NATIONAL HEALTH SERVICE.

MEMORANDUM BY THE LORD PRESIDENT OF THE COUNCIL.

THE public will expect at the Election to know where the Government stand on the National Health proposals on which we have given no indication of policy apart from the White Paper of February 1944.

In order to carry the Labour part of the Coalition, we put into that White Paper certain proposals envisaging that there might be salaried practice in Health Centres and that doctors practising in the Centres would be in contract with the local authority as well as with a Central Medical Board. These proposals proved unpopular with the doctors.

The Minister of Health has, with the late Secretary of State for Scotland, carried through many months of negotiation with the several professional bodies concerned.

He has come down against salaried practice in the Health Centres and any direct contract between the local authorities and general practitioners. This will give great satisfaction to the medical profession.

Further, in all substantial matters, he has got agreement with the Voluntary Hospitals and with all local authorities except the London County Council. In Scotland, too, a wide measure of agreement has been secured.

I suggest that it would be well to state the Government position now in the form of the attached short Parliamentary paper submitted by the Minister of Health and Secretary of State for Scotland.

W.

Office of the Lord President of the Council,
4th June, 1945.
MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND

PROGRESS WITH THE PROPOSALS FOR A NATIONAL HEALTH SERVICE

Presented by the Minister of Health and the Secretary of State for Scotland to Parliament by Command of His Majesty
June 1945

LONDON
HIS MAJESTY'S STATIONERY OFFICE

Cmd.
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INTRODUCTORY

1. The White Paper on a National Health Service was published in February, 1944. Its purpose was not to announce a finally settled scheme. It was intended that the proposed service should be freely examined and discussed with all concerned before final decisions were taken, and that the Paper itself should serve as a focus for such discussions. It was hoped that draft legislation for establishing the service could then be prepared, in the light of the discussions, for submission to Parliament.

2. In March, 1944, the White Paper was debated in both Houses of Parliament and both Houses welcomed the intention, declared in the Paper, to establish a comprehensive health service.

3. Since then, discussions have taken place between the Health Ministers (the Minister of Health and the Secretary of State for Scotland) and representatives of the local government authorities, voluntary hospitals, and the medical and dental professions, of nursing, midwifery, and pharmacy, and of other organisations and bodies concerned in the proposals. In these discussions the ways and means of establishing and maintaining the new service have been reviewed, various alternative suggestions have been examined and ideas have been exchanged—in accordance with the intention expressed in the White Paper.

4. The content of these discussions could not be made public while the discussions proceeded. It was of their purpose and nature that the talks should be free and informal and should not involve the taking and announcing of Government decisions at all stages. It was felt to be more profitable that there should first be consultations between the two Ministers and the various representative bodies over the whole field and that after that the Government should assess the situation as a whole, in the light of these consultations, and make known their conclusions to Parliament in the form of a Bill. This point, at which draft legislation could have been considered and settled, had practically been reached when, in view of the imminence of a dissolution, it became clear that there was insufficient time for consideration of the detailed terms of a Bill or for its introduction in the present session.

5. In this situation there was an obvious possibility that much of the protracted work of the last year might lead to no early conclusions, in spite of the energy and the goodwill which all the different representative bodies had devoted to it in the interests of arriving at a good service. It might have been that the discussions would have been interrupted, for several months at least, without Parliament and the public being able in any way to judge of their usefulness and of the progress so far made.

6. The Government therefore think it their duty to report to Parliament. They have reviewed the whole of the ground so far covered and have decided, on as many as possible of the issues involved, what measures they would be prepared to recommend to Parliament for inclusion in new legislation when it can be introduced. The purpose of this Paper is to set out the decisions which they have reached.

7. These decisions do not cover every aspect of the necessary legislation. There are some points on which the Government feel that further consideration is desirable before conclusions are reached. There will also be many matters—forming more naturally the subject of detailed statutory regulations.
submitted after the general legislative framework has been settled—on which the various representative organisations ought to be further consulted. But the conclusions summarised in this Paper touch upon most of the issues with which any Bill will have to deal, and indicate the way in which the present Government would propose to deal with them.

8. These proposals differ in a number of respects from the corresponding proposals set out in the White Paper of 1944. They do not differ in regard to any of the fundamental objectives of the comprehensive service, or in regard to the fullness of its range or its universal availability to the public; they do not differ in regard to any of its governing principles or its general conception. They affect only ways and means and not ends. Where they differ, the changes from the earlier proposals are mainly designed to strengthen the protection of individual freedom in using or providing any part of the service, to eliminate any possible excess of standardisation and to encourage variety and individuality in the services provided.

