CONTENTS

1  A Service for the Nation, page 2
2  The New Hospital and Specialist Services, page 9
3  Services of the Local Health Authorities, page 16
4  The Family Doctor and his Patients, page 24
5  The Authorities and the Professions, page 32
6  Building the New Service, page 34

Prepared by the Ministry of Health and the Central Office of Information

CROWN COPYRIGHT RESERVED

To be purchased directly from H.M. Stationery Office at the following addresses: York House, Kingsway, London, W.C.2; 13a Castle Street, Edinburgh, 2; 39 King Street, Manchester, 2; 2 Edmund Street, Birmingham, 3; 1 St. Andrew's Crescent, Cardiff; Tower Lane, Bristol, 1; 80 Chichester Street, Belfast or through any bookseller.

Price 6d. net.  
S.O. Code No. 32-389

UNDER THE NATIONAL HEALTH SERVICE ACT, WHICH CAME INTO FORCE ON 5TH JULY, 1948, IT IS NOW THE DUTY OF 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 of England and Wales, and the prevention, diagnosis and treatment of illness".

This booklet is intended for people at home and overseas who are interested in the National Health Service, how it was planned, what it has set out to do, and how it is operated; and for those who are workers in the Service, without whose understanding and whole-hearted effort it cannot succeed.
A SERVICE FOR THE NATION

THE aim of the National Health Service Act, which came into force on 5th July, 1948, is to make all the health services available to every man, woman and child in the population, irrespective of their age, or where they live, or how much money they have; and to make the total cost of the Service a charge on the national income, in the same way as the Defence Services and other national necessities. The Act aims at accomplishing this reform while fully maintaining the freedom of the individual. Members of the public can use the Service or not, as they wish; use one complete part of it and not another; and choose the family doctor whom they want. For the doctors, specialists, dentists and other professional men and women there is complete freedom to work for the Service or not; or to work partly within the Service and partly in private practice.

In fact, 19 out of 20 people very quickly chose their doctors and decided to use the family practitioner service; and nine out of ten doctors and dentists, and nearly all the specialists, pharmacists and opticians are taking part. The National Health Service has been launched—with remarkable smoothness. Now Parliament, Press, public and professions have the task of helping the Government to ensure that it is developed on the best possible lines and used in the right way.

The National Health Service is part of a programme of social legislation which also includes the National Insurance Act and National Assistance Act. Great enterprises such as these require large resources which can be made available only by the determined efforts of a people paying its way by its work. Britain and the world have been impoverished by a ruinous war. There is no quick or easy road from present shortages to future plenty; but advances in post-war reconstruction can be maintained if the nation uses its resources sensibly, and steadily improves its productive capacity.

The National Health Service started on 5th July, 1948, with the resources already at hand. There is still an urgent need for more nurses; hospitals are short of staffed beds, and their out-patient departments are crowded. But doctors, dentists and nurses cannot be trained overnight, nor can new hospitals or health centres be built quickly when many thousands of new homes and hundreds of new schools are required at the same time. There have never been sufficient hospitals, clinics, nurses, midwives, or doctors of all kinds for the needs of all the people. In some ways the war made these shortages worse. It is a main aim of the new Health Service to enlarge facilities and bring equipment up to date as quickly as is practicable—and above all to make what there is equally accessible to all. The shortages themselves indicated that new forms of organisation were required to rescue the health of the people from what Lord Horder called 'the maze, the unwieldiness, the overlap, the uneconomy, the lack of integration of our health services'.

Many of these difficulties will eventually be removed by means of better organisation, although new resources must be adopted before the services can be complete. There was one immediate change on 5th July—nothing need any longer pay doctors' bills and hospital bills when they are sick. Consideration of fees has ceased to be an obstacle between a patient and the medical care he requires. The wealth or poverty of an individual becomes irrelevant to health care, as it should be. Bills are paid collectively instead of individually. The clubbing together of all citizens to meet the cost of medical care provides free service for any citizen at the moment when he needs it. There need be no more bargaining over fees, or arguments about insurance status.

The full bill for the National Health Service, averaged over the whole population, comes out at just about half a crown per head per week. A very large part of the total cost was previously paid in hospital charges and as private fees, and so represents a redistribution of national spending and not a new strain on the economy. Yet clearly the present expenditure can be justified only on the basis that the essential aim of the Service, and all who work in it, must be to prevent illness. It has been estimated that loss of production due to absenteeism through sickness costs the country at least £300,000,000 a year—and this figure does not include reduction of working capacity due to poor health and bad eyesight. Much of this absenteeism and impaired capacity is preventable.

Why a Change was Needed

Looking at the old Health Services as a whole, it is not difficult to see why a new scheme was needed. Those Services were everybody's business yet nobody's full responsibility. Although insured workers could get medical treatment free, their wives and children could not, and over half the population had to make private arrangements for medical care, whether with a personal doctor, a specialist, or a hospital. For many middle-class people excluded from compulsory and voluntary insurance a serious illness in the family could be ruinously expensive. In order to fill the widest gaps in the system, public services and voluntary schemes of mutual assistance were added to deal with particular needs as they
were discovered, without much regard to the total effect on either patient or doctor. Medicine itself was becoming departmentalised. The family doctor, working single-handed or in a small partnership, usually had too much to do because he had too many patients, insufficient help, and insufficient equipment, and he was unable except with great difficulty to keep up to date or to enjoy reasonable leisure. Surrounded by a host of services and schemes managed in different ways by different public and voluntary authorities not themselves working to any clear common plan, the doctor has often been almost as bewildered as his patients. Specialists and consultants in order to make a living—for they have hardly ever been paid for their work in the voluntary hospitals—were obliged to charge their private patients heavy fees, and to settle in towns and districts where people able to afford those fees were numerous. Over wide areas of the country this made it difficult for any but wealthy patients to obtain their services.

In the face of this multiplicity there is now a unified Service available for the medical care of all citizens, regardless of class or income. The new Service is there for everyone who wants to use it, and is designed to be the normal way for people to get all the advice and help they need. But, as has already been briefly explained, there is no sort of compulsion. Anyone is free to make his own private arrangements if he so prefers; or to use the Service for some purposes, such as hospital care, while making private arrangements for other purposes, such as sight-testing and the obtaining of spectacles, or dentistry (a patient who chooses to pay a doctor, however, must also pay to have his prescription made up at the chemist's—because the medical cannot be regarded as separable from the doctor's advice and treatment). In the same way, any doctor is free, if he wishes, to stay outside, confining his practice to patients who want to pay fees; and he is also free to work partly in the Service and partly in private practice. As in the past, the citizen remains free to choose, and change, his personal doctor, and the doctor remains free to accept or refuse a patient.

How the National Bill is Paid

The national doctor's bill—the cost of the whole range of services—is paid mainly out of rates and taxes. (A minor part comes from insurance contributions as well; but insurance is not a condition of using the Health Service, which is open to all.) For the services provided by the 146 Local Health Authorities the money comes partly from the rates and partly from Government grants. By paying in advance (indirectly, as a taxpayer, etc.) the citizen spares himself any personal payment when he uses the Service. There is no charge for any advice, treatment, drug, appliance or service which is medically necessary; charges are made only for certain 'extras' which are not medically necessary and—according to the patient's ability to pay—for some supplementary services, such as domestic help, blankets, foods, etc., provided by Local Health Authorities. It is worth emphasising again that when he wants free medical care the patient does not have to prove that he is insured and 'in benefit'. The Health Service is quite separate from the insurance scheme, which exists to give people not medical care, but money during sickness and unemployment, and to provide pensions.

