CABINET.

PROPOSALS FOR A NATIONAL HEALTH SERVICE.

MEMORANDUM BY THE MINISTER OF HEALTH.

1. I submit my general proposals for a National Health Service. I should like to be authorised to prepare a Bill on the lines of these proposals now, so as to come back to my colleagues with it as early as possible in the new year. I do not seek detailed decisions until then. But I need a decision now as to whether this is the broad shape which the Bill should take.

2. When my proposals for the hospital part of the service were approved in principle by the Cabinet on the 18th October [C.M. (45) 43rd meeting] some further details were asked for, particularly as to the new regional and local administration. These are included in the present paper. Misgivings among some of my colleagues attached to the effect of my proposals on local government and—more generally—to the risk of losing from the health service the benefits of local interest and local knowledge in day-to-day administration. I am alive to the importance of both points.

3. I have reviewed, not only the hospital service, but the health service as a whole, in the light of the views expressed at the Cabinet meeting. It is only by seeing the new service as a whole that we can judge the right shape for its parts.

4. As I see it, the undertaking to provide all people with all kinds of health care, using virtually the whole of the medical and other health professions to do it, creates an entirely new situation and calls for something bolder than a mere extension and adaptation of existing services. Here is an opportunity, which may not recur for years, for a thorough overhaul and reconstruction of the country's health position. I see in this reconstruction a proper place both for local and for central government, as the complementary instruments of the public who will be paying for this service through insurance contributions and taxes to the exchequer and through local rates. In a fully modernised service there will be some things which the State can do better than local authorities, and some things which local authorities can do better than the State. There is also, in my view, both room and need for giving a voice, in the guiding and providing of the service, to those professional people who will in future be almost wholly absorbed in it and on whom its success will depend. This will involve in some cases—as in the provision for a family doctor service—new forms of executive machinery, in which the representatives of the potential patients and those of the professional people undertaking their care can combine.

5. I set out my proposals in the appended statement, as shortly as the range of the subject allows. I believe that they will achieve a sensible—although new—distribution of responsibility between local and central government, that they will preserve proper decentralisation (in functions which central government assumes) so as to keep up a healthy local interest in administration, and that they will give a useful and reasonable share in future to professional people in helping to steer the service along the right lines.

[31041]
6. To keep the proposals as short as possible, I have omitted argument. There is much general matter in the original White Paper with which I agree—in particular with the scope of the service to be provided, with the conception of the Health Centre as the new feature of general medical practice, with the importance of rationalising the hospital services for the first time, with the need to take the present bite and pieces of the health services as they have historically emerged and to recast them into a coherent single new service, and generally with the objective of a universal and free service. On method, however, I often disagree; hence these amended proposals.

7. All of this is concerned only with the general treatment services. It has to be backed by a review, as we go on, of the environmental provision for health—in local government and otherwise—and by a vigorous policy of health education. It leaves untouched, for the present, the question of industrial health and hygiene. It will need to be supplemented, next session, with measures for the general care and welfare (other than health treatment) of young children, the aged, the blind and the permanently crippled—all of which must become the responsibility of some new service (and I hope, a local government service) when the present system of Public Assistance is superseded.

8. But the immediate need is to settle the shape of a National Health Service, backing National Insurance, for a Bill this session. If the appended proposals commend themselves to my colleagues, I will prepare the Bill. While I do this, I propose to meet the representative bodies of the local authorities, medical profession and others, for some discussion of the principal points in the Bill. But I do not propose, nor would time allow, to embark upon any long series of negotiations before the Bill is settled. Nor will the Bill itself have to settle all the details; it will provide the general structure, within which many matters will have to be later discussed and negotiated.

Ministry of Health, S.W. 1,
13th December, 1945.

A. B.

APPENDIX.

SUMMARY OF PROPOSALS FOR A NATIONAL HEALTH SERVICE.

1. The Minister as the central authority.

1. General responsibility for the service will rest on the Minister of Health. This will extend to mental, as well as physical, health services—the administrative functions of the Board of Control in mental health being absorbed by the Minister, and the Board exercising only the quasi-judicial functions relating to the liberty of the subject under the lunacy and mental deficiency Acts.