9. The position in Scotland.—The proposals which follow refer to the service in England and Wales. While maintaining the same objectives and general principles for the service in Scotland, the earlier White Paper proposed a somewhat different administrative structure, chiefly as regards local organisation, to fit the different conditions there. The considered views of certain of the organisations concerned, with which the special Scottish features of the proposed service have been discussed, have not yet been made known to the Government, and in particular the medical profession have yet to hold their Representative Meeting on the subject. In any case a separate Bill for Scotland will be necessary. Apart, however, from certain points mentioned below (para. ) the Government do not contemplate that any substantial modifications of the Scottish proposals as contained in the earlier White Paper will be found necessary.

II

OUTLINE OF THE REVISED PROPOSALS

General objectives and principles

10. All the main objectives and principles of the earlier White Paper must, in the Government's view, be fully assured, including:—

(i) a comprehensive service, covering all forms of medical and allied care for all people who wish to take advantage of it, free from any financial deterrents;

(ii) freedom for everybody to use the service or not, and freedom for every professional man or woman to take part in the service or not;

(iii) freedom of choice of doctor, with no question of creating a separate state medical service distinct from the ordinary practice of medicine;

(iv) complete clinical freedom for doctors and other professional people taking part, with no question of lay supervision of the professional person's clinical discretion and judgment in his patients' interests;

(v) the full partnership of the two great hospital systems of the country, with participation of the voluntary hospitals as autonomous bodies and no question of them being "taken over" by the State;

(vi) a proper combination of public responsibility for the service and the participation of the expert in its provision centrally and locally.
II. The new service must be designed to secure:

(a) a family doctor of the patient's own choice, working usually from his own surgery as now—but with a full experiment conducted in the opening years in the varied possibilities of publicly equipped Health Centres;

(b) all kinds of hospital and sanatorium services, including medical rehabilitation, and all kinds of specialist and "second-opinion" services organised in and from the hospitals;

(c) priority dental services for expectant and nursing mothers, young children and schoolchildren; also a general dental service which, while not able to guarantee that during the present shortage of dentists, treatment will be available in every instance, would offer all necessary treatment to all who can arrange with a dentist taking part in the service to provide it;

(d) a service for the care of the eyes and provision of spectacles;

(e) maternity and child welfare, midwifery and home-nursing services; and home-helps in case of need through sickness;

(f) all necessary drugs, medicines and appliances, and ambulances and hospital transport services;

(g) a public health laboratory service and a blood transfusion service organised on a national basis;

(h) the greater fusion, in future, of responsibility for the mental and the physical health services in a single administrative organisation centrally and locally.

Central organisation of the service

12. As the earlier White Paper emphasised, the central organisation of the service will be based upon the central responsibility to Parliament and the people, in the normal constitutional manner, of the Minister of Health. The present responsibilities of the Board of Control for mental health, under the Lunacy Acts and Mental Deficiency Acts will be transferred to the Minister of Health, with the exception of functions specially concerned with the liberty of the subject in respect of the detention of persons of unsound mind and mental defectives; for these the Board will be continued.

13. A new and statutory organisation will be set up at the centre, to advise the Minister. This will consist of a Central Health Services Council—representing in a single body all the main expert fields, medicine and surgery, dentistry, nursing, midwifery, pharmacy, and voluntary hospital and local government experience—and also of various separate Standing Advisory Committees associated with the Council, but with direct access to the Minister as well as to the Council.

14. These separate Advisory Committees will include a general medical advisory committee, a hospitals advisory committee, another on dentistry, one on nursing, one on mental health and one on pharmacy. All the proceedings and reports of these Committees will automatically be made known to the Central Council as well as to the Minister, and the Central Council will be able to pick up any subject on which it thinks that its wider general point of view should be expressed, and advise the Minister on it.

15. The members of the Central Council and the Standing Advisory Committees will be appointed by the Minister only after full consultation with the professional and other organisations concerned; there will also be some ex officio members. The Council and the Committees will be able to advise at all times, of their own initiative, and will not be restricted to questions referred to them by the Minister. The Minister will publish an annual report
of the work of the Council and Committees, prepared by the Council itself, except in so far as there may be some reason of the public interest for not doing so. The Council and Committees will appoint their own Chairmen and arrange their own procedure; they will have joint secretariats—i.e. one secretary appointed by themselves and one supplied by the Minister.

