and on that Captain Baird had to be satisfied and withdraw his amendment.

The next three amendments suggested by the profession concerned the fortieth section which on their interpretation seemed firstly, to limit the patient to a

choice of dentists in his area. The matter was raised in the House when the Minister said the dentists would be able to put their names down on more than one Executive Council list and could thus attract patients from areas in which the dentists did not reside or work. The matter was discussed further in the House of Lords but the Government refused to alter this method, which the profession regarded as unnecessarily clumsy.

The second of the three amendments was moved in Standing Committee by Captain Baird but not pressed. It sought to provide for the remuneration of dental practitioners on a method to be determined nationally except in that some regard be paid to the need for so remunerating dentists as to attract them to otherwise unremunerative areas. Captain Baird did not favour higher payments for work done but rather the payment of subsidies to dentists in a manner similar to that adopted in the Highlands and Islands Scheme of North Scotland. The Minister replied that any such schemes would be premature until the Spens Committee on dental remuneration had reported. He acknowledged the necessity, however, for attracting[1] dentists to unremunerative areas.

(1) It is noteworthy that there was a second dentist on the Standing Committee of the House of Commons, Mr. McGhee but he took little part in the proceedings.

Captain Baird was again in action to move the third amendment to this same section. This amendment aimed at preventing dentists having to wait[1] for the acceptance by the Dental Estimates Board of their estimate of treatment needed. He wanted dentists to be able to go ahead pending such acceptance. He claimed that the absence of such a provision in the section was contrary to the wording of the ~~accompanying~~ White Paper accompanying the Bill where it said 'Dentists will normally be able to start 'treatment without further reference..' The Minister replied that this reference covered only the more general types of treatment and that the more expensive forms would need the prior approval of estimates. The exact definition of the various classes of work would be a matter for discussion with the dental profession, and on this assurance Captain Baird withdrew his amendment.

The next three amendments concerned the section which dealt with the disqualification of practitioners, section 42. One sought to provide the Tribunal set up under the section with powers to inflict lesser penalties than disqualifications, the second to give the right of appeal to any practitioner from a decision of the Tribunal to the High Court and the third to ensure the right of legal representation at hearings of these disciplinary bodies. None of these amendments were moved though the topics were

(1) See footnote on previous page.

discussed widely on similar amendments. An amendment of similar wording to the second above caused the only defeat of the Government in the Standing Committee.(1) The third amendment was raised in a different form during a discussion on the second, and was later accepted by the Government, and thus marked one of the two successes achieved by the profession (even though in this case the amendment accepted was not of their authorship).

Two amendments sought to enlarge the powers under section 44 (recovery of charges in respect of certain appliances and dentral treatment) in two ways. In the first place, Mr. Hopkin Morris moved an amendment in the Commons Standing Committee to include powers to recover part of the charge when the patient had, by choice, more expensive treatment than strictly necessary. This amendment was opposed by the Minister, and by the dental member Captain Baird. Mr. Bevan said that it had been decided that where expensive treatment was necessary from a dental point of view, it should be given as part of the free service. Where it was not necessary the patient must pay all the cost or have the less expensive form of treatment free. The second of this pair of amendments was not discussed in Parliament - it sought to make the Minister's permissory power to make regulations for the recovery of charges into a compulsory power.

~~The next two amendments sought to write into the~~

(1) See p. 371.

The next two amendments sought to write into the Fifth Schedule that one of the three dental representatives on the Executive Councils should be a 'Dentist 1921' (i.e. one with qualifications prior to 1921 and brought onto the Dental Register by an Act of that year). The Minister was not prepared to accept these amendments pointing out that these dentists were gradually dieing out and that 'only by getting into touch with the astral regions would &it be possible to carry out the intentions' of these amendments.

In response to the profession's claim for compensation for dentists suffering as a result of competition from health centres, the Minister proposed that he reconsider the question in the light of some experience of the working of the new service, and on his assurance the profession decided not to raise the matter in the Parliamentary discussions on the Bill.

The representatives of the profession met Mr, Bevan in June and afterwards reported that 'in general the 'deputation was satisfied by the reception accorded and the 'explanations given'. Subsequently, however, one finds them in one of the statements headed 'You and the Bill', saying 'If all the amendments had been obtained, however generous the remuneration and however acceptable the conditions of service may appear, the position of the profession will still be insecure ..' As remarked

elsewhere the feeling of insecurity in the profession led them to extravagances of statement and opposition to the Bill. All their efforts brought but success only in two amendments, in neither case on major matters. Attempts to increase dental representation on the bodies of the service, to abandon the free service in favour of a grant in aid system and to define the method of remuneration failed. Some assurances were obtained but all in all the dental profession, if their earlier plans are taken into consideration, had little to be joyful about in the Bill as it became an Act.

Pharmacists:

The first real response of the pharmacists to the Bill came in the Pharmaceutical Journal of 30th March. It claimed that pharmacists would have common doubts on the health centre proposals; pharmacy departments therein might be proper pharmacies or 'hole and corner' affairs. In the former case such pharmacies would have a great advantage over the chemists shops in the matter of accessibility. They would be alongside the doctor's surgery and few patients would wish to walk further to get their prescriptions made up. The possibility of this happening reinforced the case for a planned service to prevent unnecessary and wasteful competition and to limit new entrants to areas where they would be most needed.

In the same copy of the Journal a speech by Mr.

W.J. Tristram, the President of the Pharmaceutical Society was reported in which he told of a meeting with Mr. Bevan at the beginning of February to discuss the confidential memorandum on the Minister's proposals. The Minister refused, according to Mr. Tristram, to take powers of controlling new entrants to the pharmaceutical service nor would he agree to pay compensation to chemists who suffered as the result of the competition of health centres.

Early in April, 1946, the Joint Committee of the Pharmaceutical organizations met to consider the Bill welcoming the acceptance therein of the principle that pharmaceutical work should be done only by parmacists. They felt, however, that the service could best be organized by extending the existing services of chemist shops. Pharmacists working in health centres should not be employees of the Local Health authority, whose health committee should be in direct liaison with the pharmaceutical committee, the local representative committee. They did not object to the disciplinary proposals of the Bill, and went on to appoint a sub-committee to draw up a list of amendments which it should seek to have introduced into Parliament. These amendments have been listed under seven headings some of which are pertinent to this chapter.

One such amendment was discussed in the last chapter when it was mentioned that pharmacists made an unsuccessful application to have the pharmacists in health centres, like

the medical and dental practitioners therein, outside local authority employment. They sought, again unsuccessfully, to include compulsory co-option of professional representatives, including one pharmacist to the health committees of local health committees. Finally they sought to include themselves under the provisions for refresher courses and therein were successful when the wording of the section was widened to include all persons providing services under the Act.

Writing in an August issue of the Pharmaceutical Journal Mr. H.N. Linstead summed up the position of the Bill as it left the Commons, a review which can well stand as a review of the final Act '... the position of 'the pharmaceutical service is that there is pharmaceutical 'representation on the central council and on executive 'councils with the possibility of pharmaceutical advice 'being put at the disposal of regional boards ... Pharma-'ceutical service for the patients of general practitioners 'will be provided by pharmacists working either as 'contractors in retail pharmacies or as employees of local 'health authorities in health centres. Medical 'practitioners will not provide medicines except in rural 'areas. Provision will be made out of central funds for 'the payment of refresher courses for pharmacists'. The pharmacists had not achieved all they asked for but their professional status was more secure, and the Government had

recognised that pharmaceutical tasks should only be performed by pharmacists, in itself a great advance on the previous situation, and at the same time a blow for those general practitioners who dispensed their own prescriptions.

