Aneurin Bevan on the National Health Service / editor, Charles Webster ; foreword by Michael Foot.

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JOFG

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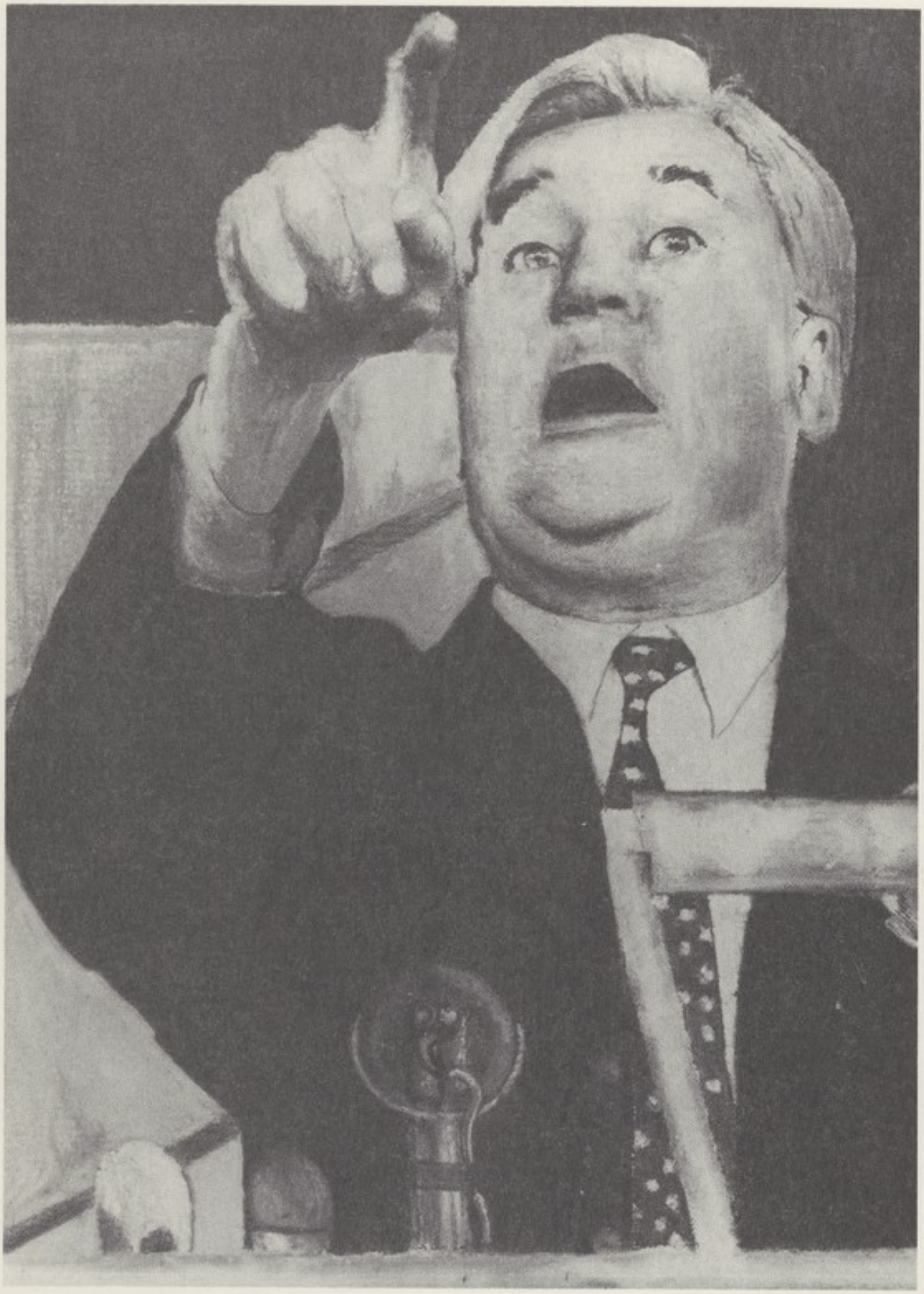

ANEURIN BEVAN

ON THE NATIONAL HEALTH SERVICE

Editor
Charles Webster

Foreword by
Rt. Hon. Michael Foot, M.P.

UNIVERSITY OF OXFORD
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JOFG

What we are doing is now being watched by the whole world. This is the biggest single experiment in social service that the world has ever seen undertaken. It is, I think, a great tribute to the vitality and the genius of the British people that we are able to undertake a task of this complexity and magnitude within three years of the end of a great war. It shows that the British people have still got the principles of innovation, and renovation, running through them yet, and that we can pioneer in many directions for the rest of the world to follow. But if we are able to start these things we are being watched as they develop, and the rest of the world will decide whether they are going to imitate us by the extent to which we make a success of what we are doing.

Aneurin Bevan
7 October 1948

Der im Glück wie im Unglück sich eifrig und tätig bestrebet

Εὐφροσύνη

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FOREWORD

This is a book about the National Health Service; it is also a book about politics in the broadest sense. Aneurin Bevan would have wished that the two should always be joined together, and that no-one should dare to put them asunder. He always believed that practical politics should derive from political principles, and that the politicians who denied this proposition were responsible for the impoverishment of our public life. The National Health Service, in which he believed and so largely shaped, was based on the principles of democratic socialism which lay at the centre of his political faith.

However, the manner in which he learnt to enlarge and reinforce his political doctrines by the detailed study of the medical needs of the nation is also an essential part of the story. He loved discussing medical questions with the experts, or the supposed experts. Some of his best friends were doctors. He had a ceaseless curiosity about every kind of medicine, especially preventive medicine. How he went about the task of converting the general will for the National Health Service into the unique structure which has more or less survived to this day is an object lesson in practical politics all on its own.

When Charles Webster's first volume on *The National Health Services since the War* - much the most comprehensive and authoritative survey of the subject - first appeared in 1988, the reviewer in *The Times Literary Supplement* marvelled, first and foremost, how amid all the political and economic pressures of the time, the whole edifice could have been constructed on such an ambitious basis. One part of that achievement he attributed to the political genius of Aneurin Bevan, and here is the detailed evidence for the claim.

Michael Foot, M.P.
(Blaenau, Gwent)

PREFACE

Bevan is one of the best remembered modern politicians. Although many of his sentiments are widely quoted, there is minimal opportunity to refer directly to the original sources. Bevan gives little assistance to the inquiring reader. He was notoriously reticent to commit his ideas to print. His favourite vehicles were debate or spontaneous address. Thus the only readily available text concerning his ideas on health care is a short chapter from *In Place of Fear.*[1] The only realistic alternative for the serious student is working through the rich collection of material included in the second volume of Michael Foot's biography.[2] In view of the continuing interest in Bevan and the early welfare state, it is useful to collect into more accessible form some representative speeches and writings on the NHS. My introduction is designed to provide a brief contextual guide, while the notes explain points in the text which might otherwise appear obscure.

This exercise is perhaps particularly relevant at a time when the record of the early welfare state established after World War II has been subjected to destructive scrutiny, as part of the wider assault on positive state intervention in the field of welfare. Bevan has come to symbolise the worst excesses of welfare socialism. In the process his ideas have been misrepresented and distorted. He is for instance accused of not appreciating the expenditure implications of a modern health care system, and he is wrongly associated with the fallacy that the NHS would become self-financing as the nation was raised to a higher state of physical fitness. It is asserted that he held exaggerated and unrealistic expectations concerning the capacity of the NHS to reduce illness. In other cases more subtle errors are committed. The reader will observe that none of the texts included in this collection contains the claim that Bevan had "stuffed the con-

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1. Aneurin Bevan, *In Place of Fear* (London, Heinemann, 1952). Later editions, essentially unchanged, appeared in 1961, 1976 and 1978, the last with an introduction by Neil Kinnock.
2. M. Foot, *Aneurin Bevan*, 2 vols. (London, Davis-Poynter, 1973; Palladin paperback edn, London, Granada, 1975). Citations below are to the Palladin edition.

sultants' mouths with gold". As a separate note explains, this comment made in private at a late date, has subsequently been accorded artificial prominence.

Full texts have been given in the majority of cases. In the case of speeches trivial interruptions have been omitted, while interjections are indicated in the notes. In one case (III), some technical sections of a memorandum are eliminated. Obvious mistakes have been silently corrected. Original spelling and punctuation have been preserved.

As indicated by the explanatory notes, the reconstruction of Bevan's speeches is not always an easy task. Parliamentary papers and public record sources offer few problems, but speeches reported in the press and in medical journals are difficult to reduce to a single definitive text. In such cases a fuller text has been arrived at on the basis of collation of the best sources currently located. Undoubtedly, in some instances, improved texts will be arrived at by more systematic and exhaustive methods. However, it is trusted that the present collection will be adequate on an interim basis. The speeches included in this collection comprise some of Bevan's most celebrated interventions. The reader is referred to the biographies of Campbell and Foot for Bevan's speeches on defence, foreign affairs and housing. The last comprised Bevan's other major preoccupation as Minister of Health.

Most of the material in this collection relates directly to Bevan. The documents vary from verbatim texts to reported summaries. In one case (XX) the full Cabinet discussion is given. As with many Ministerial speeches, some of the texts included in this collection derive from other hands, especially from the Minister's official advisers. This is perhaps particularly the case with the Appendix to III and speeches X and XV. However, it is felt that these texts are helpful in supplying useful background information not provided elsewhere. In a collection of this kind there is inevitably a certain amount of repetition, but it is hoped that this will not detract from the value of the project. The sources contained in this edition give an insight into many sides of the character of Aneurin Bevan. They also serve the wider purpose of providing a timely reminder of the grounds for establishment of the National Health Service and the postwar welfare state. Much of the justification for state involvement

in welfare advanced by Bevan retains its relevance, regardless of the social and political transformations of recent decades. These historical documents therefore have a real part to play in the dialogue concerning the future of our health and welfare services.

Charles Webster
All Souls College, Oxford
December 1990

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In the first place, I would like to thank my friends and colleagues at the Wellcome Unit in Oxford for their indulgence and patient interest in my work on the National Health Service. I am grateful to Richard Smith, the Director of the Wellcome Unit, for allowing this edition to appear in the Unit publication series, and also for generously making available the facilities of the Unit for production purposes. Humaira Ahmed has given invaluable assistance with typing, Deborah McGovern with related correspondence, and for technical presentation, I have Helena Webster and Tamar Burchill to thank. John Mooney has given expert assistance with photography. Margaret Pelling has yet again assisted me at all stages of the project. I am particularly grateful for her comments on the introduction.

Brian Abel-Smith and Michael Foot have kindly allowed me to quote from personal correspondence. I am also indebted to their writings on Bevan and the modern health service. It was particularly kind of Michael Foot to spare time from his public engagements to contribute a foreword.

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INTRODUCTION

Of all modern institutions of the British state the National Health Service is arguably the most cherished. When it was established after World War II the new health service was recognised as meeting a long felt and desperate need. Since then the NHS has grown in popular estimation until it has assumed almost unchallenged authority. Faith in the NHS remains undiminished, even in the face of onslaughts from zealots of the right. The health service also possesses a wider significance by virtue of its central importance in the welfare state.[1]

In the popular imagination the NHS remains indissolubly linked with the name of Aneurin Bevan (1897-1960). At the end of a decade when the values of the welfare state have come under sustained attack, Bevan's role as architect of the NHS and articulate defender of welfare socialism has attained a renewed significance. Almost alone among postwar Labour leaders, Bevan retains his capacity to inspire.

Many investigations have confirmed the importance of Bevan's personal contribution in the establishment of the NHS. However, in recent years it has become fashionable to question whether Aneurin Bevan was particularly essential to the new health service or indeed whether the health service was important to him. For instance, Campbell's biography describes health care as a "sideshow" in Bevan's abortive campaign to transform Britain into a socialist society.[2] The most recent historian of the early NHS concludes that "Bevan had the good fortune to spearhead a movement that already had force".[3] The general thrust of recent interpretation suggests that Bevan and the Labour government were carried forward on an inevitable tide of initiative, largely stemming from the medical profession, the influence of which was mediated by civil servants in the health departments.[4] There is in consequence a tendency in the new orthodoxy to write Bevan out of the story, as an inconvenient obstacle to "consensus" or "bipartisanship" models of political change.[5] The first semi-official history of the NHS, where Bevan's name does not appear in the index and is difficult to locate in the text, provides a

precedent for the modern revisionism.[6]

The texts included in this collection are sufficient evidence of the importance of the health service to Bevan. According to the *British Medical Journal* he announced his intention to serve a full five years of office in his first address to a medical audience.[7] This was an unusual commitment for a senior politician and no previous Minister of Health had lasted for more than three years. It is clear that Bevan quickly realised that the fields of health and housing offered ideal opportunities for application of his socialist ideals. Reform of the health services in particular challenged Bevan's instinct for socialist reconstruction. Thus a free and comprehensive health service and liberal provision for welfare were regarded as major priorities in themselves rather than as minor policy considerations for a politician primarily concerned with international affairs. The two facets of Bevan's outlook were integrally related and mutually reinforcing. Bevan's obsessive and uncompromising adherence to the NHS, amply demonstrated in the following documents, is only explicable on the basis of its fundamental importance to his political philosophy.

In the event, the system of administration embodied in the 1946 legislation represented a set of compromises designed to appease the various interest groups and conditioned by the realities of an obsolete system of local government. Authors of histories of the early NHS have tended to concentrate on the minutiae of these compromises, with the result that Bevan's significance seems limited to marginal issues, or spectacular and controversial interventions at the negotiating table. It should not be overlooked that Bevan was instrumental in effecting a secular change in the pattern of health care and a fundamental shift in values, without which the NHS would not have attracted and maintained the confidence of all social classes, as well as the vast NHS workforce, including all sections of the medical profession. Bevan's self-consciously imposed revolution involved a break with traditions inherited from an entrenched system which subjected the recipients of health care to every species of humiliation. Bevan made a determined effort to erase the stigmata of the poor law, the means test, the "panel", or the more vicious aspects of the paternalism of the voluntary agencies. Hospital nationalisation was fundamental to this reorientation. This not only created a unified hospital service capable of adaptation to modern conditions; it also

permitted the NHS to adopt standards hitherto restricted to only the most privileged classes - Bevan's principle of "universalising the best". Hospital nationalisation involved a further revolutionary implication; it transferred the weight of funding the new health service to general taxation, thereby maximising the redistributive effects of the new health service. Exchequer funding provided a premise upon which Bevan could insist on the universal, comprehensive and free nature of the services provided by the NHS. In all of the above respects, Bevan was transcending expectations of the vested interests within the health establishment, which predominantly urged a slower, evolutionary development of health care. His critics, including leading figures in the Labour Cabinet, recognised that Bevan was unleashing a social experiment which would entail an ever-increasing commitment of public expenditure to health care. Attainment of an appropriate level of funding for the NHS was never likely to be an easy objective, and few of Bevan's successors have displayed the qualities needed for success in this mission. Whatever the limitations of the achievement of his successors, Bevan established the essential preconditions for a humane system of health care appropriate to the aspirations of the later twentieth century. By this display of remarkable political imagination Bevan was making more than a marginal contribution to the reshaping of British society.

Aneurin Bevan made a precipitous entry into the affairs of the health service after the landslide General Election victory of the Labour Party in July 1945. The recalcitrant backbencher, recently dubbed by Churchill a "squalid nuisance", found himself translated to a senior post in Attlee's Cabinet. His selection as Minister of Health surprised both the media and officials.[8] The sagacious Attlee considered Bevan for no other Cabinet appointment and apparently he considered no other candidate for the Ministry of Health.[9] Bevan was an unexpected but not unreasonable choice. The discipline of high office would stifle Bevan's capacity to irritate the Government in the House of Commons. The appointment also seemed like a generous gesture towards the parliamentary left, and recognition of Bevan's increasing popularity within the labour movement. Finally, Attlee was subjecting Bevan to an unenviable test. In both health and housing the Labour Party had made extravagant promises. High

expectations had been aroused among the electorate. Failure on either front was likely to destroy Bevan's reputation. The people still remembered Christopher Addison, the first Minister of Health, whose career was ruined by the failure of the post-World War I reconstruction programme.

Housing arguably presented the more intractable problems, but health was a political minefield, as had been discovered by the health Ministers during World War II. The Coalition Government had intended to reform the health and education services before the end of the war. The Education Act was duly dispatched in 1944, but health was left behind. A health White Paper was indeed produced in 1944, but this was given a lukewarm response and it was vigorously contested by the medical profession. By the end of the war all the government schemes lay in ruins, while the powerful interest groups involved were more divided than ever they had been.[10]

This was the inauspicious scene upon which Bevan made his debut as fourteenth Minister of Health. His predecessors had lasted for an average of two years. Of their number, only Neville Chamberlain had made a substantial mark, and his achievement was largely confined to local government reform. The promises concerning major health service development made after 1918 had not materialised. The result was a scandal which in 1945 could not be allowed to persist. The greatest obstacle in the way of change was the medical profession. The British Medical Association had evolved its own plan for the health service, which it maintained inflexibly, regardless of rejection by the government of the day. Nevertheless, the profession pursued its aims with ruthless determination until it wrested the initiative from the democratically elected agencies of the state.

By 1945 the BMA was in firm command of events. During the war this organisation had emerged as a powerful fighting force.[11] It had conducted ferocious onslaughts against the wartime Ministers of Health. The emergence of a socialist government heightened the fears of the BMA leadership and sharpened their instincts for aggression. They immediately identified Bevan as a maverick extremist even more likely than his errant predecessors to pose a threat to their values and interests. His views were awaited with morbid anticipation.

Bevan's first opportunity to announce his plans for health service reform occurred on 5 September 1945, when he agreed to address the annual dinner of the Royal Medico-Psychological Association at the Savoy Hotel (I). At this early stage it was not practicable or prudent for Bevan to enter into specific policy commitments. Nevertheless his audience was assured that the new health service would be an ambitious construction, indeed the "envy of all other nations in the world". Instead of addressing questions of mental health he used the Savoy platform to appeal for the cooperation of the whole medical profession and general practitioners in particular. No doubt Bevan hoped that a generous and conciliatory gesture would calm the nerves of his embattled professional critics. The Minister even implied that socialism would prove a positive asset to the doctors because it assured them of industrial democracy, thereby guaranteeing that they would exercise a substantial voice in the control of the new health service.

Although Bevan's tone was emollient, his speech was interspersed with radical sentiments. He was a socialist, and known to be unorthodox, and committed to experimentation. The new health service would reflect this disposition.

The medical profession was left wondering at the true meaning of what they identified as Bevan's "maiden speech". Hill affected surprised approval at the Minister's conviviality and modesty, but he was not confident that the future would be a "placid time".[12] Nevertheless the profession took heart from Bevan's promise that the formulation of the new health scheme would involve "very lengthy discussions" with the medical profession, seemingly at a leisurely pace over the course of the next year.

In practice, the Minister made no moves to negotiate. At first he was excused on the ground of preoccupation with housing problems. Soon the BMA became restive. The grounds for suspicion mounted. On 17 October the Minister told the Society of Physiotherapists to expect the health service Bill in the early months of 1946.[13] Between 4 and 6 November the newspapers were alive with leaks concerning the government's intentions. It seemed that a complete scheme had been evolved and that negotiation with the medical profession would be limited to terms and conditions of employment. Bevan was silent about his plans when he gave a short address at the fork luncheon

on 7 November which formally inaugurated his contacts with the BMA.[14] By this stage Bevan's invocation to "harmonious association" had developed a hollow ring. The BMA tried by letter to prise out of Bevan a promise of negotiation, but this elicited a complete rebuttal. Protracted negotiations "would mean covering all over again ground which has been repeatedly tilled and so wasting time which we cannot now afford".[15] In the hands of Bevan the elected government again assumed the initiative and the profession was reduced to a reactive role.

Bevan inherited onerous responsibilities on both the health and housing fronts of his Ministry. In addition there was obvious need for local government reform. This latter problem was effectively shelved, but health and housing received urgent attention. Although housing occupied the limelight in the press, Bevan was also quietly pushing on with preparations for the National Health Service. Already in August 1945 he was provided with a memorandum outlining a "National Hospital Service" involving ownership of hospitals by a central authority.[16] The source of Bevan's inspiration on hospital nationalisation is not entirely clear, but it is evident that this opportunity was grasped with alacrity and he made this radical policy initiative the central feature of Labour's NHS legislation.

Confirmation of the strength of Bevan's personal involvement is provided by the firmness of his resolve on hospital nationalisation in the face of determined opposition from his senior civil servants and Cabinet colleagues. The first obstacle comprised the two most senior officials on the administrative side of his Department. Their opposition was not broken until the end of September, only a few days before the Minister's memorandum on the future of the hospital services was circulated to the Cabinet (II).[17] In this document Bevan cogently argued the case for taking over voluntary hospitals, and against pursuing the option of a local authority hospital service, the alternative hitherto most favoured in Labour Party policy documents. Instead he offered his bold scheme for hospital nationalisation, even hinting that all local authority services might be swallowed up into his regional machinery in order to create a "unified health service". He was, however, silent on the relationship of family practitioner services to his regional system.

Bevan's next problem was dispelling scepticism concerning his scheme within the Cabinet. Morrison in particular kept up a rear-guard action in favour of local government administration of the hospital service. Although the newspapers in early November suggested that the Cabinet had approved hospital nationalisation, Morrison's opposition had not finally died down when Bevan circulated his plan for the complete health service to the Cabinet on 13 December 1945 (III). Nevertheless at the Cabinet meeting on 20 December it was agreed that Bevan should prepare a Bill on the basis of his preferred scheme. This effectively marked the end of Cabinet opposition to Bevan's proposal.[18]

On reflection Bevan decided that it was premature to adopt a totally unified health service administration (see Illustration 1). Even within the hospital service the teaching hospitals were promised special status, a point laboured in his memoranda and speeches (III, IV, V). Concentration on the privileges accorded to major teaching centres was calculated to win the confidence of the medical elite, thereby precluding consolidation of opposition within the profession.

Outside the nationalised hospital service he left clinic services in the hands of local authorities and the family practitioner services were to be administered by Executive Councils (see Illustration 3). Except for the expectation that clinics and family practitioner services might become integrated into health centres, it was proposed to leave these services very much as they had existed before the NHS. The circulated memoranda were vague about the method of remuneration of general practitioners, but Bevan confided to colleagues that he wanted to move "eventually to a full-time salaried service".[19] Determined not to repeat the mistakes of his wartime predecessors by giving critics the opportunity to conduct a war of attrition against his scheme, Bevan delayed discussions with outside bodies until the outlines of legislation were agreed by the Cabinet. His colleagues sanctioned discussions on the understanding that "the main features of the attached proposals must stand, and that any concessions or adjustments will be only in the detailed ways and means of carrying the proposals out".[20]

Bevan predicted "considerable opposition" to his proposals, but he hoped for a positive response from the medical profession, support from some local authorities, and an enthusiastic welcome from

Government supporters, both in the country and in Parliament.[21] The anticipated opposition emerged from the voluntary hospital lobby, but Bevan was shocked by the antagonism of the medical profession, which began with minor rumblings on points of detail, but rapidly escalated into fanatical opposition. Bevan soon found himself characterised as a "medical Führer" or "Medical Service Dictator". In their first plebiscite on the 1946 Proposals the doctors were asked to choose between "Bevan and Belsen".[22] The Minister was drawn into a conflict with the BMA which lasted until the eve of the introduction of the new service.

Bevan's provocative style in this contest has been widely criticised, but his command of detail and skill in negotiation earned the respect and even admiration of his foes. The BMA leaders were surprised to find that the ex-miner was altogether a more accomplished performer than the dreary professional men who had preceded him as Ministers of Health.[23] Although the colourful controversies with the BMA were conducted with passionate regard to high principle, the points of disagreement mainly related to minor points concerning the terms and conditions of employment of general practitioners. The most important features of the NHS legislation were not contested by the BMA. Although Bevan was obliged to sacrifice the prize of salaried employment for general practitioners, most concessions to the BMA related to inessentials. He was satisfied that none of the modifications introduced into his scheme fundamentally prejudiced its character as an exemplary product of socialist welfare planning.[24]

In Place of Fear described the new health service as "a triumphant example of the superiority of collective action and public initiative applied to a segment of society [the sick] where commercial principles are seen at their worst". The free health service therefore represented "pure socialism".[25] For Bevan, the mission to establish the NHS took on something of a messianic significance. In a more sceptical and sophisticated age Bevan's sentiments may seem somewhat naive, but at the time they served to heighten expectations and promote an image of the NHS as a visionary experiment rather than a minor administrative adaptation. Such an inspirational approach provided a boost to the morale of health workers and the public alike in a period marked by austerity and a drabness of civic life. Bevan's

capacities for leadership were not appreciated by his Cabinet colleagues, in whom, for the most part, these qualities were conspicuously lacking.

Although Bevan's address to an expert audience (IV) or his lucid and compelling Second Reading Speech in the House of Commons (V) were dominated by technical considerations, these expositions contain many expressions of socialist commitment and awareness of the great potentiality of the humanitarian endeavour implicit in a universal, comprehensive and free health service.

The opposition to the NHS Bill in Parliament was feeble and it caused no discomfort to Bevan. The Bill received the Royal Assent on 6 November 1946.[26] The Minister was therefore in buoyant mood when he addressed the Royal College of Nursing in June 1946 (VI). He explained to nurses the advantages to their profession of the balance between regional administration and local devolution adopted in the new service. They were assured that a new era had commenced for their profession. Yet the Minister could not disguise the crisis facing nursing. He could scarcely have believed that his empty admonishments offered to nurses any significant inducement, which might alleviate the chronic shortage and high wastage rate within the profession. As a trades unionist he knew that the real problem lay in artificially low rates of remuneration. As a Minister he realised that any realistic pay award to the 174,000 civilian nurses would escalate costs of the new health service, and possibly set off a wage spiral in the public sector, thereby prejudicing his already strained relations with Cabinet colleagues. In practice nurses would be asked to make further sacrifices without receiving significant material benefits.

Nurses were offered a few symbolic inducements. They took Bevan's calls for industrial democracy as a sign that they would be represented on regional and local management committees. This had become a popular expectation among nurses. However the Minister subtly changed his ground, regarding representation on local hospital staff councils or specialist advisory committees as adequate gestures to industrial democracy.[27] He was disingenuous in claiming that "nobody will be represented on the regional boards, not even doctors". In fact the guidelines circulated on the composition of regional boards advised that one-quarter of the members should represent the medical profession.[28]

Like the nurses, the Medical Officers of Health were a professional group supportive of the National Health Service. However, they were aggrieved by their loss of power and status under Bevan's scheme. They were particularly suspicious that the tripartite system of administration would undermine coordination in such fields as maternity and child welfare, tuberculosis, mental health, or in services for the elderly. In his address to the Medical Officers of Health, Bevan attempted to set their minds at rest (VII). However his speech was mainly addressed to the wider medical audience. With the end of the legislative process in sight, he appealed to the medical profession to end its campaign of hostility and engage in preparation for the new service in the short time available before the Appointed Day.

Nurses and Medical Officers of Health represented the most pliable sectors of the health service workforce. The doctors, especially the general practitioners, were the most intransigent. The medical profession decided only narrowly to enter into discussion with the government over the implementation of the NHS legislation. These negotiations were not begun until March 1947 and they dragged on until December. It then became apparent that little progress had been made.[29] Until this point Bevan's speeches were characterised by restraint. He had replied to the provocations of the BMA leadership with constructive suggestions and only the mildest admonitions. In January 1948 the Minister suddenly changed tactics. With Cabinet support, 5 July 1948 was fixed for the introduction of the NHS. The government embarked on a public campaign designed to counteract the delaying tactics of the medical profession.[30] The Cabinet resorted to the unusual device of introducing a parliamentary motion welcoming the new service and inviting the profession to participate on the basis of the terms offered, which were described as "generous and fully in accord with their traditional freedom and dignity".[31] Bevan issued a few points of clarification in an open reply to questions helpfully addressed to him by *The Lancet*.[32] Any good done by this little public relations exercise was undone by his adverse comments on the BMA decision to hold a plebiscite, his appeal to the profession to bypass its leadership (VIII), and by the vitriolic attack made on the BMA leadership in the House of Commons (IX). Bevan's spirited defence of the Government's negotiating position was lost from sight in the furore over his outburst against the

profession. The anger was, of course, reciprocated by the BMA negotiators. All of this drama was perhaps a necessary part of the climax of the ritual of negotiation. The storm rapidly subsided and a settlement was reached in the spring of 1948, in time for the new health service to be introduced in a spirit of accord on the Appointed Day, 5 July 1948.[33]

An end to wrangling with the BMA brought the first glimpse of tranquillity since Bevan had assumed office. His speech on the pioneers of public health is a product of this peaceful interlude (X). The contrast in content and style with all other items of this collection is self-evident. However not too much significance should be attached to this address or its timing because it was Bevan's formal address at a dinner held to commemorate the first Public Health Act (1848), which coincidentally had preceded the Appointed Day adopted for the NHS by exactly a century. Perhaps a personal note was sounded by Bevan in singling out Lord Morpeth for special mention. Morpeth seemed to symbolise the role of the politician in the advance of public health. Bevan epitomised the politician as the "accoucheur of the public conscience". This speech is also useful in signifying Bevan's sensitivity to the importance of preventive medicine. He realised that preventive measures had brought about enormous improvements in the health of people since the time of the Victorian pioneers. Since preventive medicine relied on collective action, it seemed an ideal embodiment of the socialist approach to the problems of health care. Bevan seized upon this principle as the starting point for his defence of the health service in his *In Place of Fear*.[34] Indeed Bevan's later speeches and writings on health care increasingly drew on historical allusions.

The preventive approach was again invoked in a further address to the Royal College of Nursing (XI), where the housing programme was somewhat disingenuously invoked as an excuse for abandoning health centres. Bevan also made little positive impact with his decision to include a nurse on each Regional Hospital Board. In the event nurses were gradually phased out in the rotation of RHB membership.[35] The nurses no doubt wanted to hear about progress with the reform of their profession, following the *Report of the Working Party on Recruitment* produced in July 1947. However

Bevan stalled and chose to end his speech on the role of the Minister as the recipient of complaints, a piece of trivialisation that he never tired of repeating with minor variation to audiences of every kind.

Attlee was insistent that the welfare reforms of the Labour government should be launched in the spirit of bipartisanship and conciliation. Bevan disagreed and on the eve of the introduction of the comprehensive social services he launched a savage attack on the Tories, the notorious "vermin" speech (XII) which earned him the disapprobation of both Attlee and Churchill.[36] In Bevan's estimate the Tories were the enemies of the welfare state and the Appointed Day was an ideal date to remind the people of this record. Reflecting the popular feeling of the day, Toryism he equated with organised Spivery. It is noticeable that a brief speech made on the Appointed Day adopted an altogether more conciliatory tone (XIII).