16. Generally, the object will be to bring to the responsible Minister’s side a strong and thoroughly representative grouping of the best expert opinion in all fields of health service policy, and to give that opinion full opportunity of expressing itself to him.

Local organisation for planning local services as a single whole

Area Planning Bodies

17. The comprehensive service needs to be planned over suitably wide areas, with a proper degree of expert and professional participation in the making, and keeping up to date, of the plan. If this is secured in the manner proposed in the next paragraph there is not, in the Government’s view, any need in England and Wales for any large scale transfer to new executive joint boards of the hospital functions of the major elected local authorities, as was contemplated in the earlier White Paper. It was always recognised that the balance of advantage in this transfer was open to question, except in Scotland where the relatively small population of the average local health authority’s area turned the scale decisively.

18. It is now proposed that there should be areas determined for the rational planning of the health service as a whole, and that these should be similar to the “Joint Authority” areas of the White Paper; i.e. there should be about 30 or 35 of them for the whole country, with a population of anything from half a million to about two millions in each. For each of these areas, there will be established a new Health Services Council, charged with the statutory duty of preparing a health services plan for the whole area and of submitting it to the Minister for final confirmation—the confirmed plan becoming the binding scheme which all concerned must observe, and being constantly revised and kept up to date.

19. These Health Services Councils will consist, in a proportion of about 3:2, of the representatives of the major local authorities (counties and county boroughs) of the area on the one hand, and of representatives of the voluntary hospitals, the medical profession, dentistry, nursing and midwifery on the other. Each will probably be a body of something like 30 members, with 18 local authority and 12 other representatives and a chairman appointed by the Minister.

20. In view of the special considerations affecting the hospital and specialist services part of the area plan, a special Hospital Services Group will be established for each of the new planning areas, which will prepare this part of the plan and provide it for incorporation in the general plan by the Health Services Council. If the latter body modifies the plan, and there is any resulting disagreement, the Minister will decide the issue. These Hospital Services Groups will consist of equal numbers of voluntary hospitals and local authority members, together with representatives of specialist and general medical practice. They will need to have special committees on the planning of the mental services.

Regional Advisory Councils

21. There is, in the Government’s view, a good case for bringing into the planning and arrangement of the service the voice of those qualified to look at the subject—particularly the more highly specialised services which need to be correlated over larger fields—from the point of view of even wider
areas or regions, based upon the natural spheres of influence of universities with medical teaching schools. It is proposed, therefore, that for each of the ten or so spheres of influence of the university medical teaching centres, there shall be set up a small, highly expert advisory body, to be known as the Regional Advisory Council. These Councils will consist of, say, 15 members, including members representing the universities with schools of medicine, specialist medical practice, and voluntary hospital and local government experts. Their functions will be to assist the area planning bodies throughout in the making of their plans, providing the necessary correlating advice over the wider regions; to have the opportunity also of advising the Minister finally on the plans as submitted to him; to establish machinery for advising on the appointment of specialists by all hospitals in the region, and to undertake such other expert functions (such as surveys of hospital resources in their region) as the Minister might call upon them at any time to perform.

The London area

22. For the special circumstances of the London area, some of the details of this planning machinery may need to be adapted; this is for further consideration. But the general principles of combined planning, the participation of the experts of various kinds, and the influence of wider regional considerations, would all apply in some suitable form.

Hospital and Specialist Services under the plan.

23. The area plan described will settle, as the earlier White Paper proposed, the general lay-out of the various hospital and specialist resources of the area, the best use to be made of existing resources and the new provision needing to be made to make up deficiencies. Both the voluntary hospitals and the local authorities will have joined in arranging this plan. It will then be for both to carry out their allotted parts in it.

24. A voluntary hospital thus agreeing to play its part in the scheme will play that part under its own management and with full autonomy as a voluntary institution. It will be, as it were, in the position of an independent contractor, providing agreed services in accordance with the arrangements of the plan which the voluntary hospitals, as well as the local authorities, will have shared in making.