The purpose of the Health Service is to provide advice or medical care for the individual man, woman, and child in need of them. Its range includes everything from advice on infant feeding to the surgery of the brain and the treatment of rare diseases, from care of mental defectives to blood transfusion, iron lungs, and artificial limbs; included also is all that goes with medical care, such as massage, the services of a midwife, treatment during convalescence, home nursing, use of ambulances, care of the eyes and teeth, drugs, special foods, spectacles, hearing aids, and so forth. The usual way of obtaining most of these services is from or through the family doctor; and the aim is to put him as quickly as possible in a position to carry out his own duties more easily and to make all the other services available for the well-being of his patients. It must be pointed out that these services cannot all be fully provided at once. Arrangements for all forms of nursing, for the care of chronic invalids, for many specialist services, and for the provision of appliances, fall far short of the ideal.

The New Health Authorities

As the effect of the Health Service is to promise every citizen the right to medical care, it must be someone's duty to see that this promise is honoured, and that each of the many branches of the service is adequate for its purpose. This duty falls to the Minister of Health, and he is answerable to Parliament for its fulfilment. But he and his officials cannot, and should not, manage the Service themselves; nor can they plan it in detail. The detailed planning and daily management of each section is done by a variety of regional or local bodies in touch with local needs and wishes, and able to make full use of local interest and experience. Each of these local bodies actually running the Service is in charge of an area sufficiently large for its particular purpose and with sufficient resources to do its job properly. These bodies, however, are not in charge of civil servants. Every regional or local body actually administering the Service is composed entirely of voluntary unpaid workers. More than 10,000 of these volunteers are running the scheme in the regions and localities.
LOCAL HEALTH AUTHORITIES AND EXECUTIVE COUNCILS

146 Local Health Authorities—62 County Councils, 83 County Boroughs and the Isles of Scilly—are responsible for all local health authority services in England and Wales; 138 Executive Councils are responsible for the family practitioner services—one for each County and County Borough, except in eight cases where two areas are combined under a single Executive Council (see foot of map).

In the following cases an Executive Council area combines more than one Local Health Authority area: Devon and Exeter; Gloucester County and City; Kent and Canterbury; Leicestershire and Rutland; Nottingham County and City; Oxford County and City; Denbigh and Flint; Monmouth and Newport.

S. of P. = Soke of Peterborough
The Service is therefore planned, managed, by a partnership of local bodies of adequate size working together under the general guidance of the Ministry. There must be an equally close partnership between all these authorities on one hand, and the doctors with the rest of the army of health workers on the other. The doctors themselves (and, to a lesser extent, the other health workers) have a direct and ample share in the making of all plans and all business arrangements and in the daily running of the services.

The problem of local control of the new Health Service has been met by dividing England and Wales into fourteen large regions, each of which contains a single hospital service authority (the Regional Hospital Board), and into 146 districts—the areas of the counties and county boroughs, whose councils have become the Local Health Authorities within those areas.

The health services themselves are divided into three main branches: (1) the hospital and specialist services; (2) a group of local government services; and (3) a group of family practitioner services including those of the family doctor and dentist.

The hospital and specialist services, then, are administered by the new Regional Boards. The major local authorities (sixty-two county councils and eighty-three county borough councils)* administer the local government services, each authority employing a medical officer of health and working through a health committee of the council.

The general medical services are those of three independent experts—the family doctor, the dentist, and the ophthalmic doctor or ophthalmic optician—aided by the chemist and the dispensing optician. These general medical services are administered by new local bodies called the Executive Councils, each of which covers the area of one major local authority (with a few exceptions, where two such areas are administered together).

There is no change in the arrangements which were in force before the Act for medical research and medical education, and no Government interference with either. Under the scheme the finance and administration of the teaching hospitals are separated from those of the medical schools, which are assisted by money provided by the University Grants Committee.

It should be explained that the more detailed (but far from complete) account of the National Health Service which is given in the following chapters refers only to England and Wales; there is a separate Act, although on similar lines, for Scotland.

* The Council of the Isles of Scilly is also a Local Health Authority.

THE NEW HOSPITAL AND SPECIALIST SERVICES

Until 5th July, 1948, there were over 1,000 independent voluntary bodies providing hospitals, and an even greater number of separate local authorities with powers to provide hospitals of one kind or another. The fourteen large new regions are each linked with a university with one or more medical schools and one or several teaching hospitals, and each regional hospital board controls the great majority of the former voluntary and municipal hospitals within the region, with their associated clinics and specialist services—but not the teaching hospitals, each of which retains its own governing body. Under the general guidance of the regional boards the hospitals are managed, singly or in convenient groups, by management committees appointed by, and responsible to the boards. The number of these new committees varies in each region from fifteen to sixty according to the size and circumstances of the region.

The patient is not tied to the hospitals of his own region, though most regions will tend more and more to be self-sufficient as time goes on. The hospital service is a single system for the whole country; the regions are for convenience of management. Each region has its intellectual centre for medical work in a city with a university medical school. Wherever possible it is also the natural ‘catchment area’ within which patients needing special treatment would usually be referred from a small local hospital to a larger centre.

On the average the regions have a population of about three million, but the size varies with geographical and other factors. For example most of the north-west of England with 4,400,000 people falls within the Manchester region; Wales has 2,500,000 people, while the Liverpool region, between the two, has only 1,800,000. But Wales has only 23,000 hospital beds, while Liverpool has 30,000 and will of course continue to serve North Wales. In south-east England, where 12,700,000 people are served by hospitals centring on London, four Metropolitan regions have been created, each containing a quarter of London and running out into
the Home Counties. The largest, the south-west Metropolitan region, stretches from Marble Arch to Hove and the outskirts of Lyme Regis.

**Why the Hospitals Have Been Taken Over**

Why have these changes been made? For many years experts have argued in favour of a hospital system planned to serve wide regions of the country. Such planning could work well only if the regional authorities could make drastic changes. They would need to amalgamate some hospitals too small to be efficient as single units, to alter the functions of many more, to close down others, and to build new ones. All this could not be properly done if the hospitals were still owned by some 2,000 separate, and often jealous and conflicting, local public or voluntary authorities; nor could the voluntary hospitals be guaranteed the financial security they so badly needed. The new regional authorities had to be given the power to plan and reorganise which goes with common ownership.

Moreover, voluntary and municipal hospitals were managed and did their work in different ways, and each way had its good and its bad features. An aim of the new service was to keep and combine the good and to discard the bad features of both kinds of hospitals. For this purpose hospital authorities of a new kind were needed—bodies with neither the municipal nor the voluntary tradition, able to fuse what was best in both methods into a new and better service. As they would be spending the public’s money, these new bodies had to be public authorities answerable in one way or another to the representatives of the people. They could not be local authorities or formed out of groups of local authorities, so they had to be appointed by a Minister responsible to Parliament. In order to give the regional boards full control, voluntary and municipal hospitals have therefore been transferred to the formal ownership of the State.

The hospitals transferred were the existing voluntary and municipal hospitals with their clinics and other associated institutions required for the new Service. Some hospitals (usually small ones), such as nursing homes, institutions run by religious orders, disused and unsuitable isolation hospitals, have not been taken over. Nursing homes run for private profit, and voluntary institutions created in the future cannot be taken over except by purchase. The Minister has power to purchase, compulsorily if necessary, land and buildings needed for hospitals, just as a local authority has powers of compulsory purchase when it needs land or buildings in order to provide houses or schools. But there is no question of using these powers to set up a State monopoly of hospitals and nursing homes. Some hospitals connected with particular denominations have been transferred to the Minister; the Act requires the preservation of their ‘character and associations’.

Thus the Minister of Health, with the Government behind him and Parliament in ultimate control, becomes the nation’s trustee for the hospital service, the cost of which will be paid from taxation. He is therefore given the duty of meeting ‘all reasonable requirements’ for hospital services, including ‘the services of specialists, whether at a hospital, a health centre . . . or a clinic or, if necessary on medical grounds, at the home of the patient’.