2. The Minister will discharge his general responsibility through three main channels:

(1) For parts of the service best organised nationally—the hospital and specialist services—he will assume direct responsibility; but he will delegate the bulk of administration to new regional and local bodies, acting on his behalf and designed to give scope to people with local experience and knowledge to serve on them.

(2) For parts of the service best organised locally—a wide variety of domiciliary and clinic services—direct responsibility will rest on local government, acting in its ordinary relationship with the Minister; this responsibility will be unified in the present major authorities, the county and county borough councils.

(3) For new family practitioner services—doctor and dentist—new local executive machinery will be set up, composed partly of members drawn from local authorities, partly of people selected by the Minister, partly of representatives of the doctors and others engaged in the service. These new local bodies will act within national regulations made by the Minister; and by the side of the Minister there will be a special, mainly professional, body to regulate the distribution of general medical practitioners over the country as a whole.
New central advisory machinery.

3. To provide the Minister with expert advice, in the technical planning and conduct of the service, there will be a new Central Health Services Council. This will be a statutory advisory body drawing members from all the main health professions—doctors, dentists, nurses, midwives, pharmacists—and from other fields of relevant technical experience, such as local government and hospital management. It will be appointed by the Minister after consulting the appropriate organisations.

4. In addition—to free the Council for its general work on the service as a whole—it will have Standing Advisory Committees on special aspects of the service (medical, hospitals, nursing, mental health services &c.). These will be appointed in the same way, after consultation. They will directly advise the Minister, but their advice will be made known to the Central Council as well so that the Council can pick up points on which its collective views may call for adjustment of the sectional advice of a particular committee. The main Council will report each year on its work and that of the committees—a report which the Minister will normally publish, in full, unless there is any reason of public interest for not doing so, when he may withhold it in whole or in part.

II.—Hospital and Specialist Services.

5. This part of the service will cover the following field:—

(a) In-patient care in all types of hospital, including maternity homes, sanatoria, mental hospitals, mental deficiency institutions, convalescent homes and medical rehabilitation centres.

(b) Out-patient care at out-patient departments of hospitals, and at specialist clinics associated with hospitals although not necessarily situated at them; including mental clinics, tuberculosis dispensaries, venereal disease clinics, eye clinics.

(c) A consultant service of all kinds; based on the hospitals, but providing services not only at them but also at the patients’ homes, where necessary, and at Health Centres, clinics, &c.

Taking over the existing hospitals.

6. The ownership of the present public hospitals, voluntary and municipal, will be taken over by the Minister (subject to special arrangements in the case of the teaching hospitals, described later). Provision will be made for the protection of existing officers and servants. No compensation will be payable in respect of buildings, equipment and other assets—including existing funds of the voluntary hospitals. Existing liabilities will be taken over. Where particular hospitals have hitherto been provided by voluntary subscribers for particular classes or groups of patients only, it will be the aim—consistently with the rational planning of the new service—to retain the identity of the special purposes for which these hospitals have previously been supported, e.g., in a separate wing or other identifiable part of the organisation.

Regional Hospitals Boards.

7. The country will be divided into about twenty natural areas or regions for hospital organisation. Each area will be based on one of the eleven university medical teaching centres—the natural focal points of specialist medicine and therefore of hospital services. Two or more areas will sometimes base on the same medical teaching centre, to avoid the areas becoming too big for practical organisation.

8. For each area or region there will be set up a Regional Hospitals Board of some 20–30 members, appointed by the Minister and drawn from the major local authorities in the area, from local people selected by the Minister for their general suitability for the work involved (some of whom may be ex-voluntary hospital experts), and from people representing the university teaching centre and specialist and general medicine in the area. Principal officers of the Boards will be appointed by the Boards subject to the approval of the Minister.

