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

(organised by the British Medical Association) summarises these trends very well. For instance, the Report states:—

"The days when a doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot now be all-sufficient. For efficient work he must have at his disposal modern facilities for diagnosis and treatment, and often these cannot be provided by a private individual or installed in a private surgery. He must also have easy and convenient access to consultant and specialist opinion, whether at hospital or elsewhere, and he must have opportunities of real collaboration with consultants. Facilities such as these are inadequate at the present time. There must also be close collaboration amongst local general practitioners themselves, for their different interests and experience can be of value to each other. Although this need is recognised by practitioners collaboration has not been developed as it should be."

Or, again, in another passage—

"At the present time the single-handed practice or partnership is usually conducted from a doctor's private residence. Certain rooms are used for professional purposes, and personal or borrowed capital is invested in equipping the practice with apparatus and in keeping it up-to-date; additional domestic staff is employed to keep the surgery and waiting rooms clean and to deal with callers; the secretarial work and record keeping are done by the doctor himself or a secretary employed for the purpose; dispensing, if done at the surgery, is undertaken either by the doctor or a dispenser employed by him. This arrangement is repeated many times over in a fairly well-populated district."

The tendency will be away from the idea of the all-sufficient doctor working alone, and towards a bigger element of grouped practice and teamwork—in which the individual doctor retains his personal link with the patient, but has at his side the pooled ability of a group of colleagues as well as consultant and hospital services behind him. To quote the Medical Planning Commission once more:—

"Diverse as are the views of the organization of medical services, there is general agreement that co-operation amongst individual general practitioners in a locality is essential to efficient practice under modern conditions, though views vary on the form of the co-operation. The principle of the organization of general practice on a group or co-operative basis is widely approved."

The Government fully agree that "grouped" practices, to which numerous privately arranged partnerships are already pointing the way, must have a high place in the planning of the new service and they are designing the service with this constantly in view. Yet the conception of grouped practices cannot represent the whole shape of the future service. In the first place, there has not yet been enough experience of the idea translated into fact. Not enough has been found out, by trial and error, to determine the conditions under which individual doctors can best collaborate or even the extent to which in the long run the public will prefer the group system. Second, it is certain that the system could not be adopted everywhere simultaneously. The change, if experience shows that it should be complete, will take time.

The Government intend, therefore, that the new service shall be based on a combination of grouped practice and of separate practice side by side. They propose to place the group idea in the forefront of their plans in order that there may be a full trial on a large scale of the working of arrangements of this kind. Grouped practices are more likely to be found suitable in densely populated and highly built-up areas and it is there particularly (though not exclusively) that they should first be tried. It will then be possible to watch

the development, with the medical profession, and to decide in the light of experience how far and how fast a change over to the new form of practice can and should be made.

The part of central and of local organisation in the service.

All doctors in general practice who join in the new relationship with their patients, and rely largely in future on public funds for their normal livelihood, must be treated on a similar footing; the terms of their remuneration, the general conditions to be observed by them and the rights to be enjoyed by them must be nationally negotiated and settled.

In the National Health Insurance scheme successive Governments have accepted this principle, on which the medical profession itself has laid much stress. Although the local Insurance Committees play a valuable and recognised part in the administration of the scheme (and particularly in handling minor matters of discipline) the service is in fact highly centralised. Terms are laid down in great detail in the Medical Benefit Regulations, and all major questions have either been matters for negotiation between the Government and representatives of the profession or—as in the case of enquiries involving the removal of a doctor from the service—have been dealt with by central tribunals appointed by, and answerable to, the Minister.

The Government are convinced that, broadly, this system is still the right one and that it would be a mistake to apply to the new general practitioner service the normal canons of local government administration. On the other hand, it is essential that general medical practice in the new health service should not be divorced from the other branches of that service; that would perpetuate what is recognised to be the outstanding defect of the present system. Therefore what is proposed, in outline, is as follows:—

(1) The present practice of settling centrally all major terms and conditions of service, including remuneration, will stand. The local Insurance Committees will be abolished and in future doctors, in so far as they take part in the new general practitioner service, will be in contractual relation with a Central Medical Board, to which they will look for their remuneration.