**The Regional Boards**

The Minister has made the regional boards responsible for carrying out most of these duties. The boards are made up of public-spirited men and women who serve without pay and have been chosen by the Minister for their personal qualities and their experience of the health services. The largest board, the Welsh board, has 32 members: the smallest, one of the four London boards, has 22. Their chairmen have all distinguished themselves in serving the public—three as chairmen of well-known voluntary hospitals, six (among them a doctor and an M.P.) as chairmen of health or hospital committees of leading local authorities. The remaining five include the Vice-Chancellor of a university.

Board members cannot be removed during their term of office unless their fellow-members ask the Minister to remove them. In each region they have been appointed on the recommendation of the university, the doctors’ organisations, and the Local Health Authorities, all of whom the Minister must consult; and also at the suggestion of other professional societies, hospital associations, trade unions, employers’ organisations and other interested bodies. Apart from their chairmen, the 364 members of the 14 boards include upwards of 120 doctors, of whom 40 are university professors and teachers of medicine, dentistry and kindred subjects, 60 specialists (many of whom teach in the hospitals), and 20 family doctors. The other professions are represented by a score of men and women, including 10 hospital matrons and two dentists in general practice. The non-professional members include others drawn from the universities (including several vice-chancellors), councillors or officers drawn from local authorities, and members of the governing bodies or officers of former voluntary hospitals.

The boards do the work of regional planning, and take the big decisions that affect the co-ordination of hospitals in their regions. They appoint the management committees which do the daily work of running the hospitals.

**Hospital Groups and Hospital Management**

Most hospitals, with clinics and convalescent homes, have been linked together by the boards into local groups, each of which can meet
most of the ordinary needs of a district (such as a town and the country areas around it, or a group of neighbouring towns with the country in between). Each of these hospital-service units has a single management committee, but there is no standardised pattern. In the large cities the hospitals are sometimes divided between two or three committees; elsewhere there is only one. Some large single hospitals have management committees of their own. The hospital-groups vary very much in size according to local conditions, and some groups are confined to hospitals of a special kind instead of being ‘all-purpose’ units. In most of the groups certain hospitals have a house committee with delegated powers appointed by the management committee.

In their membership the management committees have been designed to reflect the communities they serve, the doctors and authorities of those communities, and the professions actually working in the hospitals. Each has members appointed after consultation with the Local Health Authority, the Executive Council responsible for the family doctor service, and the senior doctors and dentists working in the hospitals, all of whom must—under the Act—be consulted by the regional boards in making the appointments. They include many of the men and women who managed the same hospitals when they were under voluntary or local authority control, with many more recommended by interested bodies of local citizens, such as Women’s Institutes, Trades Councils, and social service organisations.

Formerly in many municipal hospitals the chief officer or ‘medical superintendent’ managed both the business and the medical arrangements. He might or might not treat patients himself, but he sometimes had some control over the way in which the other doctors cared for their patients, and those doctors were mostly employed full-time in one hospital. This limited both the responsibility and the medical experience of the doctors, and, because the medical superintendent was paid more than they, offered the best posts to men who gave up medicine for management. The tendency is likely to be to change this arrangement to something nearer to that of the former voluntary hospitals. That is to say the hospital manager, whether doctor or layman, will be a business manager. Medical matters will be in the hands of a committee of the senior medical staff working closely with the hospital management committee, and being consulted on everything affecting their professional work. While junior doctors will commonly continue to work full-time in one hospital, most of the senior doctors will serve several hospitals, giving part of their time to each; this is the best way for them to spread, and to improve still further, their own skill and experience. The formation of representative committees of nurses and other sections of hospital staffs is also being encouraged, so that all who work in hospitals may have a proper voice in their daily management.

Some special institutions, such as large mental hospitals and tuberculosis sanatoria, may continue to be managed by a full-time senior doctor.

One effect of the new arrangements is to break down the isolation in which the Mental Health Service has tended to function. Through the integration of that Service in the National Health Service, the treatment of mental illness will have a chance of approximating more closely to the treatment of physical illness. More provision will be made for the treatment of early nervous and mental disorders in general hospitals. The specialists in general hospitals in turn will enter more freely into the work in mental hospitals.

Universities and Teaching Hospitals

The teaching hospitals share with the universities the tasks of training students to become doctors and dentists, of turning doctors into specialists, and of conducting medical research. In the regional centres of Birmingham, Bristol, Cardiff, Newcastle, Leeds, Liverpool, Manchester, Oxford and Sheffield, the existing teaching hospitals, each with its group of associated hospitals (for diseases of women and children, for dentistry, maternity, and so forth), have been designated as the medical teaching centres of their regions. For the Cambridge region, which had a postgraduate teaching hospital, a similar group of existing hospitals has been formed and designated. In the same way the twelve undergraduate teaching hospitals in London (each with its associated group of satellite institutions) have been designated. The teaching hospitals are used for postgraduate as well as undergraduate training, but in London there are many special hospitals reserved for postgraduate studies. They include a famous children’s hospital and hospitals for the study and treatment of cancer, tuberculosis, nervous and mental disorders, diseases of the eye, the skin, the heart, the teeth and other special conditions. These have been designated singly or in groups, and constitute the basis for the postgraduate institutes of the University of London in the British Postgraduate Medical Federation serving the whole country and, indeed, the Empire.

The very important duties of the teaching hospitals can best be fulfilled if these hospitals remain separate from, though very closely linked with, both the regional service and the university. Though they serve the public exceptionally well like any other hospital, the teaching hospitals are specially picked centres for medical training and study, and therefore draw their patients from a wider area than the ordinary hospital. There need be no clash between direct service of the public by the giving of treatment, and indirect service by the advancement of medical science. Each designated teaching hospital has its own mixed governing
board, arranged to link it both with the university and with the hospital service. The university, the regional board, and the doctors and dentists actually teaching in the hospital each nominate up to one-fifth of the governors; the remainder are appointed by the Minister after consultation with Local Health Authorities and other interested bodies. They include many leading members of the former voluntary governing bodies.

Voluntary Help Still Needed

The teaching hospitals keep the gifts, legacies and other endowments which have helped them so much in the past. The endowments of other voluntary hospitals, passing with them to the State, are now pooled in a special Hospital Endowments Fund. Each regional board then receives a share of this fund, but the greater part of it is to be divided among the hospital management committees, to be spent as they like for hospital purposes on any sort of ‘extras’, ranging from outings for convalescent patients to new research projects. Teaching hospitals, regional boards, and management committees are all free to accept new gifts and endowments in the future. But all will look to the Exchequer for the running of their real service, and none will have to depend on gifts, endowments or flag days.

Voluntary gifts of money or property are, nevertheless, very welcome. Even more important, however, is voluntary service, which remains as necessary and valuable now as in the past. The regional boards, management committees, and boards of teaching hospitals are in a real sense mixed voluntary bodies of the best type. They are designed to organise the freely given services of experts of all kinds—professors, specialists, family doctors, nurses and others—and of non-professional men and women who are interested in the hospitals and in the good of their own communities. Thousands of these well-wishers are helping to run local hospitals as members of the new management committees; many more will serve as co-opted members on the many house committees (for individual hospitals) and committees for special purposes (such as the social life of hospitals and the welfare of patients) which management committees need to help them in their work. Nor is committee work the only field for personal service. Practical help in the daily affairs of the hospitals is needed as much as ever, and there are a hundred and one ways of giving it—such as the visiting of patients, the running of hospital libraries, the work of linen guilds, and so on.

The universities, the Local Health Authorities, and the different professions of the Service are all well represented on the regional boards and the teaching hospital boards; health authorities and hospital and family doctors are also well represented on the local management committees, while the regional boards which appoint the latter are also represented on the teaching hospital boards. By this system of cross-representation, and with support from the Ministry of Health, teamwork on a new scale is now made possible. Circumstances will no longer compel the leaders of the medical profession largely to confine their influence to the universities, the teaching hospitals, the largest cities, or the individual hospitals with which they are connected.

