The purpose of these bodies will be to provide locally the same kind of medium for expressing the expert point of view on technical aspects of the service as has been proposed at the centre. The appropriate area for each will be the larger areas of the new joint authorities already discussed. Their functions will be not only to advise on matters referred to them by the joint authorities or other local authorities in the area, but also to initiate advice on any matters within their expert province on which they think it right to do so and, if they wish, to submit their views and advice not only to the joint authority or other local authorities concerned with the matters in question, but to the Minister. Apart from its ordinary consultation, the joint authority will be required to consult them on the area plan for the local health service which it submits to the Minister, and on subsequent material alterations or additions to that plan.

The constitution and membership of these bodies will call for detailed consideration later. Provided that all the professional interests are fairly represented, there is no reason why the pattern should be precisely uniform throughout the country and the most convenient course will probably be to provide for the matter by way of local schemes approved by the Minister.

Direct professional representation on local authorities.

It is sometimes suggested that the best method of linking the expert point of view with the direct administration of the service would be to include in the local administrative authorities themselves, and in their committees, a proportion of professional members appointed for the purpose by the appropriate professional organisations, with or without voting powers. Arguments can be adduced both for and against a system of this kind, but on balance the Government feel that the risk of impairing the principle of public responsibility—that effective decisions on policy must lie entirely with elected representatives answerable to the people for the decisions that they take—outweighs any advantages likely to accrue.

IV.

HOSPITAL AND CONSULTANT SERVICES.

The term " hospital services " is used in this Paper to include all forms of institutional care of every kind of sickness and injury. It comprises the whole range of general and special hospitals, including infectious disease hospitals, sanatoria for tuberculosis, accommodation for maternity cases and for the chronic sick, and for rehabilitation; and it comprises also the usual ancillary hospital services for pathological examinations, X-ray, electro-therapy, ambulances and other purposes. Out-patient no less than in-patient treatment is included. It will be the aim to restore the out-patient work of the hospitals as much as possible to its proper field of specialist and consultant care, when the existence of a general " family doctor " for all has been secured.

The mental hospitals and mental deficiency institutions have also to be included in the scope of the hospital and consultant part of the new service, under the care of the new joint authorities. They will present many problems of their own, calling for some degree of special organisation to fit them. The present general review does not attempt to deal with this special subject, and the discussion which follows is directed mainly to the more general range of hospital and consultant services—although much of it can obviously be applied to the mental health services as well.

The present hospital services are described in Appendix A. They present two main problems. The first is to bring together over suitable areas the

activities of the various separate and independent hospitals, to ensure that all the different kinds of special and general hospital treatment are so linked that the individual can get the best of each. The second is to enable the two quite different hospital systems (the voluntary hospitals and the municipal hospitals) to join forces in future in a single service.

The proposed joint authority, operating over a large area, has been described. It will be that authority's responsibility, with the Minister, to see that a full hospital service of all kinds is available for people in its area. But the authority neither will, nor will need to, provide the whole service itself.

The part of the voluntary hospital.

The conception of a public authority discharging its duty by contracting with others for the provision of services has long been familiar. As early as 1875 local authorities were enabled both to provide hospitals themselves and to enter into agreements with other hospitals for the reception of people from their district. Later legislation followed similar lines; in recent Acts dealing with special services (e.g., the Midwives Act, 1936, the Cancer Act, 1939) the use of voluntary agencies has been clearly contemplated. There are already large numbers of agreements under which existing local authorities arrange for accommodation in hospitals, sanatoria, dispensaries, or clinics, sometimes belonging to other local authorities and sometimes to voluntary agencies.

The facts of the existing accommodation in voluntary and municipal hospitals (given in Appendix A) make it clear that without the collaboration of the voluntary hospitals it would be many years before the new joint authorities could build up a system adequate for the needs of the whole population; so that, from that point of view alone, the co-operation of the voluntary hospitals is a necessity. But the matter cannot be regarded from that point of view alone. The voluntary hospital movement not only represents the oldest established hospital system of the country, but it attracts the active personal interest and support of a large number of people who believe in it as a social organisation and who wish to see it maintained side by side with the hospitals which are directly provided out of public funds. It is not merely that the best of the voluntary hospitals have, in a degree so far unsurpassed, developed specialist and general hospital resources which they will be able at once to make available, while most of the rest of the voluntary hospitals have experience and an existing organisation which it will be obviously sensible to enlist. It is certainly not the wish of the Government to destroy or to diminish a system which is so well rooted in the good will of its supporters.

