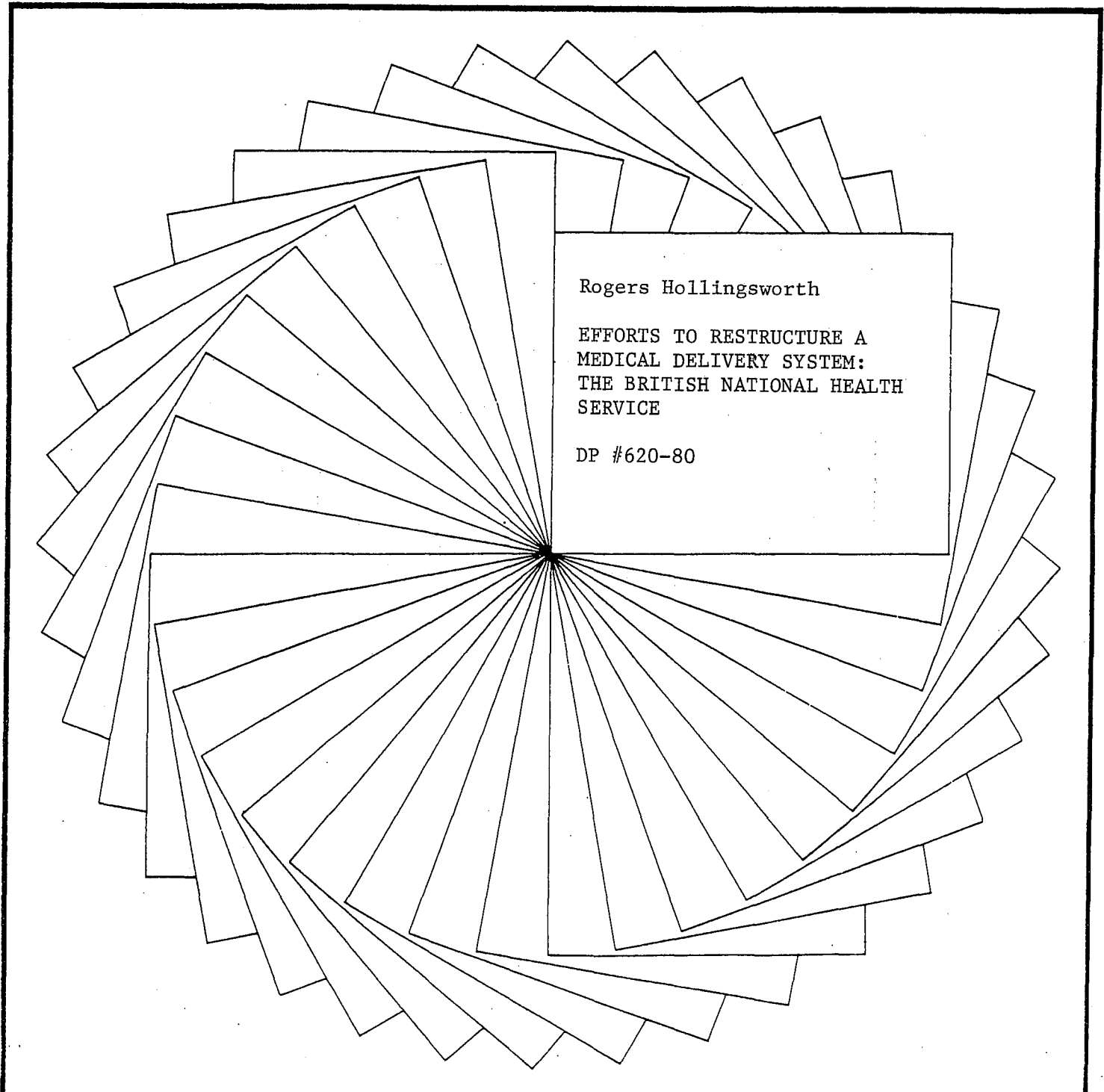




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EFFORTS TO RESTRUCTURE A
MEDICAL DELIVERY SYSTEM:
THE BRITISH NATIONAL HEALTH
SERVICE

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System: The British National Health Service

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ABSTRACT

This paper focuses on the pressures which led to the legislation providing for the National Health Service in 1946. Though many groups had long advocated a coherent and highly rationalized system of health care, the National Health Service was not a highly coordinated system. Probably no country in the world has produced so many wise reports for the delivery of medical services as Great Britain between the two world wars, but the structures of the system which emerged in 1948 were not greatly dissimilar from those which existed before the National Health Service. As a result of the National Health Service, Britain was still without an integration of curative and preventive medical services, and there continued to be poor communication between the hospital-based doctors and the general practitioners.

Efforts to Restructure a Medical Delivery System:
The British National Health Service

The National Health Service is an excellent example of the difficulties facing a nation which attempts to restructure its medical services. Probably no country in the world produced so many wise reports for improving the delivery of medical services as did Great Britain in the years between 1918 and 1948. And yet, the policies implemented in 1948 with the enactment of the National Health Service were not greatly dissimilar from those which existed before. Despite the determination of the government to integrate curative and preventive medicine, develop local health centers, and equalize the quality of hospitals, none of these plans was implemented. It is, of course, true that access to medical care became much more available to all citizens as a result of the N.H.S., but other than this, the basic structure of medical delivery persisted as it had existed prior to the enactment of the National Health Service. The history of the British medical delivery system is an example of how governments may formulate plans for substantial changes in a delivery system, but unless there are substantial changes in the power of the major actors, the policy which is implemented is not likely to result in any major structural change.

The discussion below explains why the National Health Service emerged and in what respects it departed from the system which existed prior to 1948.

1. MEDICAL DELIVERY PRIOR TO THE NATIONAL HEALTH SERVICE

By 1938, medical technology and the delivery of medical services had substantially changed since Lloyd George first presented Parliament

with his plans for a National Health Insurance plan. Discoveries in the physical and biological sciences continued to alter the practice of medicine. Most notably, there were improvements in anesthesia and surgical techniques, enhanced understanding of blood groups, and considerable progress in the field of biochemistry. The public's belief in the efficaciousness of medical technology increased accordingly, and the demand for medical services rose.

The number of hospital beds had increased from 197,494 in 1911 to 263,103 in 1938; in the decade prior to the Second World War, the number of beds in voluntary hospitals in England and Wales increased by almost one-third, the number of beds in local authority general hospitals by approximately nine percent. Throughout the country, a few new hospitals were constructed, though most hospital construction consisted either of expansion or improvement of existing facilities--but even during the depression of the thirties, local authorities developed and implemented plans for hospital improvements. The need for more maternity beds in the municipal hospitals led to the construction of a number of maternity blocks, and some municipal hospitals added new operating suites and X-ray departments. In addition, throughout the country there were efforts to develop cooperation between the voluntary and public sector hospitals.

Meantime, the number of nurses, doctors, and specialists increased dramatically between 1911 and 1938 (see Table 1; Pinker, 1966, p. 61; Jewkes and Jewkes, 1961, pp. 9-10, 25, 53).

Table 1
Number of Medical Professionals and Hospital Beds Per
100,000 of the Population

	Number of Doctors	Number of Specialists	Number of Nurses	Number of Hospital Beds
1911	65	6.5	235	58.4
1921	66	6.6	329	70.9
1931	77	7.7	329	
1941	88	8.8	465	76.4

Source: Hollingsworth *et al.*, forthcoming.

Moreover, the working conditions of doctors greatly improved after 1911. For example, the medical journals at the turn of the century had complained bitterly about the low standards of living, about fee splitting, bribery, and commissions among doctors, and the overcrowded surgeries of general practitioners; but the development of the National Health Insurance system had caused these practices to diminish. Whereas Beatrice and Sidney Webb had concluded in 1910 (p. 253) that the incomes of a very large proportion of doctors were scandalously inadequate, the official historian of the British Medical Association was able to report in 1932 that the financial position of doctors had greatly improved as a result of the National Health Insurance system (Little, 1932, p. 328).

Despite these changes in medical technology and services, however, there were still many inadequacies in British medical care in 1938. These

shortcomings led to considerable dissatisfaction both within the medical profession and without, generating pressures which eventually led to the enactment of the National Health Service in 1946. One set of problems resulted from the fact that Britain still had two distinct hospital systems--voluntary and public--which were organized and financed differently and cared for different types of patients. The great teaching hospitals were in the voluntary sector, but so were large numbers of debt-ridden hospitals which had an acute shortage of facilities. For the most part, the public sector hospitals were still affected by the stigma of Poor Law institutions and tended to receive most of the unwanted and uninteresting cases, particularly the chronically ill and incurables. Despite efforts in some localities to coordinate the services of the two types of hospitals (Titmuss, 1950, p. 70; Jewkes and Jewkes, 1961), the results were almost negligible. For example, as a rule, voluntary hospitals drew their patients from an entire area, whereas the local authority hospital could only serve patients who resided within its particular boundaries. This, of course, gave rise to many complications, a typical one of which is described in a Nuffield Hospital Trust survey:

A patient on one side of a street may be admitted without delay to a municipal hospital close at hand, while another patient living on the other side of the street and suffering from the same condition may be admitted after delay and difficulty to a hospital many miles away. Instances have been quoted to us of patients living in sight of one suitable hospital being sent 10 miles or more to another of similar type. [Hospital Survey, 1945, p. 64]

Even if the number of hospital beds was increasing during the interwar years, there remained, in the judgment of most competent observers, a critical

shortage of beds in relation to needs. There were usually adequate numbers of beds in large cities, but there was much more limited access in less populous areas. However, a matter of far more serious concern was the maldistribution of hospital facilities other than beds. For example, the Ministry of Health in 1938 and the Goodenough Committee on Medical Education reported that there were serious deficiencies in accommodation and equipment in virtually all types of hospitals--even the "prestigious" teaching hospitals. Only 3 of 141 hospitals in South Wales had diagnostic laboratories with staff and equipment, and the hospitals in many regions had grossly inadequate x-ray and pathology equipment. A number of hospital surveys reported the widespread existence of out-of-date equipment, inadequate wards, and prisonlike buildings. In particular, there was still an acute shortage of facilities for maternity, pediatric, and tuberculosis cases (Titmuss, 1950, pp. 66-73).