(2) In general, the other functions of the Insurance Committees will also fall to the Board, but to avoid over-centralisation in detail the Board will discharge many of the minor day-to-day functions through a local committee or similar agency, on which there will be included members of the local authority in each area.

(3) The new joint authority will have an important part to play of a different kind. As the general planning authority for the whole health service in its area, it will include the needs of general medical practice, no less than of other services, in its area plan; it will provide for the linking of general practitioners (whether in grouped or separate practices) with the hospital and consultant and other services in the area.

(4) The county and county borough councils which make up the joint authority will normally each have the function of providing and maintaining such premises (in Health Centres and otherwise) as are approved in the area plan.

(5) The doctor himself will, in his contract with the Board, be required to observe the arrangements of the area plan and will be given all the necessary information and facilities to enable him to do this.

These are all matters for further explanation. The arrangement adopted is, first, to deal with the particular points arising on "grouped" general practice and on "separate" general practice respectively, and then to deal with features common to both kinds of practice and with the constitution and functions of the proposed Central Medical Board.

GROUPED GENERAL PRACTICE.

The conception of grouped practice finds its most usual expression in the idea, advocated by the Medical Planning Commission and others, of conducting practice in specially designed and equipped premises where the group can collaborate and share up-to-date resources—the idea of the "Health Centre". The Government agree that it is in this form that the advantages of the group system can be most fully realised, though it will also be desirable to encourage the idea of grouped practice without special premises. They intend, therefore, to design the new service so as to give scope to a full trial of this new method of organising medical practice, and so as to enable it to be expanded and developed as time goes on to the maximum extent which the practical experience of its working is found to justify.

General lines of Health Centre development.

Where Health Centres are set up, their types will need, particularly at first, to be varied. Scope must be given (with central and local professional guidance) to experiment and to design capable of later adaptation. Broadly, the design should provide for individual consulting-rooms, for reception and waiting-rooms, for simple laboratory work, for nursing and secretarial staff, telephone services and other accessories, as well as—in varying degree according to circumstances—recovery and rest rooms, dark rooms, facilities for minor surgery, and other ancillaries. The object will be to provide the doctors with first-class premises and equipment and assistance and so give them the best facilities for meeting their patients' needs. The doctors will thus be freed from the necessity to provide these things at their own cost. They will join in something like the partnership groups already often privately formed, and there will be new scope for the young doctor, fresh from hospital training, to take his share in the Centre as an assistant to the practitioners engaged there, and then, later on, to be eligible for full participation.

Limitation of the permitted number of patients will apply whether in the Centre or outside it, and the ordinary basis of the patient's choice of doctor will not be affected. Each Centre will need to be so planned as to be regarded by patients not as a complete break with present habit but as a new place at which they can, if they wish, continue to see their own doctor when he has joined the Centre, or can choose the doctor in the Centre whom they want to attend them. Alternatively, they must be able, if they prefer it, simply to select a Health Centre as such, rather than choose a particular doctor at the Centre; and then arrangements will be made by the Centre to ensure that they obtain all the proper advice and treatment which they need.

There has often been misconception as to the precise implications of Health Centre practice. It has been assumed that a doctor would be "on duty" only for stated periods and that, outside those periods, his patients would always be attended by some other doctor. That need not be so. Normally, a doctor will attend his own patients as necessary, either at the Centre or at the home. He will have his consulting hours and visit his patients as at present. But the grouping of practices at a Centre will make possible a greater fluidity of arrangements; for example, as arrangements will be made for continuous staffing, a patient will, in emergency, get immediate attention even though his own doctor does not happen to be available. The grouping of practices will, moreover, make it easier for doctors to obtain reasonable holidays and to attend refresher courses. The internal organisation of the Centre so as to facilitate reasonable absences consistent with the doctor's responsibilities will be a matter for the doctors themselves.