9. Each Regional Board will be required to appoint, subject to the Minister’s approval, a number of smaller Local Hospital Management Committees. There will be one of these committees for each local group of hospitals which together
form a natural hospital unit in a planned service—i.e., one or more main hospitals, with some outlying smaller "feeder" hospitals, together providing about 1,000 beds under a common specialist staff, and capable of dealing as a group with all the more normal hospital needs of their immediate area. Sometimes a large hospital not needing to be so grouped—e.g., a mental hospital—will have one of those committees to itself. All the committees will be essentially local executive bodies, although their field of operation cannot be restricted to existing local government boundaries. Their members will be drawn from the local authorities of the areas served by the hospitals after consultation with those local authorities, and from other local people selected by the Regional Boards (including, where desirable, people of local voluntary hospital experience), together with some professional members.

10. The Minister will determine with each Regional Board the best reorganisation of all available hospital and specialist resources in their region, and will supplement those resources as and where necessary, as soon as this can be done. Owning the hospitals, he will entrust their administration to the Regional Boards. The Boards will settle with the Minister each year a budget of normal expenditure, and within that budget will be given as much independence as possible; abnormal, or excess, expenditure will be under more detailed control. The Boards will make all consultant and specialist appointments in the hospitals—regional advisory panels of experts being set up to advise on the professional suitability of candidates.

11. The day-to-day work of running the hospitals will then be entrusted by the Boards to the Local Management Committees. These will be the effective managers on the spot, appointing all ordinary staff of the hospitals, dealing with supplies, handling ordinary running and minor capital expenditure, and generally acting as the "governing bodies." In mental hospitals they will take the place of the present Visiting Committees. The principal officer of each Committee will be appointed by the Committee with the approval of the Regional Board, and will act also as the chief administrative officer of each hospital covered by the Committee.

Special Provision for Teaching Hospitals.

12. Special provision will be made in relation to hospitals providing the bases for the clinical teaching of medical students. They will be taken over by the Minister like other hospitals, and play their part in the national service; but they will be given the special status and measure of independence necessary to enable them to take their proper place as academic institutions standing in close association with the universities whose educational needs they must be organised to meet. Universities must be enabled to exercise an effective influence on the policy and activities of teaching hospitals. Essential features of the organisation of a teaching hospital emphasised by the Goodenough Committee are a governing body which is personal to the hospital and has wide discretion as to expenditure within a reasonable budget; representation of the university and of the teaching staff on that governing body; and selection of medical staff (other than holders of university posts) by a special advisory committee, representative of the governing body of the hospital and of the university.

With these objects in mind it is proposed that the hospitals which are from time to time regarded by the universities and the Minister as providing the main facilities for undergraduate or post-graduate clinical teaching and research shall be differentiated from other hospitals in the following manner:

1. Instead of being entrusted to the ordinary Regional Boards and local management committees described above, the teaching hospital (in some instances the main and associated hospitals which together constitute the teaching centre) will have its own specially constituted Board of Governors.

2. The Board of Governors will, as recommended by the Goodenough Committee, include reasonable representation of the university and of the teaching staff. In addition, it will have members nominated by the Regional Hospitals Board and by the Minister (some of whom will be drawn from the present governing bodies).

3. The teaching hospital will have a separate annual budget approved by the Minister, and within that budget the Governors will have the fullest discretion in expenditure (subject always to observance of any nationally agreed terms of service and remuneration). They can
also be allowed to retain various endowments in their possession. Further, the Governors will receive additional funds from university sources, and will be at liberty to accept them from private sources for experimental work and innovations in organisation.

4. The Governors will have full freedom to appoint their own staff, and in making medical staff appointments will be advised by a special selection committee constituted in the light of the Goodenough Committee recommendations.

13. In London one additional reform is necessary if these proposals for the development and improvement of medical education are to take full effect—namely, the incorporation of the medical schools (as distinct from the teaching hospitals used by the schools) as separate legal entities. At present ten of the twelve London medical schools are legally merely creatures of the teaching hospitals, and ultimate power and responsibility for their conduct lies with the governing body of the hospital. The Goodenough Committee strongly recommended the ending of this historical anomaly and the granting of legal independence to the schools by omnibus legislation. The reorganisation of the teaching hospitals proposed above makes this reform essential, and it is therefore intended to include in the Bill provision for the incorporation of the London medical schools.