Yet the acceptance by the community of responsibility for a service for all might affect fundamentally the position of the voluntary hospitals. A new universal public hospital service might have the gradual effect of undermining the foundations on which the voluntary hospitals are based. If this is not to happen, a way has to be found of combining the general responsibility of the new joint authority for the service with the continued participation in that service of the voluntary movement as such; a way, in fact, of securing a whole service under one ultimate public responsibility without destroying the independence and traditions to which the voluntary hospitals attach value. The Government believe that this can be done, and in settling the details arising out of the following proposals they will welcome the help and the suggestions of the voluntary hospital representatives in securing it.

Preparation of local area plan.

The joint authority's first task will be to assess in detail the hospital needs of its area and the hospital resources available to its area.

This it will do in close consultation with the local expert body, the Local Health Services Council. It is hoped that the hospital surveys, referred to in Appendix B and now nearing completion, will be of valuable help in this.

The authority's next task, in consultation with the local expert body and other local interests (including the voluntary hospitals and, where appropriate, the medical schools) will be to work out a plan of hospital arrangements for its area, based on using, adapting and, where necessary, supplementing existing resources. The object of the plan will be to arrive at the right quantities, kinds and distribution of hospital facilities for the area; to settle where, how, and by what hospitals, each branch of hospital treatment can best be secured; to produce a balanced scheme in which all the necessary specialist facilities in medicine and surgery (including fracture and orthopaedic, gynaecological, paediatric, ophthalmic, psychiatric and others) are provided in due proportion, together with general accommodation for cases, acute or chronic, of the ordinary type. The plan must ensure that the various special treatments are concentrated in centres competent and convenient to provide them, and not dispersed haphazard in uneconomic and overlapping units; that proper linking of services is secured by relating the work of special and general hospitals; that arrangements are at hand for the transfer of patients to the hospitals best suited to their medical needs; and that the skill of the consultant staffs of the various hospitals taking part can be used to the maximum advantage of the area as a whole.

It will be the aim of the authority to make its area (which will have been determined with this in view) as self-sufficient as possible in hospital and consultant services. But where it is obviously more sensible, as in some of the rarer services, the plan will provide for certain services by agreed arrangements outside the area.

The basis of the plan will be that the joint authority will secure the necessary service for its area partly through its own hospitals and institutions, partly through contractual arrangements made with voluntary hospitals for the performance of agreed services set out in the plan, to a minor degree (where necessary) through arrangements with the joint authorities of other areas.

Central approval of local area plans.

The plan will then be submitted to the Minister for approval, and will have no validity until so approved. The Minister, able to look at the country as a whole and at the effect of the local plans one upon another, will have power to modify or supplement the plan before giving his approval. He will consider all objections or representations made to him by local organisations (including the Local Health Services Council), voluntary hospitals or others.

The plan, when approved, will be open to amendment at any time, and the Minister will be empowered to call on the joint authority to reconsider the plan and submit fresh proposals. The procedure for amending the plan will be the same as for its original preparation and will include all necessary local consultation.

No voluntary hospital will be compelled to participate. Its participation will rest on a contract between it and the joint authority to provide the services specified in the plan. Where it agrees to participate, it will—like each of the authority's own hospitals—have to observe certain general conditions, just as it will obtain certain advantages.

General conditions to be observed by hospitals.

These conditions will be settled centrally, for the country as a whole, and they will then become the conditions on which exchequer grant will be payable.

In framing the conditions the Minister will seek the advice of the Central Health Services Council; but the more important conditions will relate to subjects such as the following:—

(*a*) each hospital will be required to maintain the services which under the approved hospital plan it undertakes to maintain, and generally to comply with the plan;

(*b*) each hospital will observe certain national requirements such as the Rushcliffe or Taylor rates and conditions for its nursing and midwifery staff and the recommendations of the Hetherington Committee for its domestic staff;

(*c*) in appointing senior medical and surgical staff each hospital will conform with any national arrangements adopted for regulating appointments and remuneration;

(*d*) each hospital will be open to visiting and inspection, in respect of its part in the public service, under arrangements laid down centrally;

(*e*) in the voluntary hospitals conditions to secure reasonable uniformity in accounts and audit will probably be necessary so far as they take part in the new service. The presentation of accounts of municipal hospitals is already largely subject to central direction.