There remains but the optical profession and here detailed comment is difficult as no evidence is available. The Bill which set out the temporary arrangements for the service with the more permanent arrangements as part of the hospital service went into no detail as to the relationship of the optician and the opthalmologist. At a meeting with the Ministry of Health on 14th June, 1946, a joint committee was set up of representatives of the Opthalmic sub-committee of the Negotiating Committee of the Medical Profession and the Joint Emergency Committee of the Optical profession. In its Interim Report in May, 1947, this Committee said that the government had made it clear that it recognized that the ultimate responsibility for eye-testing must rest with a medical specialist but that the testing of the errors of refraction would, as far as possible, be delegated to opticians. The optical profession in its comments on these proposals said that as a concession they had agreed that the administrative control of the permanent eye service must rest with the opthalmic specialist, but these proposals went too far. The profession claimed it was not seeking a special

position but only freedom from fear of ultimate extinction by the medical profession. One may, therefore, say that, although on the face of it, there was little in the Act the profession could disagree with, the details which followed left them strongly opposed to the Government's plans. It is not proposed to follow this dispute further as it really lies outside the scope of this study. In this case whilst the main proposals were acceptable, the details which followed the Act were far from satisfactory to the group. One amendment accepted by the Government on the recommendation of the Joint Committee of opticians and the medical profession already referred to, altered the designations of the various types of practitioner in the opthalmic services.(1)

The National Health Service Act, therefore, left the pharmacists and opticians reasonably satisfied with the provisions of the Act itself, with the proviso that the details might become a source of disagreement. The

(1) Those persons providing services under this section (s41) were divided into three categories viz: medical practitioner with appropriate qualification, opthalmic opticians qualified to test refraction in eyes and dispensing spectacles, and dispensing opticians qualified to dispense spectacles.

dental profession, however, were far from satisfied with the Act which made no attempt to deal with their remuneration.

(F) Conclusions:

This chapter shows, again, the thread of developing plans throughout the period studied. Despite the wrath of the dental profession and the later wrath of the optical profession the lack of comment on these services by any of the other groups suggests that the proposals were not unduly displeasing to the majority of the groups. In the face of this body of agreement or lack of disagreement, the Government was able to ignore the wild language of the dental profession, and proceed on agreed plans. A study of the period after 1946 would, however, show the dental profession achieving some successes - indeed the profession was regarded by some as coming out of the new service, best, better than all the other professions and groups.

CHAPTER 7.

Local Authority Services.

According to the National Health Service Act, these services include the provision, equipment and maintenance of health centres, the care of mothers and young children, midwifery services, health visiting and home nursing, vaccination and immunization, provision of ambulances, the prevention of illness, care and after care and the provision of domestic help. The school medical and dental services are not discussed here as they are not included in the Act. The priority dental service for mothers and young children is part of the maternity and child welfare services, so that, with the school services, make up the priority service referred to in the previous chapter.[1]

(A) Some Alternatives:

The problems concerning these services were not many, the decisions taken here being mainly dependent on the decisions on other parts of the national health service. The major problem was whether some unification of all health services would pass to such unifying bodies. Without such unification the problem; pending any reform of local government, was what type or types of local authority should administer the services, and what services if any should be transferred to other bodies.[2]

(1) See p. 277f

(2) Most of these services were already provided by local authorities.

The hospital services of the local authorities before 1948 came into this latter category and were transferred to ad hoc bodies.(1) Between local authorities, the main problem was whether the services should be unified under one authority, e.g. county council, or divided between the county and its minor authorities, a problem tinged with the jealousies of one local authority type for another.

The two general problems underlying all the discussions on these services can be briefly mentioned. The first was the repeated call by the local authority organizations for the reform of local government, believing that such reform should precede any reform of the services of local government. Although no government accepted this order of procedure, the local authority organizations never abandoned their hopes and always spoke of the Governments' plans as temporary measures pending the reform of local government. The second major underlying problem is the relationship between the medical profession (and, to a lesser extent, the other professions) and the local authorities. The profession were strongly opposed to any extension of local government control over the medical services and resisted all such attempts trying all the while to whittle down

(1) See p. 13. Regional Hospital Boards and Hospital Management Committees.

the powers actually available to local government. This antipathy between the professions and the local government bodies was ever present as an emotional rather than rational force to be considered by any Minister planning the health services.

(B) Mr. E. Brown's Plan, 1943:

With the exception of this plan the plans of the various Ministers ignored the environmental health services of local government, but Mr. Brown, however, was aiming at a unified health service under one authority in each area linking institutional, domiciliary and environmental health services. Joint Health Boards for this purpose would be set up for combinations of local authorities with precepting powers on those local authorities. These Boards would be mainly composed of local authority members but the Minister was reported to be considering professional representation thereon. These Boards were acknowledged by the Minister to be a temporary measure pending the reform of local government with, presumably, the adoption of local government units covering wider areas. This plan, therefore, meant the transference of all local authority health and hospital services to a Joint Board - a type of administration never favoured by local government.

The reaction of the medical profession to local

government control, through the Joint Boards, of all the medical services and in particular of the general practitioner service has been noticed,[1] but in their reaction to the plan they made no comment on the proposed changes to what are here called the local authority health services.

Reporting on the contents of the plan the County Councils Association could not agree to counties and county boroughs being deprived of their domiciliary services although they recognised the need for effective liaison between institutional and domiciliary health services.[2] They accepted joint committees or Boards on condition that 'the proposed joint committees be 'required to submit to the appointing councils an annual 'report of their proceedings and also triennial 'estimates of their capital and revenue expenditure for 'approval, with provision for the settlement of any 'resultant financial disputes by the Minister of Health, 'and also to arrangement being made for such committees 'to be staffed by the chief officers of the councils 'concerned'[3] The use of the term 'joint committee'

(1) See p. 236.

(2) Implicitly accepting them for the institutional services.

(3) County Councils Association Official Gazette Sept. 1943.

may not have been accidental; a joint committee being normally accorded much less power than a joint board.

No other comment on this section of Mr. Brown's plan is available and no purpose would be served by attempting to deduce the views of the other groups, if indeed they could be deduced. Two points, however, need to be reiterated: in the first place the Minister was attempting a unified health service, and in the second place his plans were admittedly provisional pending the reform of local government. Neither of these two points occurred again in the same directness.

(C) The White Paper, 1944:

The White Paper proposed the establishment of Joint Authorities to plan all the health services for their areas, the division of powers between these Joint Authorities and their constituent local authorities being a matter for the area plan but it was suggested that, in the main, county councils and county borough councils would be responsible, under the general supervision of the Joint Authorities, for the local authority health services. There was one important exception, the ambulance service which would be the responsibility of the Joint Authority as hospital authority. The maternity and child welfare services might be arranged, the White Paper suggested, to fit in with the arrangements made for the school medical service,

whilst health centres would be provided, equipped and maintained by the county and county borough councils. These Joint Authorities would be composed of local authority representatives, the Government reaching this decision after considering all the arguments put before them, for they felt 'that the risk of impairing the 'principle of public responsibility ... outweighed any 'advantages likely to accrue' from the direct representation thereon of the professions.(1) Instead they proposed to establish, as advisory bodies to the Joint Authorities, Local Health Services Council, representative of all interests, like their central counterpart. The scheme was thus for Joint Authorities, of local authority members and advised by a professional council, to plan the health services for its area, and subject to Ministerial approval divide the local authority health services among its constituent authorities.

The medical profession questioned the Minister on his decision to exclude professional representatives from the Joint Authorities, and were reminded that the decision had been reached by the Government only after study of all the arguments and that medical advice would be available at all stages of planning and administration. In the British Medical Association questionnaire doctors were asked if they regarded this situation as satisfactory.

(1) White Paper (Cmd.6502) p.20.

Four-fifths of the profession regarded the White Paper as infringing the principle that 'the profession 'rejects any proposals for the control of the future 'medical service by local authorities as at present 'constituted', Both questions showed the profession strongly united in opposition to local authorities, a view which was faithfully reflected by the professions' leaders.