III.—Local Clinic, Domiciliary and Welfare Services.

14. This part of the service will be the direct function of local government of the county and county borough councils—and will include:

(a) School medical services.
(b) Maternity and child welfare (in co-operation with the hospital service on the specialist side).
(c) Domiciliary midwifery.
(d) Health visiting.
(e) Home nursing services.
(f) Home help services for households in time of sickness.
(g) Vaccination and immunisation services.
(h) Various forms of care and after-care for the sick and those recovering from sickness.
(i) A general ambulance service.
(j) The provision and maintenance of Health Centres, Dental Centres, and similar local premises as bases for the Family Practitioner service (to be described later).
(k) Ascertainment of mental cases.

15. There is no need to describe the administrative machinery for these services; it will be the familiar machinery of local government. The general nature of the services is outlined below. It is proposed that all local authority expenditure on these services should be assisted by an average 50 per cent. Exchequer grant, appropriately weighted to fit the needs of the different areas. Also—so as to ensure the related planning of the health service as a whole—the local authorities will need to obtain Ministerial approval to the general content of the services which they provide (just as they do now in Maternity and Child Welfare and in the School Medical Service; in the case of the School Medical Service the approval will continue to be that of the Minister of Education).

(a) School Medical Service.

16. This is already provided for in the Education Act, 1944. The ultimate object must be to make unnecessary the provision of medical treatment by the school services as such—medical inspection, the supervision of the health of the child in the school itself, the conduct of special investigations, and the guidance and persuasion of parents, remaining with them. For some time, however, much of the special school treatment provision—particularly dentistry—will need to continue, until the stage is reached at which it duplicates, and does not supplement, the general health provision. The school service is already in the same hands as is proposed for the other local services below—the counties and county boroughs.
Maternity and child welfare.

17. The care of normal maternity and child welfare—pre-natal and post-natal clinics, child clinics, confinements in the home, &c.—will be the responsibility of the local authorities. But present powers will be converted into a duty, and will be concentrated in the counties and county boroughs.

18. The specialist and institutional aspects of maternity will be in the care of the hospital and specialist service, organised regionally in the manner already proposed. Also, for continuity of case treatment, the hospital service must itself be able to provide pre-natal clinics for cases destined for confinement in the hospitals rather than in their own homes. In approving local authorities’ arrangements the Minister will satisfy himself that these provide for the early detection and reference to the specialist service of abnormal or complicated cases, and for ease of access to specialist facilities for all cases—for examination and advice.

19. The local authorities’ child welfare functions will be subject to the same kind and degree of delegation—divisional administration within the local authority’s area—as the school medical service, so that the care of the children under five at school and not at school can run closely in parallel.

c) Domiciliary midwifery.

20. As part of their maternity functions the county and county borough councils will be responsible for securing a domiciliary midwifery service for their areas.

21. There are at present voluntary associations which provide a domiciliary midwife service on behalf of some local authorities. Subject to satisfying the Minister that their arrangements will be efficient, the local authorities can still be allowed to provide part or all of their service by contract with such agencies—on terms to be agreed or, failing agreement, settled by the Minister.

d) Health Visiting.

22. Local authorities now provide Health Visiting services under their maternity and child welfare functions, and this will go on. But it will be important to extend the scope of it to include many other types of case to which the Health Visitor’s attention may be drawn by the family doctor service—particularly from the Health Centres. The duties of the county and county borough councils will be enlarged accordingly.

e) Home Nursing.

23. A new duty will be put upon the county and county borough councils to make sufficient provision in their areas for the attendance of properly qualified nurses on people who require nursing in their own homes—usually on the recommendation of the family doctor service. Shortage of nurses will at first limit the scope of this service, but the ultimate object will be to secure that wherever there is genuine need for a nurse in the home, or visiting the home, that nurse will be publicly provided.