Financial arrangements with voluntary hospitals.

As already emphasised, it is the aim of the Government to enable the voluntary hospitals to take their important part in the service without loss of identity or autonomy. But it is essential to this conception that the hospitals should still look substantially to their own financial resources, to personal benefactions and the continuing support of those who believe in the voluntary hospital movement. So long, and so long only, can they retain their individuality. If once the situation were to arise in which the whole cost of the voluntary hospitals' part in the public service (a service designed for the whole population) was repaid from public money, or indeed in which it was recognised that public funds were to be used to guarantee those hospitals' financial security, the end of the voluntary movement would be near at hand.

On this footing, the financial relation between the joint authority and the individual voluntary hospital must be that of an agreement to pay a specified sum in return for services rendered or to be rendered, and this should not be assessed as a total reimbursement of costs incurred. Whether the sum will be calculated in terms of beds or occupied beds, or otherwise, is for the moment immaterial. In order to avoid a large number of individual bargains, and the risk of competitive bargaining leading to undesirable results, it will be convenient for standard payments, in respect of different kinds of hospital service which involve different levels of expense, to be settled centrally. These payments will be made by the joint authorities and will fall on local rates, assisted by exchequer grant.

In addition, both the municipal and the voluntary hospitals will receive a direct grant from central funds which will include the share, attributable to hospital services, of any sum allocated towards the cost of the comprehensive health service from the contributions of the public to any scheme of social insurance. So far as this sum represented contributions by potential patients of hospitals it could fairly be said that the Government would have collected money which might otherwise have been paid to the hospitals direct, and that the proposed grant would thus restore the balance. This grant could be based on the number of beds provided by each hospital, but in the case of voluntary hospitals it would be feasible, if so desired, to regard the aggregate of their share of the payments as a central pool from which payments to individual hospitals could be varied according to the needs and resources of each.

In either case it will be the Minister's responsibility to see that the conditions of the grant are fulfilled. If the idea of a variable grant to the voluntary

hospitals is adopted, the Minister will be prepared to be guided in questions of relative need by some suitable body representing the hospitals, though the final responsibility and decision must remain with him.

Particular regard will need to be given, in connection with the area plans, to the position of hospitals used for the clinical teaching of medical students, and the question of financial assistance in respect of teaching work will be reviewed when the report is available of the Committee on Medical Schools now sitting under the chairmanship of Sir William Goodenough.

Inspection of hospitals.

In a service of this magnitude, in which hundreds of hospitals under different and independent managements will be taking part, the problem of inspection is a difficult one. Apart from special inspection in cases of difficulties arising or changes in contemplation, routine inspections—at not too frequent intervals—would serve the double purpose of bringing to notice defects of organisation or management and, what is equally important, of enabling individual hospitals to be kept in touch with the latest practice and ideas. The foundation of any inspectorate must clearly be a team of highly qualified medical men, but the inspectors need not all be persons employed whole-time on this work; from many points of view there are advantages in employing on a part-time basis medical men or women of distinction in various branches of professional work or medical administration. In addition to doctors, there is scope for experts of various kinds for dealing with an organisation so varied and complex as a modern hospital. Hospital administrators, nurses, catering experts and others—should find a place.

A solution would be the appointment by the Minister of a body of persons of the types mentioned, some of whom would be on a whole-time and others on a part-time basis. These appointments could be made with the advice of the Central Health Services Council and for convenience those appointed might be grouped in suitable panels operating over different areas of the country. The selection of the part-time doctors could be partly from those associated with consultant practice and voluntary hospitals and partly from those with experience of municipal hospitals, as in the case of those who are already conducting on the Minister's behalf the survey of hospital resources referred to in Appendix B. In cases of importance the inspectors could, again like the hospital surveyors, work in pairs.

