Britain's National Health Service

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A MINOR social revolution was effected in Great Britain on 5 July, 1948, by the coming into force of four Acts of Parliament which had been passed during the preceeding two years.

The National Insurance (Industrial Iniuries) Act makes radical changes in the fifty-year-old method of compensating employed persons who have sustained injury (which includes certain industrial diseases) during the course of their work. *The National Insurance Act* provides benefit by right of contribution to all members of the community in respect of unemployment, sickness, retirement from work, widowhood, orphanhood, maternity, and death. *The National Assistance Act* (which abolished the Poor Law) meets the financial needs of the small minority who for various reasons may not be entitled to benefit under the preceding Act and those for whom benefit may be inadequate for particular reasons. This Act requires the major local authorities to provide various welfare services—for example, residential accommodation for those in need of care and attention. *The National Health Service Act* offers comprehensive medical care without charge to all who like to avail themselves of it.

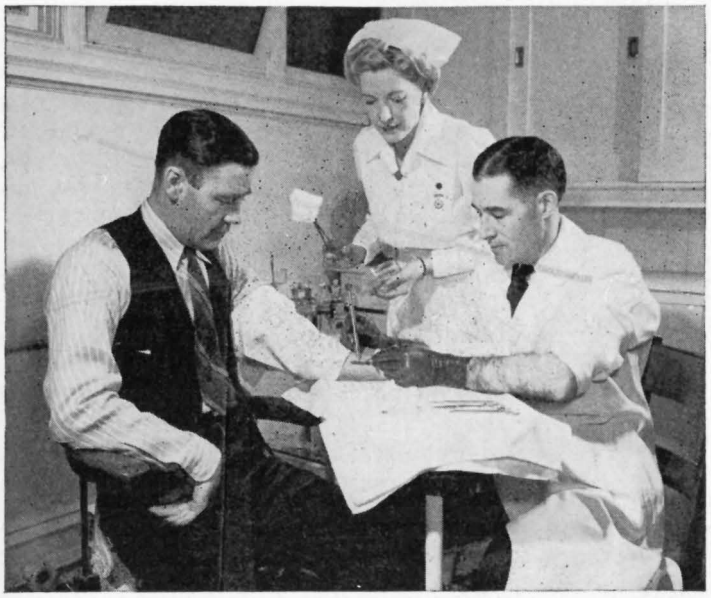
It is commonly declared by members of the Government and, indeed, said in general that these Acts, together with the Family Allowances Act which came into operation in 1945, have, in combination, provided social security. This however, is an exaggeration. The amounts of benefit are considerably below even a relatively low wage. Loss of earnings or other sources of income through unemployment, sickness, or old age actually means, in the absence of other resources, a fall in the normal standard of living—a fall which becomes more serious as the gap between normal income and a fixed benefit increases. Rates of benefit, nevertheless, are more generous than under the earlier measures, and the quite unjustifiable differences in the rates according to the various causes of need have been removed. Coverage has been extended not only to all employed persons, but also to the whole adult population. There is now a minimum below which the great majority is guaranteed, by the right of contribution, that they shall not fall, whatever the occasion of their need.

National Health Service Act

The National Health Service Act makes some contribution, although indirect, to a greater degree of economic security. It elimates the necessity for expenditures on securing medical attention, which has been burdensome for some persons outside the scope of the national health insurance scheme and, in certain circumstances, for dependents of those who were included.

The Act may be expected to contribute in other ways. Clearly it will be of material advantage to both employed and self-employed persons that the incidence and the length of illness shall be reduced, since, as noted previously, sickness benefit is substantially lower than normal income. Reduction of the total of benefit payments, consequent upon a reduction of illness, could result either in the rate of contribution being lowered, or the rate of benefit being raised or the taxpayer's share of the total cost being diminished. A healthy working population should mean increased productivity and a higher national income, of which expenditure on the national insurance scheme would be a proportionately smaller part.