25. A voluntary hospital will receive from public funds two kinds of service payments, central and local, for the services which it will have agreed to render under the local plan:—

(a) The central payments will be made by the Exchequer, and will be at rates settled with the voluntary hospitals' representatives in respect of each of the main types or classes of services rendered. If it proves desirable to arrange for some element of grouping of any part of the total moneys so due, and their redistribution among individual hospitals on some basis taking more account of individual needs, the Government will be prepared to consider this.

(b) The local service payments will also be at rates settled centrally, in consultation with the voluntary hospitals' representatives and those of the local authorities. They will be received by the voluntary hospitals, not from individual local authorities, but from a single new "clearing house" serving each planning area. This clearing house will be provided so as to enable both voluntary hospitals and municipal hospitals taking patients from other local authority areas all to draw their appropriate service payment from one source, while all local authorities can
simply pay into that source a flat rate payment for every patient from their area going into any hospital other than their own hospitals—no matter to what hospital, voluntary or municipal the patient goes.

26. In fixing the appropriate scales for central and local service payments, in consultation with the voluntary hospitals, the desirability of making clear their continuing voluntary status and their continuing link with the voluntary good-will of the public will be kept fully in mind. This will be relevant in determining the proportion of their resources for which they will look to public funds, and it is therefore a vital matter to them and to the voluntary contributory and savings associations which have been so valuable a link between the hospitals and the public in the past. The Government does not want to determine it finally at this stage, until it has been discussed with them in further detail. There will also need to be proper provision for enabling the voluntary hospitals to obtain necessary capital assistance in carrying out new undertakings which they may have agreed to carry out in accordance with the new area plans.

27. As already indicated, there will be no general transfer of the municipal hospitals to new Joint Authorities, and the duty to provide municipal hospital services of all kinds in accordance with the area plans will fall in future upon the county and county borough councils. The expenditure of these Local Authorities on the hospital services as on all other local health services for which they are responsible, will be the subject of appropriate exchequer assistance to be determined in consultation with their representatives.

28. The general objects and scope of the hospital and specialist services will be the same as those in the original White Paper, and need not be set out again here. The principal changes in the proposed ways and means lie in (a) the complete re-arrangement of the earlier proposals for "Joint Authorities" and area planning, already referred to, (b) the direct participation of the voluntary hospitals and professional experts in the making of the area plans and in the new regional advisory machinery already described, (c) the modified system of payments for services rendered, just outlined, (d) the amplification of the central advisory resources at the Minister’s side, mentioned earlier in this Paper.

Other local authority services

29. In the new organisation the new general duty to secure all kinds of hospital and specialist services will, as was always intended, absorb in a larger whole many of the present separate services which really belong to that sphere—e.g. tuberculosis, isolation hospitals for infectious diseases, institutional maternity, cancer; and the poor law medical institutions will cease to exist as such.

30. But, outside the new range of the hospital and specialist services, there will be certain local authority services (e.g. the provision of maternity and child welfare clinics) which will still require special statutory provision in the new legislation. There will also be some new functions (e.g. the provision of a home-nursing service and of home-helps in illness) which will need to be added. All of these local authority services will be joined in future in the hands of the county and county borough councils, as the earlier White Paper proposed, except for the delegation of child welfare arrangements where child education is already delegated.

31. All of this will be broadly as the earlier White Paper contemplated, and there is no material new point to record under this heading. All of these local authority services will, of course, become the subject of the new area planning system, and in future all will rest upon a clear duty to provide a full service, and not merely upon a power to do so.
32. The local authorities should, it is felt, each be required to establish in future a new all-purpose health committee (comparable to their statutory education committees). In the Government's view, these health committees ought in future to include a proportion of doctors and persons of special experience in the health services. The committees will have various sub-committees, including one on mental health.

**General medical practitioner service**

33. Arrangements for assuring a personal or family doctor's care for all will, as the earlier White Paper stressed, be the first-line provision of the new service. But there will be some changes in the means proposed in the earlier Paper for securing this.

34. In the main, this part of the new service will be organised on lines already familiar under the present National Health Insurance system, with the great difference that it will in future be backed by all the specialist and hospital services and home-nursing and other facilities provided under the new area schemes—and, of course, that it will in future be equally available to all people. At the same time, there will be conducted a carefully worked out experiment, on a substantial scale, in new developments of the "Health Centre" type to which the earlier White Paper referred.