The regional hospital service, Part II of the NHS Act, dominated the new health service (see Illustration 2). Inevitably, Bevan's personal interest and sympathy gravitated to making available to the entire population a first-class consultant service so long confined to the few. Nevertheless, other sides of the health service were not neglected in his speeches. For instance, the development of Part III (Local Health Authority) and Part IV (Family Practitioner) services were considered in addresses to the Society of Medical Officers of Health and the Executive Councils Association respectively (XIV, XV; see Illustration 3). The health service had been in operation for only a few months when the Minister addressed these two groups. He was still able at this stage to react optimistically to the high rate of participation and utilisation, hardly adverting to the growing anxiety over the cost of the new service. Bevan was even joyous about the high rate of recruitment of dentists, who were entering the NHS in the face of opposition from their professional associations. At this stage Bevan's latent fears related more to the high cost of the pharmaceutical service than to the more obvious abuse of the over-generous scale of fees for dentists. The Minister was quietly satisfied that the "revolution" of making primary care facilities available to the entire population had justified his rejection of BMA demands for a phased introduction of new services.

The Medical Officers of Health, whose confidence had been

shaken in 1948 by the loss of their responsibilities for hospital administration, were asked to adopt an entirely new role by exploiting the opportunities of the new discipline of social medicine. This, Bevan believed, would assure them of a "gleaming future" in which their services would regain the initiative and become the main spur of progress within the new health service. Entirely against the course of his determined policy, the Medical Officers of Health were told that health centres might become a reality. Health centres had been the only substantial compensation offered to local authorities for the loss of their hospital responsibilities. The main planning effort of the largest local health authorities had been channelled into promotion of comprehensive health centre schemes, most of which had already been abandoned in the face of the hostility of Bevan's officials. No doubt this speech left the Medical Officers of Health bemused about the future of the health centre programme.

Bevan enjoyed only the briefest respite from controversy over the NHS. Ironically, the next round of difficulties came from his Cabinet colleagues. Owing to the miscalculations of his own officials and lack of realistic Treasury oversight, the original Estimates adopted for the NHS were grotesque underestimates. Bevan was therefore in January 1949 forced to apply for a substantial Supplementary Estimate to cover the first nine months of the service. At this time the Cabinet accepted his explanations for overspending without demur.[37] On the other hand, taking their cue from a few sensationalist reports in the Tory press, the Opposition made a somewhat incompetent attempt to discredit Bevan. The whole exercise was premature and ill-conceived, as demonstrated by Bevan's counter-attack which enabled him again to identify the Conservatives as saboteurs of the new service (XVI). The Conservative Party seemed to favour reform only in the abstract, while opposing every specific reform.

Bevan's more urgent difficulties lay with saboteurs within the Labour Cabinet. Morrison in particular exploited the high level of NHS expenditure to embarrass Bevan. He advocated a more gradualistic approach to the development of the health service. It was therefore easy to gain his support for abandonment of the free service and introduction of direct charges. Treasury officials were

Morrison's keen allies.[38] Bevan was pressed to make major economies on both the housing and health fronts. He resisted health service charges as "drastic modifications of the basic principles of the Health Service".[39] The Minister also made a public declaration clearly designed to limit the Cabinet's freedom of action over health service economies: "I have made up my mind that the National Health Service is not going to be touched, and there is no disposition of the Government to touch it... The Government have made up their mind to solve their problems without raiding the social services, and the health service is sacrosanct".[40]

This manoeuvre was partly successful. In the event the only significant health service economy agreed by Bevan was the introduction of legislation to permit the imposition of a shilling prescription charge, with an estimated yield of only £10m per annum. His colleagues had wanted savings in the order of £50m. Explaining the prescription charge in the House of Commons was not a comfortable occasion for Bevan (XVII). He was certainly dismayed about the high cost of the pharmaceutical service, which he regarded as one of the least beneficial aspects of the new health service. He inveighed against "the ceaseless cascade of medicine which is pouring down British throats".[41] Nevertheless he was averse to setting a precedent for the introduction of direct charges. Shrewd deployment of delaying tactics enabled him to evade imposition of the prescription charge. Then, largely owing to Bevan's tactics even after he had ceased to be Minister of Health, Attlee's government never found it practicable to introduce this charge. Finally, at the time of his resignation he disclaimed association with the prescription charge (XX) and boasted that he had manoeuvred to prevent its introduction (XXI).[42]

Before the 1950 General Election Bevan had contained the influence of his Cabinet critics with reasonable ease. The Estimates for the first months of the service, and then the first full year 1949/50 had been exceeded without penalty. The situation changed after the February 1950 General Election. Contrary to rumour Bevan was left at the Ministry of Health.[43] The Treasury now made a more determined attempt to drive down NHS expenditure. It was too late to take effective action on the £392m budget for 1950/51, but the Treasury adopted a draconian target of £350m for future years, which

inevitably implied the imposition of extensive direct charges. Bevan was called to account by the Cabinet in April 1950 (XVIII), where he defended maintenance of the free and comprehensive health service, repeating the arguments used successfully in October 1949 (XVIII).[44] Once again he was moderately successful. The £350m target was abandoned and it was left to be decided what action would be taken in the event of the £392m ceiling being exceeded. On this occasion however Bevan incurred a substantial penalty, the establishment of a Cabinet Committee to monitor NHS expenditure and fix limits for future years. This committee provided an ideal platform for Morrison and Gaitskell to pursue their campaign against Bevan. The threat posed by Gaitskell increased in October 1950 upon his appointment as Chancellor of the Exchequer.[45]

Bevan was now on the defensive. As indicated by his address to the Institute of Hospital Administrators (XIX), the maintenance of NHS spending within the Estimates became his first priority. The hospital administrators, as the officers responsible for the largest slice of NHS expenditure, were fundamental to the success of this operation. Bevan defended his ground effectively and to his relief NHS spending was maintained within the defined ceiling. However, bad-tempered exchanges with Gaitskell and constant interference from the Cabinet NHS Committee soured the atmosphere and persuaded Bevan in late 1950 to accept transfer to the Ministry of Labour, seemingly on the understanding from Attlee that the social services would be protected from cuts.[46]

In his new capacity Bevan lost none of his zeal for the welfare state. However, the diminutive Hilary Marquand, his successor as Minister of Health, was more responsive to Treasury pressure. A £400m ceiling for health expenditure in 1951/52 was adopted, with the consequence that charges for services were unavoidable. Furthermore, although these charges were expected to yield only £13m in the first year of operation, Gaitskell anticipated that they would be progressively expanded to maintain the Exchequer commitment to the NHS at its 1951/52 level.[47] Thus this minor breach in the principle of the free health service was intended in due course to alter the basis of funding in a regressive direction, with the result that the poor, the elderly and the sick would shoulder all future development costs.

Bevan denounced Gaitskell's approach to the NHS at *ad hoc* meetings of Ministers and at the Cabinet meeting on 22 March.[48] On 4 April he declared to dockers that he would "never be a member of a government which makes charges on the National Health Service for the patient".[49] This set the atmosphere for Bevan's last debate with Cabinet colleagues on the issue, which was conducted over two Cabinet meetings held on 9 April 1951 (XX). Ever since 1949 Bevan had believed that cuts in the social services were being introduced to finance a precipitous and ill-considered rush into rearmament.[50] Now he drew the equation sharply, pointing out that a major principle of Labour policy was being sacrificed for the sake of wasteful expenditure on weapons. His position was caricatured in the press, but the essential point of conflict was firmly identified: "the essence of Mr. Bevan's position is not that he objects to tanks but that he rates them lower than dentures... Mr. Bevan is determined that rearmament should not stop the development of the social services. Rearmament is acceptable if it can be added to the state's existing obligations and met by squeezing the rich".[51] In the Cabinet discussion Bevan was by no means isolated.[52] He was supported actively by Harold Wilson (President of the Board of Trade) on stage, and offstage by John Freeman (Under-Secretary at the Ministry of Supply). In the discussion the Home Secretary (James Chuter Ede) and Minister of Education (George Tomlinson) were anxious for compromise, while James Griffiths (Secretary of State for Colonies) was known to be basically sympathetic with Bevan. The general tenor of argument favoured compromise or deferment of health charges, and it was realised that capitulation to Gaitskell's demands would spell political disaster for the government. Disunity, defeat and possibly years in opposition seemed a large price to pay for charges valued at £13m. However Gaitskell had elevated the charges issue into a matter of principle. He was supported by Attlee from his sick-bed, and predictably by Morrison, who presided at the Cabinet meeting. Bevan, together with Wilson and Freeman, resigned from the government.[53] Bevan's resignation speech repeated his arguments in Cabinet debate, but in more trenchant terms (XXI). He was now more overtly anti-American. The Americans were blamed for having set off a spiral of commodity shortage, inflation and industrial strife. By allowing themselves to be "dragged behind the wheels of

American diplomacy" his colleagues had abandoned their responsibilities to the poor and deserted their greatest achievement in the field of welfare. In view of his persistent public defence of the free and comprehensive health service he was unable to remain in a government which had jettisoned this principle. For Bevan the resignation speech was an event charged with emotion. A somewhat unkind commentator remarked that "he developed his case in the violent style that he at times resurrects from his street meeting days - his fists and arms flailing as if he were literally pounding his opponents, his voice thundering, his eyes blazing".[54]

The legislation introducing charges for dentures and spectacles received the Royal Assent in May 1951. The Labour Government was defeated on 25 October 1951. By this stage perhaps as little as £2m had been collected in charges. The electoral loss to Labour brought about by the acrimonious split over the NHS is not quantifiable, but Attlee's Cabinet feared that this issue was gravely damaging.

Observing from the sidelines, Bevan hoped that the NHS had gained in popular support to such an extent that it would be immune from depredations of the advocates of retrenchment: "Doubtless other defects can be found and further improvements made. What emerges, however, in the final count, is the massive contribution the British Health Service makes to the equipment of a civilised society. It has now become a part of the texture of our national life. No political party would survive that tried to destroy it".[55]

This judgement was rapidly vindicated, as denoted by the demise of H.F.C. Crookshank, the first Minister of Health under Churchill's Conservative administration. Crookshank approached the health service in the same miserly spirit as Gaitskell. He embarked on a regime of cuts and charges, only to discover little taste for these objectives within the Conservative government. Although the prescription charge was now introduced, and the other charges extended, Crookshank was replaced by Iain Macleod who adopted a more liberal course of policy, which survived until the end of the Conservative administration in 1964.[56]

Even in opposition Bevan continued to make interventions on health policy. For instance in 1954 he argued that it was essential to

take up the problem of local government reorganisation (XXII). This question had already been tentatively discussed in his *In Place of Fear*.[57] Bevan argued that reorganisation would enable the health services to be unified under local government and become better co-ordinated with related services. This arrangement would restore the element of democratic accountability lost in the 1948 system. He envisaged creation of some 235 to 240 authorities. Bevan was therefore one of the first leading figures to advocate NHS reorganisation. By contrast, the Guillebaud Report (1956) opted for the *status quo*, although Sir John Maude (until 1945 Permanent Secretary at the Ministry of Health) entered a reservation advocating the local government alternative.[58] The real pressure for reorganisation commenced only after Bevan's death. Ultimately the 213 Districts in England and Wales created in 1974 represented an approach to unification, but the opportunity was not taken to assimilate the health services into the reorganised structure of local government.

A fitting conclusion to the present collection of texts is provided by Bevan's speech marking the tenth anniversary of the NHS (XXIII). By his standards this address was statesmanlike and uncontroversial. It went over much of the ground of the Second Reading speech of 1946. But he was not entirely willing to overlook bitter memories of past conflicts. Dr. Charles Hill, erstwhile Secretary of the BMA, effortlessly turned Conservative politician, rewarded with the office of Chancellor of the Duchy of Lancaster, and eventually target of Macmillan's "night of the long knives", was the particular target of Bevan's caustic wit. However, the main purpose of Bevan's address was the serious issue of the role of the National Insurance Appropriation-in-Aid in the funding of the NHS. At the outset of his term of office Bevan had decisively rejected funding the NHS on an insurance basis. Beveridge had proposed that a subsidy from the National Insurance Fund should be appropriated to the NHS and this advice was followed. Beveridge later denied that he intended the insurance contribution to bear a fixed proportion of the cost of the NHS.[59] This attitude was adopted by the Labour Government which allowed the Appropriation-in-Aid to fall from 9.0 per cent of the gross cost of the NHS in 1949/50 to 6.2 per cent in 1956/57. On the basis of inadequate preliminary estimates it seemed in the 1944 White Paper that the insurance contribution might support the NHS to the

extent of 20 per cent. Both the Treasury and the Ministry of Pensions and National Insurance were satisfied to allow this "NHS Contribution" to decline in value, but the idea of a 20 per cent target for the yield from insurance and charges was revived by the Conservative Government in the aftermath of Suez. The NHS Contribution was raised in two stages in 1957 and 1958, taking its level to 9 per cent and then 14 per cent of the gross cost of the NHS. The combined yield from charges and the NHS Contribution was projected to reach almost 20 per cent in the year 1958/59.[60]

The Labour Party allowed the government to make this major alteration in the funding of the NHS without effective opposition. Bevan drew attention to the serious implications of the retreat from progressive taxation. He pointed out that the government had undermined the redistributive aims of the NHS, much to the disadvantage of the poor.

In fact the drift towards elevating the NHS Contribution into a major poll tax had been resisted by both the Treasury and the Ministry of Pensions and National Insurance. Macmillan as Chancellor of the Exchequer was advised against pursuing this suggestion, but only shortly afterwards as Prime Minister he decided to extend the NHS Contribution to the maximum degree politically attainable. Macmillan and Thorneycroft, the new Chancellor of the Exchequer, were warned by Cabinet critics that they were courting working-class revolt against the National Insurance contribution. Arguments within the Cabinet over the NHS Contribution lasted from 1956 until 1961. In the latter year one further small increase proved so politically damaging that the idea of exploiting the National Insurance scheme for funding the NHS was abandoned and never effectively reintroduced. In the Macmillan Cabinet the critics, led by Boyd-Carpenter, the Minister of Pensions and National Insurance, found themselves using exactly the same rhetoric and arguments against this "regressive poll tax" as those deployed by Bevan in his anniversary speech.[61] This little episode should perhaps have been studied before the Thatcher administration embarked on its own disastrous poll tax expedition.

Bevan's argument against the poll tax principle illustrates his capacity to identify with the low paid. His defence of the free dental and optical services illustrates a similar sensitivity to the importance

of such services to such deprived groups as the elderly. His anniversary speech also referred sympathetically to the value of the hearing aid service in rescuing the deaf from "a kind of twilight life".[62] He took understandable pride in creating a health service in which the strong paid for the benefits of the weak, and which brought the benefits of a civilised existence to the poor, the elderly and the handicapped. It was on the basis of such priorities that Bevan was able to claim the NHS as the "most civilized achievement of modern government".

In 1958 Bevan's speech was followed by a pedestrian performance from Derek Walker-Smith, who was the third Minister of Health to take office since 1955. The Minister paid somewhat grudging tribute to Bevan's speech. He found it gratifying that the shadow Foreign Secretary was finding time to revisit the "scenes of his earlier activity", at which point the official report records the intervention [Hon. Members: "Triumph"].[63] This sentiment would have been echoed by the masses of the population for whom the NHS had brought about a transformation in the level of their existence. Nearly half a century later, in the cold winter days, the poor, the homeless and the handicapped are no doubt wondering why no new Bevan has stepped forward from the ranks of the strong to be their advocate.

Notes:

1. As Bevan observed: "the National Health Service and the Welfare State have come to be used as interchangeable terms": Aneurin Bevan, *In Place of Fear* (London, Heinemann, 1952), p. 81.
2. J. Campbell, *Nye Bevan and the Mirage of British Socialism* (London, Weidenfeld and Nicolson, 1987), p. 149.
3. F. Honigsbaum, *Health Happiness and Security. The Creation of the National Health Service* (London, Routledge, 1989), p. 217.
4. H. Eckstein, *The English Health Service* (Cambridge, Mass., Harvard University Press, 1958); D.M. Fox, *Health Policies and Health Politics, the British and American Experience 1911-1965* (Princeton, N.J., Princeton University Press, 1986); R. Klein, *The Politics of the National Health Service* (London, Longman, 1983; 2nd edn 1989).
5. For a critique of this point of view, C. Webster, "Conflict and Consensus: Explaining the British Health Service", *Twentieth Century British*

History, 1990, **1**, 115-51; R. Lowe, "The Second World War, Consensus, and the Foundation of the Welfare State", *ibid.*, pp. 152-82.

6. J.S. Ross, *The National Health Service in Great Britain* (London, Oxford University Press, 1952).

7. *British Medical Journal*, ii, 1945, *Supplement*, *p. 64*, 15 September 1945.

8. C. Webster, *The Health Services Since the War. Volume I. Problems of Health Care. The National Health Service Before 1957* (London, HMSO, 1988), p. 76.

9. Campbell, pp. 150-2; Foot, ii, pp. 20-2; K. Harris, *Attlee* (London, Weidenfeld and Nicolson, 1982), p. 405; Webster, *Problems*, p. 76. For general background, K.O. Morgan, *Labour in Power* (Oxford, Clarendon Press, 1984).

10. Eckstein, *The English Health Service*, pp. 133-66; Honigsbaum, pp. 33-93; J.E. Pater, *The Making of the National Health Service* (London, King Edward's Hospital Fund, 1981), pp. 23-104; Webster, *Problems*, pp. 44-75.

11. H. Eckstein, *Pressure Group Politics. The Case of the British Medical Association* (London, Allen and Unwin, 1960).

12. Charles Hill, reply to toast, 5 September 1945, *B.M.J.*, ii, 1945, *Supplement*, *p. 63*, 15 September 1945.

13. *The Times*, 22 October 1945.

14. *B.M.J.*, ii, 1945, *Supplement*, *p. 106*, 17 November 1945.

15. *B.M.J.*, ii, 1945, *Supplement*, *p. 112*, 24 November 1945.

16. Public Record Office, MH 80/28 [J.E. Pater].

17. Webster, *Problems*, pp. 84-8.

18. Morgan, pp. 151-8; Pater, pp. 105-7, 114-19; Webster, *Problems*, pp. 84-8.

19. CM(45)65th mtg, 20 December 1945, PRO CAB 128/2.

20. CP(46)3, 3 January 1946, PRO CAB 129/6.

21. CM(45)65th mtg, 20 December 1945, PRO CAB 128/2.

22. Foot, ii, pp. 138-9; Webster, *Problems*, p. 110.

23. Foot, ii, pp. 118, 120, 124-5.

24. Eckstein, *Pressure Group Politics*, pp. 92-112; Honigsbaum, pp. 94-112; Pater, pp. 139-58; Webster, *Problems*, pp. 107-20.

25. Bevan, *In Place of Fear*, pp. 81, 85.
26. Webster, *Problems*, pp. 94-103.
27. Webster, *Problems*, p. 227.
28. Webster, *Problems*, pp. 275-6.
29. Webster, *Problems*, pp. 109-13.
30. CM(48)6th mtg, 22 January 1948, CM(48)8th mtg, 29 January 1948, PRO CAB 128/12.
31. CM(48)9th mtg, 2 February 1948, PRO CAB 128/12.
32. *The Lancet*, i, 1948, pp. 149-50, 24 January 1948.
33. Honigsbaum, pp. 219-21; Pater, pp. 158-63; Webster, *Problems*, pp. 114-20.
34. Bevan, *In Place of Fear*, p. 72.
35. Webster, *Problems*, p. 279.
36. Campbell, pp. 204-5, 213-14, 229; Foot, ii, pp. 236-41 and *passim*; Harris, pp. 424-5. For Churchill, *The Times*, 12 July 1948, where Bevan is chastised as "Minister of Disease".
37. CP(48)302, 13 December 1948, PRO CAB 129/3; CM(49)12th mtg, 17 February 1949, PRO CAB 128/15. Webster, *Problems*, pp. 133-7.
38. Webster, *Problems*, pp. 141-3. H. Dalton, *High Tide and After: Memoirs 1945-1960* (London, Muller, 1963), p. 106. See below, XVIII, n.7.
39. EPC(49)34th mtg and 35th mtg, 14 October 1949, PRO CAB 134/220.
40. Bevan, speech at Labour Party Rally, Hednesford, Staffordshire, 25 September 1949, *The Times*, 26 September 1949.
41. Bevan, address to Indian students, University College London, 15 November 1949, *The Times*, 16 November 1949.
42. Webster, *Problems*, pp. 143-8.
43. Campbell, pp. 215-16; Foot, ii, pp. 294-5; Webster, *Problems*, pp. 148-9.
44. Webster, *Problems*, pp. 148-56.
45. Foot, ii, pp. 289-94, 296-8; Webster, *Problems*, p. 166.
46. Campbell, pp. 222-3; Foot, ii, p. 309; Webster, *Problems*, pp. 164-76.
47. Webster, *Problems*, pp. 167-71.

48. CM(51)22nd mtg, 22 March 1951, PRO CAB 128/19. Morgan, pp. 447-8; Webster, *Problems*, pp. 171-4.

49. *News Chronicle*, 4 April 1951.

50. Foot, ii, pp. 273-4.

51. *The Economist*, 23 April 1951, p. 962.

52. Campbell, pp. 234-6; Foot, ii, pp. 321-3; Morgan, pp. 448-9; Webster, *Problems*, pp. 174-6.

53. Campbell, pp. 236-41; Foot, ii, pp. 322-9; Morgan, pp. 449-54; Webster, *Problems*, pp. 176-7.

54. *The Economist*, 23 April 1951, p. 969. For other estimates, see Campbell, p. 241; Foot, ii, pp. 330-1.

55. Bevan, *In Place of Fear*, p. 72.

56. Webster, *Problems*, pp. 187-200.

57. Bevan, *In Place of Fear*, pp. 91, 188.

58. *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmd. 9663 (London, HMSO, 1956).

59. House of Lords Debates, vol. 230, col. 18, 27 March 1961: "the poll tax... was not proposed by me in the Beveridge Report at all. I left it absolutely open... I have no responsibility at all for the idea of contributions to the Health Service".

60. PRO T 227/748.

61. PRO T 227/425,745. Treasury, SS1018/534/01A. Boyd-Carpenter's Memorandum of 2 May 1956 (SS(56)20) opens with citations to Bevan's argument that the NHS Contributions placed the low-paid worker at a disadvantage. He agreed with Bevan that general taxation was the correct basis for financing the NHS because it allotted the burden of payment according to the ability to pay: PRO CAB 134/1327. Boyd-Carpenter pursued this line of argument again in 1960 when he attacked the NHS Contribution as "a poll tax which ... disregards alike the means and family circumstances of the taxpayer": SS(60)8, 15 January 1960, SS(60)2nd mtg, 25 January 1960, PRO CAB 134/2533.

62. See also, Bevan, *In Place of Fear*, pp. 85, 184.

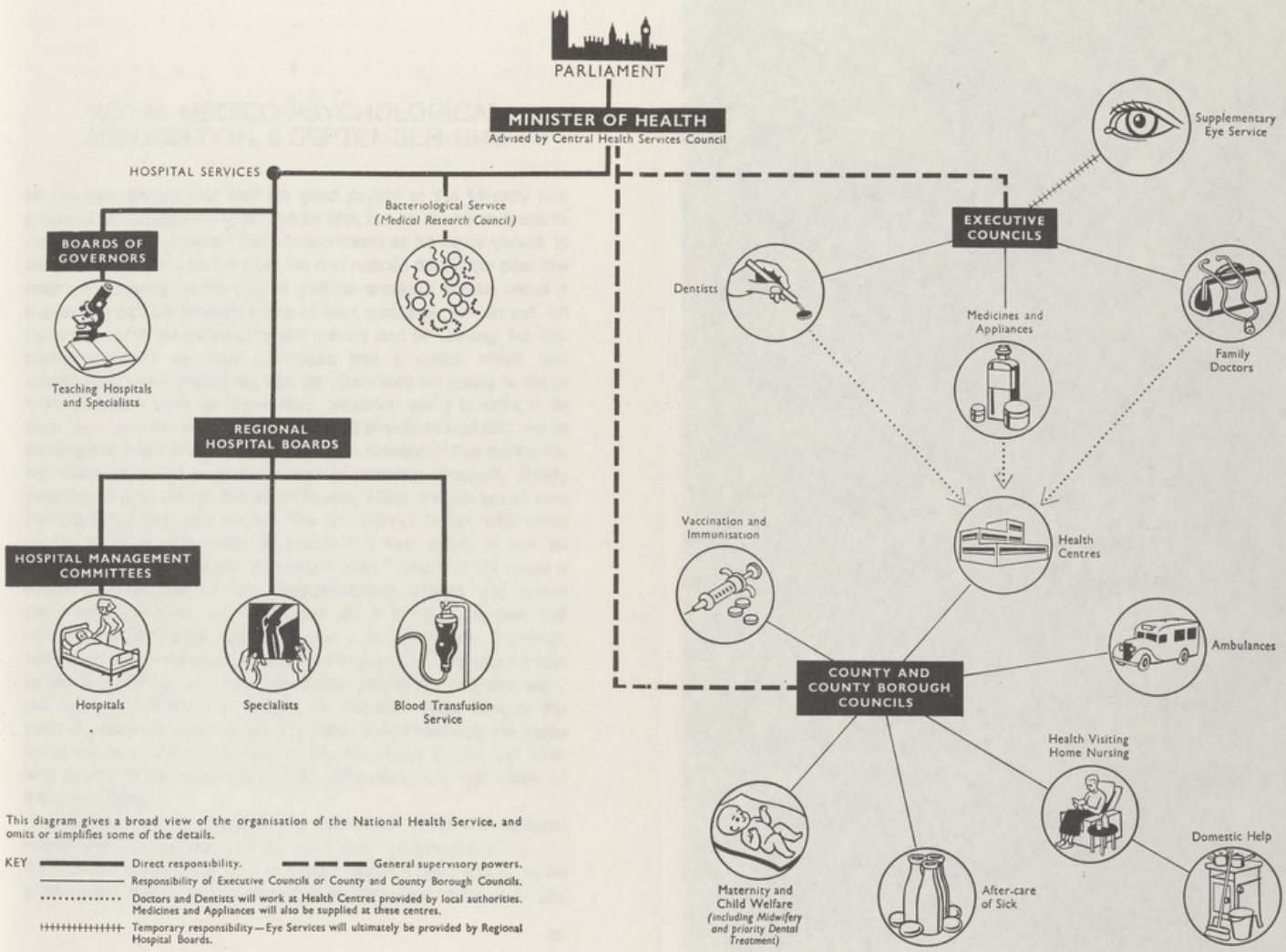
63. House of Commons Debates, vol. 592, col. 1398, 30 July 1958.

Illustration 1

National Health Service Organisation

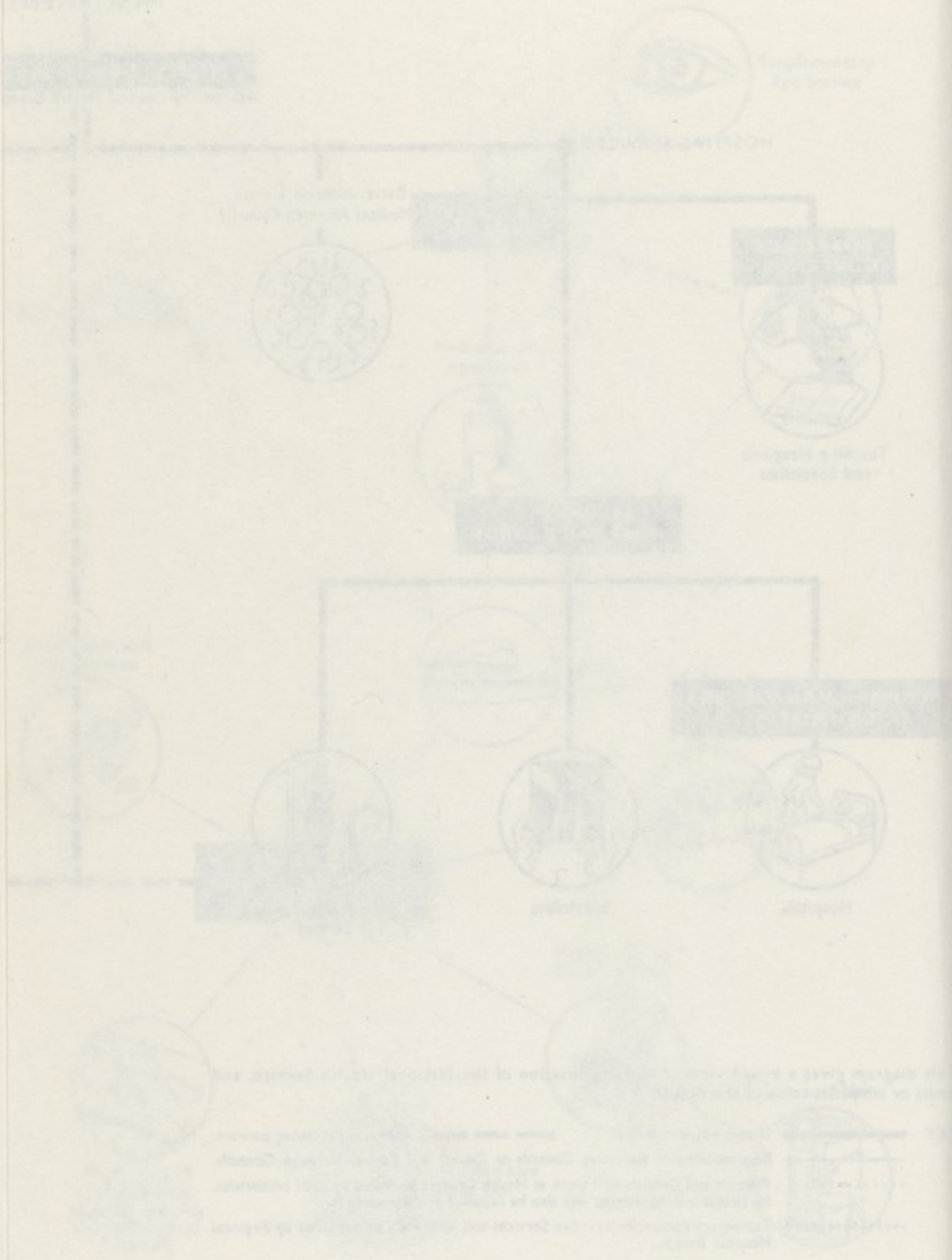
Illustration 1

National Health Service Organisation



This diagram gives a broad view of the organisation of the National Health Service, and omits or simplifies some of the details.

