$60.00 for a couple, and $90.00 for a family of three or more. Adding Blue Cross Hospitalization premiums brings the annual totals to $41.00, $82.00, and $120.00 respectively. If an employer pays at least half of these, as the City of New York and the United Nations have agreed to do for all their employees (and dependents) who wish to join, the most any family will have to pay for full service is thus $5.00 a month. HIP services began March 1 of this year.

In its essential principles, the pattern being established by HIP is, as indicated previously, an old one in the United States. But its use on a community-wide scale is new and will provide a demonstration worthy of the attention of other localities. With adequate financial backing (which in the case of HIP has been furnished by three Foundations) a similar medical care plan might well be established in any community located in a State where the laws would permit this type of organization. This pattern offers an opportunity for the medical profession and the public to demonstrate that comprehensive medical service can be furnished on a sound insurance basis. Insurance for a broad range of services combined with group medical practice will, HIP believes, go far toward helping attain better distribution of top-quality medical care.

State Medical Service in Britain

By E. Clayton Jones

EDITOR'S NOTE: While Britain's new national health program was before Parliament, PUBLIC AFFAIRS published (in the issue of September, 1946) an article dealing with the general principles embodied in the program. It has meanwhile been put on the statute books and this article, written by a British physician, describes the organization of the new services.

THE National Health Service Act, which gives Britain's Minister of Health, Mr. Aneurin Bevan, powers to set up a free comprehensive medical service for everyone in England and Wales (a similar Bill has since been introduced for Scotland) reached the end of its lively voyage through Parliament last November and so became law. The "appointed day," when its provisions will begin to take effect is expected to be April 1, 1948.

Though this Act has been passed when a Labour Government is in power, and though its nationalising function is one of the main platforms of the Labour Party's policy, it represents the culmination of the efforts of successive Governments, for a scheme for a national health service was first outlined in a Parliamentary White Paper by the Coalition Government in 1943. The schemes differ in some administrative respects, particularly as regards hospital and specialist services, but have a great deal in common.

The Act deals only with the main structure of the new services, leaving details to be filled in later by means of regulations which will be subject to the control of Parliament. It is in effect an enabling Act, erecting a framework into which the Minister of Health hopes, with the help of his staff and representatives of the medical profession, to fit a workable and generally acceptable medical service.

The framework of the scheme was described in a Government White Paper in March, 1946, and though it has since been more or less continuously under fire from its critics, both inside and outside Parliament, the broad design remains unchanged.

Universal Availability

Unlike the present "panel" doctor service, which supplies medical attention for a strictly limited class of patient—

employed persons in the lower income groups who have paid a certain number of weekly contributions— the new service will be available for the whole population, irrespective of their financial means, age, sex, state of health, trade or profession, place of residence, and number of contributions paid.

But this is no mere 100 per cent "panel" system; it really aims to provide everything that the sick person needs and medical science can devise to make him well, and in addition to cover a wide range of preventive measures.

At the head of the new service will be the Minister of Health himself, advised by a Central Health Services Council, composed of professional people representing the various branches of the service, together with laymen possessing special experience of hospital management, local government and the mental-health service. This Council will present an annual report to the Minister and this will be laid before Parliament unless the Minister, after consulting the Council, is satisfied it would not be in the public interest to do so.

For administrative purposes the service is divided into three main parts, and one of the difficulties to be faced is in the linking up of these parts.

Hospitals and specialists will be the direct responsibility of the Minister, but he will delegate the planning and administration of this part of the service to regional hospital boards, each having jurisdiction over one of the 14 regions, centred on the universities, into which the country will be divided. The regional boards appointed by the Minister after consultation with interested bodies, will set up local hospital management committees, one for each large hospital or group of hospitals in their regions, which will supervise the day-to-day running of the hospitals.

These arrangements apply to all hospitals except those with a medical or dental school. The teaching hospitals will be administered by governors, appointed by the Minister and including nominees of the universities, the regional boards and the hospitals' medical staffs. They will thus retain a large measure of autonomy, but there will be a close liaison between them and the non-teaching hospitals, as well as with the universities.

On the appointed day the premises and equipment of the hospitals will become the property of the Minister of Health; in the case of the non-teaching hospitals this will include all endowments with certain exceptions and other funds, which will be pooled and redistributed to the regional boards and management committees to serve as pocket money for the hospitals in their regions. The management committees will also be free to accept gifts from the public. The teaching hospitals will keep their endowments, which will pass to the new governors, and they can also accept new gifts. This decision has given general satisfaction, for it will mean that the most famous hospitals will still have money to spend on projects of their own choosing.

Hospitals may still be allowed to provide private rooms or paying blocks for patients who are prepared to pay for extra privacy, provided such accommodation is also available for non-paying patients who need it on medical grounds.

General Practitioner Services

Each local health authority (county or county borough) will have its local executive council, half of which will consist of representatives of the local doctors, dentists and pharmacists, to provide a service of family doctors, dentists and pharmacists for their area.

An important feature of this part of the new service will be the establishment of "health centres." These will be built, equipped, staffed and maintained by local health authorities for the purpose of their special clinics, such as for ante-natal care, child welfare, etc., and will include premises for group practice by doctors and dentists who, under contract with the executive coun-

cils, are working in the new general practitioner service. Health centres are, however, likely to appear only gradually and the general practitioner will at the outset continue to treat patients at his own surgery.