The Task Before the Hospitals

All that is medically necessary for a patient, as has already been stated, is provided without charge by the hospital and specialist services when the patient requires it. Usually—that is, apart from emergency—he is put in touch with them by, and on the advice of, his family doctor. The first duty of the hospital and specialist services is to help the patient by helping his doctor when the doctor asks for advice or skilled support. In most cases patients requiring to be seen by a hospital specialist will visit the hospital out-patient department for this purpose. Quite often special clinics will be held in other places (such as clinics for venereal disease and tuberculosis); or specialists will hold regular sessions at the welfare clinics of local authorities and at health centres. In all these clinics patients can be examined by experts at the request of their family doctors; in many of them X-rays, and other aids to diagnosis which the family doctor does not possess, can be brought into action.

In addition to providing accommodation for in-patients requiring specialist care there are many hospitals in which facilities will be available for patients to be admitted for treatment by their own family doctors. Treatment by the specialist service includes the provision of any appliances, such as artificial limbs or the Government's new hearing aids, necessary for fitness. The patient is free to use any branch of the Service without using all of it, just as the doctor or dentist is free to work partly in the Service and partly outside. In seeking expert help for his patient the family doctor is not tied to hospitals and specialists either of his own district or his own region.

‘Free’ Patient and Paying Patient

As far as is humanly possible in present hospital conditions, the hospital patient who must for medical reasons have privacy will be given it; the aim is to ensure accommodation in small wards or single rooms for all who need it for medical reasons and for as many as possible who would prefer it for other reasons. In a great many hospitals this cannot be done today; the design of the buildings will not permit it, and there are not enough beds and nurses. But in hospitals
where such accommodation is available patients using the Service, and wanting privacy when it is not medically essential, will be able to get it as an 'extra' by paying part of the cost so long as the accommodation is not wanted by a patient who needs it on medical grounds.

Until there is ample room for all the hospitals, the first loyalty of the Service must be to the patients using it and to the doctors serving them. But the patient who does not want to use the Service, preferring to pay for his own specialist treatment, cannot simply be shut out of the public hospital for—other considerations apart—this would often mean also shutting out the specialist, whom the hospital needs and who wants to combine private with public work. It would also mean driving such private patients as remain into nursing homes which do not possess the fuller facilities of the hospitals. The private paying patient may therefore be given hospital accommodation, but on payment of the whole cost, in accommodation specially set aside for him. But the private patient 'pay beds' set aside for his use can be used for ordinary patients of the Service, for whom the Service is obliged to make provision, if their medical needs urgently require it. The fees which specialists charge patients admitted to private patient 'pay beds' are usually subject to a maximum, but for a proportion of private cases the maximum can be waived by the hospital authority.

SERVICES OF THE LOCAL HEALTH AUTHORITIES

In the hospital the doctor cannot do his work without the support of a whole team of other health workers—fellow-doctors, pharmacists, nurses, midwives, laboratory technicians, radiographers, social workers, and other experts. Similarly the need for team work does not stop at the hospital doors. People ill at home or needing advice or care not normally given by hospitals cannot look to the family doctor for everything. While the doctor will turn to the hospital for expert advice, or if necessary for help at the patient's bedside, he may also require the support of auxiliary health workers, especially nurses in the home. The doctor does not employ the home nurse, the midwife, or the health visitor, but they must be available, and it is now the duty of the Local Health Authorities to see that they are.

Protection, Welfare, Social Care

The home patient may also need sick-room equipment, extra bedding, special food, or care during convalescence. A father's illness may leave his family in difficulties; a mother's may make domestic help essential. Children may need to be sent away to avoid infection. Work under special conditions may be needed for a man with some disability such as tuberculosis. Sick and injured people and expectant mothers have to be transported from home to hospital and back again. Arrangements have to be made for the supervision and occupation of mentally defective children. There is constant need to help some parents to understand how they can rear healthy children and for education of ordinary families in the elementary rules of personal health and the avoidance of infection. The doctor has his part to play in all this educative, protective and welfare work, but it is the special field of the Local Health Authority, which reinforces the efforts of the hospital and the family doctor with various supplementary and welfare services.

In the past these local protective and welfare services were divided piecemeal between many different types of authority. Now the duty of providing them is laid upon the major local authorities—the 62 county councils and the 83 county borough councils—with the help of a Government grant. To repeat what was said at the end of Chapter I, each of these councils is now the single Local Health Authority for its area, employing a Medical Officer of Health and working through a health committee of the council. The Ministry has asked all councils to co-opt to their health committee members proposed by the local medical committee, as well as various other experts and representatives of local hospital management committees and the Executive Councils. Most councils have strengthened their health committees in this way.

Personal Service at Home

Under the Health Act the Local Health Authority has the duty of seeing that the family is properly served without charge in its own home by midwives, home nurses, and health visitors. In the case of the midwife this duty is not new, but big changes are being made in the maternity services. The home (or district) nurse is a well-known and invaluable member of the health team, but never before has it been anyone's duty to see that her services are available. Almost everywhere district nurses have been provided by voluntary associations which local authorities have had limited power to help; almost everywhere they are
This diagram gives a broad view of the organisation of the National Health Service, and omits or simplifies some of the details.

**KEY**
- Direct responsibility
- General supervisory powers
- Responsibility of Executive Councils or County and County Borough Councils
- Doctors and Dentists will work at Health Centres provided by local authorities. Medicines and Appliances will also be supplied at these centres.
- Temporary responsibility—Eye Services will ultimately be provided by Regional Hospital Boards.

**MINISTER OF HEALTH**
Advised by Central Health Services Council

**HOSPITAL SERVICES**
- Bacteriological Service (Medical Research Council)

**BOARDS OF GOVERNORS**
- Teaching Hospitals and Specialists

**REGIONAL HOSPITAL BOARDS**
- Hospital
- Specialists
- Blood Transfusion Service

**HOSPITAL MANAGEMENT COMMITTEES**

**EXECUTIVE COUNCILS**
- Dentists
- Medicines and Appliances
- Family Doctors

**Vaccination and Immunisation**

**COUNTY AND COUNTY BOROUGH COUNCILS**
- Health Centres
- Ambulances
- Health Visiting Home Nursing
- Maternity and Child Welfare (including Midwifery and priority Dental Treatment)
- After-care of Sick
- Domestic Help
too few and overworked. When the Service is really adequate, the
district nurse should be able to do much more than now to help the
family of a patient ill at home; she will also be able to relieve the doctor
of some kinds of work, and to relieve the hospital of the necessity of
taking patients in merely because there are not enough nurses to care for
them at home.

The health visitor is a nurse with special training in health education,
child welfare and social work. Hitherto she has specialised chiefly in
mothercraft, though some health visitors have also visited the homes of
 sufferers from tuberculosis, mental illness and venereal disease. But
under the new Service she is the friend and adviser of the whole family.
The Health Act requires the Local Health Authorities to arrange a
home-visiting service for ‘giving advice as to the care of young children,
persons suffering from ill health and expectant or nursing mothers, and
as to the measures necessary to prevent the spread of infection’. On
behalf of the authority (though she may be employed by a voluntary
organisation) the health visitor visits the home of every newborn baby
at least once during its first few weeks, and answers questions about the
care of children, putting parents in touch with social services they may
need. Hitherto she has largely worked in conjunction with the doctors
working in the 4,000 infant welfare centres, but the aim is that she should
work in much closer contact with the family doctor, so that he can
deadly call her in when he finds a family needing advice or social service
which she can give or arrange.

In most places nurses with much the same training as health visitors
watch over the health and cleanliness of children at school, making any
necessary home visits; but in London school nursing and home visits
for school children are separated, the latter being done mainly by
voluntary welfare workers.