KEY
- Direct responsibility.
- General supervisory powers.
- Responsibility of Executive Councils or County and County Borough Councils.
- Doctors and Dentists will work at Health Centres provided by local authorities. Medicines and Appliances will also be supplied at these centres.
- Temporary responsibility — Eye Services will ultimately be provided by Regional Hospital Boards.



I

ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, 5 SEPTEMBER 1945

Mr. Aneurin Bevan said that his good people at the Ministry had prepared three separate speeches for him, but he did not propose to make use of any of them.[1] Such indiscretions as he made should, in this maiden speech, be his own. He had noticed during the past few weeks a tendency on the part of political speakers to take rather a depressing attitude towards some of their problems. He himself, on the problems of the national health service and of housing, felt distinctly optimistic. He was convinced that a nation which had achieved so much during the last six years was not going to fail to solve problems such as these. War, whatever evil it brought in its train, was good for mental health. A great physician had told him at the beginning of the war that he was quite convinced that during the war there would be a great decline in stomach diseases, simply because, in their concentration on beating Hitler, people would stop thinking about their own insides. The late Wilfred Trotter, who wrote on the instincts of the herd in peace and war, spoke of war as bringing all people together in a moral unity.[2] War brought about a certain psychological buoyancy and dedication of spirit, and he had yet to find a man who was dedicated and ill at the same time. But now the war was over, and there was a possibility that the moral unity which had sustained us would be fragmented. Therefore it was for the Government to provide the British people not only with work, but with work informed by design, so that they could bring to the tasks of peace the same effort, the same self-confidence, the same buoyancy as had enabled them to win the victory in war. Let them stop saying "Woe! woe!" about their difficulties, and talk rather of their possibilities.

He would not be expected to say much about the National Health Service, first because his mind was not fully made up, and any definite conclusions he had formed about it must first of all be given to the House of Commons. If he committed himself to any

statement that evening it would take his Cabinet colleagues by surprise because they had not been informed thereon. But he was confident, although he detected a certain gleam in the eye of Dr. Charles Hill when he met him that evening, that when they got down to principles and administrative details there would not be very much that separated him from the medical profession.[3] All of them were anxious to provide the people of Great Britain with the best kind of medical service. The doctors felt anxious lest a national machine close upon them which would obliterate their individuality.

"They need have no fear - no fear at all. I conceive it the function of the Ministry of Health to provide the medical profession with the best and most modern apparatus of medicine and to enable them freely to use it, in accordance with their training, for the benefit of the people of the country. Every doctor must be free to use that apparatus without interference from secular organizations. The individual citizen must be free to choose his doctor and the doctor must be able to treat his patient in conditions of inviolable privacy. I look upon the general practitioner as the most important man in the medical profession, but I hope - and I trust this will not be regarded as tendentious - that we shall be able to organize a service which will take general practitioners away from the isolation in which at present many of them live and work, and that more group associations will be organized amongst them."

It would be necessary, he knew, to have very lengthy discussions with the medical profession. He wished to say, without any desire to be controversial, that he hoped the doctors would turn up at the meetings of their own organizations, and not allow their spokesmen to speak for silent thousands. There was always a tendency for the man who had come to the top to be the spokesman for all below him, and the man at the top was always inclined to take a very complacent view of the circumstances which had led to his survival. He therefore hoped that in the discussions they were bound to have in the near future the general body of the profession would make itself felt and make quite clear its own point of view, so that Dr. Charles Hill, when he met him, might speak for a unanimous profession.

He knew that many doctors felt that with a state medical service there was a danger of the doctor being placed too much under the

control of the bureaucratic machine. "After all - I need not remind you of this - I am a Socialist, and, being a Socialist, I believe in industrial democracy, and because I believe in industrial democracy I believe that doctors as a profession must have a greater and greater say in the management of their own services. I want for the miners, the railwaymen, the engineers, a far greater share in the management of their work and the policies that govern it, and I claim no less for the doctors. The doctors themselves must have a recognized status in the new service. Therefore I hope they will not come and meet me as if I were an antagonist on the other side of the table; on the contrary, I am one whose enthusiasm for democratic medicine is as great as their own."

He wanted co-operation from the profession, not suspicion or antagonism, and he believed he would get it. "At the same time we are going to do some unorthodox things - a good many unorthodox things. Whatever reputation I have managed to achieve, it has not been a reputation for orthodoxy. Undoubtedly we shall try a number of experiments, but in such experiments I hope to obtain the enthusiastic co-operation of the profession. There is something seriously wrong with the health service of Great Britain when free treatment is given to the insured person, and the members of his family are left to find treatment as they can. I should have thought - indeed I am convinced - that this job of organizing a good medical and hospital service for all the people of Great Britain will inspire the idealism of all worth-while members of the profession."

Of course, they were approaching it under conditions of great difficulty. The war had destroyed many of our hospitals. Furthermore, a thing that was haunting them at the Ministry of Health was the dangerous depletion of nursing and domestic staffs at hospitals. He was informed that wards were closing down all over the country because of the lack of nursing staffs. They would have to pull together to try to attract to the nursing profession very many more nurses.[4]

He would say nothing about the organization of mental health.[5] If by insanity was meant the failure of the organism to adapt itself to environment, then they should be worried about the condition of insanity in the general population, because society itself was quite insane. What kind of therapy they were going to adopt he did not

know. He seemed to have been living in an insane world ever since he came to adult years. He was brought up in a community in which there was mass unemployment. It was their duty as statesmen, politicians, and citizens to try to bring about a sane condition of society. Many of the maladjustments and neuroses of modern society arose directly out of such conditions. Unless in the future we were able to plan our social life intelligently, with a design and purpose into which the individual could adapt himself, there would be increasing mental malady which no clinical measures could solve.

Speaking again of the forthcoming discussions concerning a National Health Service, Mr. Bevan drew a distinction between doctors individually and doctors collectively. He did not know that their collective intelligence was higher than that of any other group, but individually they were sympathetic and charming.

"I know very well I am not going to succeed in my task by bullying methods. I have to meet them across the table and try to break down their suspicions. I am satisfied we can do it, and that before another year is over we shall be able to lay before the people of Great Britain a structure of medical and hospital services which will make Great Britain the envy of all other nations in the world."

"I hope that you will all try to dissipate the atmosphere which has been created during the last few months by the suggestion that the new Minister is going to come into head-on collision with members of the medical profession. No such thing. We are going to show that there exists amongst us a fund of knowledge and good will upon which we shall be able to call in order to provide the people with a medical service of which we shall all be proud."

Sources: *The Journal of Mental Science*, *Supplement*, January 1946, pp. 15-16; *British Medical Journal*, *Supplement*, 15 September 1945, pp. 63-4.

Notes:

1. Bevan was addressing the 104th Annual Meeting of the Royal Medico-Psychological Association at the Savoy Hotel on 5 September 1945.
2. Wilfred Trotter (1872-1939), the noted surgeon of University College Hospital, London. Author of *The Instincts of the Herd in Peace and*

War (1916). Bevan was introduced by the President, Lieut.-Col. A.A.W. Petrie.

3. Charles Hill (1904-1989). Hill became Secretary of the BMA in 1944. Shrewd and ambitious, he was more than a match for the officials within the Ministry of Health. He entered parliament as Conservative M.P. for Luton in 1950. Owing to a superficial similarity in appearance with Bevan, Hill was mistaken for the Minister on his arrival at the Savoy dinner. In his reply to the toast Hill warned that the medical profession would oppose the "translation of an independent profession into a branch of central or local government". *B.M.J.*, *Supplement*, 15 September 1945, p. 64.

4. Bevan's first major task as Minister of Health was to address the problem of the shortage of nurses and midwives. Together with the Secretary of State for Scotland and the Minister of Labour and National Service, he issued in November 1945, *Staffing the Hospitals: An Urgent National Need*. This pamphlet estimated a requirement for 30,000 and perhaps as many as 42,000 recruits (p. 3). See B. Abel-Smith, *A History of the Nursing Profession* (London, Heinemann, 1960), pp. 176-90.

5. The decision to integrate the mental health services into the NHS was not made until late 1943. After the 1944 White Paper, plans were made for integrated local authority mental health services, but these were undermined by Bevan's proposal for hospital nationalisation. Consequently in September 1945 Bevan was unsure about the distribution of responsibility for mental health. Webster, *Problems*, pp. 326-8. The RMPA and associated bodies had only recently completed their report, *The Future Organization of the Psychiatric Services*. The September 1945 Annual Meeting of the RMPA was the first opportunity for members to discuss this report: *The Journal of Mental Science*, *Supplement*, January 1946, pp. 20-4.

Illustration 2

Regional Hospital Organisation

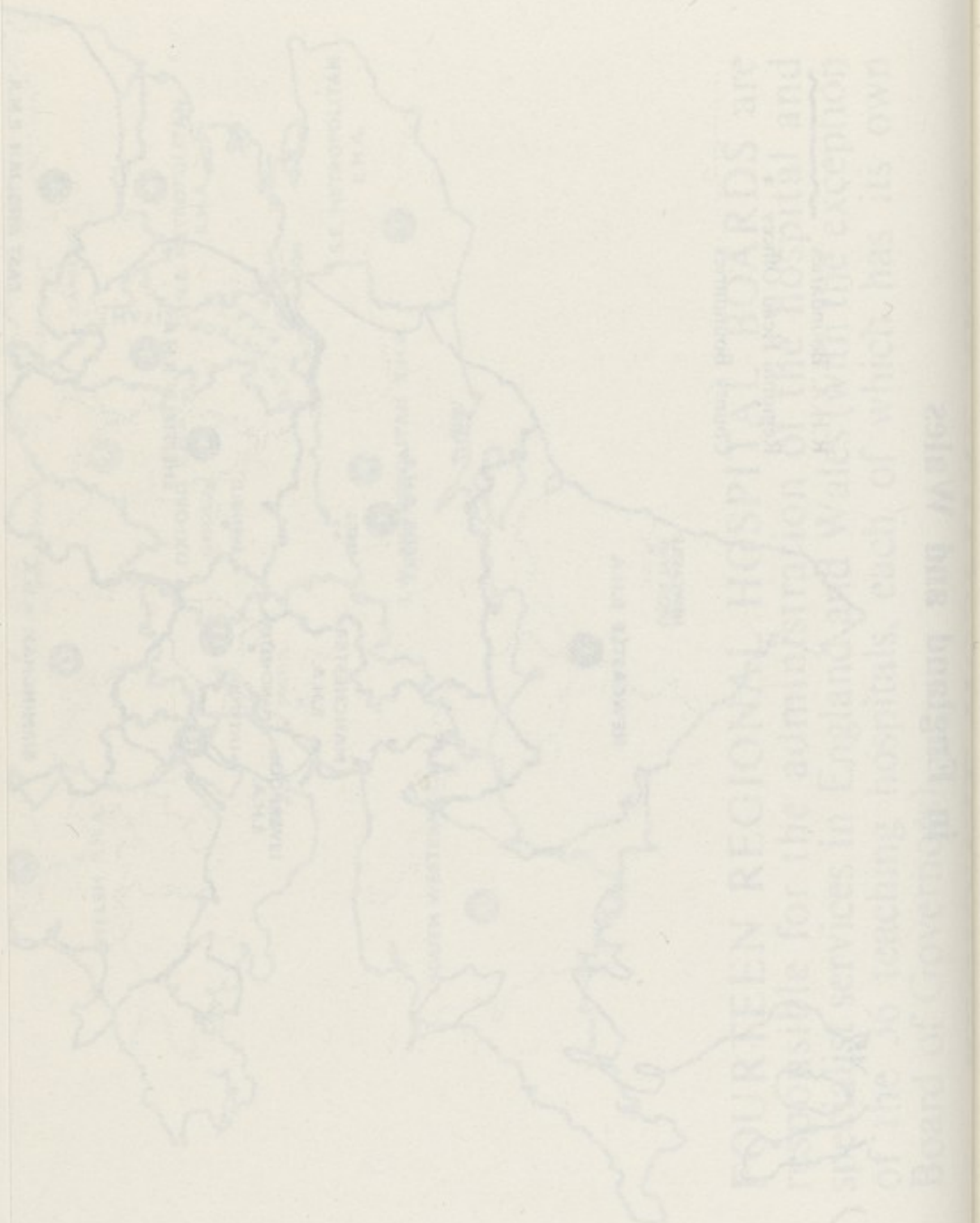
FOURTEEN REGIONAL HOSPITAL BOARDS are responsible for the administration of the hospital and specialist services in England and Wales (with the exception of the 36 teaching hospitals, each of which has its own Board of Governors).

Illustration 2

Regional Hospital Organisation

REGIONAL HOSPITAL AREAS
in England and Wales

FOURTEEN REGIONAL HOSPITAL BOARDS are responsible for the administration of the hospital and specialist services in England and Wales (with the exception of the 36 teaching hospitals, each of which has its own Board of Governors).



II

THE FUTURE OF THE HOSPITAL SERVICES, 5 OCTOBER 1945

I hope to put to my colleagues soon my general proposals for a National Health Service. Before I can make further headway, I need a decision on one big question of principle - the future of the voluntary and municipal hospital systems. I am going to propose:-

(*a*) the complete taking over - into one national service - of both voluntary and municipal hospitals; but with special provision for the big teaching hospitals;

(*b*) the concentration in the Minister of Health of responsibility for a single hospital service, coupled with the delegation of day-to-day administration to new regional and local bodies appointed by the Minister (after consultation with the appropriate local organisations) and responsible to him;

(*c*) the centralising of the whole finance of the country's hospital system, taking it right out of local rating and local government.

The Voluntary Hospitals

2. In the White Paper it was proposed:-[1]

(i) to regard the voluntary hospitals as separate contractors, providing services in accord with a local health services plan for their areas and being paid from public funds for doing so;

(ii) to impose on them, apart from the local area plan, certain national conditions - *e.g.*, regulating the terms of service of nursing and other staff, the selection of properly qualified specialist staff;

(iii) to provide for regular inspection of the hospitals;

(iv) to pay them from the local rates and from the Exchequer sums which would together represent the greater part of each hospital's income, although leaving some field for continued appeal for voluntary support;

(v) subject to the above points, to leave them entirely under their own independent management as autonomous bodies.[2]

In the discussions since the White Paper there have been various changes suggested; but, broadly, the attitude which I have just summarised has remained the general attitude adopted towards the voluntary hospitals.

3. From estimates formed in my Department it seems clear that the moneys which would have to flow into the voluntary hospitals from public funds, local or central, would certainly amount to 70 per cent. or more, and would often amount to 80 or 90 per cent. of the individual hospital's income - and even that is on the questionable assumption that some voluntary support will continue to be forthcoming. Even the small remainder of the voluntary hospitals' income would not wholly represent current voluntary support, as it would include income from investments and endowments dating from the past. In such a situation I do not see how we could possibly be justified in doing what the White Paper proposed and leaving the hospitals under the independent management which they have now. I believe strongly that we must insist on the principle of public control accompanying the public financing of the hospitals, broadly in proportion to the extent of that financing.

4. If we do insist on this, it follows from the above estimates that we shall have to impose effective public control on every voluntary hospital. We might, it is true, limit ourselves to inserting a majority of publicly appointed representatives on the governing bodies, but this would only mean creating a new hybrid sort of hospital under publicly provided governors and finance, with some relic of their previous identity and separate status. That would get us nowhere, and if we are in effect to take over the hospitals publicly we must do it completely - *i.e.*, put them completely in the hands of

some form of public authority.

5. No doubt compromise schemes could be devised which would start by introducing only a minority element of public control into the governing bodies, and would then enable this to be developed into a full majority control gradually, hospital by hospital, as the dwindling remnant of voluntary resources dried up. But, apart from offending against the principle of public control following public money, any such schemes for introducing and gradually expanding control would not much ease the opposition of the hospitals while achieving nothing of any real value in reforming the hospital services. I am sure the real choice lies between leaving the voluntary system broadly on the footing of the White Paper or taking it over, under some form of public authority, decisively and openly now. On merits I think there is no doubt but that we ought to take a bold course and do the latter.

6. I am strengthened in this by the conviction that, whatever its usefulness in earlier days, the voluntary hospital system has not succeeded in producing a really good hospital service.[3] (I am not thinking of the relatively few big teaching hospitals, for which I want to make special proposals later.) Some of the hospitals are thoroughly bad, just as some of them are good; but the great majority are mediocre and too small, the specialist staffing arrangements of many of them are inadequate - and sometimes non-existent; the whole notion on which most of them have grown up, the notion of the self-contained, separate, independent "local hospital," is nowadays a complete anachronism. I think the system has outlived its usefulness, and the time has come to leave it behind.

7. If the case for taking over the hospitals under full public control is admitted, this means taking over either by some form of local government machinery, or by the central government - and the next question is which is it to be. I would strongly deprecate the former, for reasons which I will give.

The Local Authority Hospitals

8. A few local authorities run a good hospital system.[4] The great majority are not suited to run a hospital service at all under modern conditions. Areas are usually too small for the needs of the specialised services; the present artificial demarcation of town and country in local government is inconsistent with the right arrange-

ment of hospital responsibilities; the ordinary local authority cannot attract and maintain the quality of expert officers needed for organising modern specialist services; the costs of up-to-date hospital and specialist facilities cannot properly be thrown on local rates without heavy Exchequer subsidy and in any case would not fall equitably (except with a great deal of juggling) upon the present variety of rating areas which a big hospital service must serve. Local government, as we know it, is already overloaded - and a new nation-wide hospital and consultant service is too big and unsuitable a burden to put upon it.

9. Nor has the record of the local authorities in this field been very encouraging. Although they run many more hospital beds than the voluntary hospitals, nearly half of their ordinary hospital accommodation is still run by them in the general surroundings and atmosphere of the old Poor Law system, and their general hospital service as a whole is of questionable efficiency. Their infectious diseases hospitals are usually too small, and are of very varying quality. Generally, they have come into the modern hospital field too late and at a time when developments in specialist medical services are moving rapidly away from a kind of local government system which was never designed for them.

10. The plain truth is that neither of the present hospital systems is the right one, and we have to look for something new in place of both. The first fundamental from now on is to picture, plan and provide a hospital service on a broad national scale, and to get rid once and for all of any purely historical impediments to doing so. The second fundamental, to my mind, is to recognise that in so highly technical and specialised a service as this we have got to achieve a new blend of the technical expert with the public representative. The full principle of direct public responsibility must, of course, be maintained, but we can - and must - afford to bring the voice of the expert right into direct participation in the planning and running of the service. We have to achieve a fair balance in this - and local government has certainly not achieved it.

11. I have considered the possibility of creating some new and reorganised form of local government unit to run the hospital service, drawing a substantial part of its finance from the local rates and resting in some way on responsibility to the local government elect-

ors. The idea of a new directly elected authority for this one purpose can be rejected at once - as unlikely to attract polling interest and as representing a method of conducting local government which, if it were generalised, would produce an impossible hotch-potch of local government areas and rating.[5] The other alternative, of combining existing authorities in some new form of joint board, must, in my view, also be rejected. There are always these objections to a joint board-system -[6]

(*a*) the removal of local responsibility to two removes from the local electorate;

(*b*) the intense unpopularity of the system with local authorities, and particularly of the system of precepting on other authorities' rates for the joint board's money;

(*c*) the difficulty usually experienced in getting the right members of the constituent authorities to serve on joint boards.

I am quite sure that the joint board is not a good solution; it is a poor instrument in itself and would be popular with nobody.

A New National Service

12. The right course, I am sure, is to nationalise the hospital services entirely and to take them out of the field of local government altogether. The future hospital situation is quite a new one. For the first time we shall be promising the whole population a full service - every kind of hospital and specialist care planned over the entire country. We shall (if my first proposal is accepted) be amalgamating the two present hospital services into one single new service, and we have got to achieve as nearly as possible a uniform standard of service for all - when all pay their contributions to a national insurance scheme. This is important. Under any local government system - even if modified by joint boards or otherwise - there will tend to be a better service in the richer areas, a worse service in the poorer. Yet all the population will be paying the same national rates of insurance contribution and will expect the State to see that an equally good service is available everywhere. Every attempt we might make to fit this new conception to a local government pattern which was never designed for it, and to areas or even

combinations of areas whose boundaries do not suit it, would simply mean hampering the sensible planning and running of the new service. This seems to me strongly to be a case of starting again with a clean slate.

13. It is true that, in the nationalising of the hospital services, the exchequer would have to make good the small proportion of the cost of the voluntary hospitals' services which would otherwise be met from voluntary sources. But even this small proportion includes income from investments and endowments, of which the exchequer would presumably get the benefit in future, and it is only the uncertain residue of purely voluntary, current gifts which would be lost. It is true, also, that by nationalising the hospital services we should be shifting a substantial body of costs from the rates to the exchequer - and that would be part of the purpose. But, even here, we must remember that sooner or later there will have to be a general examination and adjustment of the relations of local to central taxation and the shifting of a particular item now need not affect the total result when that adjustment is made.

14. This is how I would do it:-

(1) The State, the central government acting through the Minister of Health, would be empowered to take over the full ownership of all hospitals, voluntary and municipal - including sanatoria, mental hospitals and mental deficiency institutions - in order to provide a national hospital service.

(2) The State would then exercise this power in respect of all these institutions except the main teaching hospitals on which the university arrangements for the training of the medical profession are principally based.[7] It would exempt the latter partly on the ground of their exceptional standing in the hospital and medical world, partly because it is a good thing in itself to keep separate a field for innovation and independent experiment in method and organisation (for which purpose the teaching hospitals are excellently suited), partly because it is undesirable to introduce a full and direct State control and regulation into the educational field (determining what and how the medical profession should be taught).

(3) There would be set up, statutorily, new regional boards, one for each natural hospital region - the ten or so regions which always feature in proposals for organising hospital services.[8] Each of these boards would be set up by the Minister and would consist of persons recommended by the major local authorities, persons selected by the Minister himself and an element of medical and other experts versed in the hospital and medical services. If at some future date local government can be reorganised on a wider regional basis - as we all want to see it - a situation may well arise in which we could adapt this system of hospital regional boards to the reorganised local government system, and perhaps get the hospital services back into a more modern form of local government.[9] My present proposals should help, to some extent, in anticipating this.

(4) To the regional boards would be entrusted by the Minister the administration of all the hospitals in their regions in accordance with a detailed regional scheme to be worked out by each board with the Minister. The boards would work under the general directions of the Minister, and - whenever it became necessary - under his specific directions on detail; but for all normal purposes the aim would be the maximum degree of decentralisation in the administration. Where the geography of a region made it desirable, the regional board might need to do some of its work through two or more Divisional Committees; but that is a matter to consider in more detailed proposals.[10]

(5) For each natural hospital district - *i.e.*, for each area able to support a general hospital or combined group of hospitals big enough to employ a full specialist staff for all normal needs (embracing about 1,000 beds in either a single major hospital or a related group of hospitals as local needs required) - there would be a District Committee to which the regional board will delegate the day-to-day running of the hospital or group of hospitals concerned.[11] These committees would be formed by the regional boards, subject to the Minister's approval, and

again the aim would be to select people of local and general experience to represent the public interest, with an admixture of medical and other experts.

(6) The whole hospital service so created would be centrally financed, but under a system ensuring a free and flexible degree of decentralised responsibility.

(7) Officers of the boards and committees would be appointed as officers of the Minister and, if possible, arrangements should be made for the interchange of such officers between the regions and the Minister's headquarters. Medical and other staff of the hospitals would be engaged and paid by the boards as agents of the Minister, and the Minister would enlist the help of proper expert advisory machinery in each region in the selection of specialist staff and persons for senior hospital appointments. Generally, the Minister would be able, by direct action in a centrally controlled service, to ensure proper terms and conditions for all types of hospital officer or servant.

(8) Activities which need to be organised as out-patient specialist activities of the hospitals (such as tuberculosis dispensaries and venereal disease clinics) would be transferred from local government to the new national service with the hospitals. The future allocation of the other local government health services - child welfare, district nursing, the provision of health centres for general medical and dental care, and so on - can be considered in detail when once a decision in principle has been reached on the hospital services. It looks at first sight as though the ultimate responsibility for these should rest with the Minister, to ensure a unified health service, but there should be provision for delegation to existing persons and agencies for doing the day-to-day job.

15. That is my general proposal. There is no question but that it would provoke an outcry both from voluntary hospitals and from the local authorities. To the governing bodies of most of the voluntary hospitals it would mean extinction. To many in the local authority world it would appear to be wrenching away from them the very

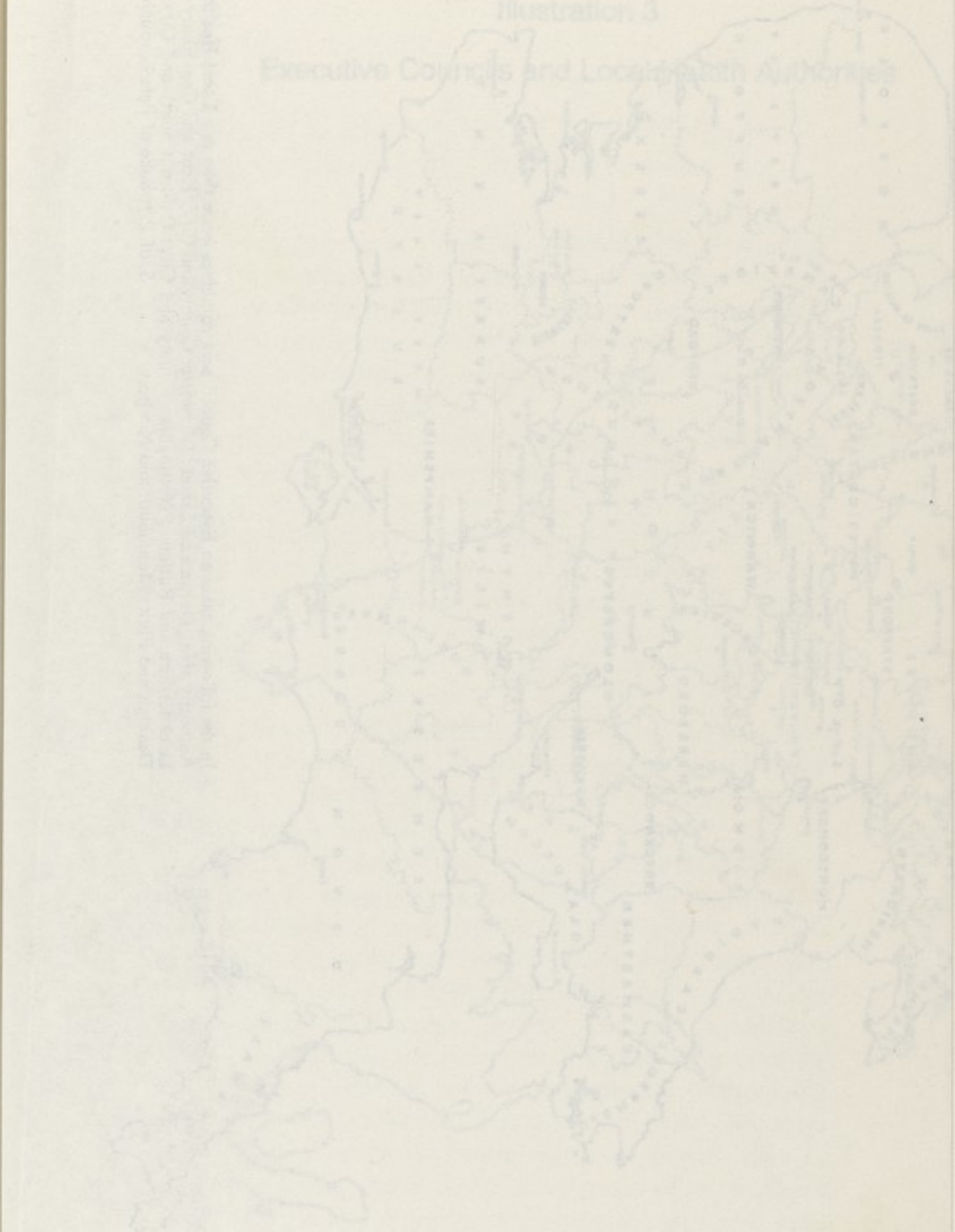
heart of their health services, although there would be some, even now, who would consider the principle sound. The attitude of the medical profession is uncertain; many doctors may take sides against the abolition of the voluntary hospitals, no doubt; but if the choice were before them between a primarily local government service and a primarily nationalised service, the overwhelming majority would prefer the latter - and, if the latter were part and parcel of a well-worked-out general health service in which they felt that the profession had a square deal, I think the profession would be solidly behind it. In any case, I believe that it is on these lines, of organisation on a nation-wide basis with regional and local delegation of management, that the best hospital service is to be attained. If my colleagues agree in principle, I will work out a detailed scheme to bring back to them.

16. A decision in principle is urgently needed. All the current administration of the hospital services by my department is affected by the present uncertainty as to the broad shape of the future. The preparation of draft legislation on the health services as a whole has to be held up for a decision on this hospital issue. Yet the drafting of that legislation needs urgently to go on as a Health Bill this session is vital if national insurance is not to be delayed, if the newly developed war services of the Emergency Hospital Scheme are not to be dissipated, and if returning men and women from the Forces - doctors, nurses and others - are to be able to make their plans in knowledge of which their future opportunities are to be. If we can reach a decision on the issue in this paper now, I can go ahead. I shall have to have some talk with the local authorities and others affected by the decision, to work out details of ways and means, but generally I shall try to avoid embarking on a new series of White Paper negotiations.

Source: Cabinet Memorandum by the Minister of Health, "The Future of the Hospital Services", CP(45)205, 5 October 1945, PRO CAB 129/3.

Notes:

1. *A National Health Service*, Cmd. 6502 (London, HMSO, 1944).
2. *A NHS*, pp. 21-6.
3. *A NHS*, p. 55.
4. *A NHS*, pp. 55-6.
5. This suggestion was canvassed in the well-known Dawson Report, conventionally regarded as the ancestral plan for a national health service: Consultative Council on Medical and Allied Services, *Interim Report on the Future Provision of Medical and Allied Services*, Cmd. 693 (London, HMSO, 1920).
6. The joint board idea was adopted in the 1944 White Paper, *A NHS*, p. 16.
7. Bevan soon modified this proposal to give special administrative status to teaching hospitals, rather than independence.
8. In the event fourteen regions were established. The increase is explained by division of the London region into four metropolitan regions. See Illustration 2.
9. This theme was again taken up by Bevan in 1954, see below XXII.
10. The only successful divisional arrangement established was in the Newcastle Region, with its Cumberland and N. Westmorland Division. Webster, *Problems*, p. 269.
11. The "District Committee" evolved into "Hospital Management Committee". The latter were more numerous and exercised a less comprehensive geographical function.