Negotiations between the British Medical Association and the Minister of Health, Mr. Aneurin Bevan, extended over a period of several months before the Act came into force. These were conducted on the part of the Association with a good deal of bitterness and by threats not to take part in the Service. There was little public approval of this recalcitrant attitude. And apart from general accusations that the Minister had been unbending and guilty of dis-



Health services for workers are recognized as an essential part of modern industrial life. While they provide first aid to the injured and sick, these services are for the most part consultative, preventative and educational.

DBS

courtesy, the opposition in Parliament, gave only small support to the doctors, for the proposals of the National (wartime coalition) Government for a new health service had been broadly on similar lines. Some of the hostility expressed by influential sections of the profession was clearly political, since objection was taken in some cases to proposals which the profession itself had previously advanced in general terms.

There were, however, four specific issues in dispute between the British Medical Association and the Minister of Health. The first concerned the right of appeal by a doctor against the removal of his name from the list of practitioners in the public service. On this the Minister refused to yield. Thus, the Act prescribes that appeal from a decision of the special Tribunal is to the Minister of Health, and not to a court.

The Association, in the second place, objected to what it called "direction" of doctors to areas in which to practise. With the objective of distributing general practitioners more evenly throughout the country, such direction as take place will, however, be of a negative character. A doctor's application to be included in a local list must be submitted to the Medical Practices Committee, which is appointed by the Minister. An application may be refused on the grounds that the area is already adequately served. Since seven of the Committee's nine members are doctors the Minister took the view (from which he would not be moved) that a doctor's application was more likely to be granted than refused.

A further cause of complaint was the proposed prohibition of the sale of wholly or partly public practices. Apart from what many people feel to be the impropriety of buying and selling patients, it was considered that negative decisions on transfer applications would result in hardship for many doctors. Thus, if the Medical Practices Committee refused to allow an applicant to take over an established practice, then the retiring doctor would be unfairly placed as against a colleague who could sell his practice because an application to con-

tinue it was allowed. The Act therefore prohibits the sale of public practices altogether, but provides such generous compensation for loss of the right of sale (over £56 million for England and Wales) that opposition was allowed to drop.

By far the most serious ground for hostility was the method of payment for general practitioners in the public service. The Minister had proposed that payment should be partly by the relatively small fixed amount of £300 per annum amd mainly by capitation fee of the order of eighteen shillings per annum. The British Medical Association objected to the fixed payment: in their view it was acceptance of the principle of a salaried service and foreshadowed transformation of doctors into civil servants if and when such a service were introduced. To meet this fear, Mr. Bevan undertook to introduce an amending Bill to make make it impossible to bring in a full time salaried service without legislation. He also asked the doctors to agree to accept the £300 fixed payment for an initial three years, after which any doctor would have the right to forgo it and to receive a higher capitation fee.

As a result of these concessions, the Council of the BMA recommended to its members that service in the new scheme be accepted. A sufficient majority in the referendum supported this recommendation and the new service therefore came into being without the "revolt" which earlier had been confidently prophesied. Certain objections by the dentists had also threatened the possibility that relatively few of them would enter the service, but fortunately these difficulities too were overcome. As a result, more than 18,000 doctors out of 21,000, and nearly 9,000 dentists out of 10,000 are now cooperating in the National Health Service Plan for England and Wales.

The Plan in Operation

Between the passing of the Act at the end of 1946 and its coming into force in July, 1948, preparatory work on a vast scale was required to provide for administration of the program throughout England and Wales. The country was divided into fourteen Hospital Regions, for each of which a Board was appointed. Over 2,500 hospitals, with 388,000 beds, were taken over. Staff numbering more than a quarter of a million was transferred to the new bodies created to administer certain parts of the service. Nearly 1,200 schemes for re-organization and extension of their powers and duties were submitted by local health authorities (county and county borough councils) for consideration and approval by the Minister. *Today, more than* 40 *million people* (*about* 90 *per cent of the population*) *are registered under the plan through doctors' lists.*

For many reasons, a fully satisfactory health service is not possible of achievement for some time—how long will depend to a large extent upon government policy. All that has happened in fact so far relates to the over-all picture. Thus, there has been a considerable measure of integration of agencies which previously functioned separately and with little co-ordination; as a result, better use can now be made of existing resources. Similarly, the financial burden which stood between many people and their need for medical care has been removed. These are material advantages, to be sure. But there are very serious inadequacies of personnel, buildings and equipment, which cannot in any case be remedied immediately.