There was also a grossly inequitable distribution of specialists and consultants. During the interwar years, the distribution of consultants and specialists was determined more by the opportunities for doctors to earn a high income than by the medical needs of an area. As a 1938 survey on London medical facilities indicated, "the tendency for consultants and specialists to congregate in the county of London is largely a by-product of the past practice of unpaid hospital work, though strengthened . . . by the popular respect for a Harley Street address." (Hospital Survey, 1945:2). Specialists were heavily concentrated in medical school centers, while many counties did not have any gynecologists, thoracic surgeons, dermatologists,

pediatricians, or psychiatrists. Moreover, there was also a considerably uneven distribution among general practitioners. A resort town like Harrogate had an oversupply of general practitioners, whereas the working class areas in neighboring cities were very much in need of doctors. In 1938, Kensington had seven times as many practitioners as South Shields, a ratio that was common across a great deal of the country. In many parts of the country--especially in small towns--both private and public hospitals permitted general practitioners to carry out surgery for which they were inadequately trained. With poor distribution of resources, patients with complicated problems often received treatment in hospitals lacking the staff and equipment to provide adequate care, while elsewhere a simple case received treatment in a hospital with highly specialized staff and superb equipment. The existence of two very decentralized hospital systems was one reason why this type of maldistribution of medical resources occurred (ibid., p. 71; see Hospital Survey, 1945).

Most voluntary hospitals had been built during the nineteenth century, and in many respects were very much out of date and lacking in amenities. In the metropolitan areas, they were concentrated in either the central or in a very noisy section of a city. Throughout the country, hospitals had made numerous patchwork additions at different time points, making for a design which was formless, inconvenient, and congested. The surveyors of the hospitals in Sheffield and the East Midlands area commented that "We have seen far too many examples of dark, overcrowded, ill-equipped infirmary blocks in which the chronic sick drag out the last days of their existence

with few of the amenities of civilized life" (Titmuss, 1950, p. 70). The larger voluntary hospitals generally had modern equipment, but they were usually housed in cramped space. Moreover, their outpatient departments were too small for the demands placed upon them.

But the condition of the public general hospitals was much worse. Most of them were converted Poor Law institutions, and their physical plants were generally older than the voluntary hospitals. Many were located adjacent to various public assistance institutions and had the stigma of public assistance hanging over them. In general, they had not been designed to serve as hospitals for the treatment of acute cases, and were now attempting to perform a function for which they were neither designed nor well suited. They were essentially without outpatient departments, and had inadequate operating theatres and x-ray departments, and although they were slowly acquiring modern equipment, still had inadequate facilities for housing it.

Originally, some municipal hospitals had been constructed to accommodate the chronically ill, but as the demand to treat acute cases increased, the chronically ill were crowded out of the hospital. Almost without exception, municipal hospital facilities for the chronic sick were poor. One study revealed that "In the same ward were to be found senile demented, restless and noisy patients who required cot beds, incontinent patients, senile bedridden patients, elderly sick patients who were treatable, patients up and about all day, and unmarried mothers and infants" (Lancet, 1946, p. 841). Despite the improvements in physical facilities which were made

in the municipal hospitals over time, patients had very little privacy, and their sanitary accommodations were generally out of date, cramped, and inaccessible.

Obviously, it is difficult to determine by prewar standards the medical care needs of the British population of 1938. A variety of factors determine the needs of a population: the medical habits of doctors, the age distribution of the population, the degree of coordination among different types of hospitals and doctors. However, the Nuffield Provincial Hospitals Trust, which conducted about this time the most extensive hospital surveys in British history, concluded that England and Wales needed at least one-third more beds in order to have an adequate supply and that the country had a critical shortage of doctors and equipment. Indeed, it is extremely difficult to find the observations of any medical professional person who did not have very serious concerns about the delivery of medical services in Britain.

The inadequacies of British medical services did not affect every group and region in the same way, of course. The working classes were covered by National Health Insurance for the services of a panel doctor, but their dependents were still not covered. In theory, anyone who was sufficiently poor could receive medical care in a voluntary or local authority hospital without payment--though in practice, the stigma attached to receiving free care acted to discourage a large proportion of low income people from seeking it. And as the discussion above suggests, the medical care provided by local authorities left a great deal to be

desired. But the middle classes were also poorly served by the medical system prior to the National Health Service. They were not covered by National Health Insurance, and their coverage by private health insurance was very inadequate. As Harry Eckstein (1958) has written, "It was the middle class which bore the principal burden of neglect. It received no concessions at all in the finance of its medical requirements and it was forced, by indirect means, to subsidize the medical coverage of the rest of the population" (p.9). In other words, the middle class paid for its own medical services (on a sliding scale), and paid more of the costs for hospital, consultant, and specialist services than did lower income groups (Jewkes and Jewkes, 1961, pp. 20-21; Watkin, 1978, p. 10).

Pressures for Changing the System

Because of the widespread dissatisfaction with medical services, between the wars there were numerous pressure groups, studies, commissions, and reports which focused on means of redressing some of the problems described above. The pressures, which emerged both from within the British medical profession and without, represented most of the basic ideas which shaped the structure of the British National Health Service. The following groups and reports were among the most important in shaping opinion which eventually facilitated the enactment of the National Health Service.

One of the earliest groups advocating a fundamental change in the medical delivery system was the State Medical Service Association (the forerunner of the Socialist Medical Association). The State Medical Service

Association (SMSA) was formed in 1912, held meetings throughout the country, and its leaders contributed many articles to journals and newspapers. Reflecting labor's demands for a higher standard of living, the SMSA argued that medical care should be free and available to everyone without any type of means test, for only then would it be possible to identify and treat disease in its earliest stages. Unlike upper income groups which generally emphasized the importance of curative medicine, it was labor and organizations sympathetic to labor such as the SMSA who insisted that medical education and research should be reorganized so that curative and preventive medicine would become integrated. Moreover, the SMSA believed that hospitals should be nationalized and all doctors paid on a salary basis, with general practitioners sharing the hospital work with specialists and consultants. The SMSA thought that to promote better access to and efficiency of medical delivery systems, the country should be divided into numerous regions, each with a major hospital as the center of medical care (Murray, 1971, pp. 1-19; Navarro, 1978, pp. 14-24; Moore and Parker, 1918, pp. 85-87; Watkin, 1975, pp. 111-113).

Reflecting many of these views, the Labour Party about the same time produced a report entitled The Organization of the Preventive and Curative Medical Services and Hospital and Laboratory Systems Under a Ministry of Health. Although the SMSA and the Labour Party spoke for only a minority of doctors, the Left was gaining momentum and was becoming increasingly vocal. Meantime, the elites of the medical profession, and of British society in general, were becoming sensitive to what the leaders of the SMSA,

trade unions, and the Labour Party were saying not only about medical care but also about general living conditions in Britain. The activities of the Left appeared to be reaching a crescendo in the December 1918 elections when the Labour Party demanded the reconstruction of society and the nationalization of most major industries. On the heels of the Labour program and of the SMSA insistence that the hospitals be nationalized, the British "medical establishment" responded in 1920 to the issue of medical services with a report by the Ministry of Health's Consultative Council under the chairmanship of Lord Dawson of Penn, a document popularly known as the Dawson Report (Watkin, 1975, p. 112; 1978, p. 12).

Even though the Dawson Report was in many respects "the response of the British establishment to the radical programme put forward by the socialist movement and its allied State Medical Services Association" (Navarro, 1978, p. 15), it was one of the most forward-looking and influential documents to emerge on British medical care during the interwar period. And it, instead of the plans of the State Medical Service Association, became known as "the parent of all regional schemes of health services" (Watkin, 1978, p. 12).

The charge of the Dawson Commission had been to propose ways of improving the nation's medical facilities. The report, which was quite visionary, made three major arguments about the inadequacy of British medical services: that the organization of British medical services deprived the nation of the benefits of some of the most important advances in medical

technology, and, related to the first argument, that advances in the organization of medical delivery had not kept pace with advances in scientific knowledge, and that third, the distribution of medical services was very much outdated (Eckstein, 1958, p. 115; Consultative Council on Medical and Allied Services, 1920).

According to the commission, these shortcomings could only be remedied by a reorganization of the delivery of medical services, along some of the lines suggested by the State Medical Service Association, which would merge preventive and curative medicine. And it was the general practitioner around which much of the system should revolve, for the commission believed that the G.P. should provide the necessary coordination for integrating communal and individualized medicine. The commission also recommended that the country be divided into different regions, each of which would contain primary and secondary health centers coordinated under a single authority. The primary centers would be essentially district hospitals or health centers staffed by general practitioners who would initially handle most cases and would provide community services involving maternity care, child welfare, and schoolchildren. Instead of doctors continuing to be isolated from one another, the primary health centers would bring general practitioners together with specialists and consultants, resulting in an intellectual exchange. The secondary centers were to be general hospitals staffed by consultants and specialists who would treat more complicated cases referred from the primary centers. The services of the primary and secondary centers were to be available to all citizens. Within each region, primary health

centers would be based on secondary health centers, and each secondary center would in turn have direct links with a teaching hospital having a medical school. In this way, the commission hoped that academic influence and spirit of inquiry would permeate the system of secondary and primary medical centers.