The Centres will be provided first in selected areas. Both central and local organisation, and local professional interests represented by the Local

Health Services Council, will all have their part to play in this provision. The wish of the local doctors to bring their work into the new Centres must obviously be a big factor in a decision to provide a Centre, but in the last resort the decision will rest on the requirements of the public interest.

Provision of Centres.

It will be essential to associate any decision to provide Centres, and their location, with the rest of the arrangements of the approved area plan. This will mean, in effect, that the decision in each case that the Health Centre system should be initiated in a particular part or parts of the area, and the consequential decisions as to the location and size and kind of Centres to be provided, will normally start in the area itself where the needs are best known and where the general health services plan is formulated, but will depend in the last resort upon the decision of the Minister in the light of his central policy on the general practitioner service and the new Health Centre experiment in the country as a whole. It will be for the joint authority in the first instance, in consultation with the local medical profession, to formulate proposals for a Centre or Centres as part of the area plan —or, later on, as an extension or alteration of that plan—and to submit them to the Minister.

The actual provision of a Centre will normally be the responsibility of the county or county borough council. This accords with the principle earlier discussed under which the clinic and other services which are not essentially part of the consultant and hospital field will be allocated to these councils and not to the joint authority.

Terms of service in Health Centres.

The terms and conditions of service will be settled centrally for all doctors taking part in the new service, whether in group practice or not, and all doctors will enter into a contract of service with the central organisation. The doctor practising in a Centre will not be debarred from private practice outside it, for those patients who do not wish to take advantage of the new public service, though there will be provision to ensure that the interests of patients within the new service do not suffer in any way as a result of this.

In certain respects the contract of the doctor in the Health Centre must differ from that of one practising outside. After the establishment of a Centre the appointment of a new doctor to the Centre will be made jointly by the Central Medical Board and the council administering the Centre, and similarly the termination of his engagement at the Centre (except where the doctor himself wishes to bring it to an end) will rest with these two bodies, or if they fail to agree, with the Minister. It will be part of the arrangement that the council provide the doctors in the Centre with the necessary premises, equipment and ancillary staff. The contract will have to be a three-party one between the doctor, the Central Medical Board and the council.

But there is one important question in regard to the method of remuneration of the doctor, when practising in co-operation with a group of colleagues in a Health Centre, which does not arise in the same way when he is in separate practice outside. That is the method of payment of the individual doctor.

It seems fundamental that inside a Centre the grouped doctors should not be in financial competition for patients. All the practical advantages of the Centre—the use of nursing and secretarial staff, record-keeping, equipment, the availability of young assistant doctors in particular—will be, under a system of a salaried team, at the disposal of the group in whatever way they like collectively to arrange; it is the whole idea that they should arrange their own affairs together in this way. But if individual remuneration is based on mutual competition for patients, complication will enter into any attempt of the group to allocate and share these services—for the more any

one individual is able to draw on the ancillary helps of the Centre (and particularly on medical assistants) the more he will gain and his fellows lose in the contest for patient lists.

There is therefore a strong case for basing future practice in a Health Centre on a salaried remuneration or on some similar alternative which will not involve mutual competition within the Centre. When the salaried or similar principle is adopted, the scales will have to be decided in consultation with the profession itself. In this respect attention is drawn to Appendix D, which suggests the method by which a basis could be arrived at for settling both salaried remuneration and the payment by capitation later proposed for " separate " practice. It may also be possible, if desired by the doctors themselves, to offer remuneration on a salaried basis or on some other basis than that of capitation fees to doctors engaged in group practice even where the practice is not conducted in a Health Centre.

SEPARATE GENERAL PRACTICE.

In " separate " practice the general framework of the National Health Insurance scheme will be retained but there will have to be important changes from the past and the scheme will have to be much extended and adapted. The nature of these changes will be evident not only from the following paragraphs which relate to " separate " practice, but also from the later paragraphs dealing with features common to both " group " and " separate " practice.