Although more than 36,000 hospitals and clinics are included in the scheme, there is a serious shortage of accommodation. Health Centres constitute one of the most important elements of the Plan, but by order of the Minister con-

Public health programs to-day make use of modern educational techniques in the battle against disease. In Canada, the National Film Board has produced a number of special films for the Department of National Health and Welfare. DBS

struction has been postponed in almost every instance. Lack of labour and materials is advanced as the reason for not building hospitals and Health Centres. While economic conditions are admittedly difficult, not everyone is satisfied that more could not be done to divert both labour and materials from less essential building and other employment.

The number of general practitioners, specialists and dentists falls far below what is needed, while the shortage of nurses is so great that many hospitals wards have had to be closed. An increase in doctors and dentists depend upon making it possible for a much larger number to be trained and, since the universities are now full to overflowing, a considerable expansion of training facilities is essential. The nursing shortage is the least difficult problem; its solution is to make pay and conditions of service sufficiently attractive so as to promote a flow of recruits.

The provision of free medical care has disclosed very clearly the extent to which people had to go without needed attention hitherto. Many general practitioners complain that they have more patients than they can properly deal with. While no doubt some merely attend a doctor because there is no charge, there are a great many who previously could not afford to pay a fee. The difficulties of the doctors are aggravated because of the insufficiency of hospital beds. Patients who should

be admitted into hospita have to be treated in their homes.

Opticians have scarcely been able to cope with the demand for spectacles. In the first twelve months of the Plan's operation, about 4,500,000 prescriptions for glasses were handled by ophthalmic services. This is evidence of the large number of people who formerly went without glasses because they were unable to pay for them, or who bought them at cheap stores or made shift with those discarded by others.

The situation in regard to dental service is similar. To July, 1949, dental treatments outside of hospitals totalled 6,800,000. Since most people tend to avoid the attentions of the dentist rather than otherwise, there is small reason to think that many of this large number were simply intent on getting something for nothing.

Finance and Organization

While some doctors protest that they are greatly overworked, others say that thay have insufficient patients to be able to make a living. The maximum number of "public" patients allowed to a doctor is 4,000, which yields an annual income in the region of £3,000. It has been reported in the daily press that in Kent the average number of patients per doctor is only 1,600, bringing an average income of £1,500 for five-sixths of the doctors there. The position is said to be similar in Middlesex and Surrey. These are southern counties in the neighbourhood of London, in which the number of private patients (many of them in the higher income ranges) was no doubt formerly high and, in consequence, allowed for practices which, though not large, were reasonably lucrative. Since most of these private patients have now elected to be treated without charge, the income from capitation fees is less than that previously obtained by individual payments. In such areas there is a demand that the capitation fee should be considerably increased. The position, however, seems clear proof that the number of doctors in certain districts is unnecessarily large. The remedy is to transfer some of them to those parts of the country (generally the industrial districts) which are now under-doctored. Rural and semi-rural areas present a particular difficulty: thinly-spread populations make it impossible for a doctor to have a reasonably large list of patients and thus to secure a satisfactory income at the normal rate of capitation fee. The Minister has agreed in such cases to make payments from the special inducement fund and to grant a higher motor-car mileage payment.