24. The same question of the use of voluntary agencies (the present County and District Nursing Associations) will arise, and the local authority can be similarly empowered to contract with such agencies for the provision, in part or in whole, of the service for them—subject to satisfying the Minister that the arrangements will be efficient.

f) Home Helps.

25. Unless this is covered by a general provision, wider than the health services, the county and county borough councils will be empowered to provide domestic help for households which are in need of it through illness.

g) Vaccination and immunisation.

26. The county and county borough councils will be given a new duty to make arrangements, to the Minister’s satisfaction, for anyone in their area to be able to be vaccinated against smallpox or immunised against diphtheria. They will have power to do the same for other diseases, and a duty to do so if the Minister so requires. They will normally do this by arrangements with the general practitioners of the area; but this will be a special arrangement, with
separate remuneration, and not part of the "family doctor's" terms of service; special inducement will be offered, in fact, to encourage development of the practice. The present obsolete law on compulsory vaccination will be repealed.

(h) Care and after-care of the sick.

27. County and county borough councils will be empowered to make such supplementary arrangements (other than cash payments) as the Minister may approve for the better care and welfare of persons suffering from, or having suffered from, sickness or injury. Examples of this would be the after-care of mental patients, the provision of milk and additional nourishment in certain cases, the loan of blankets, and guidance and help in getting suitable living conditions (e.g., in tuberculosis).

(i) Ambulance Services.

28. The county and county borough councils will be given the duty of providing an adequate ambulance service for the use of the inhabitants of their areas, but with provision for the vehicles to undertake all necessary inter-area journeys without regard to boundaries. The hospital service will, no doubt, need itself to provide certain hospital transport, but it will in the main look to arrangements with the local authorities for its ambulance services.

(j) Health Centres.

29. The functions of the local authorities in this connection are dealt with under the Family Practitioner Services below.

(k) Ascertainment of Mental Cases.

30. County and county borough councils will have the duty of making arrangements for the early detection and reference to the hospital and specialist service of mental patients or mental deficients requiring care or treatment under the lunacy and mental deficiency Acts.

IV.—Family Practitioner Services.

31. This part of the service will cover general medical care by a personal, or family, doctor—with necessary medicines, drugs and appliances—to be available to the whole population as from an appointed day. General dental care—with necessary dentures—will be developed as fast as the supply of dentists allows. There will be priority dental provision from the outset, however, for mothers and children. (This priority dentistry will be provided by local authorities through their maternity and child welfare services and school medical service—and it is not affected, therefore, by the following proposals for the more general service.)

32. A principal objective from the outset, in the general medical and general dental services, will be the development of the Health Centre system, equipping the practitioner with publicly provided premises, apparatus and ancillary staff. This system will be developed as fast and as widely as possible. The arrangements for the provision of the Centres and the engagement of the doctors and dentists in them are referred to below.

33. While the Health Centre system is developing, it will be supplemented by arrangements with doctors in separate practice—to join in the service from their own surgeries. This will be so arranged that everyone can be assured of a family doctor from the outset—either in a Health Centre or not. For dentistry, this assurance cannot be given until more practitioners are available, but during the development of the Health Centre system arrangements will be made to supplement it as much as possible by enabling individual dentists to treat patients at the cost of the new service wherever this can be arranged.

Local Executive Committees.

34. There will be a new system of Local Executive Committees for the family practitioner services. There will be a Committee for each county and county borough area, but with power to the Minister to combine two or more areas under one Committee, wherever desirable. Each Committee will have a chairman, appointed by the Minister, and one half of its members will represent the "consumer" interest, the public, while the other half represents the professional
people providing the service—doctors, dentists and chemists. Of the public representatives, two-thirds will be nominated by the Local Authority of the area and the other third by the Minister.