While the report was somewhat vague on many features, it clearly emphasized the need for the integration of curative and preventive medicine, for more coordination among all aspects of medical care, and for some type of regional planning (Forsyth, 1966; Ross, 1952; Eckstein, 1958; Stevens, 1966; Lindsey, 1962). Within each region, all services were to be brought into close coordination under a single health authority.

As the Dawson Commission represented the establishment, its recommendations were much more conservative than those advocated by the Labour Party and the SMSA. Whereas the socialist-oriented SMSA advocated a salaried system for doctors, the Dawson Commission essentially sidestepped the issue of how to compensate the doctors. It believed that patients should make some contribution to the cost of their treatment, and therefore endorsed in principle the idea of medical insurance. Moreover, the commission rejected the idea of nationalizing the voluntary hospitals, but recognizing that those hospitals were in serious financial difficulty recommended that they receive further study by another commission.

Because the Dawson Commission had focused special attention on the financial difficulties which voluntary hospitals encountered in their efforts to adjust to rapid technological changes in medical care, the

Ministry of Health appointed another commission in 1921, under the chairmanship of Viscount Cave, to explore solutions to those financial problems. The Cave Commission reported that the financial condition of the voluntary hospitals was so poor that only state assistance could maintain them (Lindsey, 1962, p. 15). Dissatisfied with the lack of coordination among voluntary hospitals, it proposed central and local administrative changes to coordinate the work and finances of the voluntary sector, and advocated within each county or county borough a voluntary hospital committee in order to achieve the following: the collection and dissemination of information about hospital needs, the creation of a uniform system of accounting, the development of a systematic plan for the grading of hospitals within regions, and the promotion of greater coordination among hospitals within each region. Like the Dawson Commission which preceded it, the Cave Commission did confront the problem of nationalizing the voluntary hospitals which the SMSA had raised, but argued that state intervention on such a scale would have disastrous effects for medical services. Although a few of the changes recommended by the Cave Commission were implemented, the problems of inadequate financing and poor coordination of the voluntary hospital system remained serious and continued to be vigorously discussed in and out of government throughout the interwar period.

These issues were broadened several years later when the Royal Commission on National Health Insurance reported in 1926 on the shortcomings of the National Health Insurance system. In particular, this commission advocated such additional insurance benefits as specialist treatment and laboratory

services, and stressed the desirability of providing coverage to dependents and others who received no protection under NHI. In terms of long-range policy implications, however, the most important argument put forth was the suggestion that insurance was not an appropriate method for financing medical care. Moreover, the commission argued that the larger the proportion of the population requiring medical care and the more extensive the services provided, the more difficult it would be to finance the system on an insurance basis and the more necessary it would be to finance medical care from public funds (Lindsey, 1962, pp. 26-27). Even so, the commission did not recommend the extension of benefits to cover inpatient hospital care, believing that the implementation of this type of benefit would, in the short term, undermine the independence of the voluntary hospitals. The concern about protecting the integrity of the voluntary hospitals resulted in much ambivalence in discussions during the interwar period about the extent to which the state should be involved in providing hospital care to citizens.

By 1930, however, the basic structure of the British medical system was very similar to that which emerged following the creation of the National Health Insurance system in 1911. Meanwhile, societal militancy increased in response to the Wall Street Crash of 1929 and the depression which followed. By the middle of 1930, almost three million people were unemployed--the highest number in British history. At this time the State Medical Service Association merged with the Socialist Medical Association, which in turn became closely associated with the Labour Party; in fact, it became the author of the Labour Party's health policy. In turn, the Labour Party

made the following demands for fundamental changes in the British medical system: it should be free and open to all; it should be nationally supervised, regionally planned, and locally administered, with regional health centers linked to general and teaching hospitals; and curative and preventive medicine should be integrated (Navarro, 1978, pp. 26-27; Murray, 1971, pp. 20-34).

As the depression deepened, the Socialist Medical Association became both more active and vocal. Its members increased their influence with the public via magazines, newspapers, and radio discussions. Moreover, the SMA established its own monthly magazine, Medicine Today and Tomorrow, a publication which received a great deal of attention throughout the British Isles. As D. Stark Murray (1971, p. 38) has observed, most of the ideas of the Socialist Medical Association were later incorporated into NHS, and others were still being discussed twenty years after its beginning.

But as the socialists became more militant, conservative forces continued to respond with changes of their own. Vincente Navarro (1978) points out that it was as though the conservative forces within the British medical establishment recognized that the system would have to make some changes for things to stay as they were. In this context, the British Hospital Association, very much concerned about the rhetoric for nationalizing the voluntary hospitals and very troubled by their continued financial problems, established a voluntary hospitals commission under Lord Sankey, which issued its report in 1937. The Sankey Commission wanted to preserve voluntary hospitals,

but was very much committed to establishing cooperation between voluntary and municipal hospitals. To achieve this, the commission accepted the Socialist and the Dawson Commission's idea of regionalization by suggesting that the country divide all of its voluntary hospitals into regions. Even though local public authorities would have representation on the regional councils, the Sankey Report was not very much concerned with public hospitals, thus reflecting the fact that most professional opinion still had difficulty in devising a scheme for integrating public and private hospitals. Though the regional planning boards would have no coercive power, the commission hoped that they would have sufficient legitimacy to achieve the following: to improve or close down inadequate and inefficient institutions, to prohibit new hospitals from being built or old ones from being expanded unless it was essential, to close down overlapping and duplication of existing facilities, and to strengthen the finances of the hospitals (Lancet, May 8, 1937, p. 1117).

Meantime, the leaders of the British Medical Association continued to discuss reform of the medical services and attempted to channel reform activities into specific directions. In 1929, the B.M.A. had advocated the extending of National Health Insurance to dependents of insured persons and other designated groups not previously covered, as well as the provision of maternity and consultant services for those who were covered (Watkin, 1975, p. 121). In response to the activities of the Socialist Medical Association and the Sankey Report, in 1938 the B.M.A. issued a report that vaguely asserted that everyone should have access to a general practitioner. Believing that there had been a great deal of abuse of hospital outpatient clinics,

the B.M.A. argued that access to outpatient clinics should be only by referral. The B.M.A. also endorsed the idea of hospital regions in which all the hospitals in a region would be grouped around a large central hospital (either voluntary or public) which would be well equipped to handle specialized and complex cases. The hospitals of each region were to be developed as an integrated whole, and each patient would be referred to each hospital because of a specific type of illness and not because of individual preferences of general practitioners or patients (Watkin, 1975, pp. 121-126).

Whereas the Socialist Medical Association and the Labour Party had advocated a full-time salaried system for doctors and the nationalization of hospitals, the B.M.A. wanted to preserve the voluntary hospitals and to maintain flexibility in the payment of doctors. The Sankey Commission, attempting to preserve traditions inherent in British voluntary hospitals, thought that doctors in teaching hospitals derived such substantial benefits from their hospital positions that they should continue to serve without pay, but the B.M.A. took the position that doctors in any hospital which received payment for treatment should be compensated for their services.

One of the most important reports prepared by medical providers was that issued by the Medical Planning Commission in 1942, a body which had been established in 1940 by the British Medical Association, the Royal Colleges, the Scottish Medical Corporations, and even members of the Socialist Medical Association. Given the broad representation of the medical profession on this commission, its report reveals a great deal

about the thinking among elite members of the medical profession concerning the desirability for fundamental changes in the delivery of medical services. In many respects, the commission echoed the views of the Dawson Report of twenty years earlier, by arguing that changes in the organization of medical practice had not kept pace with changes in medical knowledge, that the direction for reforms should be through the development of hospital regions, and that the transition of general practice should be from a decentralized, individualistic type service to a more centralized, less competitive corporate work situation (Forsyth, 1966, p. 118). In addition, the report argued that medical need, not economic status, should determine access to medical care, that the rich should not receive better medical care than the poor (Lindsey, 1962, pp. 28-29). To achieve this goal, the report proposed that the National Health Insurance program be extended to cover at least 90 percent of the population; hospitals should continue to charge patients according to their ability to pay, however. In order to promote a more integrated and efficient general practice service, the report advocated a collective form of service, with general practitioners working from health centers sponsored largely by local authorities. Ideally, the local health centers would be closely linked with the regional hospital system, thus achieving a medical service which would integrate curative and preventive medicine. Believing that one of Britain's major problems in medical delivery resulted from inadequacies in the distribution of medical resources across the country, as well as inefficiencies resulting from a lack of coordination of the various parts of the system, the commission

devoted considerable attention to improving the coordination of the voluntary and public hospital sectors and to integrating hospital and general practice care. The Medical Planning Commission, however, issued only an interim report; because of cleavages within the commission, a final report was never issued (Navarro, 1978, p. 32).