The County Councils Association at first accepted joint authorities on three conditions: firstly the establishment of such authorities was not to be regarded, in general or in particular, as a precedent for the introduction of regionalism in local government, secondly the individual county councils should be consulted before any joint authority were established and, thirdly, in the preparation of that part of the plan which concerns services to be administered by the existing authorities, the individual county councils should be consulted by the Joint Authority and by the Ministry of Health. They agreed that the direct representation of the professions on the Joint Authority would be a dangerous impairment of the principle of public responsibility, and therefore, as stated in the White Paper, should be rejected. The Association of Municipal Corporations, on the other hand, would only accept Joint Authorities if their functions

were limited to planning and did not include administration.

This latter view was accepted at a later meeting by a joint meeting of two committees of the County Councils Association who felt that the proposed joint authorities 'should be charged with the duties of 'preparing and keeping under general review a scheme for 'a comprehensive health service' but should not have any administrative functions, except in cases of local authority default, the administration of the services remaining with the constituent authorities. The joint authority should have to submit to the local authorities concerned, annual reports of its proceedings and triennial estimates of expenditure together with estimates for major capital proposals, these latter two items being subject to the approval of the constituent authorities. They agreed that counties should omly be split between the jurisdiction of more than one joint authority in cases of 'proved necessity' although they made no attempt to define cases of 'proved necessity'.

After discussions with the Ministry on the White Paper the County Councils Association further changed its proposals slightly claiming that the local authority health services should be the responsibility of the county and county borough councils both in their planning and administration i.e. removing these services altogether

from the responsibility of the Joint Authorities.

The Urban District Councils Association welcomed the ambitious scheme of the White Paper but added that it 'should not be assumed either that the constitution 'of an authority for all health services operating over 'a large area is desirable or that the part now played 'by urban district councils in connection with health 'administration can be entrusted with any certainty of 'efficient administration to such an authority'. The Association was convinced that local responsibility for the domiciliary services, particularly the maternity and child welfare service, 'should be increased rather 'than reduced and that it would be a retrograde step to 'transfer supreme responsibility to another authority'. Counties and county boroughs had nothing to commend them over an enterprising and progressive urban district council and the Association urged a scheme of divisional administration, similar to that in the new education service, in which any borough or urban district would be entitled to exercise full delegated power in regard to the dimiciliary services. This reaction of the Urban District Councils Association is quoted here as an example of a weakness in local government as an interest group. Each type of authority was prepared to concede little or nothing to any other type and any scheme to entrust local government with new powers immediately produced these internal and eternal squabbles. A united local government

plan, on the other hand, having the backing of all local government associations would have been a much more formidable weapon with which to approach the Government and might well have considerably altered the pattern of these health services in the national health service.

The Society of Medical Officers of Health, to turn to local government administrators, complained of the divorce in administration of many of the services. It exampled the tuberculosis service where the specialist clinical side would be divorced from the preventitive and domiciliary work of the local authorities, and the maternity and child welfare service which would be divided between the general medical practitioner service, the hospital service and the local authorities. It re-iterated its plans for a co-ordinated service in a reformed system of local government and put forward suggestions, as temporary measures, for increasing the co-ordination among the various parts of the health service. This problem had become an acute one as soon as Mr. Brown's idea of a unified health service was dropped in favour of Mr. Willink's attempt to achieve this co-ordination through the Joint Authority's plan.

Finally a paragraph must be devoted to the special problems of the London area, a problem which was very briefly dismissed in the White Paper. The Metropolitan

Boroughs Standing Joint Committee consulted the Minister on his proposals which they discovered included the centralizing of local health services in the London County Council, proposals which they refused to accept. They entered into discussion with the London County Council, telling the Council that they felt they should have full responsibility (or failing that, delegated responsibility) for these services. 'The Metropolitan 'boroughs are the foundation stones of democratic local 'government in London, and with the growth of London 'they should be strengthened and not weakened as the 'White Paper proposes'. (1) In a subsequent interview with Mr. Willink they agreed that final decisions should await an agreement on this point between the Standing Joint Committee and the London County Council.

Towards the end of 1944 an agreed scheme was drawn up whereby local authority health services would be formally given to the County Council who would be statutorily bound to delegate them to the metropolitan boroughs. Moving beyond the time limit of this section, the Council and the Boroughs agreed in October, 1945, to submit this scheme to the new Minister of Health for inclusion in his proposed Bill. This agreement attracted a considerable amount of notoriety in the debate on that Bill particularly so as on that occasion the Chairman of the Metropolitan Borough's delegation, Alderman C.Key,

(1) Statement issued by Metropolitan Borough's Standing Joint Committee on 30.6.44.

was, in his capacity as Parliamentary Secretary to the Ministry of Health, given the task of refusing to accept the plan he had earlier sponsored. It is perhaps needless to add that the Opposition made full play with this peculiar reversal of roles.

Mr. Willink had sought to maintain some measure of a unified health service through the Joint Authority as a planning body. He had suggested that it delegate its powers regarding the local authority health services to county and county boroughs thus retaining the hospital services. In fact Mr. Willink's suggestion to use county and county boroughs as executive units for local authority health services persisted through the subsequent years. The only other point to be emphasized here is his recognition of the ambulance service as part of the hospital services - a point not accepted by Mr. Bevan.

(D) <u>The Revised White Paper (or Willink) Plan, 1945</u>:

The detailed planning and advisory machinery envisaged in this plan had already been outlined and it only remains here to observe that county and county borough councils would be the local executive authorities for these services with powers to combine into joint authorities if necessary.[(1)] Each of these local

(1) The Education Act, 1944, was suggested as a parallel - e.g. Section 6 and Part I of the First Schedule.

authorities would be required to appoint a health committee and include thereon doctors or other persons with experience of the health services of the area. The Minister would encourage, by administrative action,(1) the recognition by county and county borough councils of medical advisory committees.

As was to have been expected the County Councils Association and the Association of Municipal Corporations appear to have had few questions on the section of the plan. Instead their difficulties and objections were concentrated on two of the problems of implementation - the amount of the central grant to local authorities and whether it should bear any relation to the needs of the area, and the arrangements to be made between local authorities for the treatment of residents of one area in another area. These problems, common to almost all local authority services, showed that, for them at least the main outlines of the local authority health services had been agreed and the detailed arrangements were under consideration. The Urban District Councils Association issued no further statement but it can be safely assumed that they were opposed to the scheme which deprived them of some of their services.

(1) The Education Act, 1944, Schedule I, Part II. S. 5.

Mr. Willink had reached therefore an agreed situation on the local authority health services, with counties and county boroughs as executive units with, above them, a complete central advisory and planning machinery.

(E) <u>National Health Service Bill and Act, 1946</u>:

The National Health Service Bill followed closely Mr. Willink's pattern for these services with two exceptions. Mr. Bevan had abandoned altogether the idea of a unified health administration (except in as far as he hoped that health centres would provide this unification), and therefore abolished the area planning authorities of the revised Willink plan, the planning and administration of the services reverting to the county and county borough councils. The services to be provided by these authorities are listed in the Act as at the beginning of this chapter [1], and the only newcomer to the list, Mr. Bevan's second exception, was the ambulance service switched from being a hospital service to a local authority service. Local health authorities would provide or contract with a voluntary body to provide an ambulance service for use by the authority ~~and by the~~

(1) See p.319. The health centre was to be the 'centre' of the new service and was, therefore, to have an important role, the key role to local health services.

~~authority~~ and by the hospital and medical sections of the service. This peculiar position which was fully discussed in the House of Commons, attracted some criticism from Labour members notably Mrs. Braddock and Mr. F. (Now Sir Frederick) Messer.

Local health authorities would be statutorily bound to refer all health matters to a health committee which would have the discretion to co-opt thereto non-members of the authority with experience of the health services, so that at least a majority of the committee were members of the authority.(1) The service would be financed in part from central government grants.

