VII.

THE SERVICE IN SCOTLAND.

What has already been said with regard to the present state of the health and medical services, the chief deficiencies in the existing arrangements, and the general shape of a comprehensive service which would make good these deficiencies applies equally to Scotland as to England and Wales.

The general administrative structure of the service in the two countries, however, cannot for various reasons be the same. The development of the health services has not been entirely uniform up to the present time; here and there differences occur in the scope and organisation of corresponding services; and each country has services for which there is no counterpart in the other. The most important of these differences are described in Appendix A. The reason why the new service, although the same in scope and objects in both countries, cannot be organised on entirely similar lines is that account must be taken of certain differences of geography and local government structure in Scotland, as compared with England and Wales. For example about 80 per cent. of Scotland's population is concentrated in about 17 per cent. of the total area of the country, across its industrial "waist." Outside the industrial belt are large and for the most part sparsely populated areas. Of the 55 existing health authorities in Scotland only 10 have populations of more than 100,000 and 32 have a population under 50,000. Against this, the population of England and Wales is on the whole much more urbanised and the local government units are larger with correspondingly greater resources.

CENTRAL ADMINISTRATION.

There will be no substantial difference in the central machinery to be set up in Scotland as compared with England and Wales.

The Secretary of State will be directly responsible to Parliament for the administration of the new service and will exercise his functions through the Department of Health for Scotland.

A Central Health Services Council for Scotland will be set up by statute with the same kind of constitution, powers and functions as the corresponding Council in England and Wales. It will consist of representatives of the medical, dental, pharmaceutical and midwifery and nursing professions and of the voluntary and municipal hospital authorities in Scotland, appointed by the Secretary of State after consultation with the organisations represented, and the Council will select its own chairman. It will advise the Secretary of State on any technical aspect of the service, either in response to a request for advice from the Secretary of State or on its own initiative, and the Secretary of State will be required to submit to Parliament annually a report on the Council's work during each year.

Similarly, Scotland will have a separate Central Medical Board to act on behalf of the Secretary of State in the day-to-day administration of the general practitioner service. This Board will perform the same functions as the corresponding English organisation described in chapter V, and like that organisation it will be created mainly from the medical profession itself. There will clearly have to be the closest liaison between the two Boards to secure uniform administration of the general practitioner service in the two countries, and special arrangements will have to be made, by a common list of doctors and in other ways, to deal with the movement of doctors from one country to the other.

LOCAL ORGANISATION.

It is in the local organisation of the service that the arrangements proposed for England and Wales must be modified to suit the special circumstances prevailing in Scotland. In England and Wales it is proposed to define areas of suitable size and resources for the direct administration of the hospital and consultant branches of the service and for the local planning of the service as a whole, and to secure suitable authorities to carry out these tasks by the combination of existing authorities in the area. To do this in quite the same way in Scotland would usually be out of the question since the areas which would have to be defined for the purpose would be so big as to be quite unwieldy and indeed destructive of local government administration. The point can probably best be illustrated in relation to the hospital service. Successive Committees on hospital problems have emphasised the need for planning and co-ordinating the hospital service in Scotland over wider areas, and for this purpose have recommended the selection of the four natural hospital regions based on the Cities of Glasgow, Edinburgh, Aberdeen and Dundee, where the key hospitals as well as the medical schools are to be found, with a fifth based for geographical reasons on Inverness. While areas of this size are necessary for the planning and co-ordination of a comprehensive hospital service, they are clearly too large for local government purposes. This means that co-ordination of the hospital service and responsibility for its actual provision have in Scotland to be separated in a way which does not apply to England and Wales.

As will be seen, these special requirements in the hospital service must to some extent affect the local organisation of the other branches of the new service as a whole, and in particular it is proposed that the scope of the duties of the new Joint Hospitals Boards in Scotland shall not extend beyond the hospital and auxiliary services.

Administration of the hospital and consultant service.

It is intended to adopt the recommendations made by various Committees, including the Committee on Scottish Health Services and the Hetherington Committee, that a Regional Hospitals Advisory Council should be set up in each of the five hospital regions referred to. The Council will consist of members nominated in equal numbers by (i) the new Joint Hospitals Boards of combined local authorities in the region, and (ii) the voluntary hospitals, with an independent chairman to be appointed by the Secretary of State. In addition, it can include a small number of representatives of the medical and medical-educational interests of the region.

The functions of the Councils will be consultative and advisory. They will advise the Secretary of State on the measures necessary to secure the co-ordination of hospital planning within the region.

A further important function which the Councils will perform will be to advise the Secretary of State on the co-ordination of the consultant service between the hospitals and other services, and they might, through sub-committees, also advise hospital authorities on the filling of vacancies in consultant and senior hospital appointments.

Next, it is proposed to set up Joint Hospitals Boards formed by such combinations of neighbouring major health authorities as are found necessary to ensure that an adequate hospital and consultant service is provided for each combined area. In one or two areas where circumstances are suitable, and where the population is large enough and the resources adequate to support a satisfactory hospital service, the major health authority will continue to be the hospital authority without combination with any other local authority.