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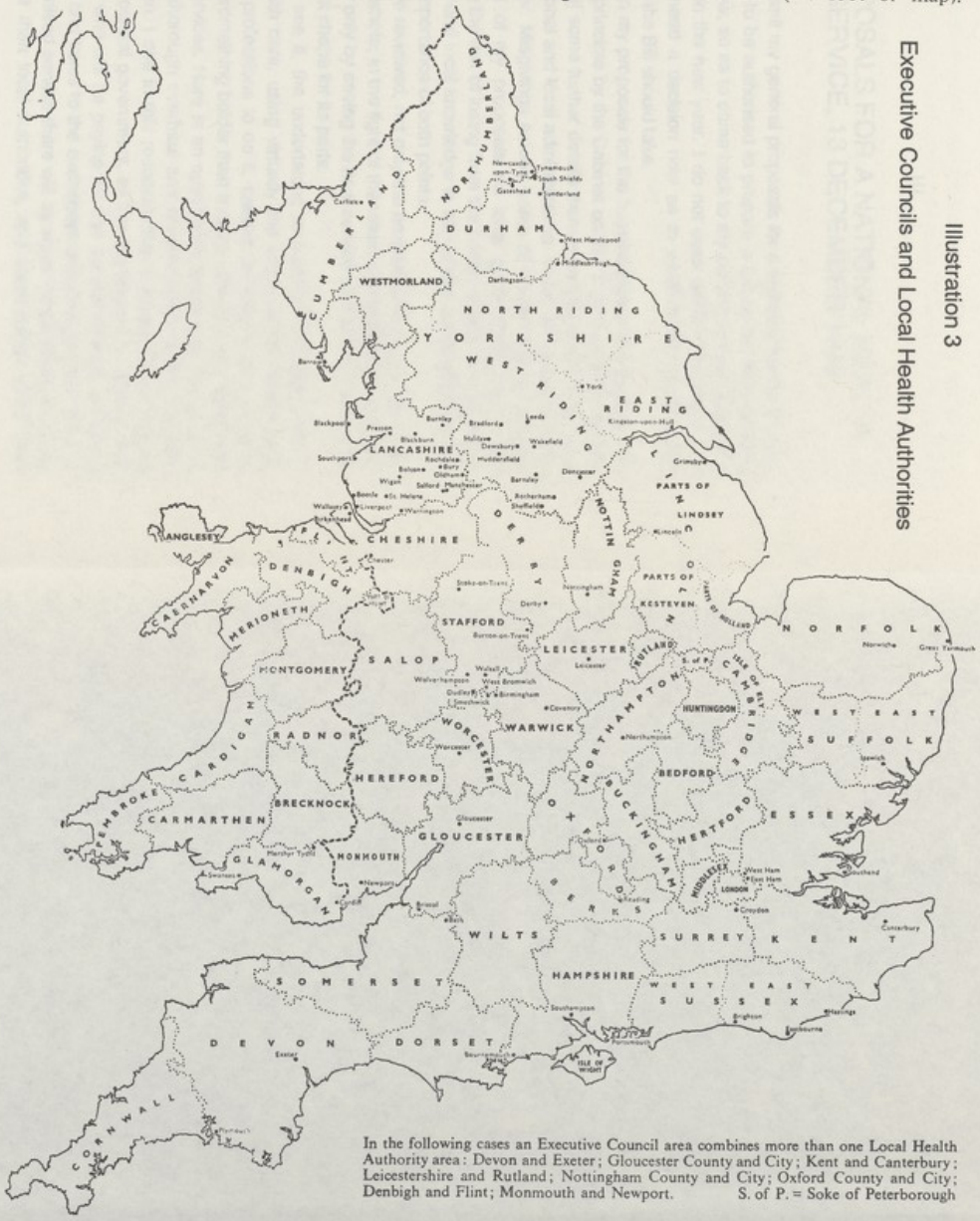
LOCAL HEALTH AUTHORITIES AND EXECUTIVE COUNCILS

146 Local Health Authorities—62 County Councils, 83 County Boroughs and the Isles of Scilly—are responsible for all local health authority services in England and Wales; 138 Executive Councils are responsible for the family practitioner services—one for each County and County Borough, except in eight cases where two areas are combined under a single Executive Council (see foot of map).



In the following cases an Executive Council area combines more than one Local Health Authority area: Devon and Exeter; Gloucester County and City; Kent and Canterbury; Leicestershire and Rutland; Nottingham County and City; Oxford County and City; Denbigh and Flint; Monmouth and Newport. S. of P. = Soke of Peterborough

Illustration 3

Executive Councils and Local Health Authorities

III

PROPOSALS FOR A NATIONAL HEALTH SERVICE, 13 DECEMBER 1945

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

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

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

4. As I see it, the undertaking to provide all people with all kinds of health care, using virtually the whole of the medical and other health professions to do it, creates an entirely new situation and calls for something bolder than a mere extension and adaptation of existing services. Here is an opportunity which may not recur for years, for a thorough overhaul and reconstruction of the country's health position. I see in this reconstruction a proper place both for local and for central government, as the complementary instruments of the public who will be paying for this service through insurance contributions and taxes to the exchequer and through local rates. In a fully modernised service there will be some things which the State can do better than local authorities, and some things which local

authorities can do better than the State. There is also, in my view, both room and need for giving a voice, in the guiding and providing of the service, to those professional people who will in future be almost wholly absorbed in it and on whom its success will depend. This will involve in some cases - as in the provision for a family doctor service - new forms of executive machinery, in which the representatives of the potential patients and those of the professional people undertaking their care can combine.

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

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

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

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

SUMMARY OF PROPOSALS FOR A NATIONAL HEALTH SERVICE

I. The Minister as the Central Authority

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

2. The Minister will discharge his general responsibility through three main channels:-[1]

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

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

(3) For new family practitioner services - doctor and dentist - new local executive machinery will be set up, composed

partly of members drawn from local authorities, partly of people selected by the Minister, partly of representatives of the doctors and others engaged in the service. These new local bodies will act within national regulations made by the Minister; and by the side of the Minister there will be a special, mainly professional, body to regulate the distribution of general medical practitioners over the country as a whole.

New central advisory machinery

3. To provide the Minister with expert advice, in the technical planning and conduct of the service, there will be a new Central Health Services Council...[2]

4. In addition - to free the Council for its general work on the service as a whole - it will have Standing Advisory Committees on special aspects of the service (medical, hospitals, nursing, mental health service, &c.)...

II. Hospital and Specialist Services

Taking over the existing hospitals

6. The ownership of the present public hospitals, voluntary and municipal, will be taken over by the Minister (subject to special arrangements in the case of the teaching hospitals, described later)...[3]

Regional Hospitals Boards

7. The country will be divided into about twenty natural areas or regions for hospital organisation.[4] Each area will be based on one of the eleven university medical teaching centres - the natural focal points of specialist medicine and therefore of hospital services. Two or more areas will sometimes base on the same medical teaching centre, to avoid the areas becoming too big for practical organisation.

8. For each area or region there will be set up a Regional Hospitals Board of some 20-30 members, appointed by the Minister and drawn from the major local authorities in the area, from local

people selected by the Minister for their general suitability for the work involved (some of whom may be ex-voluntary hospital experts), and from people representing the university teaching centre and specialist and general medicine in the area. Principal officers of the Boards will be appointed by the Boards subject to the approval of the Minister.[5]

9. Each Regional Board will be required to appoint, subject to the Minister's approval, a number of smaller Local Hospital Management Committees.[6] There will be one of these committees for each local group of hospitals which together form a natural hospital unit in a planned service - *i.e.*, one or more main hospitals, with some outlying smaller "feeder" hospitals, together providing about 1,000 beds under a common specialist staff, and capable of dealing as a group with all the more normal hospital needs of their immediate area. Sometimes a large hospital not needing to be so grouped - *e.g.*, a mental hospital - will have one of those committees to itself.[7] All the committees will be essentially local executive bodies, although their field of operation cannot be restricted to existing local government boundaries. Their members will be drawn from the local authorities of the areas served by the hospitals after consultation with those local authorities, and from other local people selected by the Regional Boards (including, where desirable, people of local voluntary hospital experience), together with some professional members.

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

11. The day-to-day work of running the hospitals will then be entrusted by the Boards to the Local Management Committees. These will be the effective managers on the spot, appointing all ordi-

nary staff of the hospitals, dealing with supplies, handling ordinary running and minor capital expenditure, and generally acting as the "governing bodies." In mental hospitals they will take the place of the present Visiting Committees. The principal officer of each Committee will be appointed by the Committee with the approval of the Regional Board, and will act also as the chief administrative officer of each hospital covered by the Committee[8].

Special Provision for Teaching Hospitals

12. Special provision will be made in relation to hospitals providing the bases for the clinical teaching of medical students. They will be taken over by the Minister like other hospitals, and play their part in the national service; but they will be given the special status and measure of independence necessary to enable them to take their proper place as academic institutions standing in close association with the universities whose educational needs they must be organised to meet. Universities must be enabled to exercise an effective influence on the policy and activities of teaching hospitals. Essential features of the organisation of a teaching hospital emphasised by the Goodenough Committee are a governing body which is personal to the hospital and has wide discretion as to expenditure within a reasonable budget; representation of the university and of the teaching staff on that governing body; and selection of medical staff (other than holders of university posts) by a special advisory committee, representative of the governing body of the hospital and of the university.[9]

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

(1) Instead of being entrusted to the ordinary Regional Boards and local management committees described above, the teaching hospital (in some instances the main and associated hospitals which together constitute the teaching centre) will have its own specially constituted Board of Governors.[10]

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

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

(4) The Governors will have full freedom to appoint their own staff, and in making medical staff appointments will be advised by a special selection committee constituted in the light of the Goodenough Committee recommendations...[11]

III. Local Clinic, Domiciliary and Welfare Services[12]

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

(*a*) School medical services.[13]

(*b*) Maternity and child welfare (in co-operation with the hospital service on the specialist side).[14]

(*c*) Domiciliary midwifery.[15]

(*d*) Health visiting.[16]

(*e*) Home nursing services.[17]

(*f*) Home help services for households in time of sickness.[18]

(*g*) Vaccination and immunisation services.[19]

(*h*) Various forms of care and after-care for the sick and those recovering from sickness.[20]

(*i*) A general ambulance service.[21]

(*j*) The provision and maintenance of Health Centres, Dental Centres, and similar local premises as bases for the Family Practitioner service (to be described later).[22]

(*k*) Ascertainment of mental cases...

IV. Family Practitioner Services

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

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

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

treat patients at the cost of the new service wherever this can be arranged.

Local Executive Committees[23]

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

Health Centres[24]

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

Remuneration of Doctors

37. Doctors working in Health Centres, whole-time or part-time, will be paid a basic salary, as part of their public income; the rest of a "sum due" to each of them will be pooled in the Centre and divided among the doctors under something like a partnership agreement.[25]

The "sum due" will be calculated on a capitation rate for all patients in the care of the doctors in the Centre, while being distributed among them as above. Doctors working outside the Health Centres (while these are being developed) will similarly be paid a basic part-salary, the rest of their remuneration depending on a capitation rate in respect of patients on their lists.

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

Remuneration of Dentists[26]

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

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

Source: Cabinet Memorandum by the Minister of Health, "Proposals for a National Health Service", CP(45)339, 13 December 1945, PRO CAB 129/5.

Notes:

1. *National Health Service Bill*, Cmd. 6761 (London, HMSO, March 1946), para 9.
2. *NHS Bill*, paras 92-4; NHS Act section 2.
3. *NHS Bill*, para 14; NHS Act, section 6. Part II of the NHS Act outlined arrangements for the hospital service. See Illustration 2.
4. *NHS Bill*, paras 19-22; NHS Act, section 11(1)-(2). Inclusion of teaching hospitals in his scheme led Bevan to base his regions on teaching centres. Except in London he abandoned the idea of two regions being served by the same teaching centre, thereby reducing the number of regions from twenty to fourteen, thirteen in England and one in Wales. See Illustration 2.
5. In CP(45)205, para 14(7) the principal officers were to be responsible to the Minister. Periodically reversion to this arrangement was considered in order to tighten up control of the regional boards. Webster, *Problems*, pp. 162, 182, 284-6.
6. *NHS Bill*, para 23; NHS Act, section 11(3). 377 Hospital Management Committees were established in England and Wales. Webster, *Problems*, p. 274.
7. Despite Bevan's encouragement of "blending" or "integration", separate administration of mental and mental handicap hospitals became rigidly applied, except for the Birmingham region. Webster, *Problems*, p. 330.
8. RHB approval of principal officer appointments was not pursued in the NHS legislation.
9. *Report of the Interdepartmental Committee on Medical Schools* (London, HMSO, 1944).
10. *NHS Bill*, paras 25-8; NHS Act, section 11(8). Thirty-six institutions were designated as teaching hospitals: 10 provincial and 12 London undergraduate teaching hospitals, and 14 London postgraduate teaching groups. NHS Act, section 11(8). Webster, *Problems*, pp. 270-4.
11. *NHS Bill*, paras 29-30; NHS Act, section 11(3).
12. Under Part III of the NHS Act 145 County Councils and County Borough Councils were established as Local Health Authorities. See Illustration 3.
13. The School Medical Service (School Health Service as it was known after 1944) remained administratively separate from the NHS until 1974.

14. *NHS Bill*, paras 78-81; NHS Act, section 22.

15. NHS Act, section 23.

16. *NHS Bill*, para 82; NHS Act, section 24.

17. *NHS Bill*, paras 83-4; NHS Act, section 25.

18. *NHS Bill*, para 89; NHS Act, section 29.

19. *NHS Bill*, para 86; NHS Act, section 26.

20. *NHS Bill*, para 88; NHS Act, section 28.

21. *NHS Bill*, para 87; NHS Act, section 27.

22. *NHS Bill*, para 90; NHS Act, section 21. In view of the importance attached to health centres in Labour Party policy this section was given priority in the 1946 NHS White Paper. See *NHS Bill*, paras 32-3, 36.

23. *NHS Bill*, para 41; NHS Act, section 31. Under Part IV of the NHS Act the old National Insurance Committees were reconstituted into 138 Executive Councils. See Illustration 3.

24. *NHS Bill*, paras 42-3, 56-7; NHS Act, section 21.

25. *NHS Bill*, para 46. The idea of the basic salary was eroded to extinction in the troubled negotiations with the profession. Webster, *Problems*, pp. 107-20.

26. Dentists refused to accept payment by salary, and also initially rejected fee for service. The latter represented continuation of National Health Insurance practice. The 1946 NHS White Paper was ambiguous over the forms of payment for dentists. *NHS Bill*, paras 62-3. Webster, *Problems*, p. 358.

IV

INSTITUTE OF HOSPITAL ADMINISTRATORS, 6 APRIL 1946

Mr. President, Ladies and Gentlemen: I must confess at the outset that my main purpose in asking you to be good enough to postpone the holding of your meeting has not been realised.[1] I had hoped that the Second Reading of the health service proposals would have taken place, and that we should have been able to discuss the proposals in the light of the decision of the House of Commons.[2] However, the time-table has not proved to be so manageable, and as a consequence I am in a little difficulty this afternoon. The Bill has been published, the House of Commons has not yet considered it, but nevertheless very considerable debate is going on.[3] It is one of the conventions - not one of the strongest, but nevertheless one of the commonest - of our constitution that a Minister shall make his report to the House of Commons first. Therefore, I am inhibited this afternoon from making many observations on the general principles of the measure, and particularly from making any reply to some of the wilder statements that have been made by men old enough to have been more sensible.

As time goes on and the White Paper is read and the Bill is examined and its contents made familiar, we shall find that many of the speeches that have been made have no relationship at all to what is contained in the proposals. Indeed, one would think, from reading some of the speeches of the more partisan of the controversialists, that they were addressing themselves to proposals which they thought were going to be brought up, and which in fact had not been brought up, and were finding it difficult to make speeches in the new situation.

The medical profession is not an easy one to handle. It is composed of eminent men and women who have devoted themselves and dedicated themselves to it, but who do not appear to bring the same collective sagacity to bear upon the profession as they do upon their individual patients. However, I have no cause for

complaint at the general response which has been given to the proposals. On the contrary, there is a wider degree of approval than ever I anticipated. It is bound to be a controversial subject; men and women's emotions are too deeply involved for them to be able to accept our proposals finally, which have to do with health and with the organisation of our medical services. Furthermore, many devoted people who have given service to our health organisation over the years and have become deeply wrapped up in it are sometimes inclined to mistake their own emotional possessiveness for wisdom. I would much rather have a person kept alive by cold and altruistic efficiency than put to death by warm-hearted sympathy. We must recognise that our hospital service is organised for the service of the patient and not for the purpose of the management board; not even for the good people who give their time and their service to it, and not even for the hospital administrators.

You have recognised in your constitution one of the underlying realities of a hospital service; you have recognised that it is in fact a common service, and your association has anticipated the wisdom of politicians. In your own association you have brought together representatives of the voluntary as well as of the municipal hospitals, and you have therefore, from your day-to-day experience and from your specialist knowledge, realised that the hospital service of Great Britain, if it is to be efficient, must be fully integrated. It is very difficult to integrate hospitals if they are to remain self-governing institutions; it is very difficult to bring voluntary hospitals and municipal hospitals into intimate functional relationship if they are each able at any stage on the road to deny the association. Therefore this integration was regarded by me as an essential first step towards laying the foundation of a great health services scheme in this country. But no one recognises more than does the Government, and certainly no one recognises more than I do, that no legislation, however wisely conceived and however efficiently embodied in an Act of Parliament, can ever give the public a great health service unless the people who administer it want to do it and are enthusiastic in doing it.

The people upon whom the efficiency of the health service will depend are largely represented in this hall this afternoon. I am exceedingly anxious, therefore, that in any proposals I should be

able to carry you with me. It is true, as the President said in his most felicitous speech, that you and I cannot, in this relationship, discuss the general principles - that you will do in your capacity as citizens in some other place, perhaps - but what we can do is to consider two features in which we are especially interested.

Staff Representation

Now if there is one thing that I do want to see accomplished throughout the health service, it is the effective participation of the hospital staff in the running of the hospitals. I do not believe that the requirements of democracy are necessarily satisfied by putting a cross opposite somebody's name every four or five years. I believe that, if we are to have a vital democracy, we can accomplish it only by the daily and hourly participation of the people who are doing the job and the people who are responsible for the administrative policies. Therefore, I hope that, when the hospitals are properly organised, we shall lay out a scheme for the effective participation in the staff organisation, in staff councils and in staff co-operation, not only of the medical staffs of the hospitals but of the domestic staffs as well - because people seem to forget that the domestic staffs are at least as important as the rest.[4]

Maintaining Traditions

In order to avoid some of the defects that might arise from a too highly centralised service, the structure of the Bill provides for a very great deal of decentralisation. I am conscious that in carrying out a great reform we might have the benefit of the innovations and yet lose some of the advantages of the present system. What we must strive to do in Great Britain is to maintain a continuity of those qualities arising out of the reform itself. We are a very old country with great traditions, our procedure in many respects is very complex. We have accumulated in our passage through history, like an old ship on a long voyage, a considerable accretion of barnacles. It is our purpose to try to cut out the barnacles without mutilating the traditions.

The Teaching Hospitals

You will have seen from the proposals how we propose to accomplish that in the case, for example, of the teaching hospitals. The teaching hospitals are very busy institutions. They are going to maintain their own traditions, they are going to maintain their own identities, but they are going to retain them in such a fashion as to enable them to be fitted into the general hospital system. The teaching hospitals, although they will have their self-governing boards and a special charter, will be expected to discharge their services within the general hospital service, and will not be expected to reject certain cases because those cases have not got specially interesting qualities about them - something of which you have heard now and again, I have no doubt. If the medical graduates are to be trained properly in our teaching hospitals they can only be trained if they are brought into contact with the widest possible diversity of patients; and therefore the teaching hospitals will be expected, in return for their charter, in return for the payments which will be made to them, to provide their proper share in the general hospital service itself.

Academic medicine is going to be wholly free, and left outside the interference of the State. Academic medicine is going to be what it ought to be, an entirely self-governing force. That is as it should be. I myself would not only hesitate, I would refuse to accept the obligation of determining the shape of academic medicine. The medical profession has shown itself on more than one occasion fully able to create resistance to change without being reinforced by the Government. Therefore, academic medicine is to be left fully free.

Finance of Teaching Hospitals

Furthermore, we have striven, Mr. President, to keep the hospital service at the regional level free from what may be called the restriction of the balance sheet. These great hospitals will be spending big money, and it is one of the great problems of State intervention in any form of activity, and especially in this one, for the State to provide all the money and to hold those who spend the money to accountability for the expenditure without paralysing the service by interfering too much with particular items of expenditure. That is one of our great problems, and we have striven to solve it,

and I believe that if the proposals are imaginatively and sympathetically examined they will be found to have gone very far to remove the hand of the accountant from the administration itself.

The teaching hospitals will receive from the Ministry of Health their annual budget, a global sum based on the assumption of what they will require to spend to provide the services that we shall need from them, and within that global sum they will have plenty of elbow room in disposing of it over particular items of expenditure. Furthermore, they will be able to receive grants from the University Grants Committee for all purposes for which those grants are permissible - and they are very wide indeed - for experimentation, for exchange of doctors and surgeons between countries - and I do most earnestly hope that with an international health service there will be very much more interchangeability between Great Britain and the rest of the world than there was before the war in regard to health services. Furthermore, so as to serve as an additional shock-absorber between the Ministry of Health and the teaching hospitals themselves, they are to retain their endowments and be free to spend them for whatever purposes they desire. So far as I can see, Mr. President, the teaching hospitals are going to be better off than ever they were before, they will receive what monies they need for their general hospital expenditure, and they will no longer find it necessary to spend their own endowments either on day-to-day necessary administration or on capital expenditure. I could have taken no more steps to have ensured the freedom of action of the teaching hospitals than I have done, consistent with their integration in the general hospital service.

No Civil Servants

When you come to the hospitals in the country generally, the same principles have been followed. The civil rights of the staffs and of the doctors generally are being preserved; because you will not be Civil Servants, you will be in contract with the Regional Boards and, being in contract with the Regional Boards, you will be fully free to conduct agitation and vote against the Ministry of Health at any time you care.[5] There will be no limitation at all upon the civil liberties of the persons working in the National Health Service. Indeed, Mr. President, it does not seem to have been grasped by many of

those who have been rushing into print that the Bill does not create an additional civil servant; on the contrary, the structure has been so devised as to leave civil rights entirely undisturbed; and indeed, in the case of those who are now in the employ of municipal authorities their civil rights should be enlarged rather than diminished.

Freedom in Local Hospital Management

The Regional Boards also will receive their global budget. There will be an assessment of what the hospitals expenditure will be in the regional area, and that sum will be given to the Regional Board and it will be free to be expended on the services that it is to provide to the public. There will therefore be elbow room left in that way. It will not be required to seek the approval of the Minister of Health or of the officials of the Ministry of Health to any particular item of expenditure. The Regional Boards will be free to do the same thing for the Hospital Management Committees in the local hospital service, and I hope that full advantage will be taken of that liberty, because not only is it necessary that a Regional Hospital Board should have freedom of movement, it is also necessary that the Management Committees should not be tyrannically controlled by the Regional Board; at all points of the service it is necessary that improvisation, experimentation, individuality should be allowed, consistent with the provision of the service.[6] Therefore, there will be no attempt to make the hospital service of the future a purely scholarship service. In fact - as you know very much more than I do - hospital management today is a highly professional and technical job, and whilst we want the help of the amateur with very great hospital experience in the management of our hospitals, we do not want in any way to undermine the highest professional performance.

Furthermore, we have left the hospitals with the funds which have been provided by endowments. It is proposed, as you know, under the Bill, to assemble all the endowments which have been made to the voluntary hospitals at the Ministry of Health and then allocate them to the Regional Boards, so that the Chancellor of the Exchequer will not put a sacrilegious hand upon a single ha'penny of the money. It is a very sizeable sum; it will be in the nature of free money, pocket money for the hospitals. Once it is allocated, the Regional Boards can spend it just as they wish. And remember, it

will be in addition to the money which will be provided for the hospital service itself. Furthermore, the Regional Boards and the Management Committees will be able to receive additional endowments, if people want to make them.

Charity and State Legislation

It does not seem to me that there is anything very wrong with it. There will be people who, in the course of time, will still want to leave benefactions in order to supplement the State service. What we desire to do, by the health service, is to universalise and make available to every citizen a service which the generosity of some has made available to some. That is always the progress of legislation in this country; it starts off by voluntary effort, it starts off by empirical experiment, it starts by improvisation, it then establishes itself by merit, and ultimately at some stage or other the State steps in and makes what was started by voluntary action and experiment a universal service. When that is done, experiment does not cease, voluntary effort does not end. Charitable inspirations are not inhibitive; they start at a higher level and push the State forward again, and then some day somebody else will be meeting here and gathering that harvest and the results of voluntary effort will attain a higher level still. So it is foolish to say that because the object of pity has become the care of the State, therefore the impulse of pity is going to be dried up; it will find new objects, new purposes, a new direction. The Regional Hospital Board will have the greatest freedom of action.

Mental Treatment

I was delighted, Mr. President, that in your speech you made reference to the new relationship of the mental hospital to the general hospital service. The isolation of the mental hospital from the general hospital service is an outrage upon medical practice. The Lunacy Acts have never been properly carried out. It ought to be possible for persons suffering from acute mental anxiety and mental disturbance to be able to get clinical advice at a general hospital without having to undergo what may be the embarrassment of going to an institution dealing with more advanced cases. I think that a great deal of mental disorder could be prevented from developing in

its earlier stages if people were able to walk into the same institution for advice on mental disorder as for a corn on the foot.

Reservoir of Administrative Ability

I said at the outset that I was inhibited rather from making general observations upon the health service as a whole, as a consequence of the fact that we meet in difficult times. I believe that there exists in this country a very general body of support for the main principles of the health service. That is a matter with which I shall have to deal later, but what gives me greater self-confidence than I might otherwise have is, not only that there exists a great volume of political support, but that in this country - and especially in you - there resides an almost illimitable reservoir of administrative knowledge and experience to carry out the scheme when Parliament has adopted it. We are a very happy country in this respect, and we have more administrative experience, skill and knowledge than any country of a similar size in the world. We are able to carry out these great reforms just because we have those qualities. Therefore, when the argument is over, when the decisions have been made, when the shape of the new health service has had the imprint of His Majesty's signature, I hope to have the advantage of many consultations with you in order to bring practical benefit to every person in the land.

Source: *The Hospital*, May 1946, pp. 179-83.

Notes:

1. Bevan was addressing the adjourned Annual General Meeting of the Institute of Hospital Administrators held on 6 April 1946.
2. The Second Reading Debate began on 30 April 1946.
3. The NHS Bill was published on 20 March 1946.
4. For the lack of progress in establishment of house committees and consultative committees at unit level, see Webster, *Problems*, pp. 286-7.
5. See above III, n. 5.
6. Despite this clarification there remained considerable ambiguity concerning the relationship between regional boards and local committees. Webster, *Problems*, pp. 282-7.

V

HOUSE OF COMMONS, 30 APRIL 1946

I beg to move "That the Bill be now read a Second time."[1]

In the last two years there has been such a clamour from sectional interests in the field of national health that we are in danger of forgetting why these proposals are brought forward at all. It is, therefore, very welcome to me - and I am quite certain to hon. Members in all parts of the House - that consideration should now be given, not to this or that sectional interest, but to the requirements of the British people as a whole. The scheme which anyone must draw up dealing with national health must necessarily be conditioned and limited by the evils it is intended to remove. Many of those who have drawn up paper plans for the health services appear to have followed the dictates of abstract principles, and not the concrete requirements of the actual situation as it exists. They drew up all sorts of tidy schemes on paper, which would be quite inoperable in practice.

The first reason why a health scheme of this sort is necessary at all is because it has been the firm conclusion of all parties that money ought not to be permitted to stand in the way of obtaining an efficient health service. Although it is true that the national health insurance system provides a general practitioner service and caters for something like 21 million of the population, the rest of the population have to pay whenever they desire the services of a doctor.[2] It is cardinal to a proper health organisation that a person ought not to be financially deterred from seeking medical assistance at the earliest possible stage. It is one of the evils of having to buy medical advice that, in addition to the natural anxiety that may arise because people do not like to hear unpleasant things about themselves, and therefore tend to postpone consultation as long as possible, there is the financial anxiety caused by having to pay doctors' bills. Therefore, the first evil that we must deal with is that which exists as a consequence of the fact that the whole thing is the wrong way round. A person ought to be able to receive medical and hospital help without

being involved in financial anxiety.

In the second place, the national health insurance scheme does not provide for the self-employed, nor, of course, for the families of dependants. It depends on insurance qualification, and no matter how ill you are, if you cease to be insured you cease to have free doctoring. Furthermore, it gives no backing to the doctor in the form of specialist services. The doctor has to provide himself, he has to use his own discretion and his own personal connections, in order to obtain hospital treatment for his patients and in order to get them specialists, and in very many cases, of course - in an overwhelming number of cases - the services of a specialist are not available to poor people.

Not only is this the case, but our hospital organisation has grown up with no plan, with no system; it is unevenly distributed over the country and indeed it is one of the tragedies of the situation, that very often the best hospital facilities are available where they are least needed. In the older industrial districts of Great Britain hospital facilities are inadequate. Many of the hospitals are too small - very much too small. About 70 per cent. have less than 100 beds, and over 30 per cent. have less than 30. No one can possibly pretend that hospitals so small can provide general hospital treatment.[3] There is a tendency in some quarters to defend the very small hospital on the ground of its localism and intimacy, and for other rather imponderable reasons of that sort, but everybody knows today that if a hospital is to be efficient it must provide a number of specialised services. Although I am not myself a devotee of bigness for bigness sake, I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one.

In addition to these defects, the health of the people of Britain is not properly looked after in one or two other respects. The condition of the teeth of the people of Britain is a national reproach.[4] As a consequence of dental treatment having to be bought, it has not been demanded on a scale to stimulate the creation of sufficient dentists, and in consequence there is a woeful shortage of dentists at the present time. Furthermore, about 25 per cent. of the people of Great Britain can obtain their spectacles and get their eyes tested and seen to by means of the assistance given by the approved societies,

but the general mass of the people have not such facilities.[5] Another of the evils from which this country suffers is the fact that sufficient attention has not been given to deafness, and hardly any attention has been given so far to the provision of cheap hearing aids and their proper maintenance.[6] I hope to be able to make very shortly a welcome announcement on this question.