Doctors in the service will not be debarred from treating patients privately (i.e., for fees), provided such patients are not on their lists in the service or on the lists of their partners. Patients will be free to choose their doctor, if the doctor agrees; in effect, the average patient is likely to have more freedom of choice than he has now.

The remuneration of general practitioners in the service has yet to be settled. The most probable method of payment seems to be by a basic salary, which may vary according to experience, special qualifications, etc., and may be raised to attract doctors to unpopular areas. Over and above this there will probably be a capitation fee for each patient the doctor takes under his care. The capitation fee will be based on the recommendations of a committee, presided over by Sir Will Spens, Master of Corpus Christi College, Cambridge University, which lately investigated the earnings of doctors and found them to be on the whole too low. They mentioned no figure, but their remarks have been taken as implying that an annual fee of 15s to £1 a head would be reasonable if there were no basic salary. It is not going to be easy to fix a fee for work whose extent can only be surmised.

All doctors in practice on the appointed day will have the right to join the service in their area. Future openings in the general practitioner service will be filled only with the consent of a Medical Practices Committee, a central body mainly professional in composition. A doctor who wants to join the service will normally ask the executive council of the area he chooses to be put on its list. Having taken the advice of the local practitioners, the council will then convey its decision to the central committee, which will withhold consent to an appointment only on the grounds that there are already enough doctors in that area.

The buying and selling of practices will cease, except in the case of private practices wholly outside the service. Strict penalties are laid down for breaches of this rule. Those who join the service at the outset will qualify for compensation for their goodwill out of a fund allotted for the purpose. Except in cases of hardship (e.g., heavy outstanding debts) the compensation will not be paid until the doctor dies or retires, interest at $2\frac{3}{4}$ per cent being added in the meantime.

Local Government Services

Parts of the National Health Service will be the responsibility of the local health authorities—i.e., the county and county borough councils. These bodies, besides providing and maintaining the health centres, will arrange for the care of expectant and nursing mothers and of pre-school children; they will also provide a complete midwifery service for mothers who are confined at home. On the other hand—and this difference has raised criticism—mothers who are confined in hospitals or maternity homes will be under the care of the hospital and specialist branch of the service.

The local health authorities will supply various miscellaneous services, such as domiciliary care and after-care for the tuberculous and the crippled, health visitors for the sick. Compulsory vaccination against smallpox will be abolished —a step which has been generally approved by the medical profession because compulsion has created artificial opposition and led to widespread evasion— but local health authorities will arrange for free vaccination, or immunization against diphtheria, for those who wish it.

The Exchequer, which means the taxpaters, will bear the whole cost of taking over existing medical practices. The sum provisionally agreed on is £66 million but it has yet to be decided how and by whom this will be distributed to the doctors.

.As regards running costs, it must be realized that the new health service, though a vast undertaking, is only part of the Government's still larger plans for the abolition of want. When Sir William (now Lord) Beveridge drew up his famous scheme for national insurance "from the cradle to the grave," in December, 1942, he assumed that a comprehensive free medical service would be introduced, and his scheme, with considerable modifications, has since been embodied in the National Insurance Act, which is already on the Statute Book. Under this insurance plan every man, woman, and child in Britain will pay a weekly contribution and so qualify for a wide range of benefits, covering unemployment and sickness payments, old-age, retirement and widows' pensions, and burial charges, besides medical needs. Of these contributions, paid by sticking stamps on a card, 10d a week for men, 8d for women, and 6d for children will go towards the cost of the National Health Service. These sums are likely to cover about a fifth of the total cost of the service, and the remainder will be shared between the Exchequer (=taxpayers) and the local authorities (=ratepayers). The total cost of the service during the early years is estimated at £152 million a year.

Problem of Staff

There are still many formidable, and some say insuperable, obstructions to be swept aside or circumnavigated before the health service can become a working entity. The most serious is the problem of staffing it. All the planning and organization will come to naught unless the doctors who are to man the service are adequate in number and willing to work it; and there is doubt on both these points.

Critics of the scheme argue, with reason, that there are not enough doctors to run even the present medical services —indeed, that it is lack of doctors and dentists which largely accounts for their shortcomings. How then, they ask, can the Government expect to man a service whose aim is to provide the best possible medical care for everyone while lightening the strain on the individual doctor by giving him shorter hours and sufficient time per patient to do his work properly? The existing doctors can be used to better advantage by spreading them more evenly, arranging for full co-operation between them, and reducing their non-medical duties by giving them more secretarial and technical assistance. The main answer, however, is by training more doctors. But, though there are plenty of young men and women anxious to study medicine, there is a serious shortage of training facilities which must be overcome before the bottleneck is broken.

Moreover, at the time of writing it is by no means certain how many of the available doctors will be willing to join the service.

As an example of the snags ahead, the Minister of Health is determined to retain the principle of a basic salary plus a capitation fee in the payment of general practitioners, whereas the British Medical Association favours a capitation fee only; this is a fundamental breach, because, despite all the Minister's reassuring statements that not a single new Civil Servant will be created under the scheme, many doctors fear that once they accept a salary they will become Civil Servants with all that implies of bureaucratic control.