The Joint Hospitals Boards will be composed entirely of representatives from the county councils and the town councils of large burghs in the area concerned. They will take over the whole ownership of and responsibility for the hospitals of their constituent authorities, will be charged with the statutory duty of securing a proper hospital service for their area—by their own provision and by arrangements with other Joint Hospitals Boards or voluntary hospitals—and will in fact be, so far as executive responsibility for the hospital service is concerned, the counterpart of the new joint authorities in England and Wales.

The Joint Hospitals Board will have the duty of preparing a scheme for the hospital services of their area, after consultation with the voluntary hospitals. They will be encouraged also to consult the Regional Hospitals Advisory Council at this stage to secure the fullest measure of agreement between the scheme and the wider regional arrangements proposed by the Council. The Joint Hospitals Board will then submit their scheme to the Secretary of State who will consult the Regional Hospitals Advisory Council to obtain their final views before deciding to approve or amend the scheme.

As will be seen, these Joint Hospitals Boards will also be charged with responsibility for the administration of certain clinic services, such as the tuberculosis dispensaries, which can be regarded as essentially a part of the hospital service.

Administration of the clinic services.

The arrangements proposed for the clinic services in England and Wales will be modified in their application to Scotland. This is necessary because, unlike the new joint authorities to be set up in England and Wales, the Joint Hospitals Boards in Scotland will not have planning functions outside the hospital service. In these circumstances the following arrangements will apply.

Responsibility for the administration of the school health service with its numerous clinics will remain with the education authorities, namely, the county councils and the town councils of Edinburgh, Glasgow, Aberdeen and Dundee, but these authorities will be expected to use the treatment services provided under the new scheme.

Normally the ordinary local clinics such as those for the maternity and child welfare service, including ante-natal clinics, for the venereal disease service and for scabies will remain with the existing major health authorities, namely, the county councils and the town councils of the large burghs which correspond in Scotland to the county and county borough councils in England and Wales. These authorities will normally retain responsibility for the midwifery and health visitor services. On the other hand, there are certain clinic services which are more nearly allied to the hospital service than to a clinic service. The most notable examples of this category are the tuberculosis dispensaries and cancer clinics. The administration of these "out-post" clinics will be entrusted to the new Joint Hospitals Boards as being ancillary to their main function of hospital administration.

No further change of general scope will be undertaken with regard to the clinic service. As recommended by the Committee on Scottish Health Services, however, it is proposed to strengthen the powers of the Secretary of State to require major health authorities, after a public local inquiry has been held, to combine for any purpose where this is proved necessary for the efficiency of the new health service as a whole. In this way it will be possible to leave essentially local clinic services with the major health authorities while securing an adequate safeguard that, should the need arise in the public interest for a combination of local authorities in any area for any specific purpose, effective machinery will be available for the purpose.

The responsibility for any new clinic services will be determined by their particular function: if they are purely local services they will be entrusted to the existing major health authorities, while if they are allied to the hospital service they will probably be entrusted to the Joint Hospitals Boards.

Administration of the general practitioner service.

There will be a difference between the two countries so far as the provision, equipment and maintenance of Health Centres are concerned. In England and Wales this responsibility will rest normally with the county or county borough councils. In Scotland, however, the smaller size of the problem, the geography and the distribution of population suggest that the whole country can more conveniently be regarded as one area for this purpose, and the Centres—where they are decided upon—can be provided by the Department of Health itself, at least in the initial and experimental years. Having in view the nature of the local organisation of the health service generally, which is proposed for Scotland, it seems desirable that the provision, equipment and maintenance of Health Centres should be administered centrally in the general practitioner service. The Secretary of State will be empowered, however, to delegate any of his functions with regard to the provision of Health Centres to a local authority where he thinks this to be desirable.

Local Medical Services Committees.

The local organisation already described will secure effective liaison between the hospital and consultant services on the one hand and the local authority clinic services on the other. There remains the general practitioner service. For the purpose of linking that service with all the other parts of the new service as a whole, there will be set up, over the same areas as those of the Joint Hospitals Boards, new advisory bodies to be known as Local Medical Services Committees.

These will be to some extent similar to the Local Health Services Councils proposed for England and Wales, but with differences of function and of organisation to suit the different local arrangements in the two countries. They will be primarily advisory bodies, but because of the vital role which they will play in linking up the various branches of the health service in their areas they will need to include not only professional but local authority representatives.

The Local Medical Services Committees will consist of representatives of all the local health authorities in the area, of the local medical, dental, pharmaceutical and nursing professions, and of other interests closely concerned with the health services. The Committees will be able to appoint such subcommittees, professional or general, as they find desirable.