Throughout the interwar years, the same themes occurred again and again: too much decentralization and diversity, and a lack of coordination of the medical delivery system and of integrated curative and preventive medical services were serious obstacles to better medical care. To rectify the situation, the concept of regionalism was frequently advocated as a means of coordinating the hospital, specialist, and general practice services. Moreover, there was an emerging consensus, both within the medical profession and without, that the coverage of the National Health Insurance system was too restricted and that some type of substitute financing mechanism was necessary in order to provide medical care for a larger portion of the population. Even so, most of the plans which were proposed during the interwar period were somewhat vague concerning the means by which an alternative medical delivery system was to emerge. An assumption shared by all of the interwar reports was that changes in medical technology and the costs of financing access to the technology dictated important changes in the structure of the delivery system. However, there were serious differences among various professional groups concerning the direction which some of the changes should take. The Socialist Medical Association and the Society of Medical Officers of Health believed that

general practitioners should practice in local health centers which would integrate curative and preventive medicine, and which would be under local government control, and that compensation should be by salary; but most of the medical profession opposed this, fearing that local centers would infringe on the independence and autonomy of general practitioners. In general, the profession was divided over which medical services should be under local government control, which should be tied to the central government, and which should be retained in the private sector. Moreover, there was much disagreement about the future status of the voluntary hospitals and the compensation of the hospital-based doctor. However, the experience of the war, a great deal of infighting among medical professionals, and various public pressures did much to resolve these differences.

British Health Delivery And World War II

More than anything else, it was the experiences of the Second World War which alerted the overwhelming majority of the British people to the serious inadequacies in the British medical delivery system. And it was the changes in medical delivery during the war which convinced both the public and medical professionals that substantial changes were possible. As World War II approached, the British government believed that in the event of war, air raids would result in heavy civilian casualties; for that reason, regional and national planning of hospital and specialist services was urgently needed. In preparation, the British government established the Emergency Medical Service (EMS) under the Ministry of Health in 1938.

The first task of EMS was to locate at least 300,000 beds for civilian casualties. Initially the government could find only 80,000 beds in England and Wales which were suitable for the prolonged treatment of casualties. To create more beds, the country was divided into twelve regions, and each hospital was classified according to various functions. Some hospitals were taken over entirely by EMS, while beds in parts of others were allocated for emergency purposes. The net effect was a great deal of overcrowding in hospitals, the premature discharge of many patients, and the construction of "hutted" annexes to many existing hospitals (Ross, 1952, pp. 76-77; Stevens, 1966, pp. 70-71; Eckstein, 1958, pp. 88-89). By September 1939, approximately 140,000 patients had been discharged from hospitals, children's homes, and mental institutions as part of the emergency measures. In addition, thousands of tubercular patients were discharged from sanatoria (Titmuss, 1950, pp. 194-95).

As the changes imposed by the war made the public increasingly aware of the shortcomings of the existing medical delivery system, pressures increased for permanent changes. It was the overcrowding of hospital services which troubled many citizens. Lengthy waiting lists for admission to hospitals had long posed a serious problem in Britain. In 1938, before the establishment of EMS, there had been 100,000 patients waiting to be admitted to a hospital. But as a result of the overcrowding during the war, the waiting lists became unusually long, especially for gynecological patients and children who needed orthopedic and eye operations (ibid., pp. 73, 493-496). In addition, some overcrowding resulted from the fact that

the government had set aside many beds in large voluntary hospitals for wartime use which were underutilized throughout the war. As a result, many chronic and "uninteresting" cases were crowded into municipal hospitals which had little authority to deny admission to patients. Because the government paid the hospitals participating in the EMS for the use of their beds, whether they were being occupied or not, the government's policy led to a critical shortage of beds throughout the country, causing many types of patients to be refused admission to any hospital. In London, for example, where more than half of the maternity beds were turned over to EMS, it became commonplace for expectant mothers to be denied admission to a hospital.

As many voluntary hospitals became accustomed to accepting large sums of money from the central government during the war, it became difficult for them to confront the possibility of returning to major dependence on private philanthropy once the war was over. The difficulty of a return to a prewar normality was compounded by the fact that wartime governmental funding led to the improvement in the quality of medical care in many voluntary hospitals, which at long last had become accustomed to coordinating their services with other hospitals, in both the public and private sectors.

At the beginning of the war, it was apparent to the planners within EMS that the shortcomings of the British medical system were far more serious than most well-informed professionals had imagined. Unfortunately, the decentralized hospital system in Britain, the lack of uniform recordkeeping among hospitals, and the poor inventory of the nation's hospital facilities

had meant that hitherto most members of the medical profession had not known a great deal about most of the small hospitals, of which there were several hundred. During the war, however, the centralized collection of information about hospitals made it increasingly apparent to the medical profession that many hospitals suffered from poverty and deteriorating physical plants. Within a very short period of time, the central government, through the Ministry of Health and EMS, attempted to upgrade the physical facilities of numerous hospitals by providing surgical equipment, new operating theatres, x-ray rooms, kitchens, blankets, beds, and clothing. As early as October 1939, EMS had installed almost 1,000 new operating theatres and had ordered more than 48,000,000 bandages, dressings, and fitments for various hospitals. By the standards that had prevailed when EMS first came into existence, the hospitals were satisfactorily equipped by the middle of 1940. By that date, the country had at least 100,000 new hospital beds, though many were in temporary "huts." Moreover, many hospitals became equipped for the first time to do serious and complicated orthopedic surgery, to handle complicated chest and head injuries, and to conduct plastic surgery (Titmuss, 1950). By the end of the war, hospitals throughout the country were quite capable of carrying out rehabilitation work. Indeed, thanks to EMS, by 1945 Britain had a large number of orthopedic centers throughout the country which maintained a high standard of practice--a situation which had greatly changed since 1938. The Emergency Medical Service had demonstrated that with a centralized organization, the quality of hospital care could be upgraded throughout the country within a

relatively short period of time. It had also demonstrated that centralized governmental authority had the potential to bring coordination and rationality into what had hitherto been a disorganized, inefficient, and competing set of hospitals (ibid., pp. 83, 480; Eckstein, 1958, pp. 89-90).

Perhaps one of the most important consequences of EMS was the effect that it had on the thinking of the doctors who participated in the service and of many upper middle and upper class citizens who during the war received medical care in many different types of hospitals. As the leaders of the Royal Colleges had urged doctors at the outset of the war to accept positions in EMS, the country's medical elite were very active in the development and implementation of EMS policy from the beginning. For the first time in the nation's history, specialists and consultants were active in shaping a medical service for the entire country. Leading consultants helped to design and organize regional hospital services and to establish blood centers and medical laboratories. Numerous consultants left their private practices and accepted government salaries at only a pittance of their former earnings, working in hospitals far removed from their elegant London offices. By the time the war ended, many consultants and specialists had become accustomed to the idea of working on a salaried basis within voluntary hospitals, had not only helped to design regional hospital plans but had become convinced that the regionalization of medical resources was highly desirable, and had become convinced that governmental planning was necessary in order to bring about a more equitable distribution of medical resources throughout the

country. London consultants who had never worked in a hospital other than a teaching one now had an opportunity for the first time to observe the inadequacies of medical facilities in much of the country, and as a result many vowed to rectify the system.

As middle and upper income people entered public hospitals for the first time, they saw firsthand the relics of old workhouses, the conditions under which the poor and the elderly received medical care, the physical deterioration and inadequate facilities of provincial hospitals. As the well-to-do intermingled with those who were less fortunate, the privileged classes became more sensitive to the problems of poverty, old age, and chronic disease. In sum, the war did much to soften temporarily the class rigidities of British society and to generate a collective conscience which began to focus more systematically on the means of reshaping medical delivery in the postwar period. By 1941, it was widely assumed by upper income groups as well as the medical profession that following the war some type of major change would occur in the nation's medical system. The war, after all, had brought about a decline in contributions to voluntary hospitals at a time when prices and taxes were rising, suggesting that the voluntary sector would not be able to support the nation's hospitals on the same scale after the war as before.

In October, 1941, the Minister of Health reflected much of the nation's mood by announcing that the government would create a national hospital service after the war. Some foreign observers have mistakenly thought that the postwar British system was almost exclusively a socialist program

forced on the British people by the postwar Labour government. It is true that the Socialist Medical Association, which was affiliated with the Labour Party, had long advocated a "free medical service," a salaried medical profession, and a nationalized hospital service coordinated by democratically elected officials. But by 1941, the expectations of a more equitable access to and distribution of medical services coordinated by public authorities were shared by leaders in the medical profession, the leaders of all major political parties, and most every group in British society. The critical question was the precise shape that the changes would take.

The expectations of a new system were intensified in 1942 when the Beveridge Report on social insurance was published. The report was vague in so far as it outlined the government's specific proposals on medical care, but it was important in that it placed medical care squarely within the context of social policy. The report stated the government's intention of providing for the country an all-inclusive health and rehabilitation program, a scheme which would "ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist, or consultant, and will ensure also the provision of dental, ophthalmic, and surgical appliances, nursing and midwifery, and rehabilitation after accidents" (Beveridge, 1943: Paragraph 42b). The service was to be available to all without regard to a means test.

Following the Beveridge Report, the government began serious consultations with doctors, public and voluntary hospitals, and other interested parties

about the structure of a national health service. Next, in February 1944 the government issued a White Paper which was designed to stimulate the imagination and focus discussion on the type of medical system which would emerge, though many groups reacted as though the White Paper contained the government's last word on the subject. The paper demonstrated the government's belief that radical changes would fail and that the new service had to be carefully built on past experience. It assumed that doctors and patients must retain their freedom to participate in the program or not, that people must not be compelled to join the program, and that the program was to be administered jointly by central and local authorities, with due regard for democratic processes (Lindsey, 1962, pp. 33-34).