Scope of Separate Practice.

In future everyone will be entitled, as only " insured " persons are entitled at present, to receive from the doctor chosen by him all the ordinary range of general medical practice, either at the consulting room or at his home, as the case requires. He will also be entitled, normally through his doctor, to all the new range of consultant and specialist and hospital or clinic services already considered.

A doctor in separate practice will engage himself to provide ordinary medical care and treatment to all persons and families accepted by him under the new arrangements. He will work from his own consulting-room and with his own equipment, as he does now, but he will be backed by the new organised service of consultants, specialists, hospitals and clinics, which he will be expected to use for his patients in accordance with the approved area plan earlier described. He will receive his remuneration for work within the new service, not from the individual patient, but from public funds; and this remuneration will be based—as it is now in National Health Insurance—on a capitation system, depending on the number of patients whose care he undertakes. (A settlement on new lines of the basis for calculating capitation or other forms of remuneration is suggested in Appendix D already referred to.) Even in the case of separate practice there will be some circumstances in which it will be possible to remunerate the practitioner on a salaried or similar basis if he so desires. Opportunity for such an arrangement may occur, for example, in sparsely populated areas where a single doctor is in fact responsible for all the work of the area and is not therefore in competition with other doctors in the neighbourhood. But, however remunerated, the doctors in separate practice will remain entitled to engage in private practice, since it is no part of the intention of the new service to prevent persons who prefer to do so from making private arrangements for medical care or to prevent doctors from meeting their needs.

Control over entry into new practice.

There will be no interference with the right of a doctor to go on practising where he is now and to take part in the public service in that area.

But an unrestricted right to any doctor to enter any new practice and there to claim public remuneration, at his own discretion, would make it impossible to fulfil the new undertaking to assure a service for all.

Under the present National Health Insurance system every qualified doctor has a right to take up panel practice where he likes. The system enables the Minister, if satisfied that the service in any area is inadequate, to replace the panel system by some other form of arrangements, although—with minor exceptions at the outset of the scheme—this power has not been invoked. There has never been any real means of securing that the doctors of the country are reasonably distributed. This has perhaps not been a pressing necessity while the scheme covered less than half the population, but it is well-known that great disparities have existed.

If under the new scheme the whole population are to be entitled to a general practitioner service, a much heavier responsibility will be thrown on the Government to see that the needs of the whole population are met. This implies some degree of regulation of the distribution of medical resources, at least to the extent of securing that a doctor does not in future take up practice in the public service (whether by purchasing a practice or by " squatting "), in a locality which is already fully or over-manned. Such control can be left in the profession's own hands as far as possible, though it must be guided by national policy. A suitable machinery will be to vest it in the Central Medical Board, working under general guidance on policy from the Government but independently in its individual decisions. Any practitioner wishing to set up a new—or take over an existing—public service practice in a particular area will seek the consent of the Board. The Board will then have regard to the need for doctors in the public service in that area, in relation to the country as a whole, and to the general policy for the time being affecting the distribution of public medical practice. If it is considered that the area has sufficient or more than sufficient doctors in public practice while other areas need more doctors, consent will be refused. Otherwise it will usually be given without question. The Board will thus be able to help the new joint authorities which, in their general concern with the health services of their area, will turn to the Board to encourage or discourage any further increases in general practice in the area.

The part of the new joint authority.

It will be the duty of the new joint authority to consider the needs of its area in general medical practice, including " separate " practice, no less than in the other branches of the comprehensive service, and to include in the area plan for central approval the arrangements—in terms of numbers and distribution of general practitioners—which it considers to be necessary to meet these needs. In this it will have the advantage of consultation with the Local Health Services Council. The plan will need the Minister's approval, after hearing any conflicting local views. The approved plan will be made known to the Central Medical Board, to be taken into account in the subsequent exercise of their functions in the distribution of public medical practice.