**Ordinary general medical practice arrangements**

35. Under the revised arrangements there will be no need in England and Wales (in the Government's view, which they understand the medical profession to share) for the creation of the Central Medical Board proposed in the earlier White Paper. General practitioners will look in future, for their contract and remuneration, to a new local Committee taking the place of—and broadly similar to—the present local Insurance Committee. This Committee will in each area consist, as to one-half, of representatives of the public (two-thirds of these being nominated by the county or county borough council, and one third by the Minister) and, as to the other half, of professional representatives of the doctors, dentists and chemists taking part in the service. There will be local professional committees for the doctors, dentists and chemists, which will stand in broadly the same relationship to the new local Committee as the Medical and Panel and Pharmaceutical Committees stand now in relation to the present Insurance Committees; and there will continue to be various special sub-committees, as now, to deal with complaints and disciplinary matters.

36. General terms of service and remuneration will be settled by central consultation with the professions concerned, as they are now, and will be broadly based on the same methods of payment (as distinct from amounts of payment) as now. The settlement of the amounts of doctors' remuneration will be reached in the light of the report of the special Committee recently set up under Sir Will Spens, by agreement with the profession, to advise afresh on the proper standards and range of remuneration in general medical practice.

37. After careful consideration the Government do not believe that any substantial advantage would be gained by the earlier proposals to try to improve the distribution of general medical practice by requiring practitioners to obtain official consent to starting or taking over a practice, or by requiring full time practice from young doctors in certain areas. They do not feel that these restrictions upon the present freedom of choice by professional men and women—and their potential patients—would be justified by any results which would in fact be likely to accrue. They believe that the same objectives can be better achieved by devising some suitable system of more attractive terms for work in less attractive areas, and they propose to explore
this further. There is already a power in the National Health Insurance Acts for the Minister to supersede the ordinary arrangements in any particular area, and to substitute other arrangements, if he is satisfied that a proper service is not being provided in that area; this power will be retained, and applied to the new and wider service.

Health Centres

38. During the opening years of the scheme, a controlled experiment will be conducted with various types of publicly provided and equipped health centre, including health centres for the conduct of general practice by doctors willing to transfer their practices, or to open new practices in them. The centres will be provided, equipped and maintained by the local county or county borough councils, as the earlier White Paper proposed, but the doctors taking part in them will remain—like the doctors in separate practice—under contract only with the new Committee which takes the place of the Insurance Committee, and will not need to join in a special three-party contract as was earlier proposed. The local authority will arrange with that Committee, and not with the individual doctors, for the use of the premises by doctors for the purposes of the new service. This will facilitate ease of movement in and out of separate and health centre practice, by eliminating any differences of contractual status between the doctors inside or outside the centres.

39. Doctors in the health centres should, it is thought, be remunerated by the Committee as a group partnership—the aggregate capitation fees due to them under the ordinary system being pooled and redistributed among themselves under a partnership agreement. Competition for patients within the group, or for the use of the facilities in the centre, will thus be avoided.

40. The health centre experiment must be on a wide enough scale to yield reliable information as to the advantages and popularity of the system, and further developments will depend on the results obtained. The Minister in controlling the experiment will have the help of the advisory machinery already described.

Sale and purchase of medical practices

41. As already announced on behalf of the coalition Government,* there will be no abolition or restriction in the first few years of the present professional custom of the sale and purchase of goodwill. As soon as the results of the operation of the new service—and the effects, for instance, upon practice values of the health centre system—can be better ascertained, there will be a full enquiry into the merits and possibilities of altering the system—with proper compensation on the lines of the recent pronouncement on the subject in Parliament.

Dental services

42. A priority dental service for mothers and young children will rest upon a new duty put upon local authorities, in place of their present power, as part of their maternity and child welfare functions. Similar provision has already been made for schoolchildren in the Education Act of last year.

43. In addition to this, the Government believe that a general dental service can be organised in accordance with the principles of the Teviot Committee's report, under which any person able to arrange with a dentist for dental care within the new scheme can be enabled to get all necessary care without fees or charges, although no guarantee can be given of the immediate availability of dental care in all cases owing to the acute shortage of professional personnel. Such a service will be an extension of the earlier White Paper proposals, and

* By the Minister of Health, in a reply to a Question in the House of Commons on 3rd May, 1944.
it needs further exploration with the dental profession. Discussions in this field have had to start later than in other fields, and are correspondingly less far advanced, owing to the need to await the report of the Teviot Committee before they could begin.

44. The merits and advantages of dental health centres, or dental departments in health centres, will be ascertained by controlled experiments on similar lines to the medical health centres.