In the towns the midwife, the home nurse and the health visitor are
different persons, each giving better service by being able to specialise;
but in country districts the home nurse is usually also the midwife, and
not uncommonly the health visitor and school nurse as well. Some
people hold that the uniting of all these duties in one woman is right
and necessary in the villages. But the general view is that health visiting,
if not midwifery too, is better separated from sick nursing wherever this
can be done without obliging the health visitor or midwife to travel
very long distances daily.

A fourth home service which Local Health Authorities may provide
is ‘domestic help for households where such help is required owing to
the presence of any person who is ill, lying-in, an expectant mother,
mentally defective, aged, or a child not over compulsory school age’. The
Act does not compel the authorities to do this, because such a
course was thought unwise while labour remains so scarce. Authorities
are, however, doing their best to build up the home help service because
of the great relief it can bring to their home nurses and midwives. The
aim is to enlarge the Service until the doctor and the family can rely on
it in emergency as readily as they rely on the home nurse. Where it is
obtainable, home help is free to families who cannot afford to pay;
others are expected to meet a reasonable charge.

Care, After-care and Transport

With the midwife goes the free supply of a maternity outfit for home
confinement. For the sick the district nurse is usually able to lend simple
articles of sick-room equipment, while sufferers from tuberculosis are
usually given sputum flasks and other necessities. The Local Health
Authorities now have a general power (which the Minister can make
into a duty by stages) to ‘make arrangements for the purpose of the
prevention of illness, the care of persons suffering from illness or mental
defectiveness, or the after-care of such persons’. The Government has
asked them to use this power to lend or lease a much wider range of aids
and comforts for the sick room, home confinement and convalescence—
such things as bedpans, bedding, feeding cups, steam kettles, waterbeds,
crutches and wheel chairs (for convalescence), and many more. When
necessary for proper medical care or for recovery of full health, such
articles will be available, not only to the patients of home nurses and
midwives, but also as far as possible to other patients nursed at home
by relatives or friends. Charges may be made for the loan of these
articles according to the patient’s ability to pay.

One ‘care and after-care’ service was already a duty of Local Health
Authorities, namely the service for the tuberculous. For the tuberculosis
patient, it is necessary that medical care should be combined with attention
to the general welfare of the patient and his family since this is essential for the effective treatment and control of tuberculosis, with its
special social and economic problems. Many local schemes, relying a
great deal on voluntary workers and funds, existed to provide the tubercu-
losus with the knowledge and help they need to live the kind of life
which will save them from relapse and their families from infection. The
Local Health Authorities must now see that adequate schemes for this
purpose exist everywhere. They must arrange for health instruction in
the home, and they have the power to do almost anything—except make
money payments—that is required, including the establishment of the
‘night sanatoria’ which some of the large cities are planning, and of
special workshops or settlements for ‘sheltered employment’ under
healthy conditions.

Local Health Authorities, though no longer responsible for running
mental hospitals and mental deficiency institutions, continue to dis-
charge important functions in the Mental Health Service. Through their
authorised officers, they have the duty of putting persons who need care and treatment into touch with the facilities available in clinics or hospitals. They are also responsible for the care of those mental defectives who can be adequately looked after in the community. Furthermore, wide functions in relation to the after-care of mental patients are assigned to Local Health Authorities.

Where special transport is necessary for the sick or injured (including the mentally afflicted and the victims of street accidents), or for mothers going to hospital for confinement, it is the duty of the Local Health Authority to provide it free. Each authority has to arrange a service of ambulances and cars to take anyone in its area who is unfit to travel by ordinary means to wherever it is necessary for him to go for medical care, nursing or mental treatment; and to take any such patient who has been receiving treatment in its area home again, wherever he may live. Provided special transport is necessary for medical reasons, the service can be used without payment by people who are not using the public medical service but have made private arrangements for treatment.

**Mothers and Children**

The remaining duties of the major local authorities are nearly all concerned with the welfare of mothers and children. As health authorities they have a general duty to 'make arrangements for the care, including in particular dental care', of expectant and nursing mothers and of children under five not attending nursery schools. As education authorities they must hold regular medical and dental inspections of all children going to schools maintained by them (including 'voluntary' schools), and must see to it that 'comprehensive facilities for free medical treatment' are available for all schoolchildren.

For some time to come these and other duties will be carried out mainly by the use of clinics where doctors, midwives, and health visitors can watch over the health of expectant mothers (antenatal care), make sure they are fit after childbirth (postnatal care), and follow the progress of their babies (infant welfare), supplying certain 'welfare foods' for mothers and children cheaply or without charge, and arranging for children to be immunised against diphtheria and vaccinated (no longer compulsorily) against smallpox. The family doctors will be brought into closer touch with this work, especially as health centres are built up, and with some of it the hospital service will co-operate.

Under the Health Act, County and County Borough Councils may provide day nurseries (which are not nursery schools) for children below school age whose mothers cannot care for them properly during the day, for instance, because they have to go out to work. Councils may charge for 'articles provided', such as meals.

One special free treatment service must be arranged for mothers, and children up to school age, by Local Health Authorities, and that is the proper care of their teeth. There is a scarcity of dentists, and mothers and children must come first. Local Health Authorities should therefore employ dentists in clinics, or arrange in other ways to give a full dental service to expectant and nursing mothers and to children until they start school, while Local Education Authorities already have the duty of providing a similar service for school children.

**Medical Inspection of Children in Schools**

The Education Department of the Council employ doctors, dentists, and nurses to watch over the children's health. The Education Authorities' duties include the periodic medical inspection of children in the schools, the 'following up' of those found to be in need of treatment, and the provision of certain forms of treatment which cannot be given so conveniently under the National Health Service. For example, minor ailment clinics are being continued as before because they provide the most expeditious means of treating these complaints and they relieve the burden on the general practitioner service. Specialist work at the school clinics, e.g. ophthalmic, aural, orthopaedic, etc., has been taken over by the Hospital and Specialist Services. Dental inspection and treatment, because its effectiveness depends so much on the close linking up of this work with the school system, continues to be a function of the Local Education Authorities; so also will those services which are partly medical, partly educational, such as speech therapy and child guidance—though in the latter the psychiatrist in many cases will also be working under the Regional Hospital Boards.

The Local Education Authority have the duty of 'ascertaining' all children in their area who on account of physical or mental handicap are in need of special educational treatment. Such children include the blind, partly sighted, deaf, partly deaf, epileptic, physically handicapped and educationally subnormal. This ascertainment in many instances necessitates examination by appropriate specialists who will usually be those conducting specialist clinics under the Hospital and Specialist Services. Once a pupil is ascertained to be handicapped it is the duty of the Authority to provide special educational treatment suited to the particular defect, either in special or ordinary schools.

**Health Centres**

A completely new local health service for which the Act makes provision is that of Health Centres. These will be buildings in which accommodation will be provided for a group of family doctors and perhaps
also for dentists, pharmaceutical services, a maternity and child welfare centre, and nursing and midwifery staff of Local Health Authorities. They may contain facilities for specialist and out-patient services in connection with the hospitals. Health Centres will be a means of bringing the branches of the service into close relationship—of linking the preventative and welfare services (including health education) of the Local Health Authorities with the curative work of the family doctors and dentists and of the hospital and specialist services.

The buildings will be provided, equipped and maintained by the Local Health Authorities who will also provide the staff except family doctors and dentists. The doctors will be under contract to the Executive Council in the ordinary way. The Executive Council will make agreed payments to the Local Health Authority for accommodation and other facilities provided at Health Centres for family doctors and will recover an appropriate sum from the individual doctors.