The primary function of these Committees and of their professional subcommittees will be to advise the Secretary of State on any questions affecting the local administration of the general practitioner service and its relationship to the other health services. As, for reasons given, the Joint Hospitals Boards will be concerned with hospital and consultant services only and not with the health services as a whole, the Secretary of State will look to these Committees—so far as the general practitioner service is concerned—for information and advice on the sufficiency and distribution of doctors in any area, the need for Health Centres, and other relevant matters.

The Committees will also provide a suitable means of liaison between the general practitioner service and the local clinic and hospital and consultant services being carried on in their areas by the local authorities and the Joint Hospitals Boards. For example they will be able to advise the

Secretary of State on methods of effecting the closer liaison between the family doctor, the child welfare clinics and the hospital, as forecast by the Orr Report on Infantile Mortality. They will be there to advise all those authorities as needed, and will be able also to send representatives to sit with the larger Regional Hospitals Advisory Councils to assist—with their right of directly expressing their views to the Secretary of State at any time—in making the liaison complete.

In addition, as the new general practitioner service will no longer require the local Insurance Committees which have operated under the National Health Insurance scheme in the past, no doubt such of the functions of these bodies as do not need in future to be centrally undertaken might be usefully entrusted to the Local Medical Services Committee. But these are matters for later consideration.

VIII.

PAYMENT FOR THE SERVICE.

The cost of the comprehensive health service will mainly fall upon central and local public funds. The ways in which it might be shared between the exchequer and the local rates, and other financial aspects of the service generally, are considered in the Financial Memorandum appended (Appendix E).

So far as individual members of the public are concerned, they will be able to obtain medical advice and treatment of every kind entirely without charge except for the cost of certain appliances. They will be paying for medical care in a new way, not by private fee but partly by an insurance contribution under whatever social insurance scheme is in operation and partly by the ordinary process of central and local taxation. The position in regard to disability benefits, for those ill at home and for those in hospital, will be dealt with in the Government's later proposals on social insurance.

Hospitals in the scheme will, as explained, receive from central funds payments which will include their share of the money representing the social insurance contributions of the public, so far as this is attributable to hospital services. This share can be payable on a bed-unit basis, according to the number of beds put into the service by each hospital under each area plan—except that the share of the voluntary hospitals can, if they wish, be pooled and redistributed in the manner earlier mentioned.

The voluntary hospitals will receive in addition fixed service payments from the new joint authority in respect of all services which they render to the scheme. For the rest, they will meet the costs of their participation in the service out of their normal resources, including charitable subscriptions and donations, on which their voluntary status depends. The position of medical teaching will be specially considered.

The joint authorities will receive from central funds the bed-unit payments which include their share of the social insurance contributions attributable to hospital services. Otherwise their expenses in the service—including their service-payments to voluntary hospitals—will be met partly out of rate resources and partly out of central funds. For their rate revenues the joint authorities will depend upon precept upon the counties and county boroughs included in each joint area. The county and county borough councils will receive Exchequer aid towards the cost of meeting these precepts and their own expenses in the service.

IX.

GENERAL SUMMARY.

It may be convenient, at this point, to summarise the proposals of this Paper in outline:—

1. **Objects in view.**

(1) To ensure that everybody in the country—irrespective of means, age, sex, or occupation—shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.

(2) To provide, therefore, for all who want it, a comprehensive service covering every branch of medical and allied activity, from the care of minor ailments to major medicine and surgery; to include the care of mental as well as physical health, and all specialist services, e.g. for tuberculosis, cancer, infectious diseases, maternity, fracture and orthopaedic treatment, and others; to include all normal general services, e.g. the family doctor, midwife and nurse, the care of the teeth and of the eyes, the day-to-day care of the child; and to include all necessary drugs and medicines and a wide range of appliances

(3) To divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge (apart from certain possible charges in respect of appliances) and to encourage a new attitude to health—the easier obtaining of advice early, the promotion of good health rather than only the treatment of bad.

2. **General principles to be observed.**

(1) Freedom for people to use or not to use these facilities at their own wish; no compulsion into the new service, either for patient or for doctor; no interference with the making of private arrangements at private cost, if anyone still prefers to do so.

(2) Freedom for people to choose their own medical advisers under the new arrangements as much as they do now; and to continue with their present advisers, if they wish, when the latter take part in the new arrangements.

(3) Freedom for the doctor to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference.

(4) The personal doctor-patient relationship to be preserved, and the whole service founded on the "family doctor" idea.

(5) These principles to be combined with the degree and kind of public organisation needed to see that the service is properly provided—e.g. to ensure better distribution of resources and to give scope to new methods, such as group practice in Health Centres.

3. **General method of organising the service.**

(1) The maximum use of good existing facilities and experience; no unnecessary uprooting of established services, but the welding together of what is there already, adapting it and adding to it and incorporating it in the larger organisation.

(2) The basis to be the creation of a new public responsibility; to make it in future somebody's clear duty to see that all medical facilities are available to all people; the placing of this duty on an organisation answerable to the public in the democratic way, while enjoying the fullest expert and professional guidance.