The main reactions of the local authority associations to the Government's proposals concerned the loss of their hospitals which has already been discussed. The Association of Municipal Corporations claimed that county councils should be statutorily bound to delegate some of their health functions to non-county boroughs, going on to say that having regard to the limited powers

(1) Normal local government procedure under the Local Government Act, 1933, only permitted co-option up to one third of the local committee - this new version made it possible up to one less than a half of the committee. This, no doubt, was a slight concession for the abandonment of local professional advisory machinery.

concerning health centres, they felt that health centres should be provided by and at the expense of the central government,[1] a view not shared by the County Councils Association. The Metropolitan Boroughs Standing Joint Committee reiterated their earlier agreement with the London County Council and called on the Government to implement the agreement. The London County Council, however, had accepted the Government's proposals and thereby implicitly rejected the agreement.

The debates on this Part of the Bill are noteworthy only for the repeated attempts by the opposition to secure delegation of these powers in county areas and in the London area, no amendment of any real importance being accepted on this part of the service during the Bill's course through Parliament. The debates on the London area were considerably enlivened by Opposition exploitation of the peculiar position in which Mr. Key found himself[2]. No concrete evidence exists to support the following contention but there is enough evidence to suggest for it a certain attractiveness - one cannot put it higher. The contention would run on these lines.

(1) It seems likely too, for Mr. Bevan, the Health Centre was to be unifying ground for all health services, and in giving powers to Local Authority in this connection, he felt he was giving an important duty as a 'consolation' for loss of hospital services.

(2) See p. 330 .

Mr. Bevan followed Mr. Willink in his intentions to make the London area a hospital region (1) probably thinking in terms of the London County Council itself as the hospital authority. This would no doubt have been strongly opposed by the voluntary hospitals and especially the teaching hospitals. The medical profession and the voluntary hospitals of London had, a year before, come out in favour (2) of splitting London and the Home Counties between several regions to widen the influence of the many teaching hospitals in London. Whether by force of argument or by playing on the Minister's desire to meet, as far as possible, the specialists and therefore the teaching hospitals, the Minister was persuaded to break up the London region. To do this meant taking away the London County Council hospitals, a plan brought only at a late date to the notice of the Council. (3) The contention would then conclude that the local authority health services agreement with the Metropolitan Boroughs was sacrificed as a consolation to the Council. Mr. Willink pointed out to the House (4) that this agreement had been accepted by the London County Council on October 23, 1945, when he

(1) See p. 194

(2) See p. 195

(3) See p. 211.

(4) Hansard Vol.425 c1823 - and other places.

alleged 13 Labour members of Parliament including the Lord President of Council (Mr. H. Morrison) were present. Thus runs the contention suggested by such evidence as is available, a contention which if true must have meant a disagreement between Mr. Morrison the proud Londoner and Mr. Bevan.

The Association of Municipal Corporations published a list of amendments it sought during the Bill's course in Parliament, which can be briefly examined. It sought to make it compulsory for county councils to delegate some, at least, of the local health services to non-county boroughs, but the amendment was never discussed in this form in the House of Commons, the main attention centring on the problems of the London Area. The amendment was, however, moved in the Lords but was opposed by the County Councils Association's representative, and by the Government spokesman who refused to accept it.

As originally worded the Bill gave the Minister power to permit delegation of the functions of the maternity and child welfare service to those divisional executives and excepted authorities of the education service to which administration of the school medical service had been delegated. The Association's attempt to widen this to delegation to all excepted authorities was refused on the ground that the aim was to bring the two services together.

The Association of Municipal Corporations objected on two grounds to the section dealing with the ambulance service: it was too widely drawn and it should allow delegation to non-county boroughs. The Minister refused to consider the second complaint but accepted the first moving two amendments to meet the point. In the first place the phrase 'where necessary' was added to the section as a limiting power and secondly an amendment was accepted putting beyond doubt which local authority was responsible for providing an ambulance service for a journey between two local authority areas - the local authority responsible would always be the one in which the need for the ambulance arose.

The Association sought many other amendments of a detailed character betraying a close and serious study of the provisions and wording of the Bill. One cannot help but feel that whatever may be the proper position of an interest group, the Association in its meticulous study of the Bill as experienced administrators of past legislation it was performing a worthwhile service for in several places it unearthed faults in the Bill which could only have been corrected by further legislation.

There were no other comments on this part of the Bill, for once again the agreed situation had been reached between its major groups and the noise and battle of the interest groups passed over these quiet sectors to

concentrate on the more controversial points.

(F) Conclusions:

The material of this chapter was not inflammatory or controversial in the same way as that of some earlier chapters. Early on in the four years studied it was decided that the local authority health services should be organized by the largest units of local government, the counties and county boroughs, and throughout, this plan was adhered to, with slight variations concerning the planning of the services. Once the attempt at a unified local administration was abandoned, successive plans gradually returned to the idea of these authorities as planning and administrative units for local health services. The basic differences of local authority associations on the reform of local government made any radical change unlikely, and the general tendency of moving in search of efficiency to the larger units of local government prevailed over the opposition of the smaller units. Beyond that, this chapter is memorable only for the peculiar position of the London County Council with the Labour Government and the introduction of the ambulance service as one of the services of local government.

CHAPTER 8.

Mental Health Services.

This chapter is a brief one due mainly to an early realization that the best way to bring the mental health service into a proper relationship with the other services was to treat them alike. The problems facing the Government were two, firstly whether or not to attempt a restatement of the chaotic and unwieldy law on mental deficiency and lunacy, and secondly whether or not to include the mental health services in the National Health Service with or without such review of the law. Beyond those problems, the mental health services were treated in the same way as the others, assuming the same problems for the institutional mental health services as for the institutional services of physical health.

(B) Mr. E. Brown's Plan, 1943:

The references in this plan to these services can be summed up in answer Mr. Brown gave to a questioner in Parliament: 'The mental services will not be included'. (1)

The Royal Medico-Psychological Association however recommended the Minister to establish a separate mental health administration organized in parallel with the other services. This administration would be headed by a

(1) House of Commons Official Report Vol.388 c1401 15.4.43.

reorganized and enlarged Board of Control, renamed the Board of Mental Health responsible to the Minister of Health. In these recommendations the Association, although making no direct reference to the Brown plan, can be assumed to be condemning the Minister's refusal to include the mental health services, a condemnation in which Dr. Charles of the British Medical Association, joined when giving reasons for the medical profession's rejection of the Brown plan. No other group, however, commented on the exclusion of the mental health services at the time. The prompt expression of the medical profession against such exclusion was, at once, successful.

(C) <u>The White Paper, 1944</u>:

The White Paper acknowledged that the inclusion of the mental health services meant some difficulty until a full restatement of the law of lunacy and mental deficiency could be undertaken, but declared that the Government, nevertheless, intended to include the mental health services. 'The aim must be to reduce the 'distinction drawn between mental ill-health and physical 'ill-health and to accept the principle declared by the 'Royal Commission on Mental Disorder that 'the treatment ''of mental disorder should approximate as nearly to the ''treatment of physical ailments as is consistent with ''the special safeguards which are indispensable when ''the liberty of the subject is infringed''. (1)

(1) White Paper Cmd 6502 p. 9.

The detailed arrangements for the mental health services were not set out beyond saying that the mental health services would be one of the duties of the new Joint Authorities and that these duties would cover institutional and non-institutional treatment and care.

The Mental Hospitals Association welcomed the proposals of the White Paper to include the mental health services but regretted that the Government, while admitting the need for a review of the law concerning lunacy and mental deficiency, did not appear to intend to make such a review. It urged upon the Government the necessity for full consultation with the Association before any such review was undertaken. The County Councils Association welcomed the comments of the Mental Hospital Association and agreed with them, calling on the Government to review this part of the law.