The system of inspection must take account of the fact that the new joint authorities, no less than the Minister, will have a responsibility for the hospital service as a whole in their respective areas. The arrangements are intended to serve the double purpose. Inspectors' reports on any hospital will be available both to the Ministry and to the joint authority, and it will be open to the latter to ask for a special inspection if it thinks it desirable. Where in the past contractual arrangements have been made between a local authority and a voluntary hospital, special provision has not uncommonly been made for a right of entry for the authority's medical officer. There would be nothing to prevent similar arrangements being locally agreed under the system now proposed, but normally a more general system of the kind described will better serve the purpose in view.

Provision for consultant services in the local plan.

A main object of the new arrangements will be to ensure all kinds of consultant and specialist advice and treatment to all who need it. This part of the service will be best and most naturally based on the hospital services, in the wide sense in which these have been defined.

This means that it will become one of the duties of the joint authority to ensure that, through the various hospitals taking part, there will be provided an adequate consultant service available to all general practitioners in the service. It will do this, as in other branches of the hospital service, partly by its own direct arrangement and partly by contracting with the voluntary hospitals. In the latter case it will be for the authority to agree with a voluntary hospital for the provision by the latter of consultant services both at the hospital and—where necessary—by visits to a clinic or Health Centre or the patient's home. The hospital will itself enter into the necessary engagements with the consultants and specialists concerned. The local service payments to the hospitals, already mentioned, can be based on the assumption of a consultant staff properly remunerated to enable the hospital to fulfil the tasks which it has undertaken to perform.

Some principles affecting consultant services.

Before proposing in detail the form of a consultant service the Government are awaiting the report of Sir William Goodenough's Committee on Medical Schools. But it is clear that there are certain general considerations of which account must be taken in devising the new service.

The need is twofold—more consultants, and a better distribution of them. Apart from distribution, there are not yet enough men and women of real consultant status and one of the aims will be to encourage more doctors of the right type to enter this branch of medicine or surgery and to provide the means for their training. As to distribution, the need is for a more even spread. The main consultant facilities now are inevitably concentrated at the medical teaching centres. The consultant service still needs to be organised with the teaching centre as its focus, but the service must be spread over a wider area by enabling and encouraging consultants taking part in it to live and work farther afield. Apart from the main effect of greater accessibility to the public, this will also have a beneficial effect upon general medical practice over larger areas—where the habitual presence and services of consultants will serve as a means of continuous postgraduate education.

The consultant taking part in the service must be associated with his particular hospital or hospitals on a much more regular basis—and with more regular attendances and duties—than is often the case now, when he is regarded as merely "on call." It will often be desirable that the consultant's association should be with more than one major hospital, so as to enable the sharing of a common consultant staff to become an effective link between hospitals. The consultant's function will be normally one of regular and frequent visiting of these hospitals, both for in-patient and for out-patient consultation; also of properly arranged visiting of outlying "general practitioner" hospitals, which need to be linked with the major hospitals; and—for certain consultants as circumstances may require—of visiting Health Centres and clinics, and, in case of need, the patient's home, at the request of the general practitioner.

For this sort of duty the proper and regular remuneration of consultants, through the hospitals with which they are associated, will become essential. This remuneration, and the engagements entered into in respect of it, can be on either a full-time or a part-time basis (and might well include part-time engagements with more than one hospital). There will be no need to make either whole-time or part-time appointment a universal rule.

The conditions, including the financial terms, on which consultants undertake work on a whole-time or part-time basis will be a matter for arrangement by the hospitals, voluntary or municipal, which offer the appointments; but in order to avoid anomalies as between hospital and hospital and between area and area some central regulation of scales will be required.

Some degree of control of the discretion of individual hospital authorities will be required in appointments to senior clinical posts. Under existing practice a danger of " in-breeding " has been commonly recognised, and while it is important that the ultimate responsibility for an appointment should rest unmistakably with the body of persons conducting the hospital's affairs, it will be necessary to consider a system under which an expert advisory body recommends a number of suitable candidates from which the hospital authority makes the final choice. The necessary machinery could be organised in a variety of ways. It might consist of a number of advisory panels, working over regions based, broadly, on the medical teaching centres and representing both the consultant members of the profession and the medical teaching organisations. One or more representatives of the appointing hospital could join the panel dealing with the sifting of candidates for appointment.