One added disability from which our health system suffers is the isolation of mental health from the rest of the health services. Although the present Bill does not rewrite the Lunacy Acts - we shall have to come to that later on - nevertheless, it does, for the first time, bring mental health into the general system of health services. It ought to be possible, and this should be one of the objectives of any civilised health service, for a person who feels mental distress, or who fears that he is liable to become unbalanced in any way to go to a general hospital to get advice and assistance, so that the condition may not develop into a more serious stage. All these disabilities our health system suffers from at the present time, and one of the first merits of this Bill is that it provides a universal health service without any insurance qualifications of any sort. It is available to the whole population, and not only is it available to the whole population freely, but it is intended, through the health service, to generalise the best health advice and treatment. It is intended that there shall be no limitation on the kind of assistance given - the general practitioner service, the specialist, the hospitals, eye treatment, spectacles, dental treatment, hearing facilities, all these are to be made available free.

There will be some limitations for a while, because we are short of many things. We have not enough dentists and it will therefore be necessary for us, in the meantime, to give priority treatment to certain classes - expectant and nursing mothers, children, school children in particular and later on we hope adolescents.[7] Finally we trust that we shall be able to build up a dental service for the whole population. We are short of nurses and we are short, of course, of hospital accommodation, and so it will be some time before the Bill can fructify fully in effective universal service. Nevertheless, it is the object of the Bill, and of the scheme, to provide this as soon as possible, and to provide it universally.

Specialists will be available not only at institutions but for

domiciliary visits when needed. Hon. Members in all parts of the House know from their own experience that very many people have suffered unnecessarily because the family has not had the financial resources to call in skilled people. The specialist services, therefore, will not only be available at the hospitals, but will be at the back of the general practitioner should he need them. The practical difficulties of carrying out all these principles and services are very great. When I approached this problem, I made up my mind that I was not going to permit any sectional or vested interests to stand in the way of providing this very valuable service for the British people.

There are, of course, three main instruments through which it is intended that the Health Bill should be worked. There are the hospitals; there are the general practitioners; and there are the health centres. The hospitals are in many ways the vertebrae of the health system, and I first examined what to do with the hospitals. The voluntary hospitals of Great Britain have done invaluable work. When hospitals could not be provided by any other means, they came along. The voluntary hospital system of this country has a long history of devotion and sacrifice behind it, and it would be a most frivolously minded man who would denigrate in any way the immense services the voluntary hospitals have rendered to this country. But they have been established often by the caprice of private charity. They bear no relationship to each other. Two hospitals close together often try to provide the same specialist services unnecessarily, while other areas have not that kind of specialist service at all. They are, as I said earlier, badly distributed throughout the country. It is unfortunate that often endowments are left to finance hospitals in those parts of the country where the well-to-do live while, in very many other of our industrial and rural districts there is inadequate hospital accommodation. These voluntary hospitals are, very many of them, far too small and, therefore, to leave them as independent units is quite impracticable.

Furthermore - I want to be quite frank with the House - I believe it is repugnant to a civilised community for hospitals to have to rely upon private charity. I believe we ought to have left hospital flag days behind. I have always felt a shudder of repulsion when I have seen nurses and sisters who ought to be at their work, and students who ought to be at their work, going about the streets collecting

money for the hospitals. I do not believe there is an hon. Member of this House who approves that system. It is repugnant, and we must leave it behind - entirely. But the implications of doing this are very considerable.

I have been forming some estimates of what might happen to voluntary hospital finance when the all-in insurance contributions fall to be paid by the people of Great Britain, when the Bill is passed and becomes an Act, and they are entitled to free hospital services. The estimates I have go to show that between 80 per cent. and 90 per cent. of the revenues of the voluntary hospitals in these circumstances will be provided by public funds, by national or rate funds.[8] And, of course, as the hon. Member reminds me, in very many parts of the country it is a travesty to call them voluntary hospitals. In the mining districts, in the textile districts, in the districts where there are heavy industries it is the industrial population who pay the weekly contributions for the maintenance of the hospitals. When I was a miner I used to find that situation, when I was on the hospital committee. We had an annual meeting and a cordial vote of thanks was moved and passed with great enthusiasm to the managing director of the colliery company for his generosity towards the hospital; and when I looked at the balance sheet, I saw that 97.5 per cent. of the revenues were provided by the miners' own contributions; but nobody passed a vote of thanks to the miners.

I can assure the hon. and gallant Member that I was no more silent then than I am now.[9] But, of course, it is a misuse of language to call these "voluntary hospitals." They are not maintained by legally enforced contributions; but, mainly, the workers pay for them because they know they will need the hospitals, and they are afraid of what they would have to pay if they did not provide them. So it is, I say, an impossible situation for the State to find something like 90 per cent. of the revenues of these hospitals and still to call them "voluntary." So I decided, for this and other reasons, that the voluntary hospitals must be taken over.

I knew very well when I decided this that it would give rise to very considerable resentment in many quarters, but, quite frankly, I am not concerned about the voluntary hospitals' authorities: I am concerned with the people whom the hospitals are supposed to serve. Every investigation which has been made into this problem

has established that the proper hospital unit has to comprise about 1,000 beds - not in the same building but, nevertheless, the general and specialist hospital services can be provided only in a group of that size. This means that a number of hospitals have to be pooled, linked together, in order to provide a unit of that sort. This cannot be done effectively if each hospital is a separate, autonomous body. It is proposed that each of these groups should have a large general hospital, providing general hospital facilities and services, and that there should be a group round it of small feeder hospitals. Many of the cottage hospitals strive to give services that they are not able to give. It very often happens that a cottage hospital harbours ambitions to the hurt of the patients, because they strive to reach a status that they never can reach. In these circumstances, the welfare of the patients is sacrificed to the vaulting ambitions of those in charge of the hospital. If, therefore, these voluntary hospitals are to be grouped in this way, it is necessary that they should submit themselves to proper organisation, and that submission, in our experience, is impracticable if the hospitals, all of them, remain under separate management.

Now, this decision to take over the voluntary hospitals meant, that I then had to decide to whom to give them. Who was to be the receiver? So I turned to an examination of the local government hospital system. Many of the local authorities in Great Britain have never been able to exercise their hospital powers. They are too poor. They are too small. Furthermore, the local authorities of Great Britain inherited their hospitals from the Poor Law, and some of them are monstrous buildings, a cross between a workhouse and a barracks - or a prison.[10] The local authorities are helpless in these matters. They have not been able to afford much money. Some local authorities are first-class. Some of the best hospitals in this country are local government hospitals. But, when I considered what to do with the voluntary hospitals when they had been taken over, and who was to receive them I had to reject the local government unit, because the local authority area is no more an effective gathering ground for the patients of the hospitals than the voluntary hospitals themselves. My hon. Friend said that some of them are too small, and some of them too large. London is an example of being too small and too large at the same time.

It is quite impossible, therefore, to hand over the voluntary hospitals to the local authorities. Furthermore - and this is an argument of the utmost importance - if it be our contract with the British people, if it be our intention that we should universalise the best, that we shall promise every citizen in this country the same standard of service, how can that be articulated through a rate-borne institution which means that the poor authority will not be able to carry out the same thing at all? It means that once more we shall be faced with all kinds of anomalies, just in those areas where hospital facilities are most needed, and in those very conditions where the mass of the poor people will be unable to find the finance to supply the hospitals. Therefore, for reasons which must be obvious - because the local authorities are too small, because their financial capacities are unevenly distributed - I decided that local authorities could not be effective hospital administration units. There are, of course, a large number of hospitals in addition to the general hospitals which the local authorities possess. Tuberculosis sanatoria, isolation hospitals, infirmaries of various kinds, rehabilitation, and all kinds of other hospitals are all necessary in a general hospital service. So I decided that the only thing to do was to create an entirely new hospital service, to take over the voluntary hospitals, and to take over the local government hospitals and to organise them as a single hospital service. If we are to carry out our obligation and to provide the people of Great Britain, no matter where they may be, with the same level of service, then the nation itself will have to carry the expenditure, and cannot put it upon the shoulders of any other authority.

A number of investigations have been made into this subject from time to time, and the conclusion has always been reached that the effective hospital unit should be associated with the medical school. If you grouped the hospitals in about 16 to 20 regions around the medical schools, you would then have within those regions the wide range of disease and disability which would provide the basis for your specialised hospital service. Furthermore, by grouping hospitals around the medical schools, we should be providing what is very badly wanted, and that is a means by which the general practitioners are kept in more intimate association with new medical thought and training.[11] One of the disabilities, one of the shortcomings of our existing medical service, is the intellectual isolation of

the general practitioners in many parts of the country. The general practitioner, quite often, practises in loneliness and does not come into sufficiently intimate association with his fellow craftsmen and has not the stimulus of that association, and in consequence of that the general practitioners have not got access to the new medical knowledge in a proper fashion. By this association of the general practitioner with the medical schools through the regional hospital organisation, it will be possible to refresh and replenish the fund of knowledge at the disposal of the general practitioner.

This has always been advised as the best solution of the difficulty. It has this great advantage to which I call the close attention of hon. Members. It means that the bodies carrying out the hospital services of the country are, at the same time, the planners of the hospital service. One of the defects of the other scheme is that the planning authority and executive authority are different. The result is that you get paper planning or bad execution. By making the regional board and regional organisation responsible both for the planning and the administration of the plans, we get a better result, and we get from time to time, adaptation of the plans by the persons accumulating the experience in the course of their administration. The other solutions to this problem which I have looked at all mean that you have an advisory body of planners in the background who are not able themselves to accumulate the experience necessary to make good planners. The regional hospital organisation is the authority with which the specialised services are to be associated, because, as I have explained, this specialised service can be made available for an area of that size, and cannot be made available over a small area.

When we come to an examination of this in Committee, I daresay there will be different points of view about the constitution of the regional boards. It is not intended that the regional boards should be conferences of persons representing different interests and different organisations.[12] If we do that, the regional boards will not be able to achieve reasonable and efficient homogeneity. It is intended that they should be drawn from members of the profession, from the health authorities in the area, from the medical schools and from those who have long experience in voluntary hospital administration. While leaving ourselves open to take the best sort of

individuals on these hospital boards which we can find, we hope before very long to build up a high tradition of hospital administration in the boards themselves. Any system which made the boards conferences, any proposal which made the members delegates, would at once throw the hospital administration into chaos. Although I am perfectly prepared and shall be happy to cooperate with hon. Members in all parts of the House in discussing how the boards should be constituted, I hope I shall not be pressed to make these regional boards merely representative of different interests and different areas. The general hospital administration, therefore, centres in that way.

When we come to the general practitioners we are, of course, in an entirely different field. The proposal which I have made is that the general practitioner shall not be in direct contract with the Ministry of Health, but in contract with new bodies. There exists in the medical profession a great resistance to coming under the authority of local government - a great resistance, with which I, to some extent, sympathise. There is a feeling in the medical profession that the general practitioner would be liable to come too much under the medical officer of health, who is the administrative doctor. This proposal does not put the doctor under the local authority; it puts the doctor in contract with an entirely new body - the local executive council, coterminous with the local health area, county or county borough. On that executive council, the dentists, doctors and chemists will have half the representation.[13] In fact, the whole scheme provides a greater degree of professional representation for the medical profession than any other scheme I have seen.

I have been criticised in some quarters for doing that. I will give the answer now: I have never believed that the demands of a democracy are necessarily satisfied merely by the opportunity of putting a cross against someone's name every four or five years. I believe that democracy exists in the active participation in administration and policy. Therefore, I believe that it is a wise thing to give the doctors full participation in the administration of their own profession. They must, of course, necessarily be subordinated to lay control - we do not want the opposite danger of syndicalism. Therefore, the communal interests must always be safeguarded in this administration. The doctors will be in contract with an executive body of this

sort. One of the advantages of that proposal is that the doctors do not become - as some of them have so wildly stated - civil servants. Indeed, one of the advantages of the scheme is that it does not create an additional civil servant.

It imposes no constitutional disability upon any person whatsoever. Indeed, by taking the hospitals from the local authorities and putting them under the regional boards, large numbers of people will be enfranchised who are now disfranchised from participation in local government. So far from this being a huge bureaucracy with all the doctors little civil servants - the slaves of the Minister of Health, as I have seen it described - instead of that, the doctors are under contract with bodies which are not under the local authority, and which are, at the same time, ever open to their own influence and control.

One of the chief problems that I was up against in considering this scheme was the distribution of the general practitioner service throughout the country. The distribution, at the moment, is most uneven. In South Shields before the war there were 4,100 persons per doctor; in Bath 1,590; in Dartford nearly 3,000 and in Bromley 1,620; in Swindon 3,100; in Hastings under 1,200. That distribution of general practitioners throughout the country is most hurtful to the health of our people. It is entirely unfair, and, therefore, if the health services are to be carried out, there must be brought about a redistribution of the general practitioners throughout the country.[14]

Indeed, I could amplify those figures a good deal, but I do not want to weary the House, as I have a great deal to say. It was, therefore, decided that there must be redistribution. One of the first consequences of that decision was the abolition of the sale and purchase of practices.[15] If we are to get the doctors where we need them, we cannot possibly allow a new doctor to go in because he has bought somebody's practice. Proper distribution kills by itself the sale and purchase of practices. I know that there is some opposition to this, and I will deal with that opposition. I have always regarded the sale and purchase of medical practices as an evil in itself. It is tantamount to the sale and purchase of patients. Indeed, every argument advanced about the value of the practice is itself an argument against freedom of choice, because the assumption underlying the high value of a practice is that the patient passes from the old doctor

to the new. If they did not pass there would be no value in it. I would like, therefore, to point out to the medical profession that every time they argue for high compensation for the loss of the value of their practices, it is an argument against the free choice which they claim. However, the decision to bring about the proper distribution of general practitioners throughout the country meant that the value of the practices was destroyed. We had, therefore, to consider compensation.

I have never admitted the legal claim, but I admit at once that very real hardship would be inflicted upon doctors if there were no compensation. Many of these doctors look forward to the value of their practices for their retirement. Many of them have had to borrow money to buy practices and, therefore, it would, I think, be inhuman, and certainly most unjust, if no compensation were paid for the value of the practices destroyed. The sum of £66,000,000 is very large.[16] In fact, I think that everyone will admit that the doctors are being treated very generously. However, it is not all loss, because if we had, in providing superannuation, given credit for back service, as we should have had to do, it would have cost £35 million. Furthermore, the compensation will fall to be paid to the dependants when the doctor dies, or when he retires, and so it is spread over a considerable number of years. This global sum has been arrived at by the actuaries and over the figure, I am afraid, we have not had very much control, because the actuaries have agreed it. But the profession itself will be asked to advise as to its distribution among the claimants, because we are interested in the global sum, and the profession, of course, is interested in the equitable distribution of the fund to the claimants.

The doctors claim that the proposals of the Bill amount to direction - not all the doctors say this but some of them do. There is no direction involved at all. When the Measure starts to operate, the doctors in a particular area will be able to enter the public service in that area. A doctor newly coming along would apply to the local executive council for permission to practise in a particular area. His application would then be re-referred to the Medical Practices Committee.[17] The Medical Practices Committee, which is mainly a professional body, would have before it the question of whether there were sufficient general practitioners in that area. If there were

enough, the committee would refuse to permit the appointment. No one can really argue that that is direction, because no profession should be allowed to enter the public service in a place where it is not needed. By that method of negative control over a number of years, we hope to bring about over the country a positive redistribution of the general practitioner service. It will not affect the existing situation, because doctors will be able to practise under the new service in the areas to which they belong, but a new doctor, as he comes on, will have to find his practice in a place inadequately served.

I cannot, at the moment, explain to the House what are going to be the rates of remuneration of doctors. The Spens Committee report is not fully available. I hope it will be out next week. I had hoped that it would be ready for this Debate, because this is an extremely important part of the subject, but I have not been able to get the full report. Therefore, it is not possible to deal with remuneration. However, it is possible to deal with some of the principles underlying the remuneration of general practitioners. Some of my hon. Friends on this side of the House are in favour of a full salaried service. I am not. I do not believe that the medical profession is ripe for it, and I cannot dispense with the principle that the payment of a doctor must in some degree be a reward for zeal, and there must be some degree of punishment for lack of it.[18] Therefore, it is proposed that capitation should remain the main source from which a doctor will obtain his remuneration. But it is proposed that there shall be a basic salary and that for a number of very cogent reasons. One is that a young doctor entering practice for the first time needs to be kept alive while he is building up his lists. The present system by which a young man gets a load of debt around his neck in order to practise is an altogether evil one. The basic salary will take care of that.

Furthermore, the basic salary has the additional advantage of being something to which I can attach an increased amount to get doctors to go into unattractive areas. It may also - and here our position is not quite so definite - be the means of attaching additional remuneration for special courses and special acquirements. The basic salary, however, must not be too large otherwise it is a disguised form of capitation. Therefore, the main source at the moment through which a general practitioner will obtain his remune-

ration will be capitation. I have also made - and I quite frankly admit it to the House - a further concession which I know will be repugnant in some quarters. The doctor, the general practitioner and the specialist, will be able to obtain fees, but not from anyone who is on any of their own lists, nor will a doctor be able to obtain fees from persons on the lists of his partner, nor from those he has worked with in group practice, but I think it is impracticable to prevent him having any fees at all. To do so would be to create a black market. There ought to be nothing to prevent anyone having advice from another doctor other than his own. Hon. Members know what happens in this field sometimes. An individual hears that a particular doctor in some place is good at this, that or the other thing, and wants to go along for a consultation and pays a fee for it. If the other doctor is better than his own all he will need to do is to transfer to him and he gets him free. It would be unreasonable to keep the patient paying fees to a doctor whose services can be got free. So the amount of fee payment on the part of the general population will be quite small. Indeed, I confess at once if the amount of fee paying is great, the system will break down, because the whole purpose of this scheme is to provide free treatment with no fee paying at all. The same principle applies to the hospitals.[19] If an individual wishes to consult, there is no reason why he should be stopped. As I have said, the fact that a person can transfer from one doctor to another ought to keep fee paying within reasonable proportions.

The same principle applies to the hospitals. Specialists in hospitals will be allowed to have fee-paying patients. I know this is criticised and I sympathise with some of the reasons for the criticism, but we are driven inevitably to this fact, that unless we permit some fee-paying patients in the public hospitals, there will be a rash of nursing homes all over the country. If people wish to pay for additional amenities, or something to which they attach value, like privacy in a single ward, we ought to aim at providing such facilities for everyone who wants them.[20] But while we have inadequate hospital facilities, and while rebuilding is postponed it inevitably happens that some people will want to buy something more than the general health service is providing. If we do not permit fees in hospitals, we will lose many specialists from the public hospitals for they will go to nursing homes. I believe that nursing homes ought to be discour-

aged. They cannot provide general hospital facilities, and we want to keep our specialists attached to our hospitals and not send them into nursing homes. Behind this there is a principle of some importance. If the State owned a theatre it would not charge the same prices for the different seats. It is not entirely analogous, but it is an illustration. For example, in the dental service the same principle will prevail. The State will provide a certain standard of dentistry free, but if a person wants to have his teeth filled with gold, the State will not provide that.

The third instrument to which the health services are to be articulated is the health centre, to which we attach very great importance indeed. It has been described in some places as an experimental idea, but we want it to be more than that, because to the extent that general practitioners can operate through health centres in their own practice, to that extent will be raised the general standard of the medical profession as a whole. Furthermore, the general practitioner cannot afford the apparatus necessary for a proper diagnosis in his own surgery. This will be available at the health centre. The health centre may well be the maternity and child welfare clinic of the local authority also. The provision of the health centre is, therefore, imposed as a duty on the local authority. There has been criticism that this creates a trichotomy in the services. It is not a trichotomy at all. If you have complete unification it would bring you back to paper planning. You cannot get all services through the regional authority, because there are many immediate and personal services which the local authority can carry out better than anybody else. So, it is proposed to leave those personal services to the local authority, and some will be carried out at the health centre. The centres will vary; there will be larger centres at which there will be dental clinics, maternity and child welfare services, and general practitioners' consultative facilities, and there will also be smaller centres - surgeries where practitioners can see their patients.[21]

[The health centres will be managed entirely] By the health authorities. The health centre itself will be provided by the local health authority and facilities will be made available there to the general practitioner. The small ones are necessary, because some centres may be a considerable distance from people's homes. So it will be necessary to have simpler ones, nearer their homes, fixed in

a constellation with the larger ones.[22]

The representatives on the local executives will be able to co-ordinate what is happening at the health centres. As I say, we regard these health centres as extremely valuable, and their creation will be encouraged in every possible way. Doctors will be encouraged to practise there, where they will have great facilities. It will, of course, be some time before these centres can be established everywhere, because of the absence of these facilities.

There you have the three main instruments through which it is proposed that the health services of the future should be articulated. There has been some criticism. Some have said that the preventive services should be under the same authority as the curative services. I wonder whether Members who advance that criticism really envisage the situation which will arise. What are the preventive services? Housing, water, sewerage, river pollution prevention, food inspection - are all these to be under a regional board? If so, a regional board of that sort would want the Albert Hall in which to meet. This, again, is paper planning. It is unification for unification's sake. There must be a frontier at which the local joins the national health service. You can fix it here or there, but it must be fixed somewhere. It is said that there is some contradiction in the health scheme because some services are left to the local authority and the rest to the national scheme. Well, day is joined to night by twilight, but nobody has suggested that it is a contradiction in nature. The argument that this is a contradiction in health services is purely pedantic, and has no relation to the facts.

It is also suggested that because maternity and child welfare services come under the local authority, and gynaecological services come under the regional board, that will make for confusion. Why should it? Continuity between one and the other is maintained by the user. The hospital is there to be used. If there are difficulties in connection with birth, the gynaecologist at the hospital centre can look after them. All that happens is that the midwife will be in charge - the mother will be examined properly, as she ought to be examined - then, if difficulties are anticipated, she can have her child in hospital, where she can be properly looked after by the gynaecologist. When she recovers, and is a perfectly normal person, she can go to the maternity and child welfare centre for post-natal treatment.

There is no confusion there. The confusion is in the minds of those who are criticising the proposal on the ground that there is a trichotomy in the services, between the local authority, the regional board and the health centre.

I apologise for detaining the House so long, but there are other matters to which I must make some reference. The two Amendments on the Order Paper rather astonish me. The hon. Member for Denbigh[23] informs me, in his Amendment, that I have not sufficiently consulted the medical profession - I intend to read the Amendment to show how extravagant the hon. Member has been.[24] He says that he and his friends are:

> "... unable to agree to a measure containing such far-reaching proposals involving the entire population without any consultations having taken place between the Minister and the organisations and bodies representing those who will be responsible for carrying out its provisions ..."

I have had prepared a list of conferences I have attended. I have met the medical profession, the dental profession, the pharmacists, nurses and midwives, voluntary hospitals, local authorities, eye services, medical aid services, herbalists, insurance committees, and various other organisations. I have had 20 conferences. The consultations have been very wide. In addition, my officials have had 13 conferences, so that altogether there have been 33 conferences with the different branches of the profession about the proposals. Can anybody argue that that is not adequate consultation? Of course, the real criticism is that I have not conducted negotiations. I am astonished that such a charge should lie in the mouth of any Member of the House. If there is one thing that will spell the death of the House of Commons it is for a Minister to negotiate Bills before they are presented to the House. I had no negotiations, because once you negotiate with outside bodies two things happen. They are made aware of the nature of the proposals before the House of Commons itself; and furthermore, the Minister puts himself into an impossible position, because, if he has agreed things with somebody outside he is bound to resist Amendments from Members in the House. Otherwise he does not play fair with them. I protested against this myself when I was a Private Member. I protested bitterly, and I am not prepared, strange though it may seem, to do

something as a Minister which as a Private Member I thought was wrong. So there has not been negotiation, and there will not be negotiation, in this matter. The House of Commons is supreme, and the House of Commons must assert its supremacy, and not allow itself to be dictated to by anybody, no matter how powerful and how strong he may be.[25]

These consultations have taken place over a very wide field, and, as a matter of fact, have produced quite a considerable amount of agreement. The opposition to the Bill is not as strong as it was thought it would be. On the contrary, there is very considerable support for this Measure among the doctors themselves. I myself have been rather aggrieved by some of the statements which have been made. They have misrepresented the proposals to a very large extent, but as these proposals become known to the medical profession, they will appreciate them, because nothing should please a good doctor more than to realise that, in future, neither he nor his patient will have any financial anxiety arising out of illness.

The leaders of the Opposition have on the Order Paper an Amendment which expresses indignation at the extent to which we are interfering with charitable foundations. The Amendment states that the Bill

> "gravely menaces all charitable foundations by diverting to purposes other than those intended by the donors the trust funds of the voluntary hospitals."

I must say that when I read that Amendment I was amused. I have been looking up some precedents. I would like to say, in passing, that a great many of these endowments and foundations have been diversions from the Chancellor of the Exchequer. The main contributor was the Chancellor of the Exchequer. But I seem to remember that, in 1941, hon. Members opposite were very much vexed by what might happen to the public schools, and they came to the House and asked for the permission of the House to lay sacrilegious hands upon educational endowments centuries old. I remember protesting against it at the time - not, however, on the grounds of sacrilege. These endowments had been left to the public schools, many of them for the maintenance of the buildings, but hon. Members opposite, being concerned lest the war might affect their favourite schools, came to the House and allowed the diversion of

money from that purpose to the payment of the salaries of the teachers and the masters. There have been other interferences with endowments. Wales has been one of the criminals. Disestablishment interfered with an enormous number of endowments. Scotland also is involved. Scotland has been behaving in a most sacrilegious manner; a whole lot of endowments have been waived by Scottish Acts. I could read out a large number of them, but I shall not do so.

Do hon. Members opposite suggest that the intelligent planning of the modern world must be prevented by the endowments of the dead? Are we to consider the dead more than the living? Are the patients of our hospitals to be sacrificed to a consideration of that sort?[26]

We are not, in fact, diverting these endowments from charitable purposes. It would have been perfectly proper for the Chancellor of the Exchequer to have taken over these funds, because they were willed for hospital purposes, and he could use them for hospital purposes; but we are doing no such thing. The teaching hospitals will be left with all their liquid endowments and more power. We are not interfering with the teaching hospitals' endowments. Academic medical education will be more free in the future than it has been in the past. Furthermore, something like £32 million belonging to the voluntary hospitals as a whole is not going to be taken from them. On the contrary, we are going to use it, and a very valuable thing it will be; we are going to use it as a shock absorber between the Treasury, the central Government, and the hospital administration. They will be given it as free money which they can spend over and above the funds provided by the State.

I welcome the opportunity of doing that, because I appreciate, as much as hon. Members in any part of the House, the absolute necessity for having an elastic, resilient service, subject to local influence as well as to central influence; and that can be accomplished by leaving this money in their hands. I shall be prepared to consider, when the Bill comes to be examined in more detail, whether any other relaxations are possible, but certainly, by leaving this money in the hands of the regional board, by allowing the regional board an annual budget and giving them freedom of movement inside that budget, by giving power to the regional board to distribute this money to the local management committees of the hospitals, by

various devices of that sort, the hospitals will be responsible to local pressure and subject to local influence as well as to central direction.

I think that on those grounds the proposals can be defended. They cover a very wide field indeed, to a great deal of which I have not been able to make reference; but I should have thought it ought to have been a pride to hon. Members in all parts of the House that Great Britain is able to embark upon an ambitious scheme of this proportion. When it is carried out, it will place this country in the forefront of all countries of the world in medical services. I myself, if I may say a personal word, take very great pride and great pleasure in being able to introduce a Bill of this comprehensiveness and value. I believe it will lift the shadow from millions of homes. It will keep very many people alive who might otherwise be dead. It will relieve suffering. It will produce higher standards for the medical profession. It will be a great contribution towards the wellbeing of the common people of Great Britain. For that reason, and for the other reasons I have mentioned, I hope hon. Members will give the Bill a Second Reading.

Source: House of Commons Debates, vol. 422, cols. 43-63, 30 April 1946.

Notes:

1. Bevan was opening the debate on the Second Reading of the NHS Bill. See Illustration 1.
2. *A NHS*, p. 54; Webster, *Problems*, pp. 10-12.
3. *A NHS*, p. 55; Webster, *Problems*, p. 3.
4. A. Lindsey, *Socialized Medicine in England and Wales. The National Health Service 1948-1961* (Chapel Hill, University of North Carolina Press, 1962), pp. 397-421; Webster, *Problems*, pp. 357-8.
5. Lindsey, pp. 422-30; Webster, *Problems*, p. 368.
6. Bevan resisted the introduction of a specific clause into the NHS Bill concerned with services for the deaf, but he promised a comprehensive service. Webster, *Problems*, p. 102. In 1948 the NHS issued "Medresco" hearing aids. Ministry of Health, *Report for 1949*, p. 294.

This was replaced by the "Medresco Mark II" in 1949, *Report for 1950*, p. 101.

7. The effect of the fee for service method of payment to dentists in the general dental service was to undermine the viability of the priority services, where dentists were employed on a salaried basis. Lindsey, pp. 397-421; Webster, *Problems*, pp. 358, 363-4; Ministry of Health, *Report for 1949*, pp. 154-5.

8. Hon. Member: "By workers' contributions".

9. Reply to interjection by Major Guy Lloyd, Conservative M.P., East Renfrewshire.

10. Hon. Member: "And a prison".

11. For the development of ideas on regionalisation, see D.M. Fox, *Health Policies and Health Politics. The British and American Experience 1911-1965* (Princeton, Princeton University Press, 1986).

12. For the composition of Regional Hospital Boards, see Webster, *Problems*, pp. 275-9. In practice the boards were constituted on the basis of fixed proportions of specific interest groups.

13. For the composition of Executive Councils, see Webster, *Problems*, pp. 348-9.

14. Captain J.E. Crowder, Conservative M.P., Finchley, sought clarification on the above figures.

15. Abolition of sale and purchase of practices was the first major departure of the Labour Government from the compromises made by Willink during the later stages of the Coalition. Webster, *Problems*, pp. 51, 55, and *passim*. *NHS Bill*, paras 52-5; NHS Act, section 35.

16. For the fixing of £66m as the level of compensation, Webster, *Problems*, pp. 90-1.

17. *NHS Bill*, paras 49-51; NHS Act, section 34. Lindsey, pp. 152-60; Webster, *Problems*, pp. 351-5.

18. For Bevan's controversial qualifications of this remark, HC Debates, vol. 422, col. 392, 30 April 1946: "There is all the difference in the world between plucking a fruit when it is ripe and plucking it when it is green".

19. Bevan was interrupted by two M.P.s asking for clarification over payment of fees.

20. For "amenity beds" and "pay beds", *NHS Bill*, paras 34-5; NHS Act, sections 4-5.

21. S.H. Marshall, Conservative M.P., Sutton and Cheam, asked whether Executive Councils would be involved in health centre administration.