For the rest all is silence. The medical profession welcomed the inclusion of the Mental health services, but for detailed comments one must turn to other chapters for the mental health services were, generally speaking, not considered separately from the physical health services by the various groups.

(D) <u>The Revised White Paper (or Willink) Plan, 1945</u>:

No direct mention of the mental health services is traceable in the available information on this plan, but obviously changes were implied. The Joint Health Authorities were dropped and county and county borough councils were to be the executive units for the hospital and domiciliary services, this meaning the concentration of all mental health services in the hands of county and county borough councils which whilst it may not have pleased the minor authorities, was certainly favourably received by the other local authorities with long experience of mental health work. Once again comment is absent, no group making any particular reference to the mental health services.

(E) <u>The National Health Service Bill and Act, 1946</u>:

The Act continued the proposal of dealing with the mental health services in parallel with the other health services. The mental hospitals passed to the general hospital administration whilst the non-institutional services went with the other local authority health services to the counties and county boroughs. The Minister made however some changes in his advisory machinery to allow for mental health services - a fact

overlooked by Mr. Willink. Many of the administrative functions of the Board of Control were transferred to the Minister whilst some of the institutions for the confinement of criminal or dangerous lunatics or defectives also passed to the Minister.[1] The Minister said that all he sought to do was 'to decant' the provisions concerning mental health into the framework of the national health service. In so doing they had come across 'one of the 'most complicated pieces of legislation ... for many 'years'.[2]

Again no public comments are available, whilst in Parliament the general reaction was one of welcome that this 'cinderella' of the health service would now be brought into line with the other services.

(F) Conclusions:

The problems of mental health services were all, from the point of view of meeting the views of the interest groups, comparatively mild ones. Once Mr. Willink had decided to include mental health, the Joint

(1) Mr. Bevan added four persons, 2 lay and 2 medical to the C.H.S.C. to represent the mental health service.

(2) Standing Committee Report c1009 3.7.46. The Minister gave this explanation for 50 amendments on the Order Paper to the Ninth Schedule dealing with the law of lunacy and mental deficiency.

Authorities were the natural administrative bodies for the service. With the abandonment of that idea the hospital and domiciliary aspects of the service went their separate ways. If the mental health services were to approximate as nearly as possible to the other health services, they were doomed to suffer the same administrative divisions.

PART IV - CONCLUSIONS.

Chapter 1 - National Health Service - Conclasions.

2 - Suggestions for a wider study of Interest Groups.

PART IV.

CHAPTER I.

National Health Service - Conclusions.

This study must rank as a case study of the development of plans for a piece of legislation and of the attempts by the various Ministers to face 'realities' i.e. to meet as far as possible the wishes of all the conflicting interest groups. Two sets of conclusions can, therefore, be drawn from this study, one set of firm conclusions concerning the National Health Service Act and its previous development, and the other set of what might better be termed 'suggestions'. It has not been, nor indeed could be, the aim of this case-study to present a series of conclusions for political theory on the place of interest groups in the system of government in Britain, but instead one can make suggestions for possible lines of further thought and broader research on the general topics of interest groups.(1)

It is, however, the main purpose to draw some conclusions about the development of plans for a National Health Service, conclusions which must remain unconfirmed until the files of the Ministry of Health are opened. The main conclusion lies in the almost question-begging title

(1) See the next chapter.

of this study - 'the development of plans' [1] - it was indeed a development of plans for a National Health Service - a development which is here studied for the four years 1943 to 1946 and which Mr. Willink has claimed spread over an even longer period. 'When I went to the 'Ministry of Health in 1943' he has said 'I discovered that 'work was going forward and had been going forward for four 'years before 1943 ...' [2] The detailed pattern of this development over the years 1943 to 1946 has been traced in the foregoing chapters.

It is the broad thesis of this study that Mr. Brown in his first plan was submitting the viewpoint of his official advisers and that from this plan (or point of view) the Succeeding Ministers and their officials moved outwards to meet the various views put to them - or in other words the plan suffered a 'process of erosion' [3]. The claim is

(1) House of Commons Hansard Vol.426 c461 26.7.46.

(2) Cf.p. 20. where the Lancet is quoted saying that the Act 'deserves more from the long discussions between the profession and the Ministry of Health than it does from any doctrinaire idea of the present Minister's political party.

(3) Mr.A.Greenwood 17.3.44 Vol.398 Hansard House of Commons. It is appropriate to quote here Levy. 'The British system of health insurance was not the outcome of an impartial choice from the many possible alternatives of the most appropriate scheme'. He goes on to speak of the interests etc. that had to be met, and ends 'the same traditional institutions, vested interests and public prejudices have still to be reckoned with today'. National Health Insurance H. Levy.

is a broad one made from the survey of four years and may, therefore, occasionally seem lost in the mass of discussion and negotiation. It is, therefore, suggested that this 'official' plan provided, as it were, a starting point from which each Minister sought to balance 'realities' against the a priori planning of the Ministry's officials. If this is so, Mr. Brown's inability to produce a White Paper may have been due to his discarding the 'basic' plan. Further, Mr. Bevan had only one new factor to face which his predecessors had not - a new and powerful interest group, his Labour supporters. For Mr. Brown and Mr. Willink there was the 'climate of opinion', a strong public opinion calling for a national health service but not stressing any particular form of service. In the face of this situation Mr. Willink could well afford to say: 'I sometimes feel that it must have been depressing for those with 'whom we have had conversations ... that in the first 'months when a project of this sort is under discussion, 'the Minister .. has, at that early stage, nothing to give, 'no terms to make, no promises. I think, however, that 'those who are experienced have understood that until a 'certain stage has been reached when we have an impression of 'the views of all concerned, we cannot begin to review the 'public mind as a whole, the views of the .. (groups) and 'reshape to the right extent the original proposals'. (1)

(1) In a lecture to the Chartered Society of Physiotherapy reported in 'Physiotherapy' November, 1944.

For him, in this instance, the original proposals were contained in the White Paper of 1944, itself the product of such a process.

For Mr. Bevan on the other hand, instead of an ill-defined public opinion, there was a strong Parliamentary group with a definite plan for a National Health Service. In such a situation he had obviously to make readjustments to the balance reached by Mr. Willink, readjustments which in almost all cases only went part way to meet his party - he had still to pay attention to the other groups.

The Labour Party's plan of 1943 had three main points to it - a regional local government body to administer all the health services, including as part of it, a full-time salaried general practitioner service, and a unified (or eventually unified) hospital service. When the Party came to power in 1945 it had a sufficient majority to enact a National Health Service including these three points. In fact, none were enacted in the form envisaged in the Plan and only in the cases of the hospitals service was anything approaching it reached. In such a situation one can only marvel that Mr. Bevan's plan was so little criticized by his own supporters. They realized, as he did, the strength of the various interest groups - it is perhaps a measure of their strength that only the voluntary hospitals lost everything - the other groups were strong enough to maintain part, at least, of what they wanted.

The previous chapters show where Mr. Bevan made readjustments because of the feelings of his followers and where he took over Mr. Willink's ideas because the Party following him supported them or had no strong feelings on them or where, for the sake of meeting other views, he had to ignore his own Party.(1) The first chapters deal with the general view of the service, with its financing and the population to be covered. Mr. Brown and Mr. Willink put forward the view that the aim of the Government was the establishment of a comprehensive health service, for all, a view shared by the Labour Party. Both earlier Ministers had refused to accept a compulsory 100% service leaving no one the right to seek private treatment. The aim of the Labour Party, on the other hand, had long been a national service so good that none would want private treatment - they were therefore bound, if they believed the service would reach such a standard, to allow private practice, for to abolish it would display a lack of such faith. On the financing of the service Beveridge had laid down the pattern of insurance contributions, rates and taxes sharing the cost - a view with which none of the Ministers and their supporters dissented. Therefore in this section the situation reached by Mr. Brown and Mr. Willink which was accepted by almost all the interest groups, was continued by Mr. Bevan without material change.