The crux of the White Paper was the joint health authorities which were to have basic responsibility for most parts of the service: general practitioners, hospitals, and homecare providers. In theory, all public medical care would be the responsibility of the Minister of Health, but area or regional planning would be under the control of a joint authority (one or more local authorities). Voluntary hospitals would come under the program only on a voluntary basis, but because there were such strong financial incentives for them to participate, it was assumed that most would join the scheme (Stevens, 1966, p. 71).

According to the White Paper, all participating G.P.'s were to practice under a contract with the Central Medical Board which would indicate in what areas of the country doctors should not practice because they were designated as overdoctored areas. In effect, the chief function of the

Central Medical Board was to bring about a more equitable spatial distribution of general practitioners. Drawing on ideas from the Dawson Report of 1920, the White Paper placed considerable emphasis on the establishment of health centers for grouped general practice, though general practitioners were to have the option of continuing in separate or individual practice. General practitioners participating through a health center would be compensated by salary, whereas those practicing on an individual basis would be compensated on a capitation basis, as under the National Health Insurance plan. The White Paper was somewhat vague in its plans for specialists and consultants, though the consultants were to be compensated on a salary basis and were to have hospital-based appointments, meaning that they would be under the jurisdiction of the joint authorities.

The White Paper was significant in that it succeeded in focusing discussion. It helped to draw the lines of opposition and support for a national health service and to shape the political process out of which emerged the National Health Service legislation introduced by Aneurin Bevan in Parliament in March 1946. The White Paper quickly won widespread approval in Parliament, and was generally received with enthusiasm in the larger society. Within the medical profession, however, a great deal of opposition greeted the document. To comprehend the medical profession's opposition, it is important to understand that professions much prefer to continue with the type of organizational structure and method of remuneration with which they have become accustomed. It is difficult for professionals

to evaluate proposals which provide for alternative organizational arrangements and different methods of payment, and for this reason, professionals generally greet organizational and remunerative rearrangements with hostility.

Fortunately, there is a great deal of information about the reaction of the British medical professions to specific aspects of the government's proposals, for shortly after the White Paper was issued the British Medical Association submitted a questionnaire to all of its members. Ironically, the medical profession was very much in favor of most of the substantive changes proposed by the White Paper, but at the same time was very fearful of being subjected to control by the government. In response to the White Paper's proposal to provide a free and comprehensive medical service to the entire population, the profession was overwhelmingly in agreement, 60 to 37 percent; on the issue of a free and complete hospital service for everyone, the profession was also in substantial agreement, 69 to 28 percent. The profession also endorsed by a vote of 63 to 24 percent the idea that there should be large administrative areas for hospitals, by a vote of 57 to 39 percent that the government regulate the geographical distribution of general practitioners in the country, by a vote of 56 to 33 percent that doctors no longer be permitted to sell their private practices, and by a vote of 68 to 24 percent that there be local health centers for both preventive and curative care in which groups of general practitioners might practice. Eighty-three percent of the doctors in the

armed forces expressed a desire to return from the war to a health center, and 89 percent of the nation's medical students supported the idea of health centers (Murray, 1971; Hart, 1972, p. 572).

Even though the profession was very much in favor of most of the substantive issues proposed by the White Paper, it tended to react negatively to the proposal, not only because of the fear of being controlled by the government but also because of objection to some specific proposals in the White Paper. Consultants and specialists had become accustomed to hospital planning on a regional scale and to working on a salary basis for the central government during the war. Moreover, they had become very sensitive to the serious financial problems of voluntary hospitals and recognized that some type of major governmental involvement in financing hospital care was necessary. However, they viewed with alarm the White Paper's proposal that local authorities should supervise and manage the hospitals. As a result, in the questionnaire the profession rejected by a vote of 78 to 13 percent the idea of local authority management of hospitals. As Harry Eckstein (1958) has observed, "the doctors did not fear nationalization as much as municipalization" (p. 149), for they tended to associate local government involvement in medical care with Poor Law workhouses, underfinanced and poorly equipped hospitals, and medical institutions which offered little opportunity for professional advancement and recognition. Although most consultants and specialists had accepted the idea of widespread government support and regulation of medical services, they were able to contemplate a more congenial relationship with the class-conscious, high-level civil

servants in the central government and Members of Parliament than with the locally oriented, petty bourgeois local government officials. In short, consultants and specialists were adamant that they and the hospitals should not come under local authority control. As an alternative, they wanted large hospital regions, in which local elected representatives would have little power but in which the voluntary teaching hospitals would be the dominant group. This type of arrangement would help to safeguard the autonomy of the teaching hospitals and the independence of medical specialists.

Meantime, the general practitioners had an entirely different set of concerns. They were fearful that the government intended eventually to move general practitioners into local health centers in which remuneration would be salaried. Whereas a salary was not objectionable to consultants because of their wartime experience, general practitioners were anxious to preserve their compensation on a capitation basis. Moreover, the general practitioners feared that if their practice became located primarily in local group health centers, they would become mere minor civil servants and it would be difficult to retain their professional autonomy.

The medical profession, divided between general practitioners on the one hand and consultants and specialists on the other, was able to emphasize negative positions on specific issues in the White Paper, but the divisions within the medical profession meant that it had great difficulty in generating a positive program of its own. The medical profession had endorsed substantial changes in the organization of medical delivery in various reports between the wars, and again in the Interim Report of the Medical Planning Commission of 1942, and now, its overall response to the B.M.A.'s questionnaire had

demonstrated that it favored major changes in the distribution of and access to medical resources.

With the public solidly in support of the White Paper, the government continued to work out the details of a national program for health delivery, though the planning activity was temporarily interrupted by the general election of July 1945 and the substantial victory of the Labour Party. However, the elections and the Labour Party victory had little disruptive effect on the process of medical planning, for "the White Paper was a coalition expression and the National Health Service a bipartisan affair" (Lindsey, 1962, p. 41).

Over a period of several months in 1945, Aneurin Bevan, the new Labour Minister of Health, carried out extensive consultations with the medical profession, voluntary hospitals, local authorities, trade unions, dentists, and other concerned groups. Bevan had strong views on medical services, and was firmly convinced that the financing of medical care on an insurance basis was totally unsatisfactory. He felt that an individual contributory scheme tended to provide only limited benefits and usually required a qualifying or waiting period, and those who failed to qualify usually had to rely on charity or pass some type of means test in order to receive medical care. Moreover, group insurance tended to provide selective rather than complete benefits and usually left a sizeable portion of the population without coverage. Bevan believed that real equity would result only if the government provided full medical coverage for all citizens. With this type of service, "society becomes more wholesome,

more serene, and spiritually healthier, if it knows that its citizens have . . . the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide" (Lindsey, 1962, p. 43). Although he had strong views on other aspects of medical delivery, he was willing to be flexible and to compromise in order to develop a National Health Service.

In response to the medical profession's opposition to local authority control of hospitals, Bevan was quite willing to propose larger regions. Moreover, he was willing to make certain that the doctors be guaranteed substantial representation in the administration of the new program, that a capitation scheme of payment be preserved for general practitioners, and that the local authorities retain their control over domiciliary services. By the end of 1945, government planners had discarded many of the more controversial points of the White Paper, and they had developed alternative plans to meet the major objections of the medical profession. After many months of careful consultation with all major interests and extensive planning, Bevan finally submitted the government's plan for a National Health Service to Parliament in March 1946; Parliament approved the program without much difficulty in November 1946.

To achieve his success, Bevan had courted the elite of the Royal Colleges, and they in turn had supported his program. He is quoted as having said that he "choked [the consultants'] mouths with gold" (Hart, 1973, p. 1196). Believing that the leaders of the Royal Colleges were more astute and powerful than members of the B.M.A., Bevan structured

the program so that the consultants and the teaching hospitals would continue to receive favored treatment, whereas the general practitioner would continue to work outside the hospital with a much lower status. There is little doubt but that the hospital-based doctors had been highly successful in their negotiations with Bevan. For example, their position on the following issues were essentially adopted by Bevan: conditions of service and pay, permission to continue with private practice but with access to National Health Service hospital beds, a high degree of control over appointments and promotions, and control over the merit award system which the NHS established (Navarro, 1978, pp. 41-42; Gill, 1971, p. 348).

2. THE STRUCTURE OF THE NATIONAL HEALTH SERVICE

Even though the National Health Service (NHS) brought about changes in the British health delivery system, with hindsight, it is apparent that it was an outgrowth or evolution from earlier arrangements in the delivery of medical care. As Almont Lindsey (1962, p. 450) suggests, the new program was a compromise among conflicting structures of the past, imperatives of the present, and the hopes of the future. A major goal of Bevan and other government planners had originally been to develop a highly rationalized and coordinated national health delivery system. In this respect, NHS failed, for the system was not well integrated; in fact, not only were the curative and preventive aspects of medicine not integrated as the various socialist groups had demanded, but there was poor communication among all

key elements of the system. Rather, the National Health Service represented the rationalization of three parts of the total medical delivery system: consisting of a tripartite administrative structure. And it was the traditional structure of medical services which gave rise to the tripartite system rather than a well-integrated and highly coordinated system. The three major parts of the structure were, first the general medical services, which were controlled by local Executive Councils and which provided primarily general practitioner, dental, optical, and pharmaceutical services; hospital services, which tended to be arranged on a regional basis; and local authority services, which provided domiciliary services (i.e., midwifery, maternity, child welfare, home nursing care, as well as ambulance and certain types of preventive health services).