35. The functions of the Local Executive Committee will be:

(a) making all arrangements to secure general practitioner services for their area in accordance with the Act and regulations made under the Act;

(b) entering into the necessary contracts with—and remunerating—the doctors, dentists and chemists taking part in the family practitioner services, both in Health Centres and outside;

(c) providing the necessary disciplinary machinery (through sub-committees or otherwise, as the Act and regulations will prescribe) for the hearing of complaints and disputes between patient and doctor, patient and chemist and so on—with proper appeals to the Minister;

(d) compiling, and making known to the public, lists of the doctors, dentists and others available for their service, in the Health Centres and outside; and generally arranging for the selection of doctors, &c., by the patients and the allocation to doctors of those unable—or unwilling—to make their own selection;

(e) providing regular information as to the situation of the general practitioner services of their area (e.g., of the need for more doctors, or less, to meet local requirements).

Health Centres.

36. The provision and maintenance of Health Centre (including Dental Centre) premises and equipment—and of nursing, secretarial and other ancillary staff—will rest with the county and county borough councils. It can thus be correlated with their provision of child welfare clinics, school clinics, and other activities. To arrange for the use of the Centres by doctors and dentists in the family practitioner services, the local authority will in each case deal with the new Local Executive Committee, which will be contracting with the doctors and dentists for these services generally—and on which the local authority will have substantial representation. The doctors' and dentists' general terms of service covered by national regulations, will cover the terms and conditions governing their use of Health Centres provided by local authorities. The doctors and dentists will thus remain in contract with the Local Executive Committee and be remunerated by it, whether inside or outside the Centres, to secure unity and mobility throughout the family practitioner services.

Remuneration of Doctors.

37. Doctors working in Health Centres, whole-time or part-time, will be paid a basic salary, as part of their public income; the rest of a "sum due" to each of them will be pooled in the Centre and divided among the doctors under something like a partnership agreement. The "sum due" will be calculated on a capitation rate for all patients in the care of the doctors in the Centre, while being distributed among them as above. Doctors working outside the Health Centres (while these are being developed) will similarly be paid a basic part-salary, the rest of their remuneration depending on a capitation rate in respect of patients on their lists.

38. All remuneration of doctors, under either system, will be fixed by national regulations and will have regard to any national standards recommended by the present Spens Committee or any subsequent body set up for the purpose. Scales of remuneration will be so arranged as to admit of extra inducement to practise in less attractive areas (probably by increase in the basic part-salary scales in areas recommended for this purpose by the Central Committee on the Distribution of Practices (below)) and of extra rewards for special qualifications.

Remuneration of Dentists.

39. Dentists, working—whole-time or part-time—in Health Centres or Dental Centres will be remunerated entirely by salary, in proportion to their attendance at the Centre. Supplementary arrangements will be made, while the Centre system is developing, whereby dentists accepting any patient under the public service in their own surgeries can be paid on a scale of fees for approved work done. This scale can provide for payment for minor or urgent work on
claims submitted after the event (to avoid delay for the patient); but for more substantial work, the dentist will submit what he proposes to do for approval by a new small professional body, which will have branch offices about the country.

40. All remuneration of dentists, by salary or under scales of fees, will be fixed by national regulations and will have regard to national standards recommended by a body analogous to the Spens Committee for doctors, or other body set up for the purpose.

Central Committee on the Distribution of Medical Practices.

41. The Minister will set up a new Central Committee, working under the general directions, to supervise the distribution of medical man-power in the family doctor service. The Committee will be small and mainly professional. It will be appointed after consulting the professional organisations, and will be provided with staff and offices by the Minister.

42. Supervision will be exercised by this Committee in the following way:

(a) all doctors wishing to start new practices or to change from one practice to another—wholly or partly in the public service—will normally apply to the Local Executive Committee for the area to which they wish to go;

(b) the Local Executive Committee will inform the Central Committee of the application, of their views on the need for the new practice or replacement and on the suitability of the applicant, and of any other relevant facts; and the Central Committee, in consultation with the Local Executive Committee as necessary, will then decide whether the practice in question is needed—to be started or to be taken over by the newcomer—and, if it is needed, will decide which applicant (if there is more than one) should fill it; they will then give any necessary consents, and the Local Executive Committee will inform applicants accordingly;

(c) this control will apply to all doctors going into an area to staff new Health Centres or to fill vacancies in existing Centres or to take part in the public service—in any degree—from their own surgeries; it need not apply to doctors, already in an area, simply changing from their own surgeries into Health Centre practice, or to doctors taking part in the public service in areas where they are at the outset of the scheme;

(d) questions of reasonable special discretion in cases of sons taking over fathers' practices, relatives joining existing partnerships, &c, can be dealt with under the Minister's power of general direction of the Committee.