THE FAMILY DOCTOR AND HIS PATIENTS

The ‘family practitioner services’—those of the family doctor, the dentist, the pharmacist, the ophthalmic doctor and the ophthalmic optician—have been outlined at the end of Chapter 1. For nearly everybody the family doctor is the pivot of the whole scheme apart from dental treatment. How is his relationship with his patients to work?

The Family Doctor

Anyone who wants to use the free family doctor service must take certain steps to join it. He chooses a doctor willing to give him medical care when he needs it and is then put on that doctor’s list of patients. This is necessary because the doctor accepts a personal responsibility for the medical care of the persons on his list as well as a collective responsibility along with other doctors for all persons using the family doctor service; so that everyone who wants to use the service—babies, children and housewives, as well as earners—needs to have a medical card. People who do not use their right of joining will, of course, have to pay the doctor’s fees until they decide to do so.

Everyone is free to change from one doctor to another whenever he or she wishes, and—subject to certain safeguards for patients under treatment—the doctor has the same right to remove from his list a person he no longer wishes to serve. There must always be a very few people whom for various reasons no doctor wants to accept as patients. These patients can apply to the Executive Council, who will allocate them to a doctor, so that no one will be denied his rights under the Act.

The family doctor’s main duty is to give his patients ‘all proper and necessary treatment’ that is within his power. He continues, for instance, to perform such minor operations under anaesthetic as he has carried out in the past, but he is not expected to conduct confinements except under special arrangement, nor to perform services usually given by specialists. On the family doctor’s prescription the patient can get, without charge, from the chemist—or, exceptionally, from the doctor himself—any necessary drugs, as well as various appliances, such as bandages, cotton wool, dressings, elastic stockings, finger stalls, ice bags, and so forth. A person who needs to have his eyes tested for the first time in the new Service will obtain a medical recommendation from his doctor and will get in touch with a doctor or optician qualified to test sight and to prescribe spectacles. The family doctor will arrange for the patient every kind of specialist care he is himself unable to give. Except in emergency, hospitals and specialists will not normally accept a patient for advice or treatment unless he has been sent by his family doctor. The family doctor is also required to give the patient such advice or assistance as he may consider appropriate to enable him to take advantage of the local health authority services and maternity medical services. Special local lists have been compiled of doctors with obstetric experience, whom women may choose to give them all necessary medical care (‘maternity medical services’) during pregnancy, the confinement and the postnatal period. Alternatively a woman may choose her own family doctor, even if he is not on a special list. She should also book a midwife through the Local Health Authority, whose antenatal clinics are available for help and advice.

People who need a doctor when away from home can apply to any doctor taking part in the Service for treatment as ‘temporary residents’. The doctor when accepting them will ask them to sign a note, which he subsequently uses to claim payment from public funds.

These and other duties (such as issuing free certificates for insurance benefits and other statutory purposes, providing adequate surgery and waiting-room accommodation, and generally providing all proper and necessary treatment) are included in the terms of service which are part of the doctor’s contract. There are similar provisions in the contracts of
dentists, opticians and chemists. For their work they are all paid from Exchequer funds. They make their contracts neither with the Government nor with Local Health Authorities, but with the Local Executive Councils. These Executive Councils make all arrangements for ‘general medical services’, ‘general dental services’, etc., and for publishing lists of all doctors, dentists, and others in the Service and keeping registers of the doctors’ patients.

**Partnership in Management**

Each Executive Council consists of a chairman and 24 members, half of whom are professional representatives—seven doctors appointed by the Local Medical Committee (which is elected by all the local doctors), three dentists appointed by the Local Dental Committee, and two chemists by the Local Pharmaceutical Committee. In addition eight members are appointed by the Local Health Authority, and four more, together with the chairman, by the Minister.

Through special committees the Executive Council hears any complaints coming from either the patients’ side or the professional side of the Service. But it has no power to dismiss a doctor, and neither has the Minister. For the doctor serves his patients, not the Executive Council or the Minister; and the council is not an ‘employer’ in the ordinary sense. Occasionally a doctor may behave in such a way that the executive council, after thorough inquiries, feels that his contract ought to be cancelled. A case of this kind is referred to a special and independent tribunal, whose decision is final if it is in favour of the doctor. But if the tribunal decides to cancel the doctor’s contract, he, and he alone, can appeal to the Minister to keep him in the Service despite the tribunal. The Minister can thus override the tribunal, but only in the doctor’s favour. Before deciding whether to do this, the Minister has to make further careful inquiries and to consult a special advisory committee of doctors, some on his own staff, others nominated by professional organisations.

* The tribunal’s chairman, a lawyer of standing, is appointed (like the judges) by the Lord Chancellor. The two other members, appointed by the Minister, are a layman appointed after consultation with the National Association of Executive Councils, and a professional man (doctor, dentist, chemist, etc., according to the case) appointed after consultation with the professional organisations. In the Health Insurance Scheme there was no statutory tribunal, the Minister himself having to decide all such cases. In the whole of England and Wales from 1924 to 1947 only 46 cases had to be decided by the Minister. He decided 16 in the doctors’ favour, and dismissed 18 other doctors from the service. The remaining 12 were allowed to resign without formal dismissal. Doctors who had resigned or been dismissed were allowed, after a time, to apply to rejoin the service. Only three who applied for reinstatement during these years were not taken back.

**The Goodwill of Patients**

The custom grew up in this country of regarding the clientele of a doctor as having a money, or ‘goodwill’ value. This was greatly stimulated by the old National Health Insurance Scheme under which all panel patients were transferred to the new doctor unless they took special steps to change. The position has been, then, that a doctor who removed or retired sold his practice to the doctor who took his place. The young doctor, therefore, has always had to buy his way into general practice. He might start as another doctor’s salaried assistant, but he usually could not go far without buying a practice of his own or a share in the practice of a partnership.

Usually he had to borrow the purchase money, often at a high rate of interest, guaranteeing repayment by means of a life insurance policy. Heavy commitments in the early years of his career, and the need to keep up and improve the value of his investment against the day for reselling it, made him work to attract as many patients as possible. Some think it often bred in him a proprietary attitude to his patients and a competitive rather than co-operative attitude to other doctors, and that the sale and purchase of practices is a bad thing in itself. But, whatever the merits of the custom, it would not fit the new circumstances. The fact that the new scheme enables the closing of an area to additional doctors or the non-filling of a vacant practice if an area needs no more doctors for the time being, itself would have destroyed the open market for sale and purchase. Moreover, the sale of public practices, as the Medical Planning Commission argued, must disappear wherever health centres are started. The sale of public practices, therefore, had to be abolished, and doctors are to be compensated at a figure of £66,000,000 for the whole of Britain, a figure agreed with the British Medical Association as a fair value. Doctors who outside the Service remain free to sell their practices; doctors in the Service, even if they also have fee-paying patients, can no longer do so, but if they joined by 5th July receive their respective shares of the compensation.

**Superannuation Scheme**

Although the doctor will not be able to sell his practice, a guarantee of security in his old age and for his widow is afforded by a scheme for superannuation and widow’s benefit (this includes all health workers in the Service). Doctors may elect to be paid by capitation fees only or, with the consent of the Executive Council after consultation with the Local Medical Committee (or, on appeal to the Minister), to have a fixed annual payment of £300 plus capitation fees at a lower rate. This arrangement is specifically intended to help doctors starting up in practice. The fixed
annual payment of £300 will normally be subject to the condition that the doctor shall have a specified minimum number of patients on his list within a given period of his inclusion in the medical list as principal. The scales of payment were arrived at after an independent inquiry by a committee (half doctors, half laymen) whose task was to take into account the whole status and circumstances of the profession and their legitimate expectations in the past, and to say what should be a proper remuneration for the future.