The rush for dental treatment has caused considerable concern to the Minister of Health, since the resulting expenditure has been far in excess of what was expected. The original estimated cost for the first nine months (July, 1948, to March, 1949) was £7 million. Provisional figures on the actual cost cost during that period indicate an outlay of £19 million, a total which does not include payment for uncompleted work. The British Dental Association considers that the cost in the first full year will be in the neighbourhood of £28 million. The scale of payments to dentists, on recommendations of the Spens Committee, aimed at providing a gross income of £3,800 for a 33-hour week working at the chair. Actually many dentists have been working far longer than this and receiving well over £4,000. There is the danger that excessive hours on over speedy work may mean inefficient dentistry. The Minister has therefore decided, as a preventive measure, that all earnings above £4,800 shall be cut by half, though this will reduce the number of patients receiving treatment. One unfortunate and apparently unforeseen consequence of the high earnings of dentists has been a steady efflux from the full-time school dental service to much more lucrative employment out-

The National Health Service in England and Wales

Estimate of Cost, 1948-49 and 1949-50

The Civil Estimates for 1949-50, presented to the House of Commons at Westminister on 23 March, 1949, included provisional figures for the actual cost of the National Health Service in England and Wales through the first nine months of operation (July, 1948—March, 1949), together with estimates of the cost in the twelve months of the financial year from April, 1949, to March, 1950. Details of these estimates are given below.

	1948-49 Provisional Cost for 9 months £'000		1949-50 Estimated Cost for 12 months £'000	
Hospital, specialist and ancillary services		129,597.5		177,531.0
Services provided by Local Health Authorities		9,283.0		14,025.0
General services—				
Administration, Executive Councils	1,606.0		2,029.0	
General medical services	29,800.0		40,400.0	
Pharmaceutical services	16,225.0		19,000.0	
General dental services	19,000.0		28,204.0	
Supplementary ophthalmic services	13,500.0		12,420.0	
Other expenses	190.5		339.6	
		80,321.5		102,392.6
Other services—				
Compensation for loss of right to sell medical practices	4,250.0		7,250.0	
Superannuation	1,360.0		1,955.0	
Central purchase of medical supplies, etc.	3,500.0		7,000.0	
Liabilities transferred to the Minister of Health	18,605.0		1,858.0	
Other expenses	669.5		642.0	
		28,384.5		18,705.0
Central Council		10.0		16.0
TOTAL		247,596.5		312,669.6
Less sundry receipts		38,165.4		48,045.0
Expenditure from public funds by Health Departments—				
Contribution from National Insurance Fund	24,000.0		36,200.0	
Net cost to heneral funds of Central Government	185,431.1		228,424.6	
		209,431.1		264,624.6
Net cost (approximate) borne by Local Authorities from rates		9,283.0		14,025.0
Total cost (approximate) to public funds		218,714.1		278,649.6

From United Kingdom Information Office, Ottawa.

side. At the end of 1948, about six months after the scheme had been put into effect, it was reported that over a quarter of London County Council's school dentists had already resigned.

The cost of the service has greatly exceeded the original estimates. Provisional figures on expenditures by the central government from general funds indicate an outlay of about £185.4 million, for the period from 1 July, 1949. to 31 March, 1949, as compared with the preliminary estimate of £132.4 million. In addition, £24 million was contributed from the National Insurance Fund, and local authorities expended over £9 million (net) from their own resources. While several million pounds of the total is non-recurring expenditure, and while there is likely to be a sharp fall in the cost of dental services (since dentures once obtained last for years) it is certain that the earlier estimate of £152 million per annum for the program must be considerably revised.

It was inevitable that difficulties of various kinds would arise as a scheme of so comprehensive a character came into operation. It may be fair criticism to say that some are the result of failure to appreciate that they might arise. Generally speaking, nevertheless, within the limits of existing circumstances and resources, the transition from the old to the new has been remarkably smooth, and many people have already had reason to be grateful. For many patients who have to undergo operative treatment, or to be equipped with expensive appliances, or to go into hospital to have their babies, it is still difficult to realize that no enquiry is going to be made about their ability to pay and that no account for payment will be presented.