(1) e.g. in pay beds in hospitals - or the remuneration of general practitioners.

The third chapter poses three questions, the degree of central control, which for reasons there explained is largely left unanswered, the type of central body and the form of the advisory machinery. On the second question the pressure of the various groups, including the Labour Party for a new central body exclusively concerned with all civilian health services, could not overcome the 'inertia' to change of the various Ministers. The reasons for this refusal to change lie in the inner sanctums of the Ministry and in the political ambitions of the various Ministers. It is, perhaps, not coincidental in this respect that when the Ministry of Health lost its housing duties, the Minister lost his Cabinet rank and much of the status previously accorded him. One group, the Medical Practitioners Union, complained of the Ministry of Health being a stepping stone for politicians to higher posts and if this were true, as seems most likely, no politician would lightly abandon his power over such duties as controlling housing where a political reputation might well be made. Further, one could not expect a Minister to agree to any controlling body outside the Department as that would deprive him of his power and responsibility. Therefore the central body was never in doubt and no changes were made.

In answer to the third of the questions above, the form of the advisory machinery, the handwriting of the

interest groups is plain to see. All the groups had desired separate professional organizations and were soothed, in part at least, by a 'strong' advisory machinery devised by Mr. Willink in his two plans. When Mr. Bevan came on the scene the views of the new group which he had to meet were not strong on this topic and after some minor alterations he followed Mr. Willink's final plan. One may, therefore, say that the central administrative and advisory machinery betrays the thread of development over the four years.

The general financial aspects, the coverage of the service and its central administrative and advisory machinery, reveal no major change by Mr. Bevan. The next topic, however, from the fourth chapter is altogether a different matter - it was in this part, the hospitals and specialist services that Mr. Bevan introduced his only major new idea - the nationalization of the hospitals. Mr. Willink had reached, starting out from Mr. Brown's plan of a co-ordinated service at 'area' level, a position of broad agreement between himself and the various groups. Mr. Bevan, however, had to face his own supporters pledged to a regional hospital service of eventually a unified type, and organized as part of a regional local government system. In these circumstances he had to make some changes and as suggested elsewhere (1) he had no real alternative but to nationalize the hospitals. In so doing he made concessions

(1) See p. 199.

(e.g. pay-beds) to please the specialists (and incidentally thereby displeasing his own followers) - to soften the opposition he knew he would get from the other groups.

The fifth chapter explains the development of plans for that most contested part of the service, the general practitioner service. In this case, by dint of patient discussion and negotiation Mr. Willink had reached a general agreement with the main group the medical profession. He had dropped ideas of a full-time salaried service, though he still spoke of a basic salary as a possibility in the remuneration of general practitioners; he had dropped the suggestion of local government control though he still talked of a planning control of the service by Area Planning Councils (with local government majorities); he had abandoned ideas of directing doctors; he had relegated health centres to experiments and had postponed decisions on the sale of public medical practices. Mr. Bevan on his entry to the Ministry was faced with his own supporters claims of a full-time salaried service based on health centres, and of the abolition of the sale of practices. He had, therefore, if he was to carry his party with him, to make some changes. On the administrative proposals which Mr. Willink had agreed there was little comment from his supporters and little change was necessary.

He, then, proceeded to resurrect some of the ideas put forward by Mr. Willink in his earliest plan. He abolished the sale of medical practices, spoke of a basic salary using terms identical with those used for the same purpose by Mr. Willink, revived the negative direction of doctors (the power favoured by a majority of doctors in the British Medical Association questionnaire) and restored the major role of health centres.(1) He did, not, however, speak of a full-time salaried service or of a refusal to allow doctors in the public service to provide private treatment. He had, in other words, adjusted Mr. Willink's plan as far as possible to the changed circumstances reviving for the purpose some of Mr. Willink's earlier ideas. Once again, then, comes the thread of developing plans.

The final chapters of this study show the development of plans for the dental, opthalmic and pharmaceutical services, the local authority services and the mental health services. The process is one of details being gradually worked out over the years. All these services deal with topics on which the Labour Party in 1945 had no strong views and in which, therefore, Mr. Bevan was able to follow his predecessor's plan.

It can, therefore, be said that the National Health

(1) See p. 247.

Service Bill as introduced by Mr. Bevan largely followed or developed from the earlier plans. At the beginning of the period studied (1), it was announced that the development of plans for an Act would be achieved in three stages; firstly non-committal discussions with all groups, to be followed secondly by the publication of a general statement of the Government's views as a basis for negotiation for the final stage - the presentation of legislation to Parliament. Mr. Willink reached the final stage, being he has said, on the brink of introducing legislation. Mr. Bevan did not, however, repeat the previous stages, applying, it wouldseem, the views of his Party to the earlier plans.

The long process was therefore complete. An official plan had been prepared and then discarded with, perhaps, chaotic results. A new Minister had worked on the plan and produced another, the White Paper. With this as his basis he had met the interest groups again and finally bit by bit emerged a plan which was largely agreed with the various interests. The end of the Government and a change of Minister with new problems, a large new interest group, his own party, meant this last plan had to be further revised. The results which were achieved by adding the views of this new group to the previous plan, were not further negotiated with the other groups, but presented to

(1) House of Commons Official Report Vol.390 c842-3 10.6.43.

Parliament as the National Health Service Bill. That then is the basis of this thesis - a conclusion which, whilst not startling, is important.

It is a conclusion which shows that the authorship of the National Health Service Act is not Mr. Bevan's alone and that his predecessors in the Ministry had played their part in producing the finished article. It shows, too, that the Act is not the expression of a dogmatic party doctrine but rather of the clash of interests and views. Even then many of the major clashes, for example on the remuneration of the medical profession, had been sidestepped temporarily - i.e. left to be decided on in the Regulations to be made under the Act. The Act, a skeleton Act, as a piece of social legislation is not based on dogma, on scientific observation and data, but as probably most other legislation is, on a balance between conflicting interests. The idea behind the Act and its aim came from outside the interest groups - the detail from the meetings of these interest groups with the Government.

From this major conclusion to some less important ones. In the first place one is bound to wonder at the approach used in the White Paper of 1944. As an open invitation to interest groups to discuss the plan it seems almost to suggest a bareness of ideas on the part of the

Government. Never did a Government more earnestly seek the view of an interest group than did the Coalition Government when copies of the White Paper were circulated to all doctors at a cost, to the Exchequer, of some £950. (1) It is perhaps symptomatic of a different approach to problems of Government that this approach should come from a Conservative and not a Labour Minister. One feature of this study has been the absence of Conservative plans for a National Health Service, whilst the Labour Party had long talked of a National Medical Service and in 1943 had published their blueprint for it. It may be that in this case, the more empirical approach of the Conservative Party gave greater scope for interest groups than the more dogmatic approach of the Labour Party. This difference must not be laboured, however, as many other factors enter into the problem.

Some account of the successes and power of the interest groups ought to be essayed. Here, however, one comes up against a problem mentioned earlier - if a Minister accepts the point of view of a group because he is rationally convinced that it is the right view of the situation, then one is loathe to call this 'pressure' and to label the result a concession. It approximates rather to what one would like to call expert advise - i.e. unbiassed presentation of a

(1) House of Commons Official Report Vol.399 c43-4 18.4.44.

specialized knowledge. Such results are obviously bettering any Bill to be presented to Parliament and are therefore benefitting the Minister, the Bill and the general public. But if, on the other hand, the Minister accepts a point of view, not because he is convinced of its correctness, but rather as a concession to the power of the groups, entirely different problems arise. It may be argued, as it could be in the case of the National Health Service, that without concessions to a group, in this case the medical profession, the service would never have been started. On the other hand, it could be stated that the Minister should have proceeded with what he felt to be right and left Parliament to decide whether it wanted the best or the concessions. If Parliament accepted the Minister's point of view, then it would be, so it is argued, up to the groups to accept the majority view. This problem is therefore, part of a wider one - is Parliament qualified to judge on such technical issues and if not, as indeed appears to be the case, what other method ought to be adopted. This one study cannot decide these questions and indeed, without a fuller study of the success or otherwise of the National Health Service since 1948, one cannot say whether the procedure adopted on this Act was the right one. One thing seems almost certain - without concessions the medical profession would not have worked the service, and as the service is working, those concessions were right.