V.

GENERAL PRACTITIONER SERVICE.

The arrangements for general medical practice in the comprehensive service —i.e. for ensuring a personal or family doctor for everybody—present the most difficult problem of all. This is partly because this will be the front-line of the service, the first source of help on which the individual will rely and one involving a close personal relation between doctor and patient. In addition, although the provision of medical benefit under National Health Insurance covers over twenty millions of persons and has afforded much experience of the working of a public general practitioner service, the widening of public responsibility to cover the whole population and the need to fit the general practitioner into a comprehensive service will create new problems and will make it necessary to reconsider, without preconception, the whole of the existing arrangements.

If the service is to be free to the people for whom it is provided, the doctors taking part in it will look to public funds for their remuneration. They must, therefore, be in some contractual relationship with public authority, which in turn must be able to attach such conditions as will ensure that the services which the people get are the services which they need (and for which they will be paying in taxation and otherwise) and that they can get them where and when they need them. The State must, therefore, take a greater part in future in regard to general medical practice.

The method of embodying general medical practice in a national service must observe two principles. The first, which mainly concerns the patient, is that people must be able to choose for themselves the doctor from whom they wish to seek their medical advice and treatment, and to change to another doctor if they so wish. Freedom of choice is not absolute now; it depends on the number and accessibility of doctors and on the fact that there is a limit to the load which any one doctor can or should take on. But the present degree of freedom must not be generally diminished, and the fact that public organisation ensures the service must not destroy the sense of choice and personal association which is at the heart of " family " doctoring. The second principle, which mainly concerns the doctor, is that the practice of medicine is an individual and personal art, impatient of regimentation. Whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best.

Methods of approach to the problem.

One method would be to abandon entirely the present system, on which National Health Insurance has been based, and to substitute for it a system under which all doctors taking part would become the direct employees of the State or of local authorities and would be remunerated by salary. As a problem of administration, there would be no insuperable difficulty in organising a scheme of this kind. But this is a highly controversial question, on which opinions are sharply divided. Many experienced and skilled doctors would be unwilling to take part in a service so conceived. They would hold that it infringed the second of the two principles just stated, and that if they became the salaried servants whether of the State or of local authorities, they would lose their professional freedom and be fettered in the exercise of their individual skill. Other doctors, with an equal right to be heard, would welcome a salaried service, believing that it would relieve them from business anxieties and enable them to devote themselves more freely to the practice of their profession. Lay opinion is similarly varied.

The Government have approached the question solely from the point of view of what is needed to make the new service efficient. Some of the proposals made in this Paper involve forms of medical practice for which present methods of payment are inappropriate, if not unworkable. Where this is so, remuneration by salary or its equivalent is suggested. A universal change to a salaried system is not however, in the Government's view, necessary to the efficiency of the service. They consider that to make, unnecessarily, so total and abrupt a change in the customary form of general medical practice would offend against the principle—earlier stated—that the new service should be achieved not by tearing up all established arrangements and starting afresh but by evolving and adapting the present to suit the future. They are averse from imposing a total salaried service merely for the sake of administrative tidiness.

Another alternative would be to maintain the " panel " system of National Health Insurance as it is now known, while extending it to the whole population and expanding it to include consultant and specialist services. This system has had, and still has, its critics, and some of the criticism is well founded. Yet, for more than a generation it has provided a better medical service than was previously available to a large section of the population and it has enlisted the regular professional services of a great majority of the doctors of the country. There are, however, two overriding reasons why it will not be possible to meet the new need merely by extending the panel system in this way.

First, there is at present no effective means of ensuring a proper distribution of doctors. To some extent the demand in any area will, by affording opportunity for practice, itself induce the supply; but that does not work out reliably or universally. It is true even now that the need for doctors in one area may be scantily or unsuitably met, while that of another area may be over-supplied. Certainly when the much bigger public responsibility is assumed of ensuring a personal doctor service for the whole population there will have to be means of securing, through public organisation, that the resources available are so disposed as to fit the public need.

Second, there is a great deal of agreement in the profession and elsewhere that developments in the modern technique of medical practice point the way to changes which need encouragement and experiment in any future service. The recent draft Interim Report of the Medical Planning Commission