It will also be the duty of the joint authority to watch that the supply of all branches of the comprehensive service is adequate to the needs of their area and in the matter of general practice, therefore, to bring to the notice of the Minister and the Central Medical Board any needs which they feel should be more adequately met. They will also be responsible for ensuring that all the other services in their area (hospital, clinic, nursing, consultant and specialist) are fully known to the general practitioners participating in the new service and that the latter are enabled (as their contract will require them) to use these services fully for their patients in accordance with the approved area plan.

GENERAL.

It remains to consider certain general questions affecting medical practice, both " grouped " and " separate ", and to describe more fully the proposals for a Central Medical Board.

Permitted number of patients.

From the outset of medical benefit under National Health Insurance, provision has been made for imposing a limit on the number of insured persons for whose treatment a doctor may make himself responsible. The limit is fixed by a local scheme which is subject to the Minister's approval, but the regulations themselves provide for certain over-all maxima. An additional number of patients is permitted to a doctor who employs one or more assistants. Under this system every doctor has a right to undertake as much private practice as he desires and is able to secure, and it is usual for the doctor of an insured head of a family to look after the uninsured wife and children under private arrangements.

In the new service also there will have to be prescribed limits to the number of patients whose care any one doctor can properly undertake. But the situation will be substantially altered by a scheme which covers the whole population and which contemplates both grouped and separate practice. It is not the wish of the Government to debar anyone who prefers not to avail himself of the public service from obtaining treatment privately, nor to prohibit a doctor in the public service from carrying on any private practice, but it will be necessary to ensure that the interests of the patients in the public service do not suffer thereby.

In fixing the appropriate limits, in future, allowance will need to be made for private practice remaining after the new service is in operation. There will need to be room for flexibility. A doctor entirely free from outside activity and able to give his whole time to general practitioner work in the new service will need to be able to work to a higher permitted limit of public patients. A doctor with an unusually large amount of private work, or with appointments in other branches of the public service, will be expected to work to a lower permitted limit. The effective way to provide reasonable flexibility is to entrust the decision in such cases to a suitable professional organisation—which will naturally be the Central Medical Board working through its local committees. The details of this are for discussion with the profession's representatives at a later stage, but the object must be to see that the care of patients under public arrangements does not suffer in quality or quantity by reason either of private commitments or other public engagements. Nor must anyone have reason to believe that he can obtain more skilled treatment by obtaining it privately than by seeking it within the new service.

Entry into the public service.

There is a strong case for requiring all young doctors, leaving hospital and entering individual practice for the first time, to go through a short period of " apprenticeship " as assistants to more experienced practitioners. There is a particularly strong case for saying that this should be required by the State in medical practice remunerated from public funds. When such a rule is made the young assistant doctor will have to be assured of reasonable conditions and opportunity, and certainly must not be at risk of being precluded from a proper professional livelihood by the operation of the rule. One way will be to require a suitable period as an assistant except where the Central Medical Board dispenses from the rule (e.g. to meet cases where an assistant post is not reasonably obtainable). There will, no doubt, be many opportunities to

employ assistants in Health Centres where terms and conditions can be regulated and the Board can help new entrants to find vacancies. In " separate " practices, the Board must be empowered to satisfy itself as to the proposed arrangements and remuneration for an assistant, before consenting to his engagement by the principal seeking him—guidance on standards being given centrally in consultation with the profession. The general practitioner wishing to undertake a larger number of public patients than the ordinary maximum will inform the Board, and the Board—after satisfying itself as above—will help an intending assistant to get the post on the terms approved. The Board must also be able to require the young doctor during the early years of his career to give his full-time to the public service where the needs of the service require this.

Compensation and superannuation.

The Government recognise that the adoption of the proposals in this Paper will, in certain cases, destroy the value of existing practices. In such cases compensation will be paid. It will be necessary to discuss this in detail with the profession but there are two classes of case in which a just claim for compensation will clearly arise.