Turning to the successes of the groups, however, one finds the most successful groups to be those who had a monopoly (or virtual monopoly) of particular skills essential in any health service. Of these undoubtedly the most successful were the medical profession, at least up to 1946. I have heard it said that by 1948 the most successful group were the dentists but this study has not provided the evidence to substantiate or challenge this statement. The original proposals for the general practitioner service as a full-time salaried service of regional local government bodies stands in great contradiction to the proposals of the Act of 1946. Local government control had gone, full-time salaried service had been dropped and even the idea of a basic salary was dropping out of the Minister's vocabulary, ad hoc machinery like the National Health Insurance system but with more medical representation had returned and the right of service doctors to provide private treatment maintained. All these points conceded to doctors in 1946 had been denied them in the original proposals. Specialists too, were to receive many 'concessions' as outlined in an earlier chapter.[1] The administrative and advisory machinery of the service, unlike that of the earliest proposals, were largely moulded in a pattern acceptable to

(1) See p. 207.

the profession. All in allthe medical profession, though still far from satisfied, had much to be thankful for when comparing Mr. Bevan's proposals with those of Mr. Brown some three years earlier. Even on one point where temporarily they had to admit defeat, i.e. remuneration, their strength was gravely underestimated by Mr. Bevan who imagined that by splitting off the specialists he could force the general practitioners into accepting his proposals. The amending Act of 1949 shows how wrong he was.(1) The dental profession, too, had their successes though they were delayed beyond the period here studied. These groups had skills to offer - a counter with which to bargain, and the Government, in the role of employer, had to offer terms and conditions of service, using the term in a far wider sense than usually accepted, such as would entice the owners of these special skills to serve in the new service. No thought of compelling them seems to have arisen, the government having a respect for individuals which it did extend to property.

For the other groups, they had no such skills to offer, their main card being their property. Once their property was confiscated, as, in different measure, the

(1) National Health Service (Amendment) Act, 1949 which, inter alia, madeimpossible the introduction of a full-time salaried medical service.

various government plans proposed, they had nothing left with which to bargain. Add to this weakness, in the case of local government, the conflicting interests within this body, and the failure to agree on any reform of local government, and one has reason enough for the 'raw deal' which local government suffered. Probably, the sole saviour of local government was the strong local government element in the Labour Party which probably prevented any thoughts of unifying all health services under regional ad hoc bodies. For voluntary hospitals there was also an additional weakness - although their Association spoke with one voice, there was never any clear evidence of the wholehearted support of the many voluntary hospitals themselves - they were too proud of their local traditions to make a really strong interest group.

Finally in this chapter one must note the battle for professional status of many of the groups. In this respect, the medical profession alone were secure, whilst the dentists, pharmacists, opticians and physiotherapists (and no doubt other professions too) saw the National Health Service as the opportunity to achieve that elusive something - professional status. It is against this background that one must see the sometimes exaggerated claims of these groups. They were part of the general trend towards

increasing specialization and splitting within the medical profession, a process which is making, so I was told, the decisions and discussions of the British Medical Association increasingly difficult. The growth of medical knowledge has brought this increasing splitting in the profession, and it seems essential that some day something will have to be done by the medical profession to reassert the unity of all medicine.

CHAPTER 2.

Suggestions for a wider study of Interest Groups.

The introduction to the last chapter speaks of some 'suggestions' which can be made on the general topic of interest groups. These suggestions are not put forward, indeed cannot be put forward, as firm conclusions but rather as possible pointers for a further study of interest groups.

The negotiations on the National Health Service have shown the importance of public opinion, but also its weakness - a lack of formal and definite expression in a matter of this kind. The point of view of the general public had no one group as its advocate, each group giving their own interpretation of it, and one has been often forced to wonder if the public were ever remembered in the discussions on the Bill. The role of Parliament in this matter is, of course, a subject too wide for discussion here. As a tentative suggestion based on the study here made it would seem that in cases where public opinion is expressed through Parliament in an undefined manner, as, for example, up to the middle of 1945, then the opportunity for the

interest groups is great. But, if on the other hand, a majority party in the Commons has definite views on how a service, or piece of legislation should be framed then the chances for the groups are fewer. Whether either course is better than the other is not for me to say on the basis of this one study.

On one occasion Mr. Bevan referred to the 'social barnacles', (1) which an old country accumulated, and of the vested interests designed to preserve them. He said that there was always the temptation to compromise with these interests, a temptation to which it would seem Mr. Bevan himself succumbed. But it may be asked whether or not such interest groups perform an essential task in the drafting of legislation, Their role in the case of one piece of legislation has been discussed here, and it would seem that they have a role to play in almost all pieces of legislation. In this case many groups brought their skills, a position which gave them a bargaining counter, but in other cases they may only bring their experience and their 'interests'. It would seem, from this study, at least, that Parliament is not able to write legislation involving specialist knowledge nor, it would appear, are the government departments. In such a situation the

(1) 3.1.46 in an address to the Council for Education in World Citizenship.

interest groups have an important part to play. No fuller study of other legislation has been undertaken to prove that interest groups do play a part in the drafting of legislation, but a glance at a copy of the minutes of the Association of Municipal Corporations[(1)] finds them considering and, where necessary, making representations on such Bills as the Public Works Loan, Education, Town and Country Planning, New Valuation Lists (post government) Bills and others.

This problem is closely linked with the problem of consultation and negotiation - is one right and the other wrong, as Mr. Bevan insisted.[(2)] Is consultation the unbiassed discussion of experts and negotiation the prejudiced claims of various interests? Or is it rather that _my_ Government consults and _yours_ negotiates? The previous paragraph has differentiated between points of view rationally accepted by any Minister and those accepted as a concession - is it 'consultation' in the first case and 'negotiation' in the latter, and is the latter improper for a Minister of the Crown? The answer to that question if such a division can be made is for the political scientist.

(1) From a Report of the Law Committee of the Association of Municipal Corporations dated 11.12.52 and appearing in Municipal Review Supplement March, 1953.

(2) See p. 102.

Turning to the interest groups themselves, two key words seem to present themselves - publicity and unity. Time and time again the profession and group journals make references to methods and modes of increasing publicity - e.g. the British Medical Association in 1946 increased its expenditure on public relations from £5,000 to £25,000.(1) It would indeed be interesting to know just what the groups hope to gain thereby, and how far they are successful. Is it aimed at unseating a Government or getting an amendment? is it aimed at the individual voter or the political party? - all these questions and more spring to mind as needing answers.

The second key word mentioned was unity - repeated references have been found, all too often in high flown phrases, to the need for unity. The motto is always 'united we stand divided we fall' but it may be that a penalty is paid for this unity - e.g. in the medical profession so many interests had to be met that resulting principles acceptable to all were meaningless or extremely vague. Again one may wonder if unity is really important and what difference it makes to the success of an interest group.

A question which springs automatically to mind at

(1) British Medical Journal (Supplement) 13.4.46.

this point, is how the groups work. Some of the methods discovered in this study can be enumerated, although they have not the sensationalism often afforded to those of their 'bigger brothers' the American pressure groups. Examples of threats to withhold labour if the service did not meet with the wishes of the group have been discovered. The guarantee fund of the British Medical Association in case of a refusal to work the service, was a threat to use this weapon and has been condemned as 'crude pressure group stuff'.(1) Another method suggested by some groups involved sponsoring candidates for Parliament. The British Medical Association was reported to have been considering this course early in 1943, but there is no evidence to suggest whether or not they did. Their Secretary stood unsuccessfully as an independent candidate for Cambridge University(2) but whether he had the backing of the Association is not known. The Trades Union Congress has, for a long time, sponsored members for Parliament.