22. Marshall repeated his question.

23. Sir Henry Morris-Jones, National Liberal M.P., Denbigh.

24. Morris-Jones objected that he was being misrepresented.

25. Morris-Jones asked whether Bevan would apply this doctrine to the Miners' Federation.

26. Lloyd interjected, "Henry VIII did it".

VI

ROYAL COLLEGE OF NURSING, 21 JUNE 1946

"When I had your invitation to come to address you this evening," Mr. Bevan began, "I accepted with alacrity because I realized from the very start that no matter how distant my relationship with the doctors might become, I had to be most friendly with the nurses, if I was ever to get our health service going properly.[1] We are meeting on a unique occasion as yesterday war-time control ceased, so you are all free men and women.[2] I was unhappy that we were obliged to retain control over nurses longer than over the rest of the population, but you must all know even better than I do how very serious is the shortage of nurses. We hope the cessation of control will not result in any greater mobility and that we shall be able to retain and increase the number of nurses."

Welcoming back nurses from the Services to civilian life, Mr. Bevan said they had done a wonderful and quite remarkable job; he hoped they would find conditions on their return better than when they went. He spoke of the shortage of nurses - a pressing problem even before the new health service, and of it being a relative shortage. As we became increasingly civilized we attached more importance to health, and nurses acquired a higher and higher status: they became more and more valued and the shortage had arisen because of the greater demand. To prove this he gave the total number of nurses employed in hospitals other than maternity and mental hospitals in 1938 and 1945: 71,500 and 87,500;[3] of nurses who passed their Preliminary and Final State Examinations in the same years: 9,647 and 15,671; 6,668 and 8,414.[4]

"We have more nurses than ever before," he said, "but we need more nurses than ever before: we are not going to succeed and all plans made by politicians or even those who aspire to be statesmen will be of no avail, unless there is staff. The health service must have an adequate supply of trained and enthusiastic nurses. I have no opinion as to the relative importance of doctor and nurse - but we all

agree it is a lamentable situation when hospital beds are rendered idle because there is not sufficient nursing staff and when hospitals have long waiting lists of patients who are unable to get in.

"One reason, and we appreciate it at the Ministry, why the nurse's job is so arduous and why a large number of girls fall out, is because far too much domestic work falls to the nurse. I am appalled at the misuse of labour when the nurse spends time doing domestic work in hospital. We are hoping to relieve her shortly. We are bringing over persons from abroad and we hope soon the atmosphere in hospitals will rather sweeten.

"I want your help in one regard. There is shortage over the whole field, but we are particularly short of tuberculosis nurses, and for the chronic cases. For though these cases might not present the most attractive form of nursing they surely should excite a sense of pity more than any other. I earnestly hope nursing of the tuberculous and the chronic sick will at least have no falling-off of recruits." Mr. Bevan spoke also of the great shortage of midwives and suggested the value of continued experience to newly-qualified midwives even if they later returned to nursing. The negotiating machinery for setting salaries and conditions was firmly established; increases in salaries were announced day by day to have effect from January 1, 1946, and fully from April 1947, and the Minister hoped all would agree that very substantial improvements were being made. "In addition to these new salaries and conditions, there are the new codes," he said. "At the moment I must admit they are slightly rhetorical. They are the ideals at which we aim but we are not able to establish the conditions until we build good hospital premises which provide better amenities." At the moment his hands were full with building houses.

A Big Step Forward

Next he spoke of the position of the nurse in the Health Bill. The Bill had aroused acute controversy in certain quarters and a marked absence of enthusiasm among certain people. We had long established customs; many were unable to imagine new ways of doing things and it is impossible to start a new health service with enthusiasm from every one. If we were going to make progress, we had to tread on a few corns. "I think it will be found," he said, "when the

Bill is established, and all its ramifications have been exposed for examination, that we are making a big step forward in the health services in this country, even in the whole world. But there is nothing I, a Government Department or even the House of Commons, can do unless we get the health service efficiently administered." Administration was going to be the chief headache, he said, for years to come; there was not only the staff, doctors and nurses, but the voluntary persons prepared to dedicate their lives to the service of the sick to be considered.

The Health Bill made a considerable change in the position of the nurse. She would be under contract not with the health authorities as in the past but with the regional board. Although her contract would be there she would not have a remote relationship with an obscure authority but would be appointed by the committee and would have a warm and intimate relationship with the management committee of the hospital in which she worked. One virtue of putting the nurse in contract with the regional board would be the greater possibility of general promotion within the schools in the region. Another would be the interchangeability of superannuation benefits; nurses had complained of the impossibility of this in the past. There would be no insistence on moving the nurse about within the regional area, for Mr. Bevan said he realized that this was one thing she took exception to. The appointment of the nurse by the hospital management committee would preserve and encourage that vital thing, *esprit de corps* and although the idea was to establish hospital centres of 1,000 beds, each unit within it would have its own hospital management committee. The new service, rather than dispersing or destroying tradition would enhance and continue it in the intimate relationship between the nursing staff and the hospital, and seek to establish a code of relationship between the nurse and those with whom she was in contact.

There was a thunder of applause when Mr. Bevan said that nurses had said that they wanted representation on the regional boards. "But," he continued, "nobody will be represented on the regional boards, not even the doctors. The regional boards will not be conferences of different interests; if they were they would have to consist of so many representatives of health authorities, of doctors, of nurses, of dentists and of many other workers. And what should

we have? An administrative homogeneous unit? No: just a conference which would want the Albert Hall to hold it. We want a company of people with knowledge, experience and dedication to the service. The status of the nurse does not necessarily consist of her representation on the regional board; her status consists of proper staff organization in the hospital". Mr. Bevan pointed out that the regional board's responsibilities were taken over by the hospital committee - this was the effective unit where day to day plans would be produced; the functions of the board compared to those of the hospital committee were rudimentary.

A Live Committee

Nurses had two representatives on the central council, and midwives one, but far more important would be the standing advisory committee on nursing which would be responsible directly to the Minister and not be under the central council where doctors would predominate.[5] Suggestions had been made that the standing advisory committees be sub-committees of the central council but this would be undesirable, for nurses would then be in a minority and any representation they wished to make would have to be vetted by the non-nurses before reaching the Minister. The central council would be able to make observations on the recommendations of the standing advisory committees, one of which would be the nurses', which would be the real live element of the whole system.

"Shock Absorber"

"At the moment," Mr. Bevan said, "the health plan is only on paper: it is still in the committee stage at the House of Commons and although I do not imagine any fundamental changes will take place we have passed some important amendments." One, he said, was the right of the hospital management committees to have funds in their own right. The State, through the Exchequer, would look after the hospital's general expenses and keep it free from financial anxiety. The voluntary hospital's funds would not be taken away but would be distributed by the regional boards: the hospital management committee would be empowered to receive benefactions for any amenities it liked over and above its revenue - a sort of pocket money which would act as a cushion or shock absorber to prevent

the hospitals becoming over-regimented organizations. The hospitals could, therefore, look forward to a time when because they would be quite free from financial embarrassment and anxiety they would be able to give the best service.

In the scheme, Mr. Bevan said, he had considered only one thing, the welfare of the patient. He had not taken into account interests or professions, but only to provide the sick of Great Britain with the best possible service. "I believe," he said, "this is your aim, too, and that in the years to come with co-operation we shall be able to offer every individual far better provision than there has ever been before. The nurse is a vital element in the health organization, her knowledge, understanding and dedication are fundamental. I have had and I expect to have in the future not less but rather more co-operation than in the past."

Source: *Nursing Times*, 29 June 1946, pp. 488-9.

Notes:

1. Bevan was addressing the professional conference of the Royal College of Nursing held in the Hall of British Medical Association House on 21 June 1946. He was introduced by Sir Ernest Rock Carling.

2. *The Times*, 19 June 1946, for removal of restrictions on nurses' employment.

3. It is difficult to reconcile Bevan's figures with those quoted in the Wood Report. In the latter, the totals for General Hospitals plus Maternity Hospitals for 1938 and 1945 are 71,100 and 86,100 respectively. Such totals are confusing because they conflate trained and untrained staff, and are not expressed in whole time equivalent terms. *Report of the Working Party on the Recruitment and Training of Nurses* (London, HMSO, 1947), p. 6.

4. The Working Party on Recruitment gives 9,400 and 10,400 as the number of nurses qualifying in 1939 and 1945 respectively (*Report of the Working Party on Nurses*, p. 24).

5. Bevan was referring to the Central Health Services Council and the Maternity and Midwifery Standing Advisory Committee established under the NHS Act, which also made provision for a parallel Nursing SAC.

VII

SOCIETY OF MEDICAL OFFICERS OF HEALTH, 20 SEPTEMBER 1946

The Minister of Health, proposing the toast of "The Society of Medical Officers of Health," said: I rise to perform a very happy task, which is to propose the toast of the Society of Medical Officers of Health, and I am happy to be able to follow the President who, in a very witty speech, has caused a maximum amount of mischief in the shortest possible space of time![1] He quoted Henley with some appositeness, said that my head was "bloody but unbowed"; he did not pay me the compliment of saying that the heads of my adversaries were bloodier. The metaphor began to be less exact as he went on because he said that one of his colleagues winced, but did not cry aloud. They have been wincing but no one can say they have not been crying aloud.

I think that I would not be doing justice to my opportunity this afternoon if I did not take advantage of this occasion to pay, on behalf of all at the Ministry of Health, a very deep and sincere tribute to the work of the medical officers of health in Great Britain during all the years of the war. They have done a most remarkable administrative job. I do not wish to apportion, because I am not competent to do so, any awards as to what is responsible for our comparatively good state of health, whether it is the preventive medical services, the prophylactic medical services or the therapeutic medical services, it is an astonishing fact, and a tribute to all who have contributed towards it that after more than a year after six and a half years of war, we are more immune from epidemics than we were at the end of the 1914-18 war. We are still crossing our fingers. Last winter I myself was deeply apprehensive; the collapse of the services on the continent and the dislocations that had resulted from fighting at one time made us apprehensive that it might become a point of infection and spread over here, but fortunately we succeeded in avoiding it partly by good luck and partly by good management, and to a very large extent - and this must also be remembered - by the extra-

ordinary work done by the squads who isolated any outbreaks of epidemic that took place.

On an occasion like this you will be expecting me to say a word or two about the national health scheme. I must be very careful in what I say; the House of Commons has passed the Bill with its main structure unaltered, there have been some modifications in detail, we have made a number of improvements both at the suggestion of our colleagues in the House of Commons and of those representatives of the medical profession whom I met from time to time in very amiable circumstances in the course of the passage of the Bill. But I must not be too optimistic because it still has to go to the House of Lords and there are a number of very eminent persons ready to pounce upon it there.[2] However, our relationship with the other House is so friendly that I do not anticipate any important alteration in the main principles of the Bill. It would be unfortunate if a Bill of this sort should be the occasion for any misunderstanding or friction between the two Houses of Parliament, and I am convinced that the House of Commons, having passed the Bill with its main structure unaltered, can anticipate the same co-operation on this very important measure that we have received on every measure in the course of the last twelve months.

I am hoping that the Bill will become law in a very short time and when that happens the main task begins, the task of the legislators will have ended and the task of the administrators will have begun and I need not tell you that the administrative task is much heavier than the legislative task, to clothe the structure with the flesh, to make it a live reality to the people of Great Britain, to make it the best health service in the world. This will require the energies of all the medical profession, and amongst those not least are the medical officers of health. The controversy has not completely died down, the armies are still arrayed on the battlefield but they are becoming, I think, increasingly listless, convinced that the issue has really been determined and that all we need to do now is to get around the peace conference table with a little more fertility than is being achieved in other places.

We have to draft the regulations and I frankly confess that it would be quite impossible to frame the regulations effectively and to administer them properly without the co-operation of the representa-

tive organisations of the medical profession in all its branches. Therefore I am hoping that when the main battle has been determined, and when the representatives of the people have made up their minds what they want to do - and we must remember, as some other people have discovered in the course of the last few weeks, that Parliament is still the sovereign power in Great Britain - it is good for good loyal citizens to co-operate in carrying out the will of the people. Any other course will spell anarchy and division, and we have too many urgent tasks awaiting us in this country at the moment and for some time to come for us to fritter our energies away in internecine strife.

The main criticisms which have been levelled against the scheme are to some extent contradictory. A great publicist of advanced years, a well-known friend of the medical profession, has been stating that in his opinion the scheme provides far too conservatively minded a profession should be entrusted with so much self-government for the doctors and he has for very many years been noteworthy for a marked lack of confidence in the medical profession, and he himself thought it disastrous that so much self-government in its own affairs. Another critic, who is a medical politician, entered the lists and took the opposite view, that the whole scheme made the Minister of Health into a complete tyrant and the doctors had no say at all effectively in the management of their professional affairs.

You can take one of those points of view; indeed, I am quite satisfied from what I have seen in the *British Medical Journal* that you can take both. I am new to the polemics of the medical profession and it is only recently that I have learned that a man so eminent in so many fields could be guilty of so many contradictions in those things he did not understand so much.

It has been my purpose, as I have said from the very beginning, to follow with fidelity the principle laid down by Lord Dawson of Penn, and that is to create an apparatus of medicine, and then leave the profession to exercise it in freedom and independence.[3] It is for us to decide ultimately what the apparatus should be, but certainly we will be overstepping the frontiers of our rights if we attempted to interfere, to guide, or even to advise, as to how the members of the profession should use that apparatus when it is put in their hands. It

is for them, I think, to do so. From the medical officers of health there has come another criticism. They say, and this is pertinent to a very important aspect in administration, that I made a mistake in putting the maternity hospitals under the regional boards, and the midwifery and domiciliary services under the local health authority and that this is a serious dichotomy in the whole administration and might give rise to difficulties. I counter that by saying that all the difficulties of lack of co-ordination of which the medical officers of health are frightened have arisen in the past because there have been local authority hospitals and there have been voluntary hospitals and there have been hospitals which lie between the two. In the future all the hospitals will be public hospitals, and the health service will be a public service, and the co-ordinating factor in it all will be the users of the service, that is, the doctors and specialists will move freely from the hospitals to the health centres, to the maternity and child welfare clinics, and from them back to the hospitals, and between the medical officers of health. This will be an essential feature of the whole service; between the local government, the specialists, and the hospitals, there must be absolute and complete co-operation, and no jealousy between one and the other. They must be able to use each others' services without any difficulty and hindrance, and the way in which it will be done, the pivotal condition for determining that will be carried out, will be the right of the individual patient, of the individual citizen, to an unquestioning use of the medical service wherever it is, or whatever it be, whether it be the local authority medical service, or whether it be the regional service, because the Bill lays it upon the Minister to provide the service, and he lays upon the local authority an obligation to provide a service. The local authority in these respects will not be a self-motivating authority, but will have to submit its schemes for approval and therefore the right of the individual is the uniting principle in the whole service. The local authority will not be able to deny him that service, nor will the regional boards. The criticisms which have been made against the service on that ground are theoretical and slightly pedantic, and we shall find out when the services are properly administered that the criticisms will fall to the ground.

We are facing a very critical year. As soon as the Bill becomes law we have to face the task of carrying it out so that the whole

machine will be ready to come into operation by April 1st, 1948.[4] It is a year of hard work; it is our intention to try to use, as far as they will allow themselves to be used, all the vast body of health workers who have built up such a splendid tradition up to now. We do not want to discard in any way the services of those who have accumulated so much experience. I am deeply conscious of the fact that one of the great dangers of a Government service is overcentralisation and the wider the decentralisation we can bring about the better for everybody. Therefore our first task will be to get the regional organisations established and then to get the management committees set up, and then, with the co-operation of the medical profession, to get the medical councils established in the districts for the proper organisation and supervision of the general public and the services.[5]

We in this country are putting our hands to many tasks, indeed, at the moment a member of the Cabinet is not so much a member of the Government as an arbitrator, an arbitrator between very many conflicting claims to priority. We have an enormous job to do and at the same time we are overhauling our social services and establishing higher standards of individual security, and we have enormous tasks of economic reconstruction. You may take whatever line you like about the politics of the present Government, you may be as partisan as you wish - I have no complaint against partisanship - but I defy anyone to point to any country more ambitiously striving to raise the standard of life of its community than Great Britain at the present time. In every field of endeavour, in housing, in public health, in the rebuilding of our industry, in the replanning of our towns and our cities, in every direction, there is in this country a renascence. I believe we shall win our way through, but we are very short in every department of professional workers, artisans, manual workers, administrative workers, and if we are to win our way through we can only do it by the utmost co-operation. The medical officers of health have a wonderful tradition in this, they are dedicated to public service, and I am most happy to ask you to drink the toast of the Society of Medical Officers of Health.

Source: *Public Health*, 1946-1947, 60, pp. 5-6, October 1946.

Notes:

1. Bevan was addressing the annual luncheon of the Society of Medical Officers of Health held at the Holborn Restaurant on 20 September 1946. The meeting was presided over by the President of the Society, Professor J. Johnstone Jervis.

2. For the NHS Bill in the House of Lords in October 1946, see Webster, *Problems*, pp. 100-2.

3. For the Dawson Report, see above II, n.5.

4. On 9 June 1947 Attlee announced that the date for the Appointed Day was changed from April to July 1948. Webster, *Problems*, p. 120.

5. "Medical Councils" of the kind mentioned here had been under consideration since the wartime preparations for the NHS, but nothing of this kind was established.

VIII

EAST GLAMORGAN COUNTY HOSPITAL, 17 JANUARY 1948

This ceremony is taking place at a time when controversy is raging in the medical world concerning the merits of the new Health Act.[1] The atmosphere is charged with partisan feeling.[2] A little later on I shall certainly find it reassuring to make a statement in the hope of creating a better sense of proportion in the minds of those who will be responsible for making the Act a success. In the meantime, I would say this to the doctors. Do not allow yourselves to be too much influenced by the statements made by a few persons who claim to be speaking for the whole profession. Read with care, and as dispassionately as possible the statement that I have circulated the profession and which each doctor has already received.[3] Do not allow your minds to be inflamed or your judgment to be distorted by slogans which are addressed to your emotions and not to your intelligence. Keep in mind that the emotions of the moment will pass, but that the obligations to provide an efficient health service for the British people will be permanent.

The Health Act will start on 5th July. That is the wish of Parliament, and Parliament, after all, is still the supreme authority in Britain. The new health service can be launched smoothly and harmoniously in the best interests of the people whom it will have to serve, or it can be launched stormily, surrounded by prejudice, poisoned by misrepresentations, and fragmented by partisan passion. The responsibility for deciding between these two rests largely with the profession. Parliament has spoken; the country now awaits and expects the cooperation of the medical world.[4]

Mr. Bevan added that that the Welsh Regional Hospital Board was already at work on the preliminaries to taking over the administration of the hospital service in Wales. There would be wider opportunity without the loosening of local ties. Transfer of the premises of the hospital to the ownership of the nation, and transfer of administration to new hands, did not mean that Glamorgan was losing its

new hospital to Whitehall, or even to Cardiff. No one was going to attempt to run the hospitals by distant control regardless of the needs and the views of those whom they served. In the new service there would certainly be no less room than in the past for local responsibility and local interest. There would be just as much need for men of goodwill to come forward and give voluntary service to their neighbours in the field of hospital management.

Source: *The Times*, 19 January 1948.

Notes:

1. Bevan was speaking at the opening of the East Glamorgan County Hospital at Church Village, Pontypridd. He went on to open Drybridge House, near Monmouth, the first home for the elderly in the area, which was a converted mansion.

2. Bevan accused the BMA leadership of acting in bad faith because the Negotiating Committee prepared its statement for distribution to the profession well in advance of the completion of the confidential negotiations that were taking place in 1947. Webster, *Problems*, p. 111. See below IX, n. 2.

3. For the 'Case' of the Negotiating Committee, together with Bevan's reply and message addressed to the individual doctor, *B.M.J., Supplement*, 1947, ii, pp. 141-62, 20 December 1947.

4. The same issue of *The Times* contained a reply to Bevan's remarks from Dr. H. Guy Dain, chairman of the BMA Council. Dain was particularly angered by Bevan's "untrue and malicious charges of 'sabotage'". It was reported that a meeting at Romford gave unanimous support for Dain and the BMA negotiating line against Bevan.

IX

HOUSE OF COMMONS, 9 FEBRUARY 1948

I beg to move:[1]

> "That this House takes note that the appointed day for the National Health Service has been fixed for July 5th; welcomes the coming into force on that date of this measure which offers to all sections of the community comprehensive medical care and treatment and lays for the first time a sound foundation for the health of the people; and is satisfied that the conditions under which all the professions concerned are invited to participate are generous and fully in accord with their traditional freedom and dignity."

The House will recollect that this Debate was requested from this side of the House, and not by the Opposition. There is some significance in that fact. During the last six months to a year there has been a sustained propaganda in the newspapers supporting the party opposite, which has resulted in grave misrepresentation of the nature of the Health Service and of the conditions under which the medical profession are asked to enter the Health Service. There has been even worse misrepresentation, sustained by a campaign of personal abuse, from a small body of spokesmen who have consistently misled the great profession to which they are supposed to belong. I make a distinction, and I hope that distinction will be maintained throughout the Debate, between the hard-working doctors who have little or no time to give to these matters, and the small body of raucous voiced people who are alleged to represent the profession as a whole.[2]

So much misrepresentation has been engaged in by the B.M.A. that the doctors who have voted or are voting in the plebiscite are doing so under a complete misapprehension of what the Health Service is. It has been frightening to speak to some doctors and to learn the extent to which their representatives have failed to inform them about the facts of the case.[3] I have even spoken to representatives

of the doctors who have attended the various conferences which have been held in London, and at which the members of the negotiating committee were supposed to have reported their discussions with me, and they themselves did not and do not understand what the facts are.

From the very beginning, this small body of politically poisoned people have decided to fight the Health Act itself and to stir up as much emotion as they can in the profession. I have before me a letter written to the "Scotsman":

> "Parliament, through the National Health Service Act - State Medical Service Act' would have been a more descriptive designation - has vested certain totalitarian powers in the Minister of Health. The Minister has not been slow in revealing these powers in his scheme of things to come. Stripped of the goodwill of his practice, subjected to 'negative' direction, denied the right of appeal to a court of law against dismissal from service and salaried from Whitehall - such is to be the lot of the physician of the Socialist future. In brigand-like fashion this would-be Fuehrer points an economic pistol at the doctor's head and blandly exclaims 'Yours is a free choice - to enter the service or not to enter it.'"

I have quoted from one of the more modest of the letters, because I am not anxious to raise the temperature just now. No doubt, hon. Members have seen letters which are even more virulent than that one.

The history of the Health Service Act is a very long one. It started with the National Insurance Act in 1911-12. Then in 1920 there was the report of a committee under Lord Dawson.[4] Then in 1943 it was revived, and in 1944 there was a Coalition White Paper.[5] Then there were protracted discussions with my predecessor. Then there was a Government White Paper in 1945 and the National Health Service Act, which took 32 days in the Commons and 10 days in the Lords.[6]

I would like to make one personal reference. It has been suggested that one of the reasons why the medical profession are so stirred up at the moment is because of personal deficiencies of my own. I am very conscious of these. They are very great. Absence of

introspection was never regarded as part of a Celtic equipment; therefore, I am very conscious of my limitations. But it can hardly be suggested that conflict between the British Medical Association and the Minister of the day is a consequence of any deficiencies that I possess, because we have never been able yet to appoint a Minister of Health with whom the B.M.A. agreed. My distinguished fellow country-man had quite a little difficulty with them.[7] He was a Liberal, and they found him an anathema. Then there was Mr. Ernest Brown who was a Liberal National, whatever that might mean, representing a Scottish constituency.[8] They found him abominable. As for Mr. Willink, a Conservative representing an English constituency, they found him intolerable.

I am a Welshman, a Socialist representing a Welsh constituency, and they find me even more impossible. Yet we are to assume that one of the reasons why the doctors are taking up this attitude is because of unreasonableness on my part. It is a quality which I appear to share in common with every Minister of Health whom the British Medical Association have met. If I may be allowed to make a facetious transgression, they remind me of a famous argument between Chesterton and Belloc. They were arguing about the cause of drunkenness, and they decided to apply the principles of pure logic. They met one night and drank nothing but whisky and water, and they got drunk. They met the next evening and drank nothing but brandy and water, and they got drunk. They met the third night and drank nothing but gin and water, and again they got drunk. They decided that as the constant factor was water it was obviously responsible - a conclusion which was probably most agreeable to Bacchic circles.

I think we can dismiss at once the suggestion that the disagreements with the medical profession are a consequence of the personal qualification or disqualification of the Minister concerned, and I have made reference to it now only in order that I might call attention to the sort of propaganda which seems to be recurrent in British politics where issues of principle are vulgarly personalised. It is becoming almost impossible for the citizens of Great Britain to see the differences of political principle through the smoke of personal misrepresentation. That is one of the reasons, but the least important reason, why the Government thought it necessary to have this

Debate this afternoon.

It has been suggested by the spokesmen of the B.M.A. that we have not negotiated with them sufficiently, that if we had only been more approachable things would have been different. But there were long negotiations with Mr. Brown and long negotiations with Mr. Willink, and on every occasion the B.M.A. rejected the advances made. I have met the Negotiating Committee itself eight times, three times before the Bill was introduced and - I hope this will not be brought against me - most irregularly I met them three times whilst the Bill was before the Committee. I consider this was somewhat of a sin against constitutional practice because I do not believe a Minister ought to be running two committees at the same time, one in the House of Commons and the other outside. I did it in order to give them every opportunity of stating their case.

Since the Act I have met them twice, and since August, 1945, the officials of my Department have met representatives of the Negotiating Committee 28 times. There have been continuous discussions, so microscopic that I am almost weary of the issues involved because they have been so much investigated. But the Negotiating Committee on its side was never in a position to negotiate. It had received from its own committees, at its own request, instructions not to negotiate. Indeed - and I would like the House to note this - when I met members of the Negotiating Committee in December of last year for a two-day discussion, I was presented with a printed circular which they had themselves caused to be printed rejecting the Act before the final negotiations had taken place. All the main features of the Act are contained in that document; not merely remuneration, not merely basic salary, not merely the appeal to the courts, but every important provision in the Act had been rejected by the Negotiating Committee before negotiations were concluded.

I called the attention of the chairman of the Negotiating Committee to that fact and asked him what was the use of two days' negotiations when one side had already decided to reject the whole scheme. The answer was that they had already made up their minds.[9]

The hospitals section is included in the rest. This document is in the Library for hon. Members to look at - it rejects the Sections deal-

ing with distribution, buying and selling of practices, remuneration, right of appeal to the courts, midwifery, the administrative bodies, public hospitals, hospital accommodation for private patients, facilities for diagnosis, statutory health committees, public health service, representation of the profession on the administrative bodies.

We are not now dealing with a body which is seeking to bring about the modification of principles in what they consider to be the legitimate interest of the members of the medical profession. We are dealing with a body organising wholesale resistance to the implementation of an Act of Parliament.

Furthermore, and I would like the House to note this, they had already rejected the Act before they knew the terms of remuneration for the general practitioner. They had not been told by me officially whether or not there would be a basic salary. They had not been told at this stage what was to be the scale of remuneration and, when they go around the country at the present time saying that one of the main causes of their decision is the basic salary, it should be remembered that they had decided to reject the Act before they knew there would be a basic salary in the remuneration.

In fact the whole thing begins to look more like a squalid political conspiracy than the representations of an honoured and learned profession and, I say this deliberately, when the bulk of the doctors in the country learn the extent to which their interests have been misrepresented by some of their spokesmen, they will turn on those spokesmen. In fact, one of the weaknesses of the B.M.A.'s present position is that they have mustered their forces on the field by misrepresenting the nature of the call and when the facts are known their forces will disperse.

There are four main issues on which the B.M.A. say they join issue. They say, in the first place, that they cannot accept the abolition of the sale and purchase of practices. The abolition of the sale and purchase of practices was recommended by the profession's own health commission. They voted for the abolition in their own plebiscite and all I have done, and all the Government and the House have done, is to put in the Act recommendations about this step based on the best medical information. We regard it as being inconsistent with a civilised community and with a reasonable health service for patients to be bought and sold over their heads. When I

am told that all they desire is that patients should have the best medical treatment, how can that be argued when a doctor succeeds to another doctor's panel not on account of personal qualifications but on the size of his purse? How can it reasonably be argued that there is any effective free choice of doctor when the doctors negotiate the terms between themselves and the patient knows nothing at all about it? This system exists in no other country in the world. It is a blot upon our medical system.

I ask the Opposition whether they accept or do not accept the abolition of the sale and purchase of practices. We should like to know. We should like the Opposition to tell us - because I think that these matters ought to be made quite clear - whether they are in favour of doctors being able to buy and sell their panels in the public service. It is very necessary that we should know. It is very necessary that we should know the body of opinion behind this practice so that we can estimate what it is worth. One of the main reasons why we are having this Debate today is not merely in order that the Government can clear up their position, but that the Opposition shall have the opportunity of making their position clear, too. After all, the second body of importance next to the Government is the Opposition, and I do not think that the nation ought to be denied the counsel of the Opposition in this matter. There cannot be, as far as we are concerned, any question at all that a Health Service which we consider to be reputable must not retain the buying and selling of private practices.

The doctors have said that their second objection - indeed, many of them said that this is the one thing that is offending them - is that they will not accept a basic salary as part of their remuneration.[10] The first time that a full-time salaried practitioner service was put before the medical profession was in 1943, in the days of the Coalition Government. It came from Mr. Ernest Brown. I hope the Opposition will note that. This principle, to which such exception is taken, which is supposed to reveal such Socialist partisanship, which is supposed to embody such regimentation, did not come from a Socialist Minister of Health but from a Government composed of Conservatives, Socialists and Liberals, and was put forward by a National Liberal. And I rejected it; I thought it contained too much of the element of regimentation.

There were some hon. Members on this side of the House who expressed the view that competition for patients on panels had the effect of degrading the standards of the service, and that, consequently, it was much better to have a full-time salaried service. It was argued out on Committee stage and on the Second and Third Readings, and it was decided that that was not what we were going to do. But what I made clear during the passage of the Bill was that young doctors ought to have the opportunity of living decently whilst they were building up their practices. At the moment, the only way in which a doctor can get into general practice is either by becoming an assistant to a principal, and accepting very important limitations when he takes up his work, or by borrowing sums of money and, therefore, for the first 15 to 30 years of his professional life, loading himself with debt, so that when he is approaching his patients he is not in the state of mind in which a doctor ought to be.