Sale and Purchase of Medical Practices, Compensation and Superannuation.

43. This control of distribution will destroy the selling value of practices. Proposals in regard to the compensation of existing practitioners, and for a superannuation scheme for the future, have already been approved by the Cabinet on the 3rd December and need not be repeated here (C.M. (45) 58th meeting).

Drugs, &c.

44. People will be entitled to obtain all necessary drugs, &c, on prescription, either from qualified chemists in their own shops or from dispensaries provided at the Health Centres, as the patient finds convenient.

45. For supply by individual chemists, the Local Executive Committee will have the duty of making arrangements within general regulations of the Minister. Lists will be published of the chemists available, with a right to the Minister to remove any chemist from the list after proper inquiry. Chemists will be paid by the Committee at nationally prescribed rates.

46. For supply in the Health Centres, the local authority providing the Centre will be able to employ such dispensing chemists as are needed, as part of the ordinary staffing of the Centre. Dispensing at the Centre will be designed, where provided, for the convenience of patients—and will, therefore, not amount to a monopoly; the patient must be free to take his prescriptions there to any individual chemist (e.g., nearer his home).
V.—Other Services.

(1) Eye Service.

47. The objective will be the provision of special clinics, as part of the hospital service, at which all will be entitled to eye-testing and the supply of spectacles. These clinics will be staffed by ophthalmologists (i.e., full eye specialists on hospital staffs) and refractionists (i.e., sight-testing opticians). The ophthalmologists will be in charge, but the extent to which they delegate eye-testing to refractionists will be a matter of internal arrangement.

48. Pending the development of this complete clinic service, the clinics will be supplemented on the following lines:—

(a) People needing eye-testing and appliances will be free to go—
   (i) to an ophthalmologist or other medical eye specialist recognised as competent for testing and prescription, and to a dispensing optician for appliances; or
   (ii) to a sight-testing optician recognised as competent for sight-testing and the provision of appliances.

(b) The Local Executive Committees (for the Family, Practitioner Services), reinforced for this purpose by representatives of medical and non-medical sight-testing practitioners, will be made responsible for the preparation and publication of lists of approved practitioners for their areas, for the inspection and supervision of premises, for the payment of nationally prescribed fees, and for the hearing of complaints (with appeal to the Minister).

(2) Public Health Laboratories.

49. A public health pathological laboratory service will be provided on a national basis by the Minister, in the first instance through the agency of the Medical Research Council. The powers of local authorities to provide laboratories will continue. The object of the Minister's service will be to supplement what is done already and to perpetuate the useful developments of the war-time emergency service.

(3) Blood Transfusion.

50. The Minister will be empowered to make national arrangements for obtaining supplies of human blood, for making these available for transfusion and for preparing and supplying blood products.

VI.—Charges for Certain Services.

51. The normal position will be that the whole range of the health service will be available free of charge to all who wish to use it—the cost being met partly from the Exchequer, partly from local rates (with Exchequer subsidy), partly from the produce of national insurance contributions. There will be some parts of the service, however, or supplements to the service, in which some payment by the patient will arise, as follows:—

(a) Home Helps (paragraph 25 above) will need to be the subject of a charge according to the ability of the household to pay.

(b) Certain supplements, like the provision of special foods in maternity and child welfare or the provision of bedding in after-care services, may need to be the subject of charges or part-charges.

(c) Appliances will be supplied free, up to a standard sufficient to restore the fullest possible working capacity and with reasonable amenity. But there will have to be charges for premature renewal (in case of negligence, &c.). Also it must be possible (e.g., in the case of spectacles or dentures) for those who wish to obtain articles of "luxury" standard—i.e., over and above the good and sound article publicly provided—to do so by paying the difference.