(1) Now Statesman and Nation - 16.3.46. The British Medical Association had proposed establishing a fund to be used to support doctors treating patients privately, in the event of the profession refusing to enter the service.

(2) British Medical Journal 12.5.45. Dr. Charles Hill.

There is some evidence of groups 'adopting' members of Parliament. Some groups like the Pharmaceutical Society were lucky to have an official in Parliament. Others, like the physiotherapists, for example, invited members to serve on their council. Local authority associations, too, invited members to become honorary officials of the Associations. In these and other ways some of the groups obtained the services of a member who could often be relied on to put their point of view in Parliamentary debates, though the evidence of the National Health Service Act suggests that few of these members carried such allegiance to the extent of voting against their party. In addition the groups met members separately or in groups, e.g. in the specialised members committees of the major parties.

Members of Parliament were bombarded with literature from the groups and on occasion the public, too, received their share of literature, e.g. the British Hospitals Association (1) distributed leaflets on their objections to the White Paper to members of the hospital contributory schemes. Press relationships too were considered important,

(1) I have not been able to verify the claims that this Association indulged in 'prestige' advertising in the Press, but no doubt they did so cf. Municipal Journal. 29.12.44.

so important that, in the case of the British Medical Association, a conference on public relations with editors of some of the leading newspapers was arranged.[1] They had, also, a link with the public through the Radio Doctor series on the B.B.C. which, at least, gave them the opportunity to create favourable general reactions to doctors. Despite all this the Association often received a bad press.

All these methods have been discovered in this study in addition to the formal ones of discussions and negotiation with the Minister and his officials. One of the methods of informing members and public alike of the groups' point of view was the official journals. One has been sorely tempted to devote more than a few lines to the emotional language, and the purple patches, contained therein. Mr. Bevan has said of the British Medical Association that 'it 'is a very adjectival body .. (and) is incapable of passing 'a resolution except in terms of hyperbole'.[2] This might well stand for comment on professional and group journals.[3]

(1) British Medical Journal (Supplement) 29.7.44.

(2) Mr. Bevan in Standing Committee on the National Health Service (Amendment) Bill 29.6.49 c1707.

(3) e.g. '... Caldaniskc and petulant body, so enthusiastically afloat on its private puddle." In these words the Municipal Journal described the British Medical Association 1.6.45.

These then are a few suggestions for a wider study of interest groups and their role in the Government of this country. On the groups, themselves, the results of the British Medical Association's questionnaire suggests that the leaders of the Association were out of step with their members on some issues. One has often wondered when reading the pronouncement of the leaders of the various groups just how far they represent the views of their members. Any full study of interest groups would need to answer that question.

APPENDIX - Standing Committee C.

On the 2nd May, 1946, the National Health Service Bill was given a Second Reading and, despite Conservative Opposition, committed to a Standing Committee of the House, Standing Committee C. Its personnel of a Chairman and 20 members was augmented by a further 30 members for the consideration of this Bill, a proceedings which lasted almost 50 hours.

The membership of the Committee was made up as follows:-

Labour	30	Conservative, Liberal National and Ind. Conservative	18.	
Liberal	1	Communist	1.	Total 50.

The Chairman was Mr. F.G. Bowles, Labour Member for Nuneaton.

The figures of the professions represented and members having direct interests in the health services are interesting:

	Doctors	Dentists	Pharma-cists.	Other Professions	Interested (2)	Total
Government (inc.Comm.)	6	2	1(1)	1	2	12
Rest	2	-	1	-	-	3
Total	8(3)	2	2	1	2	15

Note: (1) Pharmacist here mentioned, Dr. Clitherow is also included as a doctor in the first column.
(2) 'Interested' has been strictly interpreted - the two Ministers and the ex-Minister Mr. Willink have not been included.
(3) According to the British Medical Journal there were 15 doctors in the House of Commons, none of them on the Government benches.

One, therefore, finds that of Government supporters including the Communist, eleven out of 29 had direct interests in the Bill before them. In the case of the Opposition including all the other parties, the figures were 3 out of 19.

In those circumstances one might expect more discussion on the Bill from the Government supporters. In fact, however, as perhaps happens in all such Committees, the Opposition were more loquacious than the Government supporters. This, the following table brings out:

Members speaking for:	Government Supporters (1)	The Rest.
Members not speaking	6	-
Under 5 columns of Hansard	12	5
5 - 10 do.	6	3
11 - 20 do.	3	4
21 - 40 do.	2	4
41 - 60 do.	-	1
Over 60 do.	-	2
	29	19

(1) The table excludes Mr. Bevan and Mr. Key, the Ministers.

Of the six members not speaking two Mr. A. Balfour and Mr. J. Snow are recorded as attending each time. One is bound to wonder if their patience failed them, and if it was one of them who earned the following rebuke from the Chairman:- 'The hon. Member who is reading a newspaper must not do so in Committee' (Official Report c 729).

Even in Committee the Minister must have those who will vote for him whether they are interested or know anything about the matter under discussion. The two Government supporters talking most were Mr. F. (now Sir Frederick) Messer and the Communist member, Mr. P. Piratin, the former the acknowledged expert of the party on health services particularly in local Government. (After the Act was passed he became Chairman of a Regional Hospital Board (the N.W. Metropolitan Board) and the Chairman of the Central Health Services Council).

It is perhaps not surprising that when one notes the Government supporters who crossed the floor to vote against the Government during the Committee stage these two names recur, Mr. Messer and Mr. Piratin. Mr. Piratin did so on two occasions as did Mrs. L. Middleton, Labour member for the Sutton

division of Plymouth. Mr. Messer who crossed the floor once was joined in this by two other members Drs. H.B. Morgan and R. Clitherow who each voted against the Government once.

The subjects of their defaults are interesting:-

(1) Mr. Messer, Mr. Piratin and Mrs. L. Middleton voted against the Government on an amendment introduced by Mr. Messer which sought to delete 'on medical grounds' from the following subsection of section 3:- 'the services of 'specialists, whether at a hospital, a health centre ... or 'a clinic, or is necessary on medical grounds, at the home 'of the patient'. They claimed that the duty on the Minister to provide these services was unduly restricted by this phrase - they wanted specialists to go to the home of the patient where social conditions (as opposed to purely medical ones) made that necessary. Their opposition was not successful.

(2) Drs. Clitherow and Morgan and Mr. Piratin voted against the government against the refusal of the Minister to allow appeal from the decisions of the Tribunal of the service to the Courts of Law. Their opposition was not successful.

(3) Mrs. Middleton voted against the Government on section 68 in an attempt to get compensation for certain types of workers in the contributory schemes who would lose their jobs as a result of the Act. Her opposition was not successful.

In no case did they vote against the Government on matters which were included in the Labour Party's Plan of 1943 but were contravened in the Bill.

Divisions:

In all some thirty five divisions were called and only once was the Government beaten. The highest number of members voting was 46 in the first division on the Bill and the lowest 27 on the penultimate division. The average vote recorded was between 37 and 38. If a graph of the number voting per division were drawn it would show a steady decline in the number of members voting as the discussions went on. Not until the ninth division did fewer than forty members vote, but in the last fifteen divisions only once were 40 votes recorded, and on two occasions fewer than thirty voted.

1 x 2

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The main information not made available is that of Government itself. Attempts were made to secure permission to see files held by the Ministry of Health on this topic, or alternatively, to release the groups from the confidence imposed on them. In both cases the Minister, Mr. Ian McLeod, regretted that 'constitutional practice' were against him accepting such requests.

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