**Ophthalmic service**

45. The Government believe that a full service for the care of the eyes, available for all who want to use it, should be organised as part of the health service from the outset, although in the earlier White Paper some doubt was expressed as to whether this was yet practicable. Discussions of the best methods by which, and the stages through which, such a service can best be achieved are in progress.

**Mental health services**

46. Arrangements need to be made for a closer association of the mental and physical health services. At the centre the mental health functions of the present Board of Control will, subject to the exceptions already mentioned in regard to restraints upon the liberty of the subject, be merged in the Ministry of Health. Locally the mental health services will be as much part of the comprehensive area planning as any other part of the new service, the existing executive duties of providing the services becoming a direct function of the county and county borough councils, as part of their wider hospital and clinic duties. Each authority's new health committee will have a special statutory sub-committee on mental health. Visiting Committees under the Lunacy Act will be abolished, and any remaining links of the mental health services with the Poor Law will be severed. A full restatement of the law of lunacy and mental deficiency will be undertaken later, as soon as conditions permit.

**Other Developments**

47. It is proposed that there shall be established a public health pathological laboratory service, organised centrally and on a national basis by the Minister, in the first instance through the agency of the Medical Research Council. Its object will be, without superseding the present laboratory work of local authorities, to provide them and others with a free bacteriological service for the control of infectious diseases, and to perpetuate the advantages of a nationally organised epidemiological service which the war experience of the Emergency Laboratory Service has so well demonstrated. Similarly, arrangements will be made on a national scale to continue the advantages of the blood transfusion service which, under the Emergency Hospital Scheme, has been vigorously developed during the war. Ambulance and hospital transport services will fall to be locally arranged within each of the new health planning areas, and the responsibility for securing them—by direct provision and by contract with voluntary agencies—will fall upon the major local authorities in each case.

**The service in Scotland**

48. The chief developments of the Scottish proposals, as contained in the earlier White Paper, will be as follows:

(a) The central advisory machinery will be elaborated, with Standing Advisory Committees in addition to the Scottish Central Health Services Council on the lines described in paragraph of this Paper.

(b) The regional Hospitals Advisory Councils (designed for a different purpose from that of the Regional Advisory Councils in England and
Wales and composed of equal numbers of local authority and voluntary hospitals representatives) take part at an earlier stage than was originally proposed in the planning of hospital and allied services. They will draw up a provisional general plan for the region to guide the Joint Hospitals Boards (i.e. combinations of local authorities) in framing their area schemes for these services.

(c) Local service payments to voluntary hospitals will be made through clearing-houses on lines described in paragraph of this Paper, operating in Scotland on a regional basis. These clearing-houses will also handle service payments between Joint Hospitals Boards. The net expenses of the Joint Hospitals Boards will be raised by requisitions from their constituent authorities, who will in turn be grant-aided on all their health services expenditure.

(d) The changes proposed in paragraph of this Paper in regard to the general medical practitioner service will be adopted in Scotland, although there may be found to be a continuing need for the Scottish Central Medical Board proposed in the earlier White Paper.

(e) The Local Medical Services Committees of the earlier White Paper, covering the same areas as the Joint Hospitals Boards, will be composed of equal numbers of lay representatives nominated by the local authorities and of professional representatives nominated by the medical and allied professions in the area, together with a few additional members, lay or professional, appointed by the Secretary of State. In addition to the advisory functions proposed in the earlier White Paper, this Committee will in each case also act as the successor to the present Insurance Committees, and for this purpose there will be associated professional committees and appropriate services sub-committees on the lines described in paragraph of this Paper.

General

49. All the necessary main organisation of the new service should, in the Government's view, be provided for in a Bill as early as possible in the new session. Meanwhile, discussions can continue with representatives of the doctors, dentists, hospitals, local authorities, nurses and others on the many other questions which need to be settled. Many of these questions will necessarily involve complicated and detailed arrangements and will, therefore, have to be the subject of subsequent statutory regulations, subject to review by Parliament.

50. The outline given in this Paper is not intended to be an exhaustive survey of the way in which the new service will be organised. It is intended mainly to draw attention, in a summary form, to certain proposals involving adjustment of the earlier White Paper proposals, and to give a general indication of the Government's conclusions on the issues which have been discussed with the various professional and other organisations over the past year. It does not take the place of the main White Paper of 1944, but supplements it and brings it up to date.