Extra Payments for Doctors

There are other sources of remuneration—e.g., for maternity services and (in rural areas) for mileage and for supplying drugs. There is also a fund of over £200,000 a year for Great Britain for extra payments to be made to doctors who practise in difficult and unpopular areas. There are extra fees for doctors undertaking the training of young assistant doctors. There are also grants for the doctor who takes time off to keep himself medically up to date by attending postgraduate refresher courses. Various public appointments and private practice are other sources of earnings.

If the whole population were shared out evenly, each family doctor would now have about 2,200 patients; but the doctors are far from being evenly distributed. In some industrial towns, mining areas and poor districts, there is only one doctor for every 4,000 people, or sometimes even more; while elsewhere, especially in prosperous suburbs, doctors have been able to make a good living from much smaller practices. To prevent doctors in the new Health Service from taking on more patients than they can properly serve, a maximum size of practice is stipulated. The uneven distribution of doctors makes it necessary to fix this maximum for the time being at normally 4,000 patients for the single-handed doctor.

Encouraging Better Distribution

With the Health Service open to everyone, doctors can count on a steady income even in the poorest of districts, and this provision of the Act will encourage better distribution. Inducements in money, building of health centres, etc., will also help, but another provision of the Act will be useful in the early years of the Service. Every doctor could join the Service at the start in the place where he was already practising. In a few places the number of family doctors can be considered adequate, remembering the much greater needs elsewhere. The Act makes it possible to prevent the opening of fresh practices in such areas, and even to reduce the number of doctors by not filling practices when they fall vacant, so long as other areas suffer from a shortage.

The young doctor just starting in practice and the established doctor moving to a new district are free to come into the Service anywhere in the country except in the few areas on the ‘full-up’ list; though they can, of course, practise in those areas if they remain outside the Service. This control is exercised not by the Ministry, but by a national Medical Practices Committee composed almost wholly of practising doctors.* The Executive Councils tell this committee the number of doctors required to meet the reasonable needs of their areas, and also report any vacancies occurring in the Service. The committee may refuse a doctor’s application to join the Service in a certain area only ‘on the ground that the number of medical practitioners undertaking to provide general medical services in the area or part of an area concerned is already adequate’.

The Medical Practices Committee has the permanent duty of filling all vacancies occurring in the Service, since such vacancies will no longer be filled by purchase. When a departing doctor has to be replaced, the Executive Council will normally advertise the vacancy. If only one doctor applies he will usually be given the practice automatically. If several apply, the Executive Council, when reporting their names to the committee, will add the opinion of the Local Medical Committee and its own recommendations. Local ties and wishes, as well as local needs, will be taken into account. For instance, a partnership of doctors may want a particular man to join them, or a son may wish to carry on his father’s practice. The doctor who has not been granted what he wanted may ask the Minister to overrule the committee or to appoint him in addition to the doctor chosen by the committee.

The Dental Service

The general dental service is managed in much the same way as the family doctor service. It is open to anyone who wants to use it (medical cards are not needed); people may go to any dentist in the Service, and change dentists when they wish. Mothers and children may use the service, too, but because of the shortage of dentists the local authority ‘priority’ service is designed and reserved for their special benefit. They may get much prompter attention if they use it instead of going to dentists in the general dental service. Both services will give the patient, free of charge, every form of treatment and appliance necessary for

*It has nine members appointed by the Minister. Seven of them (including the chairman) are doctors appointed after consultation with doctors’ organisations, of whom at least five must be ‘actively engaged in medical practice’.
dental fitness. Any dentist who feels he has not the facilities or experience to treat a patient with some unusual condition has the duty of putting him in touch with another dentist or with a hospital. A patient who wants certain kinds of 'extra', such as a gold filling instead of an ordinary one, will be expected to pay the extra cost if it is not clinically necessary. If the dentist thinks the patient needs one of a specified list of medicines, he can give him a prescription to be dispensed by a chemist.

In the old health insurance scheme the dentist was allowed to do little to a patient's teeth without first sending in an estimate for approval by the lay authorities. In the new Service, if any, outside control is needed when dentists are working in clinics or health centres. But when they are working individually in their own separate surgeries, some control must be continued in the early years. In 1946 the British Dental Association* suggested the rule with which to begin the new service: that the dentist should be free to conserve teeth without any prior approval, but should get permission before removing teeth (except in emergency) which have to be replaced by dentures. The Service frees from outside control probably rather less than half the work dentists have hitherto been doing, and at least half the work, it is hoped, they will do in the future, when people have learned to visit the dentist regularly. The 'uncontrolled' list covers all normal conservative treatment (including anaesthetics, and removal of teeth to relieve pain or not requiring replacement); ordinary repairs to teeth; and (with certain limits of cost) certain other kinds of treatment.

The 'controlled' list includes the removal of teeth which have to be replaced by dentures; certain special kinds of work (such as extensive and prolonged treatment of the gums and surgery of the mouth); and certain things which may be 'extras', such as gold fillings, inlays, crowns, and various special appliances. For 'controlled' work the dentist will need prior approval from the Dental Estimates Board, a body made up like the Medical Practices Committee, seven of its nine members (including the chairman) being dentists appointed after consultation with professional organisations. For the rest he sends in particulars (to claim his fees) after the event.

Care of the Eyes

Care of the eyes, whether for injury, disease or vision, is mainly specialist work. At present, as in the past, the hospital and specialist services supply all medical treatment of the eyes which is beyond the scope of the family doctor. But in the past most of the work of testing people's eyesight, in order to decide if they need spectacles or corrective

treatment, has been done by ophthalmic opticians who, though qualified experts, are not doctors. This situation cannot be changed at once, because the necessary resources are lacking, but the Government aim to bring sight-testing right into the hospital service as rapidly as possible, with special eye departments and clinics in the charge of medical specialists (ophthalmologists) and with opticians on the staff. Spectacles would then be obtained either directly from the clinics or, on the prescription provided, from opticians working in their own shops.

There is already a nucleus of a hospital eye service in various parts of the country; but until this can be built up, area by area, 'supplementary ophthalmic services' are arranged by the Executive Councils, each council having a special committee for the purpose.* The first step for anyone troubled about his eyes is to go to his family doctor. If the doctor advises a sight test, he will give a certificate enabling the patient to visit someone qualified to make the test. This expert may be a doctor with special ophthalmic qualifications and experience or a non-medical ophthalmic optician. (There are local lists of 'ophthalmic medical practitioners' and of ophthalmic opticians.) If spectacles are prescribed, they will be supplied by any optician who dispenses spectacles.† If treatment of some other kind seems necessary, a report will go to the family doctor, who will then advise his patient on the next step. After getting his first pair of spectacles the patient can go straight to the ophthalmic doctor or ophthalmic optician for further tests when he thinks he may need a change of glasses.

Spectacles are supplied without charge in a reasonable variety of styles. Those who want a spare pair will have to pay for them, and those who prefer spectacles outside the free range can get certain more expensive kinds by paying the extra cost. People who lose their spectacles at any time or who break them within two years will have to pay for replacement or repair, unless they can prove that they have not been careless. After two years a further sight test will be necessary before replacement or repair; the Ophthalmic Services Committee will make inquiries in any case where they think there may have been carelessness, and if this is proved the patient will still have to pay.

---

* Proposals for a Dental Health Service for the Nation.

† Most ophthalmic opticians also dispense, but some opticians who dispense are not qualified to test vision.
THE AUTHOCRITIES AND THE PROFESSIONS

THE NATIONAL HEALTH SERVICE could not possibly work if it were not divided into sections and parts for daily management, and it will not work well unless the members of all these sections join forces to serve the patient. The regional board, the Local Health Authority and the Executive Council must each weave together the work of the various services and institutions for which it is responsible. But the work of all these bodies and of the teaching hospitals must itself be woven together to avoid ‘departmentalising’ the patient, whose needs cut across the boundaries of business management. This will be done partly by the sharing of representatives between all the various boards, committees and councils—the cross-representation which has already been explained—and still more by their sharing of doctors and other experts in teams for the service of the patient.