The Executive Councils

The National Health Service provided for free general medical services to be under the authority of local Executive Councils. It was a relatively simple matter for the councils to begin their work, for they were essentially the same organizations which had functioned as the local insurance committees under the National Health Insurance program. Originally, there were 138 Executive Councils which covered the same territory as the larger local governing authorities--the county councils and county borough councils--though administratively they were independent of all other local government. The duties of the Executive Councils were widened to provide dental care and optical services, but in no other area of NHS was there so much continuity

between the National Health Insurance program and the National Health Service. Each Executive Council had 25 members, 8 of whom were appointed by the local health authority, 7 by doctors in the area, 3 by the local dentists, 2 by the local pharmacists, and 5 by the Minister of Health. Basically, the work of the councils was to keep records and to dispense payments, as its policymaking role was very limited.

Most general practitioners continued, as before, to provide medical services on a capitation basis and to be excluded from the hospitals. All patients, as under the National Health Insurance program, were free to choose their own general practitioner, though each doctor was at liberty to refuse to accept a patient on his list. Moreover, a patient was free to transfer to another doctor, and each doctor could remove a patient from his list if he chose to do so. Each doctor participating in the system was also permitted to treat patients privately on a fee-for-service basis, but as most all citizens were on a doctor's NHS list, very few patients sought this option. In order to protect the quality of service, an individual general practitioner was not permitted to have more than 3,500 persons on a list, though in most years the average tended to be somewhat less than 2,500. On average, the income of the general practitioners improved substantially as a result of the NHS, just as participation in the National Health Insurance system represented an improvement over what had existed before 1911 (Titmuss, 1958; Navarro, 1978, p. 42).

Over the years, the general practitioner has been a small businessman. He has had considerable freedom to choose his methods of work, has usually

provided his own premises, and if he has practiced efficiently, has generally been successful. He has been free to practice privately, where he can adjust the size of his practice to suit himself, or to work in industry or for an insurance company. But in general, the G.P. has been isolated, lacking the close contact with professional colleagues available to those who work in hospitals or health centers, and conducting very little research. Even his process of recordkeeping has been rather antiquated. There have been no mechanisms for certifying that the standard of work by general practitioners is high. Moreover, their earnings have depended on the quantity of patients seen rather than the quality of care provided, though if the quality was perceived to be very low, the G.P. ran the risk of losing patients. (Royal Commission on the National Health Service, 1979, pp. 73-82, 89, 231, 288).

As recommended in the White Paper preceding adoption of the NHS, every general practitioner was free to participate or not, but a major idea behind NHS was to coordinate and rationalize the distribution of general practitioners across the country. The Medical Practices Committee was created as a government agency, the major responsibility of which was to make periodic surveys of the country in order to determine the distribution of doctors. The committee would classify areas as (1) designated, which meant that an area was understaffed and that doctors had a right to move there, (2) restricted, which meant that an area was overdoctored and additional doctors should not be permitted, or (3) intermediate, which meant that an area could not be properly classified into either of the

above categories. The Medical Practices Committee consisted of seven doctors which the medical profession nominated, one lawyer recommended by the Lord Chancellor, and a representative from the Executive Councils (Stevens, 1966, p. 227).

The Executive Councils also administered the services of pharmacists, ophthalmologists, and dentists, though they were subject to less control than the general practitioners. Their participation in NHS was also voluntary, but unlike the situation with the general practitioners, they could practice wherever they wished (Eckstein, 1958, p. 203). Moreover, there was no limit to the number of people to whom they could provide services, and they were compensated on a fee-for-service basis, though the government did attempt to regulate their fees. To prevent providers and consumers from abusing the system, after the early 1950s patients were charged a minimum fee for certain services, and for certain dental and optical benefits, a Dental Estimates Boards and an Ophthalmic Services Committee were required to provide approval for certain types of services before a professional could provide treatment, unless the service was to be financed by the consumer.

At the level of primary care, the National Health Service represented an extension of the Lloyd George type of panel system to the entire population (Hart, 1972, p. 573). Much of the medical profession had endorsed the idea of health centers for primary care, and most of the doctors had supported the principle of primary health centers in the British Medical Association's questionnaire. Moreover, Bevan had thought of health centers for both

preventive and curative care as the cornerstone of the new health system. However, the proposal for group practice from health centers was quietly dropped by Bevan without parliamentary debate as a result of the costs of the cold war, which competed with Britain's reconstruction program. Once the idea of group health centers was put aside, any hope of integrating preventive and curative health services was essentially doomed (ibid., 1973, p. 1197; Gill, 1971, p. 349). Public health practitioners remained keen supporters for group health centers, but they lacked sufficient prestige and power to keep the issue high on the health policy agenda.

To the consternation of older doctors but with the support of younger practitioners, NHS put an end to the custom of buying and selling practices. It was common under NHI that the patients on a retiring doctor's list were transferred to the acquiring doctor's list. But young doctors had to make a substantial investment in order to acquire a practice, often going heavily in debt. The retiring doctor, of course, used the money to retire. NHS, however, provided cash compensation, payable upon death or retirement, to all doctors who were enrolled in the National Health Service at its inception as a result of the loss of their right to sell their practice (Davis, 1949, p. 166).

Hospital Services

The second basic pillar of the National Health Service was hospital services, and it was here that NHS made the most radical departure from what existed prior to 1948. The government nationalized its 1,143 voluntary

hospitals with approximately 90,000 beds, and 1,545 municipal hospitals with about 390,000 beds. The nationalization did not include old people's homes, or many nursing homes and convalescent homes, but it did include general, mental, and tuberculosis hospitals, as well as chronic disease hospitals. Within NHS hospitals, everyone was entitled to hospital care without charge. Within a relatively short period of time, the National Health Service upgraded former Poor Law hospitals into very acceptable hospitals, many of which acquired for the first time fully trained specialists and ancillary staff as well as up to date diagnostic equipment (Hart, 1971, p. 406).

The government divided England and Wales into 14 (later 15) hospital regions, each of which was to be affiliated with a university with one or more medical schools. Each hospital region was to operate under the control of regional hospital boards, members of which were not elected but appointed by the Minister of Health after consultation with the university within the region, the medical profession, the various local health authorities, as well as other organizations which the Minister considered relevant. The regional boards ranged in size from 20 to 30 people, whose responsibilities were considerable. Although they met on average only once a month, committee assignments and other duties consumed much time--for most members, a minimum of eight to ten hours a week (Lindsey, 1962, pp. 245-46).

Some regions contained as many as 250 hospitals whereas others had fewer than 100, and some covered large areas of the country, whereas others did not (Stevens, 1966, p. 170). Indeed, there was much variation

in the size of regions, the largest having more than 4.5 million people with more than 65,000 hospital beds, and the smallest approximately 1.5 million people with about 14,000 beds (Lindsey, 1962, pp. 244-45).

Significantly, the National Health Service provided the teaching hospitals with a preferred status by treating them differently. But although the regions were based on a teaching hospital, the teaching hospitals were nevertheless excluded from the regional organization. In short, though nationalized, the teaching hospitals were treated as regions of their own (Stevens, 1966, p. 74), each administered by a separate Board of Governors directly responsible to the Minister of Health, who would appoint the governors from among representatives of the university, the senior staff of the hospital, and the local authorities.

Whereas the teaching hospitals were administered directly by the Board of Governors in a two-tier system operating under the Minister of Health, the administration of the other NHS hospitals was more complex. Operating under the Regional Hospital Boards (R.H.B.) were Hospital Management Committees (H.M.C.), which had the task of coordinating the large number of hospitals operating within a region. Many small hospitals were grouped together in an effort to assure that they would provide similar services to those provided by the large hospitals with hundreds of beds. Hospital Management Committees had the responsibility of supervising the day to day activities of hospitals such as maintaining equipment and physical facilities, purchasing supplies, and appointing personnel other than medical specialists and dentists (Lindsey, 1962, p. 247). Ideally, they were to standardize hospital services across the country. There were originally 388 management committees, some of which

managed one very large hospital, others of which managed more than a dozen each. The size of the committees ranged between 15 and 20 members who were chosen by the Regional Hospital Boards. Members of both the regional boards and the management committees served without compensation, though they were reimbursed for their expenses.

The function of the Regional Hospital Boards was to plan for the distribution of specialists and hospitals under their jurisdiction, to determine and supervise the allocation of money to individual hospitals, and to supervise the staffs of hospitals. Significantly, the R.H.B. employed all the specialists working in the hospitals except those who were still primarily engaged in training. The purpose of this was to prevent the specialists from being too attached to an individual hospital when they could serve several hospitals. This procedure assured small hospitals of having access to the same medical specialities as the larger ones.

The members of the Regional Hospital Boards and Hospital Management Committees were, in theory, to come from all walks of life, with doctors prohibited (after 1957) from constituting more than one-fourth of the membership (Lindsey, 1962, p. 245). In 1948, there had been a widespread belief that the National Health Service would be controlled by those whom it was to serve. Commenting on the membership of the Hospital Boards however, Harry Eckstein (1958) observed, "doctors, retired persons, those of independent means, and the sort of people who usually get themselves nominated to civic bodies--the local councillor type . . . predominate."