We not only desire in this scheme to relieve patients of financial anxiety; we desire to relieve the doctor of financial anxiety when he approaches his patients. It is one of the most deplorable features of the existing system that young doctors, when they go into practice - and they are by no means boys, but men of 24 to 30 years of age, with young families to feed and educate and clothe and look after - just at that time when the young doctors ought to be freest of financial burdens, they have financial burdens put upon them. We consider, therefore, that a salary, only of £300 - but, nevertheless, a salary of £6 a week - plus what he can get from capitation fees, would be a financial support for the young doctor whilst he is building up his practice.[11]

It is perfectly true that if a general practitioner believes that this element of basic salary is repugnant, and by its very existence makes him into a State salaried servant, he need not take it. He can give it back. The Chancellor of the Exchequer would be delighted. It will be of interest to see how many general practitioners find this so dishonourable to the traditions of the profession, so besmirched by the element of regimentation that they will hand it back as though it were poison. There is nothing at all to prevent a general practitioner from handing it back if he likes. But it would be a most complicated arrangement if we had two capitation fees running simultaneously in the Service. We can see how extremely complicated it would be if

we consider what effect it would have on the national and local pool available for the payment of general practitioner's remuneration. One of the concessions made, which has not been italicised, is that for the first two years we shall pay into the pool a sum equal to 95 per cent. of the total population of the country, because the general practitioners will be assumed to be at risk for a large number of people who will not have signed their lists at all. To work that basic salary under conditions of that sort would be extremely difficult and cumbersome.

Another argument we have heard advanced is that the partnership agreements will be rendered very difficult and that it is hard to see what the Act means when partnership agreements remain after the Act has come into operation. The mind of the general practitioner has been confused by the B.M.A. propaganda in this respect; but there is natural anxiety among general practitioners as to what is the effect of the Act upon partnership agreements. In order to try to clear it up I have decided, with the co-operation of the Attorney-General and the Lord Chancellor, to appoint a legal committee to inquire into it and to recommend what they consider should be done.[12] It is a most unusual proceeding. As a general rule, when Parliament passes a Bill and it becomes law, it is left for the courts to construe it. However, if any further light can be thrown on this matter, if competent legal opinion can find any way in which those Sections of the Act can be clarified, I shall be perfectly prepared to recommend the Government to have an amending Bill for that part of the Act to make clear where the general practitioners stand.

The other thing to which the B.M.A. take serious objection is what they consider to be the removal of their legal rights. Here, the representation has reached really staggering proportions. It has been said that a doctor has taken away from him his rights of appeal to the courts against unlawful dismissal. That is entirely untrue. A doctor will have exactly the same right of appeal to the courts against unlawful dismissal as any other citizen in the country. It has never been challenged during the whole of my negotiations with the representatives of the profession. They have never been able to show any part of the Act which takes away from the doctors those legal rights. But some of them want to go further than that. They want to have the right of appeal to the courts against dismissal from

the service on the ground of misconduct or neglect.[13]

I want the House fully to appreciate the significance of what is being asked. It is perfectly competent to go to the courts against a Minister on the ground that he has unlawfully removed any doctor from the Service. That remains. It is an entirely different matter if they want to take the Minister - whoever he might be - to the courts on the ground that he has acted wisely or unwisely, because whether a Minister has acted wisely or unwisely is for this House to determine, not the courts. If a doctor has the right to go to the courts to ask the courts to arbitrate, not on the law, but on the merits, how can that right be denied to anybody else - to the teachers, to the railwaymen, the miners, everybody, in both public and private service?

Under this reasoning, if there were this right to go to the courts of law, appealing not on the ground that the doctor has been unlawfully dismissed, but on the ground that he has been wrongfully dismissed in the terms of his contract, what would be the situation? The relationship of the judiciary to the legislature would be completely revolutionised. Day by day the courts would be arbitrating on a thousand and one matters on which they are utterly incompetent to judge. The courts are competent to judge the law and to construe the statutes; but the courts are not competent to say whether a foreman ought to get rid of a workman or a workman ought to dismiss an employer - because the converse is always the case, and under conditions of full employment it is as easy for the workman to dismiss the employer as for the employer to dismiss the workman. But if the B.M.A. had their way, if this queer constitutional doctrine were accepted, both would be tied together by an Act and with the courts. We should find ourselves in an entirely impossible situation. Therefore, we decided it was constitutionally impossible to give the doctors this concession.

However, when the Act was being drawn up and the protection of the doctor being considered, I gave this point special attention. I would have the House realise that, under the existing National Health Insurance Act, protection for the doctor is merely an appeal to the Minister. It is only that. The local insurance committee reports the doctor to the Minister; the Minister makes an inquiry, and the doctor is upheld or removed. That is the existing situation. That was the situation as it was left by my predecessor. Mr. Willink, in his

scheme, had left the position under the new Health Service exactly the same as it is now; but I, of my own volition, decided that that protection for the doctor was not sufficient, on the ground that the new Health Service would be universal and that removal from the Health Service of the future would carry heavier penalties than removal from the National Health Insurance Act scheme. So I decided to put a tribunal in between the local executive council and the Minister.

The present position, therefore, is that, under the scheme the general practitioners are in contract with the local executive council, on which they have seven direct representatives - I emphasise, seven direct representatives - not appointed by the Minister, but elected by the doctors in the locality themselves. That is the first body to discuss the behaviour of a doctor. If, after examination, that body decide that a doctor ought to be removed, they report it to the Minister. At that stage the Minister can do nothing. All he can do is to refer it to this tribunal, the chairman of which is appointed by the Lord Chancellor, and on which there is another doctor and a layman. If that tribunal decides that the doctor should be retained, the Minister can do nothing at all about it, and the doctor is retained.

The Minister is brought into the picture only where the doctor himself invokes the Minister against the decision of the tribunal. The Minister can then order another inquiry, public or private, as the doctor requires, with witnesses if need be, and with all the apparatus of full investigation; and the Minister can then decide whether or not the contention of the doctor should be upheld. There is no professional body in Great Britain or the world where more protection exists than that. The fact is, I am myself beginning to wonder whether the public is sufficiently protected under machinery of that sort. Certainly no doctor could claim that he is not adequately protected in those circumstances.

Let me ask this question, which I hope the doctors will read tomorrow: what would be the consequence of the sort of protection for which their so-called spokesmen are asking? Compare it with this. Suppose that we did find it constitutionally practicable - which we do not - to give the doctor the right of appeal to the courts in these circumstances. Consider what a weapon of tyranny that would put in the hands of the Minister. Because remember, not only would

the doctor have the right of appeal to the courts, but the Minister, being responsible to the House, would himself have the right of appeal to the courts for the removal of a doctor. In such circumstances any Minister would have very considerable powers of intimidation over the doctor, because he could take a doctor to the courts, force the man to undergo all the odium of publicity, to have his conduct examined, newspapers reporting it, all the circumstances of the case revealed to everybody, and his professional reputation besmirched.

The fact is that, if the medical profession could be given what they are demanding, then in six months' time they would be cursing the people who asked for it. In fact, in this matter lay people like ourselves have acted with a far greater sense of responsibility in protecting the doctor than their own professional representatives. Those are the main facts on which the doctors are at present making their complaint.[14]

These are the four main grounds upon which the doctors have been alleging their opposition to entrance into the service. I apologise for keeping the House so long, but this is a matter of very great importance, and I am desperately anxious to get the medical profession into the scheme, enthusiastically and harmoniously, and I deplore the atmosphere which has been created in the last six months. I would point out to the House that so anxious was I not to take part in these polemics, that I made no public speech of any sort until the meetings in January, when the B.M.A. decided to reject the Act. Although, for between six months and a year, meetings have been held all over the country and the most extravagant things have been said, I nevertheless took the view that it would be better for me to say nothing at all at that stage, or I might have added to the acrimony rather than reduced it. Therefore, I made no statements of any sort. It may be that the mis-education of the doctors is partly my responsibility, and that if I had not left their education solely to those who are supposed to speak on their behalf, they might now know a little more than they do about the Act.

It may be said by the right hon. Gentleman the Member for Saffron Walden when he replies, more in sorrow than in anger, "Well, now, cannot we get together?[15] Is it not possible, at this late hour, for some concession to be made to assuage the high feeling

and try to bring about greater harmony between the Government and the doctors?" The Opposition might want to put themselves into the position of "honest broker" - a position, historically, very difficult for them to occupy; but it might appear to them to be congenial in these circumstances to take up that position. But, that would be to assume that there have been no concessions made to the medical profession, and that we should start off once more negotiating and making concessions. I want to point out to hon. Members in all parts of the House that these negotiations have been a long series of concessions from us, and none from the medical profession - not a single one. Indeed, one Member of the Negotiating Committee boasted that during these negotiations they had not yielded a single inch.

Consider what we have done. Consider the long record of concessions we have made. First of all, in the hospital services we have accorded paid bed blocks to specialists, where they are able to charge private fees.[16] We have accorded, in addition to those fees for those beds which will have a ceiling, a limited number of beds in the hospitals where there is no ceiling at all.[17] I agree at once that these are very serious things, and that, unless properly controlled, we can have a two-tier system in which it will be thought that members of the general public will be having worse treatment than those who are able to pay. That is a very grave danger, and it is a very serious and substantial concession made to the medical profession. We have also conceded that general practitioners and specialists can have private patients. That was repugnant to many of my hon. Friends. They hated it, because they said at once that we can have, if we are not careful, a revival of the old Poor Law system, under which the man who does not pay, does not get the same treatment as the man who does.

This kind of propaganda contains the possibility of developing that atmosphere. I would warn hon. Members opposite that it is not only the British working class, the lower income groups, which stands to benefit by a free health service. Consider very seriously the tradition of the professional classes. Consider that social class which is called the "middle class." Their entrance into the scheme, and their having a free doctor and a free hospital service, is emancipation for many of them. There is nothing that destroys the family

budget of the professional worker more than heavy hospital bills and doctors' bills. There is no doubt about that at all, and if hon. Members do not know it, they are really living in another world. I know of middle-class families who are mortgaging their future because of heavy surgeons' bills and doctors' bills. Therefore, it is absolutely vital, not only for the physical good health of the community, but in the interests of all social groups, that they should all be put in the system on 1st July and that there should not be some in and some out of the scheme. That is why I deplore the letter today in "The Times" from a distinguished orthopaedist, who talked about private practice as though it should be the glory of the profession.[18] What should be the glory of the profession is that a doctor should be able to meet his patients with no financial anxiety.

I now come to the Amendment on the Paper, and may I say at once that the Government are prepared to add the Amendment to this Motion? I think that the language of the Amendment reflects the political sagacity of the Opposition. They are not anxious to enter the tilting yard led by such doubtful leaders as the B.M.A. They wish to avoid the tourney, and are prepared to stand on one side and gather up whatever spoils may come to them. If hon. Members look at the Amendment, they will see that it is one to which all Members of the House can subscribe. It:

> "declines to prejudice in any way the right of individuals in all the professions concerned to express their opinions freely, according to their traditions, and in the interest of their patients, upon the terms and conditions of service under the proposed National Health Scheme."

Who disagrees with that? A more innocuous collection of bromides I have never heard of or seen.[19]

The sting in the Amendment is, of course, that it leaves out the last part of the Motion. If Members opposite think there is anything in the Act which interferes with the freedom of choice, they should say so; we should hear it. If they think there is anything in the Act, scheme, or terms of remuneration, which prejudices the doctor-patient relationship, we should hear it. So far, we have not. We do not object, and never have objected, to the doctors expressing their opinions freely; we do not object to the B.M.A. recommending their doctors not to take service under this scheme. What we do take

serious objection to is to organised sabotage of an Act of Parliament. We desire to know from the Opposition whether they support that. Do they support the B.M.A. organising resistance on 5th July, because I would warn them that the beginning of that road might look very pleasant but the end would be exceedingly unpleasant, not only for us but for Members opposite.[20] It must be clear to everybody that if there is one thing we must assert, it is the sovereignty of Parliament over any section of the community. We have not yet made B.M.A. House into another revising Chamber. We have never accepted the position that this House can be dictated to by any section of the community.

We do concur in the right of any section of the community to try to persuade the House of Commons to change its mind. That is perfectly sound. The position we are taking up is that the B.M.A. have exceeded their just constitutional limitations, and that the best thing they can do now is to put on record their opinion that while they may disagree with the Act in this or that particular, or in general if they wish, nevertheless, they will loyally accept the decision of Parliament and continue to agitate for such revisions as they think proper. That is the right position for any section of the community to take up.

May I say this in conclusion? I think it is a sad reflection that this great Act, to which every party has made its contribution, in which every section of the community is vitally interested, should have so stormy a birth. I should have thought, and we all hoped, that the possibilities contained in this Act would have excited the medical profession, that they would have realised that we are setting their feet on a new path entirely, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world - put the welfare of the sick in front of every other consideration. I, therefore, deplore the fact that the best elements in the profession have been thrust on one side by the medical politicians, who are not really concerned about the welfare of the people or of their own profession, but are seeking to fish in these troubled waters. I hope the House will not hesitate to tell the British Medical Association that we look forward to this Act starting on 5th July, and that we expect the medical profession to take their proper part in it because we are satisfied that there is nothing in it that any doctor should be otherwise than proud to acknowledge.

Source: House of Commons Debates, vol. 447, cols. 35-50, 9 February 1948.

Notes:

1. For full discussion of this speech, Foot, ii, pp. 176-88. The *Manchester Guardian*, 10 February 1948, reported that the Labour benches were "wild with delight" at Bevan's "brilliant performance" or "gladiatorial triumph".
2. During January and February 1948, the *B.M.J.* received letters amounting to some 75,000 words attacking Bevan. The letters published were given provocative captions such as "The Fight for Freedom", "Doctors and Dictators", "The Act or Liberty", or "Defiance of Dictatorship", Lindsey, p. 55.
3. The plebiscite revealed that nearly ninety per cent of the doctors voting were opposed to accepting the NHS Act in its existing form. *B.M.J.*, 1948, i, 454-5, 6 March 1945.
4. See above, II, n. 5.
5. See above, II, n. 1. 1943 is a somewhat arbitrary date for the "revival". 1942 would be more appropriate for the plan for a comprehensive health service, and 1941 for a national hospital service.
6. Presumably Bevan was referring to his own White Paper of March 1946 rather than the suppressed Conservative caretaker White Paper of June 1945. Webster, *Problems*, pp. 73-4.
7. Bevan was perhaps referring to David Lloyd George who, as Chancellor of the Exchequer, faced vehement BMA opposition in connection with the National Insurance Act, 1911.
8. Ernest Brown was Minister of Health from February 1941 to November 1943.
9. H.W. Harris, Conservative M.P., Cambridge University, asked whether the Negotiating Committee rejected the whole hospital section of the NHS Act.
10. In May 1948 Bevan agreed to abandon the basic salary as a universal feature of payment of general practitioners, replacing it with the Fixed Annual Payment, also of £300, to be paid only in cases of proven need, at the discretion of Executive Councils. Webster, *Problems*, pp. 117, 351-2.

11. D.L. Lipson, Independent M.P., Cheltenham, interrupted to suggest that the basic salary should be optional.

12. The official view on the vexed question of compensation for the extinction of goodwill was stated by Bevan in *B.M.J.*, *Supplement*, 1947, ii, p. 156, 20 December 1947. This interpretation was contested by counsel for the profession, *B.M.J.*, *Supplement*, 1947, ii, p. 151, 20 December 1947. A committee under G.O. Slade K.C. made recommendations which were incorporated into sections 1-9 of the NHS (Amendment) Act, 1949. Webster, *Problems*, p. 130.

13. The question of disciplinary procedures for general practitioners (NHS Act, 1946, section 42) caused some difficulty for the Government during parliamentary consideration of the 1946 Bill. The only concession granted in 1948 by Bevan was greater flexibility in the choice of the professional members serving on the disciplinary tribunal. NHS (Amendment) Act, 1949, section 14. Webster, *Problems*, pp. 99, 102, 130.

14. R.T. Paget, Labour M.P., Northampton, accused Bevan of misrepresentation, to which Bevan reasserted that the accused practitioner was adequately protected at every stage.

15. R.A. Butler, Conservative M.P., Saffron Walden.

16. Hon. Members: "Shame".

17. Hon. Members: "Why?".

18. Letter from Reginald Watson-Jones, *The Times*, 9 February 1948. The writer claimed that the profession would not be able to "serve the people well if proposals are enforced which conflict with instinct based upon a history of 2000 years". The same issue contained a letter from A.W.M. Ellis, Regius Professor of Medicine at Oxford, regretting the government's attempt to impose its general practitioner service at the same time as its hospital plan. For further attacks on Bevan from influential quarters see letters of Dain and Lord Horder, *The Times*, 16 January 1948.

19. Sir Arthur Salter, Independent M.P., Oxford University, pressed Bevan to withdraw allegations about lack of secrecy in the BMA plebiscite.

20. Hon. Member: "Is that a threat?".

X

THE PIONEERS OF PUBLIC HEALTH, 7 MAY 1948

In paying tribute to the Pioneers of Public Health it is not my task to stretch back to the earliest pioneers, to the forgotten Roman engineers whose pipes and paving made Londinium a healthier city than it was to be for another 1,500 years, nor to look at the work of the reformers of the Renaissance, Sir Thomas More and Sir T. Elyot, not even to the edicts of the Lord Mayor and the city council for maintaining the health of the city in times of plague and pestilence.[1]

Our gaze to-day is fixed on the first Public Health Act of 1848, on the men who formed the opinion which made it possible, and men who carried it through and the men whose administration of its provisions laid the foundation of the century-long struggle to provide a comprehensive service for the health of the people.

I do not even need to remind you of the appalling task which the reformers of 1848 faced.

Their labours were two-fold. One lay in the immensity of the practical problems themselves. The unpaved streets, the ordure-ridden water supply, the non-existent sewers, the hovels which served the people as homes, paralleled by the writers of the day only to the negro huts of the West Indies. These conditions led to an infantile mortality of 200 per 1,000; to a maternal mortality of 6 per 1,000. They led from time to time to the cholera epidemics of Asiatic violence which claimed their deaths not in hundreds as in the outbreak of poliomyelitis in 1947, not even in thousands as the influenza epidemics in living memory, but in tens and scores of thousands mounting, as in 1832, to national disasters only exceeded by the Black Plague of the Middle Ages and the Great Plague of 1666.[2]

The second problem lay in the bitter opposition of many vested interests to reform. "The Parish Officers," wrote Chadwick, "frequently oppose improved modes of paving and efficient cleansing, as they generally opposed the new police on the ground that it diminished the means of sustenance of decrepit old men as watchmen,

for the avowed reason that it is expedient to keep up the means of employing indigent persons as street-sweepers and sweepers of crossings in removing it."

Property and bumbledom fought together to deny the child the right to live; ignorance and indifference presented his father with a choice between quick death by foul water and slow death by foul spirits.

To blatant opposition add bored indifference.

No one thought public health a good investment. "The Great Plague of London will be revived and naturalised," said *The Times*, "for the sake of saving half as many pounds as are found readily forthcoming for a German mine or a French railway."

Even the leading Radicals of the day ignored the cause of public health. It is recorded that John Bright in twenty years of political life only spoke once on the subject and then to oppose a measure of smoke abatement.

The task of rallying public opinion and getting anything done was, therefore, enormous. "Stench and smoke," wrote *The Times*, "could not have preserved that which corn and sugar lost if they had been attacked with half the same determination." It was from the pioneers - Edwin Chadwick, John Simon and William Farr - that the determination came.[3]

J.L. and Barbara Hammond in their *Life of Lord Shaftesbury* describe Chadwick as a man "chiefly known for his success in making enemies." Chadwick, the Poor Law Commissioner, was one of the most heartily hated men in our history. He worked unhesitatingly to his object, listening neither to opposition nor advice. The newspapers detested him for his fierce unyielding spirit. The Government disliked him just as much. His fearless energy meant unanswerable reports which it was embarrassing to shelve.

It was never a part of Chadwick's work to *cure* disease in the medical sense of the word. He was for *prevention*. He stated that men could live longer if they took the trouble to clear away the evils which shortened human life. (His career was a good example of this as he died at the age of 90, and Simon lived to be 88, Farr to be 76.)

His seminal work was the great report of his Royal Commission on the Sanitary Condition of the Labouring Population of Great Britain published in 1842.[4]

For six years the cause of public health fought an apparently losing battle with the Corn Laws for public attention. Then at last in 1848, the first Public Health Act went through. The General Board of Health was finally set up but only lasted six years.[5]

When, in 1854, it came to an end, one of the main reasons for this was personal antipathy to Chadwick. In Parliament, they saw him as a man fighting against private property and private interests. He was a danger to their comfort and prosperity. He was deposed.

Unfortunately, the disfavour which Chadwick had aroused attached itself to the whole movement of public health. In fact, the post of chief medical officer, first filled in 1855 by Sir John Simon, would have been abolished had not the Prince Consort intervened.[6]

John Simon had been London's first medical officer of health since 1848. The conception of a medical officer in an administrative post was then quite new. It had not been realised that the appalling conditions brought to light mainly through Chadwick could be put right in any way by the medical profession.

John Simon's annual reports for the years 1848-55, when he held the office of medical officer of health for the city, have become classics in the history of English sanitation.[7]

In these reports, Simon exposed all the degradation under which the masses were obliged to live. He showed the risks that arose from bad drainage in the spread of cholera and other diseases. He got in touch with the Registrar-General and made an arrangement with him by which punctually every Monday morning, the nine city registrars provided the Registrar-General with returns of deaths registered during the previous week and the causes of such deaths, and these papers were placed at Simon's disposal. Gradually through his influence a weekly inspection in all the poorer parts of the city took place.

Yet when in 1855 Simon accepted the post of medical officer in the new Board of Health, he said: "None but the vaguest notions had been formed as to the work which the officer ought to do." The general view was that a medical officer's functions should be confined to fighting the dangers of the diseases when they occurred. This was not Simon's idea. But he was up against great difficulties because, as he wrote: "The legislature recognises no medical authority. Occasionally this fact stands out in painful conspicuousness and brings

most injurious results."

His report on the Sanitary State of the People of England presented an unanswerable case for the establishment of a medical department of Government;[8] and in 1859, after the passing of the Public Health Act of 1858, when the functions of the Board of Health were absorbed by the Privy Council, Simon was permanently appointed medical officer to that council.

In 1858 he published a Paper on the Constitution of the Medical Profession,[9] and this was followed by the passing of the Medical Act by which the General Medical Council was established with a system of registration "to enable persons requiring medical aid to distinguish qualified or unqualified practitioners." Before this Act, Simon said: "The legal titles of medical practitioners were as various as the names of snuffs and sauces."

It was at Simon's instigation that the Royal Sanitary Commission was set up in 1868 to inquire into the administration of sanitary laws and the formation of local sanitary areas.[10] In 1871, as an outcome of this, the Local Government Board was set up. Simon accepted the post of chief medical officer of the new Board. But he found that the medical department was placed in a subordinate position, and in 1876 he retired. Had his statesmanlike conception of a Ministry of Health prevailed over local board methods, the progress of sanitary science would have been unquestionably more rapid.

So much for the work of Simon and Chadwick. But the administrator of to-day cannot write his bluebooks nor the medical officer of health his reports unless both can draw upon the bullion of statistically analysed experience.

Soon after civil registration of births, etc., began in 1837, there was appointed to the post of Compiler of Abstracts in the newly created General Register Office a "gentleman of the medical profession," a young general practitioner whose medical qualification was the Society of Apothecaries. William Farr, son of a farm labourer, first became known through his free-lance journalism in *The Lancet* and elsewhere on matters medical and economic. A notable article on Vital Statistics in 1837 put him at once in the front rank, and for the rest of his life this self-taught mathematician gave himself without stint to the development of his chosen science, medical statistics.[11]

Farr was a true pioneer; he was original and courageous; in his field he was a genius. His Annual Letters to the Registrar-General on the causes of death in England, and the reports to which they are appended, covering a period of forty years, provide a statistical record of disease of the time such as is possessed by no other country in the world.

The answers to the questions in the 1851 Census of Great Britain provided a wealth of information which he used in his enquiry into the mortality of the English working man; the tool-grinder inhaling sharp particles of metal dust, the clerk poring over his ledgers in a stuffy office, the miner hewing at the coal-face, all these and many more became the objects of study and concern. And he was not content only with study. He was one of the first - far ahead of his time - to point out the advantages of a government system of health insurance.

Farr was no collector of facts for facts' sake; it was not ink he had in his veins but good red blood. Throughout his life his aim was the use of medical statistics to reveal the *causes* of disease, to compare the value of various forms of treatment and to compel social and sanitary reforms. To him "prevention is better than cure" was not merely a truism - to him it was a constant challenge. "Medical men, the guardians of public health," he wrote, "never have their attention called to the prevention of sickness; it forms no part of their education. To promote health is apparently contrary to their interests." In his unceasing efforts to change this attitude Farr was a great force in his day and he has been a source of inspiration to generations of our health workers right down to our own times.

I have spoken so far of Chadwick, Simon and Farr. Many others might be mentioned, particularly Delane, the great editor of *The Times*, and Dickens. But I should like to save my concluding words for a fourth figure - Lord Morpeth.[12]

It is not enough for the social reformers to smell out abuses and bring them to light. It is not enough even for the administrator to have the knowledge and the ability to deal with the abuses once he is given power. In our method of government, no social reform can come to fruition and no new system of administration can be inaugurated until public opinion accepts, or is induced to tolerate, the reform. It is here that the politician becomes essential to give form to

the idea; to modify it, if necessary, in such a way as to make it acceptable to the many interests affected; to keep intact the kernel of the matter and to place the new principle upon the statute book.

Morpeth is not remembered as a man of great ideas or sweeping principles but to him and not to Chadwick goes the final credit of steering the first Public Health Act through Parliament after one initial failure. His popularity and his gift for compromise succeeded where the unyielding Chadwick would have failed. That, as I see it, is the essential function of the despised politician. He is the accoucheur of the public conscience. Not in himself the pioneer but yet in the final stages the catalyst by which the pioneers' reforms are transformed into practical realities. And so tonight, we remember Lord Morpeth as one who not only got the Act through, but who kept its principles alive during the first six vital and challenging years and, in so doing, paved the way to the development of the most effective Public Health Service in the world.

I give you the toast of Edwin Chadwick, John Simon, William Farr, coupled with the name of Lord Morpeth.

Source: *The Medical Officer*, 15 May 1948, pp. 207-8.

Notes:

1. Bevan was speaking in the Guildhall Library on 7 May 1948 at the commemoration dinner to mark the centenary of the Public Health Act, 1848. This date also coincided with the centenary of the appointment of John Simon as Medical Officer of Health to the City of London. Simon and H.W. Duncan of Liverpool were the first appointees to such posts. On 6 May Princess Elizabeth opened "The Health of the People Exhibition" organised by the Central Office of Information for the Ministry of Health to mark the centenary of the Public Health Act. See *The Times*, 29 April and 30 April 1948 for a major two-part article on the 1848 Act. The best reviews of Victorian sanitarianism are Flinn (see n.4 below), R. Lambert, *Sir John Simon* (London, MacGibbon and Kee, 1963), M. Pelling, *Cholera, Fever and English Medicine 1825-1865* (Oxford, Oxford University Press, 1978), A.S. Wohl, *Endangered Lives. Public Health in Victorian Britain* (Cambridge, Mass., Harvard University Press, 1983).

2. Approximately 23,000 deaths in England and Wales were occasioned by the 1831/1832 cholera epidemic. Pelling, p. 2.

3. Edwin Chadwick (1810-1890), layman, Benthamite and main agent in poor law reform before he turned to public health. John Simon (1816-1904), successively Medical Officer to the Board of Health, the Privy Council and the Local Government Board. William Farr (1807-1883), Compiler of Abstracts to the General Register Office.

4. *Report on the Sanitary Condition of the Labouring Population of Great Britain* (London, HMSO, 1842). Reprint with introduction by M.W. Flinn (Edinburgh, Edinburgh University Press, 1965).

5. Chadwick's membership of the Board of Health lasted from 1848 to 1854, but the Board was continued in an attenuated form until 1858, when it was abolished.

6. Lambert, pp. 276-9.

7. *Reports relating to the Sanitary Condition of the City of London* (London, 1854).

8. *Papers Relating to the Sanitary State of England by E.H. Greenhow, with Introduction by John Simon*, PP 1857-8, xxiii, p. 267.

9. Presumably the *Memorandum prepared in 1858 by the Medical Officer of the General Board of Health*, included in, *Report of the Select Committee on the Medical Act (1858) Amendment Bill*, PP 1878-9, xii, p. 315.

10. *Second Report of the Royal Sanitary Commission*, C.281 (London, HMSO, 1871).

11. Farr, *Vital Statistics* (London, Sanitary Institute of Great Britain, 1885).

12. For Lord Morpeth, see S.E. Finer, *The Life and Times of Sir Edwin Chadwick* (London, Methuen, 1952), pp. 311-13. Finer's characterisation of Morpeth would have appealed to Bevan. Finer concluded that Chadwick, the arrogant technocrat, would yield to nobody else, "because he completely trusted his motives, admired his sagacity and realized... that Morpeth and Morpeth alone could manage parliaments and private individuals" (p. 311). Bevan as the natural aristocrat of labour felt an intuitive affinity with the enlightened hereditary nobility of the age of reform. For Morpeth and the Public Health Act, 1848, Finer, pp. 319-31; Lambert, pp. 64-70.

XI

ROYAL COLLEGE OF NURSING, 2 JUNE 1948

"Nurses - I can say this as the doctors are not here - are the most important part of the Health Service," Mr. Bevan began.[1] It had been suggested that the introduction of the National Health Service should be postponed because there was a shortage of nurses, doctors, dentists, hospitals, equipment and "things of that sort." "That," the Minister affirmed, "is a lot of stupid nonsense, because we never shall have all we need. If we are short it is all the more reason why we should intelligently use what we have got." If there were a scarcity of doctors and nurses it was better that they should spend their time "looking after those who need them, and not a lot of hypochondriacs who can afford to pay."

"Mobile" Superannuation Rights

Referring to what had been done in the way of increasing domestic staff, Mr. Bevan claimed that nurses were able to give more attention to their patients now than they had been able to do formerly. The Act itself should be the best advertisement for recruitment. "We have improved nurses' conditions and we are going to improve them still more," said Mr. Bevan. There would be a superannuation scheme in which the nurses' rights would be "mobile"; she could transfer them from one post to another in a way which she could not do now.

