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

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

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

## II.

## THE NEXT STAGE:

## A COMPREHENSIVE SERVICE FOR ALL.

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

**The method of approach.**

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

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



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

**The scope of a " comprehensive " service.**

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

**Temporary exceptions to " comprehensiveness."**

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

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

**Mental health.**

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

**Some misconceptions about the meaning of " comprehensive."**

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

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

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

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

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



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

**General nature of the Government's proposals**

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

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

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

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

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

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

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

## III.

## THE GENERAL ADMINISTRATIVE STRUCTURE OF THE SERVICE.

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

### CENTRAL AND LOCAL RESPONSIBILITY.

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

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

### CENTRAL ORGANISATION.

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



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

**Central responsibility of the Minister.**

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

**A Central Health Services Council.**

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

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

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

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