In 1957, the Trade Union Congress protested that trade unionists constituted only 7 percent of the Hospital Boards and Management Committees (Lindsey, 1962, p. 245). In 1964, a study of several Regional Hospital Boards revealed that 46 percent of the members had a medical background, and among these, approximately 70 percent had been or were university professors, deans, or consultants, and 21 percent superintendents in charge of hospitals or medical officers. In general, there was an effort to have people serve on the Hospital Boards and management committees because they represented some social and economic group living in an area, though the individuals chosen were ideally to have some knowledge of the world of medicine; but the medical representation and corporate interests have, however, tended to dominate the boards. Of the 15 chairmen of the Regional Hospital Boards in 1964, 11 were either partners, directors, or chairmen of one or more of 50 different companies. Aside from the medical profession, company director was the background most frequently represented. This is work that has been unpaid and has been very time-consuming, but one can hardly conclude that the Regional Hospital Boards were representative of the British population--though in theory they were supposed to have been (ibid.; Robson, 1973, pp. 421-422; Eckstein, 1958, p. 188).

Most of the work of the R.H.B.'s and H.M.C.'s was conducted by their committees and by salaried officials attached to them. Because the salaried officials were full-time, however, they were able to shape the decisions which the Hospital Boards and Management Committees reached. For all practical purposes, the real running of the hospitals was executed by a professional staff rather than by representatives from the community.

The management of the teaching hospitals was less affected by the National Health Service, as they were permitted to continue their privileged position in the medical delivery system. The Boards of Governors of the teaching hospitals contained a relatively high proportion of doctors, as the 25 percent limit on the number of doctors that applied to Regional Boards was not applicable to the Boards of Governors. Their responsibility was to assure that their staff had sufficient facilities for clinical research and teaching. After the nationalization of the hospitals, the endowment of each nonteaching hospital was brought under national control and placed in a central fund from which money was then allocated to Regional Boards and Hospital Management Committees in proportion to the number of hospital beds which they controlled. In this, as in many other matters, the teaching hospitals were given special treatment, as they were permitted to retain their endowment, a factor which assured that they would continue to behave differently from the nonteaching hospitals.

While the hospitals, consultants and the Royal Colleges initially engaged in some sulking about the National Health Service, they soon accepted the system, for they recognized that their privileged status was enhanced by NHS: The large voluntary hospitals had not been in a viable financial position in 1945 and nationalization meant that they had secure and well-paying jobs, sizeable support staffs, wide-ranging diagnostic equipment and departments, and the exclusion of general practitioners from hospitals. For the consultants, NHS provided better

work conditions, enhanced their power over the nation's medical resources, and provided the opportunity for private beds and private practice in government facilities.

Unlike the situation in America, the British specialist has historically worked mostly in the hospital and has seen patients who have been referred by a general practitioner. And British specialists have tended to hold different ranks based on age, training, and achievements. Since the implementation of the NHS, the highest rank has been that of consultant, and in descending order, the other gradations have been senior hospital medical officer, senior registrars, registrars, and house officers.

In contrast to the period prior to the National Health Service when a consultant served in a voluntary hospital on an unpaid, honorary basis, under the NHS the consultant has worked on a salaried basis with a contract. Whereas most general practitioners had long worked on a capitation basis, this was unacceptable to the hospital specialist who had long been dependent on the general practitioner for the referral of patients. The hospital-based specialists might have been paid on a fee for service basis, but this type of compensation had never been acceptable to the doctors in Britain's public hospitals, and as professionals are usually unwilling to tolerate radically different forms of compensation from those that they have previously experienced, the specialists had ruled out a fee for service type of compensation. Moreover, university appointments and hospital medical officers had long been paid on a salaried basis. In addition, a salary was much easier to administer than payment on a fee-for-service

basis, and consultants had become somewhat accustomed to and tolerant of salaries under the Emergency Medical Service during the Second World War.

Whereas consultants formerly had an appointment in and an attachment to a single hospital, consultants under the National Health Service were expected to serve in various hospitals in a broad geographical area. The exact type of work which consultants were to do in the various hospitals was arranged among the consultant, the local doctors, and other professionals in specific hospitals (Stevens, 1966, p. 190). To prevent the nepotism and favoritism which had characterized appointments at the consultant level earlier in the twentieth century, applicants for consultant positions were accepted from candidates throughout the country once a Regional Hospital Board announced an open position and advertised it, and an individual could become a consultant only when and where the Ministry of Health and the Regional Hospital Boards designated an opening. In this respect, the consultant had less choice about the location of his practice than the general practitioner, whose place of practice was subject to the direction of the Medical Practices Committee (*ibid.*, p. 189).

The salary of the medical specialists was nationally based, subject to no variation across specialties, regions, or localities. Of course, there were salary increments which occurred over time for advances in rank. Consultants were not required to work full-time, however, as they were compensated primarily for the time which they spent in the hospital.

Indeed, most consultants did not accept appointments on a full-time basis; for example, more than two-thirds of the consultants worked on a part-time basis in 1959 (Lindsey, 1962, p. 337). There had long been a widespread feeling among specialists that part time service carried high prestige and status--a carryover from the days when consultants worked on a part-time, honorary basis in the hospitals. Most consultants, therefore, entered into part-time contracts with their Regional Hospital Boards. Although consultants examined the outpatients referred to them, they had a staff of junior and senior doctors who assumed a substantial portion of the medical care for which the consultants were responsible.

Because the consultants were employed by the Regional Hospital Board rather than the individual hospital, in some respects they have enjoyed much more professional autonomy than their American counterparts. For example, the consultants were subject to little quality control over their practice, there being virtually no programs of medical audit or issue committees which were formed in many of the better American hospitals. The British medical leaders have often argued that the vigorous screening procedures for selecting their consultants have rendered such quality controls less necessary than in a large country such as the United States in which the senior medical staff of a hospital has been subject to less national screening and competition. There have been few formal procedures for disciplining consultants who have performed inadequately or even for determining whether consultants have performed satisfactorily.

Generally the consultants have worked as they have thought best, according to the standards which they have accepted for themselves, and they have been relatively impervious to criticism. Unlike general practitioners, consultants were not disciplined for excess prescribing, for being rude to patients, for making minor breaches in their contracts, or for wasting hospital money (Stevens, 1966, pp. 191-196).

At any rate, the consultants, by being employed at the regional rather than at the hospital level, retained much of their independence. The consultants were allocated a specified block of beds but were not subject to much control by the Hospital Management Committees or their colleagues in the hospitals in which they worked; in fact, they operated more on a basis of equality with the Hospital Management Committee, as both were responsible to the Regional Hospital Board. As Rosemary Stevens comments, "consultants continue to behave as if they were still independent professional men, voluntarily donating their services" (Stevens, 1966, p. 192). Once a Regional Hospital Board appointed an individual to rank of consultant at an average age of 37, the person had a tenured appointment until retirement at age 65. The consultant, in short, had a very secure appointment. In addition, aside from the salary which consultants earned they were also permitted to receive income from other sources for practice: (1) for domiciliary consultations, (2) from distinction awards, and (3) from private practice.

Domiciliary consultations. The National Health Service provided for a free domiciliary consultation service for all patients who, for medical

reasons, could not see a consultant at an outpatient clinic. One of the ideas behind the service was to provide greater coordination among the hospital, the specialist, and the general practitioner; another idea was to save money--many patients could be examined in their homes by a specialist instead of having to be placed in a hospital in order to see a consultant. As most of this kind of activity was diagnostic or advisory in nature, it tended to work quite satisfactorily.

When the consultant received additional NHS fees for examining patients in their homes, the visit was usually at the request of the general practitioner, and generally in his company so that advice could more efficiently be provided. If more than one visit were necessary for the same patient, the payment was reduced for subsequent visits. In addition, NHS compensated the consultant for travel expenses. In order to prevent abuse of the system, an upper limit was placed on the amount which a consultant could earn under domiciliary practice, though few consultants ever received the maximum permitted, and most fell far short of it. Most domiciliary consultations occurred in the area of internal medicine, general surgery, general psychiatry, pediatrics, gynecology, and orthopedics, with neurology, neurosurgery, plastic surgery, and radiotherapy being least frequently involved, as the practice of these specialties were more tied to physical equipment which was located in the hospital. In 1949, more than 5,000 specialists were available for domiciliary practice, and more than 130,000 consultative visits in the home occurred. Ten years later, the number of visits had more than doubled, and this type of home service has continued to grow (Lindsey, 1962, pp. 328, 344).

Distinction awards. The fee-for-service type practice that is widespread in America offers incentives to practitioners to excel in quality, and be attentive to the needs of patients. In response to the concern that a salaried service might not provide sufficient incentives to consultants to practice high-quality medicine, NHS provided distinction awards for consultants. The stated goal of the awards was "to stimulate effort and encourage initiative." The number of consultants receiving awards was in theory determined by the Minister of Health, but those receiving awards were actually determined by the elite of the medical profession--usually by a committee which included the presidents of the Royal Colleges. There have been several types of awards, each one being a handsome sum of money which supplemented the consultants' salary each year until they retired, whereupon they received an additional pension as a result of the award. In addition, the awards have amounted to substantial salary increases for those who have been singled out for meritorious service. As the awards have been made by a national committee rather than by a local or regional group, it has been one's professional seniors rather than one's peers who made the awards. Many foreign observers have thought it curious that the names of those who have received awards have been kept secret from both the profession and the public. The secrecy has meant that patients have no way of determining whether their consultant has been designated for a distinction award, and encourages all patients to believe that one consultant is as good as another.