The first is that of a practice in an " over-doctored " area, to the sale of which the Board refuses consent. Here the out-going doctor or his representatives will be paid compensation.

The second is that of a doctor who gives up his " separate " public practice and takes service in a Health Centre. It will be incompatible with the conception of a Health Centre that individual practices within the Centre should be bought and sold and a doctor will therefore, by entering a Centre, exchange a practice having a realisable value for a practice which he will be debarred from selling. On the other hand an efficient superannuation system will be an essential part of the Health Centre organisation. A doctor entering a Centre will acquire superannuation rights and other facilities of considerable value. The proper course will be to strike a fair balance between what he is gaining and losing and to compensate him accordingly.

It would be more difficult to institute superannuation for doctors in " separate " practices, but the Government will discuss with the profession the possibility of an acceptable scheme to provide for retirement within specified age limits and for superannuation on a contributory basis.

Sale and purchase of public practices.

The Government have not overlooked the case which can be made for the total abolition of the sale and purchase of publicly remunerated practices. The abolition would, however, involve great practical difficulty and is not essential to the working of the new service now proposed. The Government intend, however, to discuss the whole question with the profession, to see if some workable and satisfactory solution can be reached. In particular, it would obviously be incongruous that the new public service should itself have the effect of increasing the capital value of an individual practice and thus increasing the amount of compensation which may have to be provided under the circumstances described in the preceding paragraphs; and measures to prevent this must be included in the discussion.

The creation of Health Centres will, meanwhile, do a great deal to limit the scope of the present system. The Centres will afford a wide opportunity to young doctors to enter their profession without financial burdens. They will also, wherever they are set up, bring into being a new form of practice which

will thereafter be entirely free from any necessity of sale and purchase. Moreover, the system proposed earlier of requiring young men who join the public service normally to undergo a period as assistants will go far to avoid the danger of a doctor purchasing a practice which he has not the necessary experience to handle successfully.

Creation of a Central Medical Board.

It is intended to create from the profession itself a special executive body at the centre, which will undertake some of the administrative work of the service requiring a specially intimate link with the profession.

As the contract of the doctor will be in a public service, remunerated from public funds, the Board will clearly have to be subject to the general directions of the Minister, but subject to those general directions it will be the organisation with which the doctor will deal as the "employer" element in the service—i.e., the organisation with which he will be in contract, whether engaged in "separate" or in grouped or Health Centre practice (although in Health Centre practice the local authority will be joined in the contract).

It is not for this Paper to suggest all the details of the doctor's contract at this stage (they will be for discussion with the profession's representatives); but they will need to provide—

(*a*) for the doctor to give all normal professional advice and services within his proper competence to those whose care he undertakes;

(*b*) for him to comply with the approved area plan for obtaining consultant and specialist and hospital services;

(*c*) for proper machinery for the hearing of complaints by patients and for the general kind of disciplinary and appeal procedure already familiar in National Health Insurance;

(*d*) for the observance of reasonable conditions, centrally determined with the profession, respecting certification and other matters which must arise in any publicly organised service.

The existing doctor will enter into the new contract in respect of his existing practice; the new doctor, or doctor entering a new practice, will first obtain the Board's consent (as already suggested) and then enter into the necessary contract in respect of his new practice. Termination of the contract will ordinarily be either by the doctor, at any time after due notice, or by the Board, under conditions which will no doubt be substantially similar to those now obtaining under National Health Insurance, with such special extra provisions as may be necessary in the case of Health Centre practice.

Under these arrangements there will be no need for the continuance of the present local Insurance Committees of the National Health Insurance scheme, and these Committees will be abolished. The minor day-to-day functions now exercised by Insurance Committees (so far as these still arise under the new and wider service) can be handled by a local Committee of the Board in each area, on which local authority members will be included.