(d) In hospital, the free service will provide all that is necessary—to a good and not a minimum standard. But it will be open to people to obtain additional amenities (e.g., private rooms, where those are not medically necessary) by payment of the extra cost involved.

(e) In some hospitals provision will be made (in separate parts of the hospital) to enable any specialist staff engaged only on a part-time basis to see
their private patients there and to admit them to pay-bed accommodation if they so choose; provided that—

(i) this is restricted to specialists serving in the hospital;
(ii) the private patients' fees are within a controlled scale;
(iii) there is no encroachment on necessary general hospital accommodation;
(iv) the whole arrangement is so designed as to further its purposes, which are to prevent the national hospital service driving all private work into a rival nursing home service and to encourage the fuller association of the specialists with their hospitals in all their professional activities.

VII.—Finance of the Service.

52. In 1938-9 the expenditure on the partial services then provided amounted to about £66 million, of which local authority services accounted for £41 million, voluntary hospitals for £11½ million, and medical benefit under national health insurance for £13½ million. The expenditure was met as follows (ignoring the effect of the block grant to local authorities):

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<tbody>
<tr>
<td>National health insurance contributions</td>
<td>11.2</td>
</tr>
<tr>
<td>Taxpayer</td>
<td>3.0</td>
</tr>
<tr>
<td>Ratepayer</td>
<td>40.3</td>
</tr>
<tr>
<td>Voluntary sources</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66.0</strong></td>
</tr>
</tbody>
</table>

53. Only very approximate estimates are possible of the cost to public funds of the comprehensive health service proposed in this paper. It will be much greater because the service is comprehensive instead of partial; because no charges will normally be made to patients; because salaries will be payable to doctors at hospitals; because of the payment of compensation for the abolition of sale and purchase of practices; because of the cost of superannuation schemes; and because of the general rise in salaries and prices. In the early years of the service the annual expenditure might be £145 million, of which hospital and specialist services would account for £87 million, local authority services for £12 million, general practitioner, dental and eye services for £41 million, and compensation and superannuation for £5 million. This expenditure would be met as follows (again ignoring the effect of the block grant):

<table>
<thead>
<tr>
<th>Source of Funds</th>
<th>Amount (£ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National insurance contributions</td>
<td>33.7*</td>
</tr>
<tr>
<td>Ratepayer</td>
<td>6.0</td>
</tr>
<tr>
<td>Taxpayer</td>
<td>103.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145.0</strong></td>
</tr>
</tbody>
</table>

Against this would be offset some saving to the exchequer by reduction in block grant consequent on the reduction in local authority expenditure, and the benefit of the accumulated funds of voluntary hospitals dedicated to hospital purposes.

VIII.—General Position of the Patient, in summary.

54. Under the arrangements described everybody will be entitled to the following health facilities:

(1) A personal or family doctor, of their own choice, working in a publicly provided and equipped Health Centre (or, during the transition period, from his own surgery), and undertaking the whole care of the patient in his home or at the Centre, as the case may require, together with all necessary drugs, &c.

* This assumes that the contribution for health services is not reduced as proposed by the Minister of National Insurance in C.P. (45) 315, paragraph 18.
(2) Through the family doctor, a full range of hospital, sanatorium, convalescent and rehabilitation services (including any necessary appliances) in a hospital scheme nationally provided—together with a full range of specialist "second opinions" and care, in the hospitals, in the Health Centres and at his home.

(3) Nursing in his home—provided through the local authority—whenever the case requires it, and domestic help in homes where sickness makes this necessary.

(4) Special dental and eye services (including dentures and spectacles), as fast as these can be developed.

(5) A full maternity service—pre-natal care, domiciliary or institutional midwifery and post-natal care—with specialist resources behind it.

(6) Health visiting in all appropriate cases.

(7) Child welfare services and school medical services.

(8) An ambulance service, from home to hospital, from hospital to hospital, from accident to hospital.

(9) Vaccination and immunisation against infectious diseases.

(10) Various forms of supplementary care and after-care in time of sickness.