Many consultants have received awards: One study concluded that 43 percent of the people who become consultants receive a

distinction award in their career. Because of the awards, the salaries of specialists remained quite unequal under NHS, despite public pronouncements about the egalitarian salary scale in the system. Moreover, the distribution of the awards was quite uneven across the medical specialties. For example, in 1964, 60 percent of internists, thoracic surgeons, cardiologists, neurologists, and neurosurgeons received awards, whereas no more than 13 percent of those in geriatrics, anesthesiology, and psychiatry received awards. Moreover, part-time consultants received more awards than full-time consultants, and consultants in teaching hospitals received more awards than those in nonteaching hospitals. For the top award, consultants had six times better opportunities of winning an award if they were attached to a teaching rather than a nonteaching hospital. (Stevens, 1966, p. 213; Royal Commission on the National Health Service, 1979, pp. 235-237).

Private practice. All part-time consultants were permitted to engage in private practice, a factor of considerable symbolic importance. It was a tradition they insisted on preserving. Moreover, it represented an alternative source of income for those specialists who chose to work part-time in the NHS. Bevan had not been sympathetic to the continuation of private practice, but he and his advisers believed that unless the government conceded the right of practitioners to continue to provide medical care on a fee-for-service basis, the NHS could not be implemented. Moreover, Bevan believed that the number of people who would continue to pay for private treatment would be quite small (Gill, 1971, p. 349).

The extent of private practice, however, has been impossible to determine. Because the government did permit a small number of pay beds to remain in the hospitals after 1948, one crude indicator of the extent of private practice is the amount these beds are used. Pay beds were approximately 1 percent of all staffed NHS hospital beds, but over time only about one-half of these have been utilized at any one point (Royal Commission on National Health Service, 1979, p. 291). In general, consultants were not permitted to admit private paying patients to beds other than pay beds. In short, the demand for private treatment was modest. Nevertheless, a high percentage of the consultants who were permitted to treat private patients did so. In 1964, part-time consultants accounted for 69 percent of all of those employed by NHS, and their incomes were higher than their full-time colleagues, not only because many part-timers received distinction awards but also because of the extra income received from private practice (Mencher, 1967; Gill, 1971, p. 350). One study has estimated that private practice has added roughly one-fifth to the incomes of consultants, but less than 10 percent to that of general practitioners (Klein, 1979, p. 466; Review Body on Doctors' and Dentists' Remuneration, 1972, p. 41). It was estimated in 1961 that there were approximately 700 general practitioners and specialists engaged in full-time private practice in Great Britain--or somewhat less than the equivalent of 2 percent of all the doctors associated with NHS.

Even so, the hospital provident societies provided private medical insurance for almost one million people in 1959, suggesting a sizeable

number of people wanted the opportunity to have private care, whether they received it or not, in private nursing homes, private hospitals, and in NHS hospitals (Lindsey, 1962, pp. 278-79). By the late 1970s, approximately 2.5 million citizens had purchased private medical insurance, and the membership in such plans was growing at a rate of approximately 10 percent a year. Most of the private insurance was purchased to provide consumers with swifter treatment by their choice of physicians and hospitals, and with a private hospital room and other amenities. The purpose of the private care was not primarily to obtain a higher quality of care, as most of the physicians who treated private patients also practiced in the NHS. However, one of the basic motives in acquiring private service was to avoid long waiting periods for elective surgery. And yet, the private sector was responsible for less than three percent of the total expenditures on medical care by 1979. Basically, more and more citizens were requesting that their employers provide some form of private medical insurance in case it was needed, but all but a small fraction of medical services were still being provided by the NHS (Spivack, 1979; Klein, 1979).

General Practitioners and Specialists

Britain was one of the few countries which introduced a national health insurance system very early in its history, at a time when hospital-based technology was relatively unimportant, and the administrative and financial structure encouraged large numbers of doctors to engage in general

practice. Significantly, the adoption of this type of decision at an early point in time helped to resist the trend toward specialization. By 1948, when the NHS came into existence, a very large proportion of Britain's medical profession were still engaged in general practice. By limiting the number of specialist posts which were available in hospitals, the NHS was able to keep the percentage of doctors who specialize in the minority. Moreover, the Ministry of Health, working with Regional Hospital Boards and the Advisory Committee on Consultant Establishments, has been in a strategic position to influence the distribution of doctors across different specialty fields (Stevens, 1966, p. 228).

Because the NHS has been in a position to limit the number of available specialty positions and because patients gained access to a specialist primarily as a result of a referral from a general practitioner, the general practitioner has remained very much the center of British medical practice. This helps to explain why, in the middle 1960s, approximately 70 percent of Britain's medical profession was engaged in general practice and 30 percent in specialty practice.

On the other hand, in those countries that developed national health insurance late (e.g., Sweden and Canada) or not at all (e.g., the United States), the governments did not have the financial and administrative structure which provided the incentive for a large proportion of its profession to engage in non-hospital-based, general practice. As medical technology shifted more toward the hospital, there has been a great deal of incentive in these countries for doctors to specialize. For example,

the specialists-general practitioner ratio in the United States was almost the reverse of that in Britain. In the middle 1960's, approximately 65 percent of all American doctors were specialists, and 35 percent were general practitioners. As a result, it has been common for the American patient to bypass the general practitioner and go directly to the specialist, without any type of referral.

In short, the timing of National Health Insurance in various western countries helps to explain the variation in the financial and administrative structures which have placed constraints on the specialist-general practitioner ratio. And even though the National Health Insurance scheme died in Britain with the introduction of the National Health Service in 1948, the establishment of local Executive Councils and Regional Hospital Boards provided a financial and administrative structure which placed effective constraints on the number of specialists in the system. In America, however, where the constraints on the number of specialists are more market place rather than governmental administrative ones, the function and number of specialists is very different from that in the British Health delivery system (Heidenheimer and Layson, 1979).

Local Authority Services

The Executive Councils and the Regional Hospital Boards were concerned primarily with providing curative care to patients, whereas the primary function of the local health authorities, the third major part of the National Health Service, was to provide preventive care. As the local

authorities lost the municipal hospitals to the national government, their basic role in NHS was to continue their traditional public health functions, most of which dealt with preventive services. Some activities which had long been optional now became mandatory, but the local authorities were able to carry out their functions more efficiently due to the availability of more funds. In each county, the chief public health official, the Medical Officer of Health (a position which had been in existence for more than a hundred years), was aided by a sizeable number of specialists in many different areas: midwives, home visitors, home nurses, speech therapists, doctors, and dentists--to mention but a few.

One of the chief activities of local government health activity continued to be home visiting for the health of mothers and children. The health visitor has generally been a female nurse who was trained to understand relationships within the family. A professional in her own right, she provides education and advice on the prevention of illness, and refers cases to the general practitioner when curative help is needed. In 1960, there were approximately 6,700 health visitors in England and Wales, many of whom worked part-time, combining home visiting with home nursing, midwifery, and tuberculosis visiting. In 1949, there were approximately 10 million home visits, and in 1960 almost 12 million (Lindsey, 1962, pp. 364-369; Royal Commission on the National Health Service, 1979, p. 76).

Distinct from home visiting was the activity of district nurses who did many types of home nursing, generally under the supervision

of a general practitioner. By 1960, there were approximately 10,300 district nurses, and almost 23 million home visits. As hospital care became increasingly costly, patients were discharged early, on the assumption that they would receive care from district nurses, and as the service expanded, some patients were kept out of the hospitals altogether (Lindsey, 1962, p. 373).

The domiciliary midwife service was another important local authority service, with a sizeable portion of all births still taking place in the home, and a midwife being present at virtually all domiciliary confinements. In a high percentage of cases, a midwife conducted the delivery without a doctor's presence. In addition, midwives were active in the local authority prenatal clinics, and in family planning and genetic counseling (Royal Commission on National Health Care, 1979, p. 77).

Some of the local authority services would not have functioned were it not for the large number of volunteers and voluntary organizations who contributed their time. Volunteers were particularly active in the domiciliary service and in the local clinics. The British Red Cross, the Leagues of Friends, the Order of St. John, and the Women's Voluntary Services are among the organizations which were especially active. The volunteers, the district nurses, and others who aided in providing nursing care in the home did much to assist in permitting patients to remain at home rather than to be removed to a hospital, convalescent institution, or nursing home. Evening and night services were also helpful for the elderly and the chronically ill. All of these services, as distinct from

institutionalized types of services, were very important in keeping the costs of the National Health Service low relative to those in other countries.

3. CONCLUDING OBSERVATIONS

Despite many coherent plans for changes in medical services which developed between 1918 and 1948, the system which was implemented in 1948 was not a coherent, highly coordinated, or rationalized program of medical care. The National Health Service is an excellent example of how traditional practices and structures have persisted despite serious efforts to reshape a system. Probably no country in the world has produced so many wise reports for improvements in the delivery of medical services as has Great Britain. And yet the structures which were implemented in 1948 were not greatly dissimilar to those which existed before the National Health Service. Probably the most important change which occurred was the nationalization of the hospitals. But like the nationalization of the steel and other industries after the Second World War, this occurred largely because the nation's elite feared that the country could not continue to finance the hospital system in the same fashion as it had before 1948.

The National Health Service did not bring about an integration of curative and preventive health centers as the Dawson Commission and others had advocated, and local health services continued to be poorly financed.

Meantime, the cleavages and poor communication between the hospital based doctors and the general practitioners continued. And while the National Health Service did much to upgrade the quality of a very high percentage of hospitals, it singled out the prestigious teaching hospitals for special treatment.

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