The Board will also watch over the distribution of public medical practice generally. In "separate" practice it will do this through the arrangements already described, under which its consent will be required before a vacant public practice is refilled or a new public practice established. In Health Centre practice it will be the agency through which any additional doctors required in future are introduced into any particular Centre, after suitable consultation with the doctors already working there, through the local

committees earlier proposed in place of the present Insurance Committees. It will be the agency through which young doctors obtain appointments as assistants at Health Centres and by which the terms and conditions of assistants in "separate" practice are protected in the way already proposed —and from which any dispensation from the requirement of an initial "apprenticeship" for new doctors will have to be sought.

The Board will also take on many functions on the doctor's behalf—e.g. in approaching the appropriate medical schools and hospitals with a view to the arrangement of post-graduate and refresher courses for those in general practice, in acting as the general centre of advice and help in the movement of doctors within the public service and in the various personal problems and requests for information which will doubtless arise. It will, with the Minister, provide the central organisation to which the new joint authorities will make known their area's needs in general practice, in accordance with the approved area plans for the health service as a whole.

The Board will be a small body, under a regular chairman—a few of its members being full-time and the rest part-time. It will be mainly professional, but it will also have lay members on its strength. In view of the wide scope of its executive functions and handling of public funds its membership and organisation will have to be finally settled by the Minister, although of course in consultation with the profession.

Supply of drugs and medical appliances.

The existing system under National Health Insurance, under which panels of chemists are formed in each area on lines closely corresponding to the panels of doctors, has worked on the whole with success. In detail the system is no doubt capable of improvement, and discussion with the appropriate pharmaceutical bodies will be welcomed by the Government. In particular, it will be necessary to consider the arrangements to be made in connection with the supply of drugs to patients attending Health Centres.

As regards medical and surgical appliances, the existing system entitles an insured person to the supply, free of charge, of certain appliances specified in the Medical Benefit Regulations if ordered by a doctor. These "prescribed appliances" are, in the main, the articles most commonly required in general practice. In a service which includes treatment of all kinds, whether in or out of hospital, the range of necessary appliances will have to be greatly extended; but it will be a matter for consideration whether in the case of the more expensive appliances the patient himself should not be called upon, if his financial resources permit, to contribute towards the cost—either of the appliances initially ordered, or at least of repairs and replacements. The point will be of particular importance in connection with the dental and ophthalmic services.

The need for a new attitude in patient and doctor.

The aim of the service will be to provide every person, or better still every family, with a personal or family practitioner who will be able to become familiar with the circumstances of those in his care—in the home and at work. It is to be hoped that doctor and patient will not wait always till the latter falls ill and urgently requires treatment. The doctor must try, in short, to become the general adviser in all matters concerned with health (no less than with disease) on which a doctor is so well qualified to advise. This means a changed outlook in much of present medical practice—a change that has long been wanted and advocated by most doctors themselves and for which they more than anyone have desired the opportunity. But such a change cannot be effected overnight. It will be helped if a new trend can be given to undergraduate medical education

and, fortunately, there are plenty of signs that medical schools are beginning to realise the importance of this. It will take time to develop; but it is worth stating clearly at the outset that, unless this kind of medical care is ultimately provided for every person and every family, the medical profession will not be giving the public the full service which it needs and which only the medical profession can give. To provide or to extend a service which considers only the treatment of the sick is neither in accordance with the modern conception of what a doctor should be trained to do nor in keeping with the general desire that the family practitioner should begin to undertake many of the duties at present performed by his colleagues in the public health service.

VI.

CLINIC AND OTHER SERVICES.

Apart from the hospital and consultant and family doctor services, the comprehensive health service must include arrangements for home nursing and midwifery and health visiting and the various kinds of local clinic and similar services which have either been provided in the past under special statutory powers or will have to be established in the future.