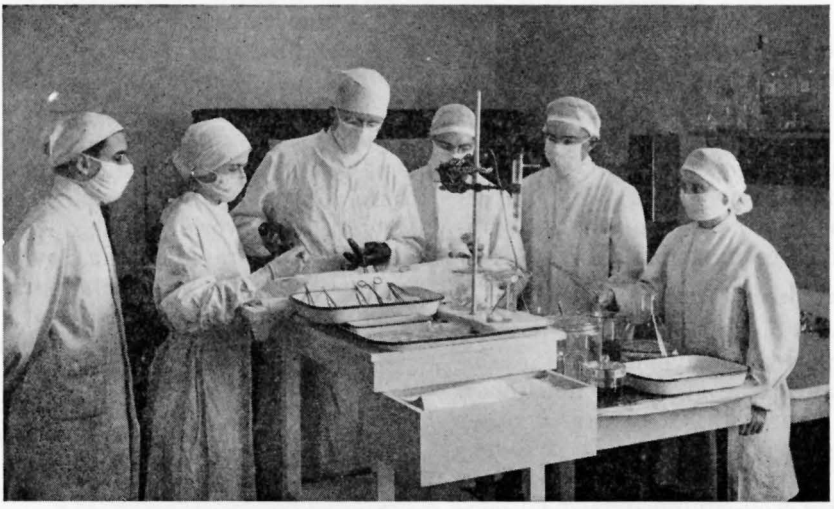
There is however, considerable concern about the way in which the health service is organized. The previous multiplicity of unco-ordinated agencies that provided medical care has been swept away and replaced by a structure divided into three compartments, under the general control of the Minister of Health. Yet this division of responsibility for hospital and specialist services, local services such as clinics and home nursing, and general practitioner services involves problems of co-ordination which are not only difficult but in the opinion of many, are unnecessary. The creation of suitable administrative areas would have made possible an integrated service in each area—an objective of prime importance when not merely irritating delays and difficulties of fixing responsibility for action or inaction are concerned, but human health and human lives.

The area suitable for the provision of satisfactory hospital services is, unfortunately, far larger than the area of practically all the Local Authorities. Fourteen *ad hoc* regions were therefore created for the purpose. These were unnecessarily large for the organization of clinic and visiting services, which accordingly remained with the counties and county boroughs. In each of the latter districts, an Executive Council was also set up in connection with the general practitioner services. A patient may in consequence be the concern of three entirely separate bodies.

Difficulties of co-ordination may be exaggerated, and certainly the larger the scale of the administrative unit the greater become the complications of internal organization. But the provision of medical care in all its forms is a single function which should have been discharged by a single responsible authority in each region and not divided among three, however careful the attempts to secure co-ordination.

The creation of Regional Hospital Boards has marked another stage in the steady loss of powers for the Local Authorities. Their hospitals, as well as those operated by voluntary organizations, were transferred (together with certain special services) to the Boards, which were not elected, even indirectly,

but appointed by the Minister and made responsible to him. The day-to-day administration of each hospital or group of hospitals is in the hands of a Hospital Management Committee, appointed by the Regional Board. The public has thus virtually no control over the hospitals, or any real remedy against neglect, indifference or wrongful practices.



This inroad into local democracy has added force to the argument of those advocating a long-overdue reform of the structure of local government. A structure which has remained unaltered for over half a century is little likely to be able to cope with new demands and changing circumstances. Many services now require administrative areas larger than those of most Local Authorities, and the creation of some form of Regional Authority to undertake these services is urgently necessary. Without such a reform, other locally-provided and locally-controlled services may go the way of gas, electricity, public assistance and hospitals. And new functions which also should be under popular control will be handed to specially established, non-representative bodies. Should some form of regional local governmemt be introduced, there is every reason for the dissolution of the Hospital Boards and Hospital Management Committees as now constituted and the transfer of their powers and duties to popularly-elected agencies.