Combined Planning

The Ministry also has a hand in the weaving together of the services. Before the plans of regional boards and Local Health Authorities were approved they were carefully examined to see whether the services had been arranged in the best available pattern. In these duties of general oversight and guidance, including the settling of any dispute which may arise, the Ministry is helped at every step by the advice of its own experts and of outside experts drawn from all the services under discussion.

The Act sets up a Central Health Services Council of 41 members, with a majority of doctors, to advise the Minister on general matters relating to any or all of the services. Six doctors are members by right of office—the presidents of the Royal Colleges, of Physicians, Surgeons, and Obstetricians, and of the General Medical Council, and the chairmen of the councils of the B.M.A. and the Society of Medical Officers of Health. The other members were appointed by the Minister after consulting the representative organisations. They are 15 doctors (including two experts in mental illness and mental defect), five non-medical experts in hospital management, three dentists, two nurses, one midwife, two chemists, two ‘persons with experience in mental health services’, and five others (not doctors) with experience in local government.

The Council advises the Minister not only on questions about which he asks for advice, but on anything about which it thinks he needs advice. There are also various standing committees to advise him on special questions—medical, dental, pharmaceutical, ophthalmic, nursing, maternity and midwifery, tuberculosis, mental health, and cancer and radiotherapy. They include members of the Central Health Services Council and others with special knowledge of their subjects. The Council and the standing committees also set up additional committees for special purposes as need arises. The Council has to make a yearly report on its work and that of the standing committees, and the Minister has to present the report to Parliament. In this way the public will know what his advisers have been telling him. There is the usual legal safeguard that the Minister may refuse to publish something in the report if, after consulting the Council, he is ‘satisfied that it would be contrary to the public interest’. This is to prevent the leakage of such things as military secrets. In the health services this safeguard will very rarely be necessary and will probably never be used except with the agreement of the Council. If the Minister wishes, as he may wish if he disagrees with some advice given him, he can add his own comments to the report, so that the public will know what he feels about the advice offered him.

The pay and conditions of all workers in the different branches of the services will in varying degrees be nationally regulated (a national superannuation scheme for the whole Service has already been created). For this purpose a system of Whitley Councils is being set up aiming to cover the whole Service. At the centre there are separate national ‘functional’ councils for opticians, pharmacists, nurses and midwives (including health visitors and nursery nurses), other professional and technical workers (such as laboratory workers), ancillary workers (such as ambulance drivers and ward maids), and administrative and clerical staffs. Each council has its employers’ side and its staff side (drawn from the various professional organisations and unions). There is also a General Council to deal with problems affecting directly more than one of the functional councils, and these together form the ‘Whitley Councils for the Health Services’.

The tasks of this organisation for bringing managers and staffs together are to enable all who work in the Service to help in improving its efficiency; to give them a ready channel for complaints and the remedying of any grievances; and to undertake collective bargaining about matters of pay and conditions of work. Experience of Whitley Councils in industry and in national and local government service shows that nearly all such matters can be settled by agreement. But if there are disputes, and if they cannot be settled by agreement, they will usually be
referred to a court of arbitration. One of the first duties of the General Whitley Council is to prepare an arbitration agreement for this purpose.

BUILDING THE NEW SERVICE

This booklet has tried to explain the reasons for the new deal in medical care, and the organisation created for it by the Act. It has described what the medical services look like in the beginning, soon after the Act is in force. What will they look like in ten years' time? The Act is only the means of getting the new deal started. In what direction will the new partnership of the professions and the ‘consumers’ work to carry out their purpose of meeting the medical needs of the people adequately, everywhere?

Six Main Aims

The aims of the new deal follow from this purpose. They are worth repeating:

1. **Up-to-date material resources.** A large programme is needed as soon as it becomes practicable, for rebuilding and re-equipping hospitals and clinics and for constructing health centres.

2. **Adequate human resources.** More health workers of most kinds will have to be trained as soon as possible.

3. **Better distribution of resources.** The aim must be to bring more of the services to the places where the patient can conveniently use them.

4. **Greater team work in serving the patient.** This is necessary among family doctors, within the hospital service, and between all the services, to avoid the departmentalising of medicine which prevents doctors from seeing the patient as a ‘whole person’ rather than as a ‘case’.

5. **Encouragement of variety and experiment.** Medical needs must be adequately met everywhere, but it would be wrong for them to be

met everywhere in the same way. Medicine thrives on experiment and comparison of different ways of doing things; uniformity of method or belief is its enemy.

6. **Encouragement of a preventive and ‘positive’ outlook on health.** All agree that the nation will not be using its doctors to the best advantage so long as they are confined so much to healing and have so little time for preventing illness.

In the hospital and specialist services the pursuit of these aims will take time. There are still too many awkward and out-of-date buildings; even the existing accommodation cannot be fully used for want of nurses and domestic workers. There are too few of many kinds of specialists, and the few there are are not always well distributed in different parts of the country. The work of the specialist has to be carried beyond the hospital doors more than in the past.

Nevertheless, the Service must be run with proper regard for economy, and capital expenditure has to be kept down to a minimum. Only the most urgent schemes for the extension or repair of hospitals can be permitted. Nor is the building of comprehensive health centres possible on any scale while so great a part of our building resources has to be locked up in urgently needed houses, factories and schools. More study is also needed of the kinds of centres most worth trying out before any large-scale experiments are launched. The building and testing of health centres in action, in different forms and circumstances, in large towns and small, in suburbs and country areas, is a task for the next few years. During that time a great many, perhaps most, family doctors will continue to practise outside health centres, though various looser forms of ‘grouped’ practice and other means of improving the efficiency of the family doctor without comprehensive health centres may prove valuable especially in country districts.

For the time being the main thing is to get the Service into good running order and to keep on improving its efficiency. All big social changes start with a certain amount of uncertainty, until people get used to the new way of doing things; and this Service cannot be comprehensive in the fullest sense until the country is farther along the road to prosperity and a rising standard of life. The public has still to learn how to use the new facilities properly and economically; and those who are actually running the Service have to get used to new conditions and changing needs. But if the various professions really join forces with the laymen in the organisation described in this booklet, they can carry out a progressive new deal in medical care which will redound to the benefit of all.

The National Health Service represents the completion of the work which was started just over a hundred years ago with the first Public
Health Act. Then the emphasis was on environmental conditions—pure water and proper sewerage. Now the National Health Service brings together the personal services. It offers a chance—and a challenge—to build the most efficient health service in the world, and one which as the years go by will add steadily to the nation's fitness, happiness and working capacity.

BIBLIOGRAPHY

Future Provision of Medical and Allied Services. Interim Report of the Consultative Council on Medical and Allied Services. Cmd. 693. 1920. 1s. net (1s. 2d.)

Social Insurance and Allied Services. Report by Sir William Beveridge, K.C.B. Cmd. 6404. 1942. 2s. (2s. 4d.)

A National Health Service. Cmd. 6502. 1944. 1s. (1s. 2d.)

National Health Service Bill. Summary of the Proposed New Service. Cmd. 6761. 1946. 3d. (4d.)

National Health Service Act, 1946. 1s. 6d. (1s. 8d.)

The British Medical Association's proposals for a General Medical Service for the Nation. B.M.A. 1930. 6d. post free.

A Charter for Health by a Committee of the B.M.A. Allen & Unwin, Ltd. 1946. 6s.

Report of the Inter-Departmental Committee on Medical Schools. Ministry of Health and Department of Health for Scotland. 1944. 4s. 6d.

FOURTEEN REGIONAL HOSPITAL BOARDS are responsible for the administration of the hospital and specialist services in England and Wales (with the exception of the 36 teaching hospitals, each of which has its own Board of Governors).