When the new service is established, these local services will not be provided as entirely separate entities, but rather as parts of the one new general duty to secure a whole provision for health. It will be the duty of the new joint authority—by means of the arrangements proposed by it and approved by the Minister in the general area plan—to ensure that all these different activities are properly related to each other, to the personal or family doctor service and to the hospitals and consultants, and that they are arranged in the right way and in the right places to meet the area's needs. This done, it will be the duty either of the joint authority or of the separate county and county borough authorities which together constitute it, as the case may be, to provide and maintain the various services on the lines of the settled area plan. The usual sharing of responsibility in this respect between the joint authority and the several counties and county boroughs—under the proposals described earlier in this Paper—will be recalled.

When these local services are arranged and regarded as parts of the one planned service of the wider area, there will be room for experiment and innovation in the way they are provided—particularly as time goes on and the full service gets into its stride. It is reasonable to look forward to the time when the general medical practitioner, the personal doctor with whom the individual and the family are regularly associated, will be able to be connected more closely with the services which are performed at special clinics—e.g. for child welfare, in which there is no doubt that in much of the general care of the young child and the handling of many of its day-to-day problems the clinics and the family doctor who has the general medical care of the child must be enabled to work in better contact for their common purpose. To make this possible on any substantial scale there will have to be much more opportunity than there is now for the family doctor to acquire special experience in the children's wards of hospitals and in general child welfare subjects and the chance of post-graduate training and refresher work in these and other special subjects. Where grouped general practice in Health Centres is tried there will be special opportunity for this kind of development.

But whatever developments there may be in the clinics or other services locally provided, or in the method of operating them in relation to other branches of the service as a whole, it is clear that the coming into operation

of the new service will certainly not involve closing down or abandoning any existing facilities—but much rather increasing and strengthening them to fit the new and wider objects in view. Therefore the effect of the proposals in this Paper on the main local services of this kind as they are known now—and on the position of the local authorities responsible for them—can be summarised.

Maternity and child welfare services.

The arrangement of lying-in accommodation in hospital or maternity home —indeed all the institutional provision for maternity, both for normal and for complicated cases—will become simply one part of the re-organised hospital and consultant services and will be the responsibility of the new joint authority. The ordinary functions of the maternity and child welfare clinics, however—concerned, as they are, not primarily with direct medical treatment but more with the convenient local provision of general advice and care in the day-to-day bringing-up of young children and in the mothers' associated problems—will not be transferred to the new joint authority but will lie wherever the related functions of child education are made by Parliament to lie under the new Education Bill. Under the proposals in that Bill, as they stand now, this will mean that the county and county borough councils will be the authorities primarily responsible, but that arrangements will be made in suitable cases for delegating much of the practical care of the service to some of the existing authorities, within the counties, which have hitherto carried the responsibility and which have accumulated good experience and local interest.

The maternity and child welfare clinics, although provided and maintained in this special way over the various parts of the joint authority's area to meet the need for the link with education, will be as much a subject as any other part of the health service for the general plan for that area which the joint authority will prepare and the Minister finally settle. The sufficiency of the clinics, their distribution, their connection with the necessary specialist services and the hospitals, and the other main arrangements concerned, will all be covered by the wider area plan.

What has been said of the clinics applies equally to those arrangements for domiciliary midwives and health visitors which need to be ancillary to the clinics' work, and responsibility for those will lie with the same authorities and be similarly affected by the general area plan.

School Medical Service.

In this service also the proposals need to be related to the proposals in the current Education Bill. The conception underlying both the Bill and the present Paper is that the education authorities will retain as part of their educational machinery the functions of inspection of children in the school group (the supervision, in fact, of the state of health in which the child attends school and of the effects of school life and activities on the child's health), together with the important function of using the influence of the school and the teacher and the whole school relationship with child and parent to encourage the recourse of the child to all desirable medical treatment. But, as from the time when the new health service is able to take over its comprehensive care of health, the child will look for its treatment to the organisation which that service provides—and the education authority, as such, will give up responsibility for medical treatment.

Tuberculosis dispensaries and other infectious disease work.

The local tuberculosis dispensaries will in future be regarded as out-patient centres of the hospital and consultant service, and responsibility