He had been asked: "What about health centres?"[2] He replied: "Of course we are going to have health centres - but not all at once." He was also the minister responsible for houses, and he had to choose between building health centres and building houses. Of the two, he thought the latter the more important. "If we have more houses, we shall not need so many health centres." If a mother had a properly equipped home, it was better for her to have her baby there, if it was a normal birth, than in a maternity hospital. "We have to weigh up the different claims," Mr. Bevan told his listeners. "We have to make the addition sum - and then we have to do the sub-

traction sum. So long as all our resources are in full use, any additional thing that we do must be at the expense of something else that we are doing." He would much rather have that kind of "headache" than the one he had before the war of finding jobs for men.

The people who worked the National Health Service should have a say in its running. There was a nurse on each regional hospital board. To cries of "Only one" the Minister remarked: "You should have seen the number of claims there were." There was also a full-time nursing officer attached to each regional hospital board. But the board was not the main administrative unit in hospital administration; so far as the day-to-day administration was concerned, the hospital management committee was the more important. Staff groups should be formed in each hospital, with direct access to these committees. "That is how we want nurses to participate in the administration," said Mr. Bevan. It was there that the nursing was done, not at the regional board level. Then there were Whitley Councils on which nurses had complete representation.[3] There would be a Nurses' Advisory Council attached to the Central Health Services Council, which would advise on "the training and organization of nurses." This advisory committee had power to initiate advice.

No Direction

The nurse would be under contract to the regional hospital board, which was an administrative convenience for this purpose; the nurse would be appointed by the hospital management committee, and if the nurse left the employ of one regional board and made another contract with a second, the contract with the first would cease, but she took all her superannuation rights with her. No government could enslave the British people: the nurse could leave her employment. The nurse could not be made to go to a certain hospital. Mr. Bevan added: "We shall ask you. We shall say: 'We are short of nurses here and we would like you to come here.'"

This brought cries of "Oh!" and laughter from the audience, to which Mr. Bevan replied: "Is there any harm in asking you? You are getting very precious, aren't you?" The nurse could say: "Oh no, I would rather stay here," in which case nothing could be done with her. "If I discovered any attempt at victimization of nurses, I should be very angry," declared Mr. Bevan. "I want to make it categorically

clear that there is no power of direction over nurses. I rescinded the direction of nurses a long time ago and there is no intention to re-instate it." At the same time he hoped to obtain from nurses and their organizations cooperation to secure the proper distribution of nurses where they were required.

Mr. Bevan said that one question which he had been asked was: "Can a regional board dismiss me over the committee's head, if they want me to go to a hospital to which I do not wish to go?" The answer was: "No." It was the task of the regional hospital board to see that all varieties of specialist therapy were available and to appoint management committees and see that these had a proper relationship with each other. They would engage specialist staff and arrange management committee's budgets. The hospital management committee might cover several hospitals or one hospital, if this were sufficiently large. Where more than one hospital was under a single hospital management committee, there would be house committees in the particular hospitals.

Mr. Bevan then discussed the Working Party's Report. "The Working Party's Report is still under consideration," he said. "A minority report has been received nine months after the majority report, but I must say frankly, that I cannot hold up decisions on the majority report by discussing the minority report."[4] He had now received comments on the majority report, and was considering what action should be taken; he hoped to have the cooperation of nurses when the decisions were put into operation. "I am exceedingly anxious to get the Bill framed at the earliest moment," the Minister declared.

Much attention had been called to what Britain had not got. But what of that which she had? "We have got something in this country which is unique," said Mr. Bevan. That was a great, centralized health scheme, organized by the Government, paid for by the State, "free at the time you use it," not based on insurance contributions - a nationally organized scheme run by voluntary people. "It is the emancipation of the voluntary worker from financial anxiety. It is that cooperation between state activity and voluntary activity which is the peculiar genius of the British people. And it is going to work." Gifts to a hospital would still be welcomed, because they "warmed it up." "We want the local hospital to be still a local hospital in that people

take a local responsibility for it," said Mr. Bevan.

A Thousand Javelins

As to whether this Service could be afforded, Mr. Bevan said: "We do not think in terms of money"; today we asked ourselves instead what resources we had. "I invite your cooperation," the Minister declared. After July 5 there would be many complaints. The order paper of the House of Commons would be covered with questions. "In fact," said the Minister, "every mistake which you make I shall have to bleed for. I shall be going about like Saint Sebastian, bleeding from a thousand javelins, so many people will be complaining. So many people are complaining now, but you cannot hear them." The Service would put a megaphone in the hands of those who had complaints. "As time goes on, the chorus of complaints will dwindle and dwindle. If you see in the press complaints about this and that, do not be disturbed - because you will be attending to them. All I shall be is a central receiver of complaints."

In a few years' time, people will come from all parts of the world to see this great service. "I am satisfied," Mr. Bevan concluded, "that you will give to whatever government there may be, the hearty, selfless cooperation of your great profession."

Source: *Nursing Times*, 12 June 1948, p. 426.

Notes:

1. Bevan was addressing the fourth Nation's Nurses Conference at the Royal College of Nursing on 2 June 1948.
2. Bevan was no doubt counteracting adverse reaction to circulars 176/47 and 3/48 of 17 December 1947 and 14 January 1948 respectively, which cancelled the requirement on Local Health Authorities to submit schemes for health centre development and restricting applications to "urgent new projects". Webster, *Problems*, p. 383.
3. H.A. Clegg and T.E. Chester, *Wage Policy and the Health Service* (Oxford, Blackwell, 1957), pp. 39-47; Abel-Smith, *A History of the Nursing Profession*, pp. 191-208.

4. The anodyne *Report of the Working Party on the Recruitment and Training of Nurses* (London, HMSO, 1947) was dated 22 July 1947; chairman, Sir Robert Wood. Dr. J. Cohen promised his *Minority Report* (London, HMSO, 1948) within a month (*Report of the Working Party on Nurses*, p. 82), but in the event it was dated 31 March 1948. The *Minority Report*, which was scathing about planning methods in the NHS, was virtually ignored by Bevan's department.

XII

MANCHESTER, 4 JULY 1948

"The eyes of the world are turning to Great Britain. We now have the moral leadership of the world, and before many years are over we shall have people coming here as to a modern Mecca, learning from us in the twentieth century as they learned from us in the seventeenth century."[1]

Mr. Bevan's speech was largely a review, followed by a pledge that the Government could carry out its entire programme, including the nationalization of steel.[2] The Labour Party, he said, would win the 1950 election because successful Toryism and an intelligent electorate were a contradiction in terms.

Poverty, generally speaking was the consequence of bad social organization. Mr. Bevan recalled what he described as the bitter experiences of his early life. For a time he had to live on the earnings of an elder sister and was told to emigrate.

"That is why no amount of cajolery, and no attempts at ethical or social seduction, can eradicate from my heart a deep burning hatred for the Tory Party that inflicted those bitter experiences on me. So far as I am concerned they are lower than vermin. They condemned millions of first-class people to semi-starvation. Now the Tories are pouring out money in propaganda of all sorts and are hoping by this organised sustained mass suggestion to eradicate from our minds all memory of what we went through. But, I warn you young men and women, do not listen to what they are saying now. Do not listen to the seductions of Lord Woolton.[3] He is a very good salesman. If you are selling shoddy stuff you have to be a good salesman. But I warn you they have not changed, or if they have they are slightly worse than they were."

Social Legislation

Discussing the new social measures, Mr. Bevan said that the "slight conflict over the National Health Act never worried him very much because - as a credulous idealist - he knew the truth would survive, and that as the medical profession came to know its

provisions they would support it. The Act was not based upon contributions, and every individual had equal rights to the scheme, whether insured or not. He paid a sincere tribute to the voluntary work of hospitals, but said private charity could never be a substitute for organized justice.

It was true there were many things the Government had not done, and the newspapers in the next few weeks would contain complaint after complaint about what they were not able to do. In the past the distress was there, but the complaints were not heard. "But after today the weak will be entitled to clamour. After a while the newspapers in the hands of our enemies will give the impression that everything is going wrong. Don't be deceived, it is then that they will start going right. We are the people to whom the people can complain. I shall be unmoved by the newspapers, but moved by the distress."

But the shortages would not fall exclusively upon those with no means. Someone would have central responsibility, and the complaints would herald the advent of things being put right. Half a million people were hard of hearing, and an aural aid would be provided, probably free of charge.

Resources were fully employed, and more for some could only be achieved by producing more or giving up something. Every such choice between a number of competing alternatives was an ethical and moral choice. The Government decided an issue in accordance with the best principles, and said "The weak first, and the strong next".

Referring to Mr. Churchill's "set-the-people-free" speech, Mr. Bevan said that the result of the free-for-all preferred by Churchill would have been cinemas, mansions, hotels, and theatres going up, but no houses for the poor.[4] "In 1945 and 1946," he said, "we were attacked on our housing policy by every spiv in the country - for what is Toryism, except organized spivery? They wanted to let the spivs loose." As a result of controls, the well-to-do had not been able to build houses, but ordinary men and women were moving into their own homes. Progress could not be made without pain, and the important thing was to make the right people suffer the pain.

People who campaigned against controls were conducting an immoral campaign. There was a kind of schizophrenia in the country,

so that people reading the newspapers and hearing talk in luxury hotels got an entirely different conception of what was happening, which did not square with the statistics. The bodies and spirits of the people were being built up, but the Government's efforts could not be sustained except by the energies and labour of the people. Production must be raised to make the new legislative reforms a living reality.

A Struggle Ahead

The Government never promised in 1945 that everybody was going to be better off. It knew that some were worse off to-day, but it always intended they should be. "In 1950 we shall face you again with all our programme carried out. And when I say all, I mean all. I mean steel is going to be added," said Mr. Bevan, amid cheers. "We are going to establish a new record: that of being the only British Government that ever carried out all its election promises."

There would be a great struggle in the next two years, and every obstacle would be put before the Government. The House of Lords would resurrect its "old cartel carcase" and try and put it between the Government and the will of the people, but steps were being taken to deal with the House of Lords. "We will set that resistance on one side. We shall meet the struggle because we know exactly what we want to do, and how the Tories will react to it."

Sources: *Daily Telegraph*, *Manchester Guardian*, and *The Times*, 5 July 1948.

Notes:

1. Bevan was addressing a rally attended by 7,000, in Manchester on 4 July 1948, called to celebrate the Labour government's accession to power. The meeting was presided over by George Tomlinson, Minister of Education, who advised conciliating Bevan at the time of the resignation crisis in 1951. Margaret Herbison spoke at the same rally. On the evening of 5 July Bevan attended a production of Ewan MacColl's "The Other Animals" at the Central Library Theatre, Manchester. The

Manchester Guardian report was headed "Mr. Bevan's Bitter Attack on Conservatives. No 'Free for All' Policy under Labour". The briefer *The Times* report was headed "Mr. Bevan's 'Burning Hatred' Attack on Tory 'Vermin'".

2. Morgan, *Labour in Power*, pp. 94-141. In his speech to Young Conservatives on 12 June 1948, Churchill described steel nationalisation as the "crucial test" of the recklessness of the Labour government, *The Times*, 14 June 1948.

3. As Chairman of the Conservative Party, Lord Woolton was much concerned with modernising its publicity and election machinery. Woolton and Churchill outlined Conservative policy on elimination of controls at the Primrose League on 30 April 1948, *The Times*, 1 May 1948. For Woolton's speech pledging removal of restrictions, *The Times*, 26 January 1948.

4. Churchill's party political broadcast on 14 February 1948 concentrated on the theme of European unity against communism. The Labour government was attacked for squandering the American loans. He called for removal of socialist restrictions on enterprise, "to allow the laws of supply and demand to play their part". He ended by claiming that the restoration of "natural and normal incentives" would serve the "welfare and salvation of all, set the people free". *The Times*, 16 February 1948.

XIII

PRESTON, 5 JULY 1948

Mr. Bevan said that "the conception behind the five great Acts that had just come into force was one to which people of all parties had made their contribution.[1] Since 1848 the health services of the country have undergone adaptation, extension and improvement, until today we can say we have the best organised system of social security in the world," he declared. Some said it was a mistake to put individual security so much to the fore, that in making the individual too secure some vital element was sucked out of life, that the spirit of adventure and the uncertainties that were the spur of original thought would be retarded. There was, however, no spirit of adventure in a mother being unable to give proper attention to her child, or in inefficient social services. The fear that was now eliminated undermined individual initiative.

Discussing the structure of the service, Mr. Bevan said, "You might say that a man of my temperament would find it difficult to obtain universal agreement in the efforts to build up the present health structure. But I sometimes wonder whether a less belligerent personality would have started the scheme at all. A certain amount of aggressiveness was necessary, to push aside many of the resistances which would have prevented the scheme from being started at all." Mr. Bevan could claim there had been no political bias in the selection of people to take part in the voluntary machinery. He had achieved that universal measure of agreement that was evidence of complete impartiality, and already a team spirit had grown up.

Balance of Authority

It had been a problem how to centralise financial responsibility and at the same time prevent hospital administration from becoming hopelessly bureaucratic. It would have been impossible to have a satisfactory system run from Whitehall and there had to be at some point in the administration, the element of public accountability. That was why the words "Minister of Health" were repeated so much in

the Act.

More reciprocity between academic and clinical medicine was desirable in the future. For many middle-class groups doctors' bills were often very serious items and the Government was anxious to get the middle and professional groups into the service with the rest.

Mr. Bevan had a sharp reproof for general practitioners, who told applicants they were prepared to keep them as paying but not public patients. This was a "wicked thing". There was no limit to the cost or quality of drugs which might be prescribed. There was no rule preventing doctors visiting patients in their homes or that they could not see them by appointment. He had a "brief but utterly sincere word of thanks for all those men and women" who had done voluntary work. They handed over much that was a going concern and the old services were not being changed because they were bad, but to make them better.

Sources: *Daily Telegraph* and *Manchester Guardian*, 6 July 1948.

Notes:

1. Bevan was addressing a meeting of NHS committee representatives at the county offices, Preston. He had previously visited the Park Hospital, Davyhulme and the county ambulance headquarters at Preston. The *Manchester Guardian* report was headed "Mr. Bevan Defends the Individual: Eliminating Fears which Check Initiative".

XIV

SOCIETY OF MEDICAL OFFICERS OF HEALTH, 16 SEPTEMBER 1948

Mr. Bevan, Minister of Health speaking at the annual dinner of the Society of Medical Officers of Health in London last night, said he regarded the present year as memorable because it had witnessed the launching of the great Health Act.[1] The period of controversy was behind them, and they were looking forward to fruitful cooperation.

There was a section of the community more harrassed than any other by the possibility of surgical and hospital bills, and that was the middle and professional classes. He had feared that unwholesome propaganda might persuade them to stand outside the Act. That would have been unfortunate from every point of view, but the danger was past. The last figure he had was that between 92 and 93 per cent of the population of Great Britain had already signed up with their doctors. They were coming in now at the rate of about 150,000 a week, and it appeared that by the end of the year, practically 100 per cent of the population would be in. He was delighted.[2] It meant that the health service would be a classless service and every section of the community would be in full enjoyment of its benefits.

Rush for Spectacles

There had been complaints from some quarters about the numbers of spectacles that had been supplied. The only misgiving he had was that now nearly everybody would be able to read some of the nonsense that had been written about the Act. It was to be expected that in the first year there would be a rush for some of the facilities, but that would settle down when the novelty wore off. When it was possible to get out figures he thought they would be surprised at the number of old age pensioners who had bought spectacles from cheap stores and even inherited spectacles.[3] He was also delighted to see that dentists were now coming in more quickly. He had no doubt that before long most of them would be in the scheme.[4]

The Public Health Horizon

The National Health Service Act of 1946, which came into operation on 5th July of this year, is designed to provide a comprehensive medical service for persons who are sick, in body or in mind. This service includes hospital care, consultant and specialist services, and medical treatment - at home or in "health" centres - from the family doctor. All these services are provided free of cost at the time of need for every man, woman and child in the realm. Good: this will surely develop into the finest and most complete medical service in the world. Critics have put forward the plea that the Government should have introduced, at one and the same time, a comprehensive *health* service. This argument was answered by the Minister of Health by the counterstroke that a complete health service is already in existence, built up by successive generations of local authorities and their medical officers of health. Excellent: now let us see what has happened to this brave structure, and then take a swift glance at its future shape.

The immediate effect of the National Health Service Act is to take away from the local authorities all responsibility for the care of persons who are sick, by the transfer of hospitals of every description to the new regional boards - and the term "hospital" denotes a wide variety of clinical institutions. In the course of time all forms of treatment, including the medical care now undertaken by local education authorities, will be appropriated by general practitioners, when the "health centres" contemplated by the Act have become a reality. These hospital and other clinical services have been, in the past two decades, a staple of interest to medical officers of health, especially in the larger towns. These medical officers of health enjoyed hospital administration, and many of them organised the services transferred under the Local Government Act of 1929 with outstanding success. In addition, a far larger number of less senior health officers have long been accustomed to undertake clinical work on a part-time basis - in hospitals, clinics and schools. This provided a happy variety of interest in a career that pointed ultimately towards pure administration. Under the new régime a number of these medical officers will devote themselves wholly to clinical work and leave the local authority service; others will stay put, casting wistful eyes on their diminishing clinical opportunities; and others, again, will take up the

public health service as their life-work.

What are the prospects for those who practise in the public health services? Most people will admit that the practice of preventive and social medicine must be more closely linked with the medical care of the individual, and that it should, therefore, be in the hands of the family doctor because he is the one person who can regard the family as a unit, and his patient as a member of that family. On the other hand, preventive medicine has a community aspect which is no less important - the prevention of disease and the promotion of health. These wide acres of public health have been cultivated by several generations of faithful medical officers of health, first through sanitary reform, later by means of personal health services for mothers, infants and children, and now more and more by the adoption of new techniques in health education.

The price of a good sanitary environment and the control of pestilence is eternal vigilance on the part of the medical officer of health. The promotion of health in a community - in the home, at work, and at play - demands his constant attention, in co-operation with the sociologist; and education in health needs for its fulfilment a completely new approach, with teacher, psychologist, and health officer in joint harness. In fact, when the prospects of a true health service, relieved of the burden of the medical care of the sick, are properly examined, one is amazed and enchanted by the gleaming horizon. The medical officer of health of the future will be, first and foremost, a teacher. It will be his job to promote health and well-being in the homes, the schools, the factories and other places of work, and the playgrounds of the people. Secondly, he will be a skilled medical adviser of the people, on such matters as clothing, food and nutrition, ways of living, and conditions favourable for growth and nurture. In the third place, the medical officer of health must be like some watcher of the skies - for portents, not merely of epidemic disease, but of anything likely to have an adverse effect on health. For this purpose medical statistics place a most powerful instrument in his hand; if he can but use it wisely. And lastly, the health officer must be an interpreter: it is his job to translate the advances of medical science into terms which a layman can understand, and to express them in a programme of action. He can do much to reduce the time-lag between discovery and its application to

everyday life.

If this picture is true in substance, then how shall we train the medical men and women who choose public health as a career, and what are their prospects when trained? The first essential is to lay a good foundation for any career in public health, and then offer a substantial choice of superstructure for those who wish to follow special interests. The system of basic and elective subjects, now adopted by many teaching schools, affords this degree of flexibility in post-graduate teaching and research. Fortunately, the emphasis on elective subjects varies with each university, so that the prospective student should study the syllabuses of a number of teaching schools before making his choice. Broadly speaking, the basic subjects are sanitary law and administration, medical statistics, epidemiology, and applied physiology (including nutrition). Elective subjects include industrial health, tropical hygiene, parasitology, medical entomology, as well as senior courses in administration, nutrition, statistics, etc. The course for the diploma in public health is no longer a study for a particular job; it is an admirable basis for any form of medical administration, for a career in the personal health services, such as child health, tuberculosis, or venereal disease, and as the gateway to the important new developments in the field of industrial health. The prospects of those who take the D.P.H. course do not stand or fall by the number of vacancies for a medical officer of health; they reach out towards a range of peaks - in industry, in general and hospital administration, and in any career involving administrative experience.

Sources: *The Times*, 17 September 1948, and *The Medical Officer*, 25 September 1948, p. 132.

Notes:

1. Bevan was addressing the annual dinner of the Society of Medical Officers of Health in London on 16 September 1948.

2. The figures for registration with Executive Councils were not altogether reliable owing to double counting, especially occasioned by movement of population.

3. In England and Wales, in the first nine months of the service, 5m persons received sight tests, while 7.5m pairs of spectacles were supplied. The annual rate of expenditure in the first year was £15m compared with an estimated £3.5m. Webster, *Problems*, p. 370.

4. By July 1948 about half of the active dentists had joined the NHS. This figure rose to 95 per cent by the end of 1948, Webster, *Problems*, pp. 124, 358.

XV

EXECUTIVE COUNCILS ASSOCIATION, 7 OCTOBER 1948

"When I received the invitation to address this Conference I responded with alacrity because I am most anxious, certainly in these, the early months of the operation of the National Health Service Act, to meet those people who are mainly responsible for the local administration, and to confer with them in their capacity as shock-absorbers between the general public and the central administration.[1]

"Yesterday afternoon I addressed, for some time, the people responsible for hospital administration, the Governors of the Teaching Hospitals, the chairmen of the Regional Hospital Boards, and the chairmen representatives of the Hospital Management Committees, and this afternoon I am addressing those who are mainly responsible for the General Practitioners' side of the scheme and for the services connected with the Ophthalmic Opticians, and with the dentists and with things of that kind. The third partner in the scheme, the Local Welfare Authorities, have, of course, got their own means of articulation which they are not slow to exercise. It is, therefore, all to the good that the Executives have found it wise to form an Association, of which this is the first annual conference, because unless you can establish effective contact with each other you will have no means of learning from each other's experience, and, what is as important to you, you will have means of effectively checking the behaviour of the central authority because if you have no means of inter-communication he will be the only person who will know what is happening over the whole thing and he will have you at a disadvantage. Speaking on behalf of myself, and, I am sure, future Ministers of Health, we would much rather that you were possessed of a complete picture of what is happening in the country as a whole so that out of your experience you can advise me, than for me to be the sole repository of what is happening over the whole thing. Therefore I say at once that I welcome the formation of the Association,

and indeed, when I spoke here before at the winding-up of the Insurance Committees' Association, I welcomed the suggestion that you should continue in another form.

"I would like, first of all, to express, on behalf of the Government and on behalf of myself, our deep gratitude to the members of the Executive for the devoted work they have been recently doing. We know what an enormous burden has devolved upon you, and if the opening months of the new Service have been accompanied by less friction and difficulty than we at first feared it is very largely because the various bodies that have been established have taken such an enormous burden upon their shoulders. I know how busy you have been, I know how busy the officers have been, I know how busy they are going to be, and therefore I take advantage of this opportunity of saying how grateful we are for what you have done. I have been hard put to it in the last few months to explain to visitors from other parts of the world the set-up of the National Health Service in this country, because they have a habit of referring to it colloquially as "nationalised medicine." This is a phrase I don't like at all because it has nothing to do with the facts, and when I try to explain that the administration of this great organisation is reposed in the hands of voluntary people they just cannot understand it. And I can understand their bewilderment, because I doubt very much whether there is any nation in the world with so large a body of experienced and dedicated voluntary workers as we have in this country. We have long experience of the administration of social services of various kinds and we have been able to call upon that experience not only in shaping, not only in the structure, but in the administration of the Service when it came into existence. Indeed, one of my chief embarrassments in the last year has not been to find people to come forward to do this work, but to select from out of a large number who were ready to do it. Many good people have been disappointed that their services have not been called upon. So we have in this country not a dearth but a plethora of individuals who are willing and able to carry out work of this kind.

"I believe that it will be universally agreed that so far things have gone reasonably smoothly. The service has been enthusiastically received by the vast mass of the population. Of course, some things have gone wrong - not much - but they have gone a bit wrong. The

difficulties that we anticipated have not been realised and those that we never anticipated happened, but, of course, we must always expect the unexpected.

"There has been a very considerable rush for some of the facilities that we are able to provide. It seems to me that a most extraordinary proportion of the population has got bad sight. I had never anticipated that we would have such a rush for the services of the Ophthalmic Opticians as we have had, and I note that there are some people writing for the newspapers who have been very cynical about this fact, although, as I have said before, why the newspapers should complain I do not know, unless it is that they are discovering a new industry I have never seen in them up to now.

"But it is undoubtedly a fact that a large number of people are making use of the free service and for a while we shall have a great rush, but I am fortified in my belief that what we are doing is worth while when I reflect upon the very large number of sick, and especially of old people, who are now having their eyes properly seen to for the first time.[2] I know of a case of an old lady of 98 years of age who went for her spectacles in the normal way and got them quite easily and now she is over-joyed. So simple and efficient is the service with which you are provided.

"I am bound to admit that the rush for spectacles has been so great that it has exceeded our productive capacity, and therefore we can expect, in some respects, a little delay.

"The general mass of the population have signed up with their doctors to a degree which is extremely satisfactory. Over 90 per cent. of the population has already signed up with a local General Practitioner, and the figures are being added to day by day, and I confidently expect that by the end of the year virtually one hundred per cent. of the population will be in.[3] This is remarkable, having regard to the fact that, of course, signing is not compulsory, although some people may think it is, because there are still large numbers of people who confuse the Health Act with the National Insurance Act and who believe that the benefits of the Health Act are in respect of insurance contributions, when we, of course, know that is not the case, and that the expenses of the Health Act are borne by the Exchequer as a whole and do not fall upon the Insurance funds. Furthermore, having regard to the heated controversies which

appear to be inseparable from any reform of the Health Services, it is extremely gratifying to know that practically all the active General Practitioners in the country have joined the Service. The last figure I had was 18,165, and this after we have made every single effort to weed out figures of duplication.[4] As I said earlier, of the population of about 42.5 millions about 90 per cent. have signed up. The number of dentists taking part in the Service is growing; they are now over 80 per cent. I know that in some quarters these figures are not accepted, but I can assure them that these are the facts: 8,039 dentists out of a possible 10,000 - and more of them are joining up day by day as the benefits of the Service become known to the members of the profession.[5] At first, of course, we are all aware that the dentists were not kindly disposed towards the scheme, and there was some difficulty in obtaining the co-operation of one or two of their organisations, but I am happy to say that the dentists themselves are now sufficiently appreciating the benefits of the scheme as to join up. Up to the 17th September, a little over two months after the scheme had started, the Dental Estimates Board had received over one million Dental Estimates Forms for the first time for authoritative payment, and some for prior approval. In that short time, in other words, over one million people had had treatment under the scheme.

"The number of prescriptions dispensed is phenomenal. It is at a rate approximately twice that of the National Insurance Scheme. If this is maintained it will mean that 140 million or 150 million prescriptions a year will be dispensed under the Service. Many chemists, as a result, are adding to their dispensing facilities with the help we are giving them for building licences.[6]

"I need hardly tell you that the work of the Executive Councils touches the population most intimately. Every man, woman and child in the population will at some time or another establish contact with the Executive Council and with its officers. Therefore, it is of the utmost importance that the efficiency of the executive machinery should be maintained at the highest level. We were fortunate in the fact that we were able to obtain from the officials of the old Insurance Committees, a very fine staff to start us off.

"We started off this Service on July 5th with all the resources that we had at our disposal before July 5th. We had not any more.

There were some who said, 'Why don't you postpone the date until you have got all the resources that you need?' and I answered by saying, 'What are all the resources we need?' because what we need in the Health Service is anybody's guess. It depends on what society is prepared to lay aside for that purpose. It depends on the actual technical resources of the medical profession. It depends upon our physical resources in the way of buildings. I was satisfied that if we had postponed the starting of the Health Act to some mythical date when we would have at our disposal all the resources about which nobody could agree we would never start at all.

"But, nevertheless, one very great revolution did start on July 5th, and that was, that whatever we have got to give, those who needed them most got them without respect of income. That was the first important revolution, and as time goes on we will be able to add to our resources, to refine our machinery, to simplify our administration, and therefore to improve what we are doing a very great deal.

"Now the Executive Council, because it is the administrative body responsible for the General Practitioners' Service and for the Ophthalmic Opticians and Dentists and Chemists has a very important function to perform in raising and retaining the highest standard of ethical conduct amongst these professions. I have been exhorting the general public in the last few weeks to make use of this National Health Service prudently, intelligently and morally, because if too great a strain is placed upon it at the beginning it might break down, and because things are free is no reason why people should abuse their opportunity. This is a very great test of the maturity of the British people - that we put at their disposal, insofar as they are available, all the resources of the medical profession without charge, and if the people abuse it, if those who don't really need it demand it, then they will be merely standing in the way of those who need it more. And so we should, in all our separate places, with all the contacts that we have at our disposal, exhort people to use this thing as though it were their own - because it is in fact their own - and that when any individual abuses it he must reckon with the sum total of abuse, which might add up to a sum very grievous to carry and very difficult to continue to provide.

"If we say this to the general mass of the population it is equally true of the professions themselves. The General Practitioner has a

very great responsibility. Over-prescribing can be as bad as under-prescribing. Those of us who have had experience of the administration of a National Health Insurance Scheme will know that some General Practitioners are very conscious of the impressiveness of long lists in prescriptions on the psychology of the patient. If they wish to impress the patient with the fact that they are having a very good bottle of medicine merely by the number of items in it, if it is merely psychological results they are after, I hope they are going to give very cheap prescriptions in that respect.

"We do not want to interfere, on the contrary, we want the General Practitioner to prescribe what he considers necessary for his patient and to put nothing at all in his way, but we do want to impress upon him that it is not a good thing to evoke merely psychological response from the patient by the prescribing of expensive drugs. The same thing is true about the general conduct of the General Practitioner. There are the local committees that consist of representatives of the professions and of the Executive Councils, who are concerned with the general conduct of the professions in their local behaviour, and we hope that these committees will realise their responsibilities because, although it might be a cliché I would like to say it, the Health Act has not come into existence for the sake of the doctor or of the Ophthalmic Optician or of the dentist or of the chemist, but it has come into existence for the benefit of the patient. The professions are able to organise pressure groups of various kinds, and to make their demands articulate, but the general mass of the patients has to depend upon you, and has to depend upon the House of Commons, and has to depend upon the Ministers for the safeguard of their position. Therefore, the highest possible standards of ethical conduct must be demanded from the professions concerned in the administration of the Health Act. It is far, far better to start off being strict and later on to be lenient than to start off being lenient and then try to be strict, because it is much more difficult to weed out bad practices than to prevent them from arising, and therefore we look to the Executive Councils and to the disciplinary machinery that has been set up under the Regulation to try and improve the administration as much as possible.

"Now I know there are some instances where the shoe pinches, I may be told, for example, that the conditions of service for the

staffs of Executive Councils ought to be looked at. I know, but there is the Whitley machinery for that purpose. There is plenty of machinery available now under the Health Act for every section concerned to have its point of view stated. There is no reason why Conferences of this sort should be used for that purpose, because they have got agencies at their disposal through which they can express themselves, and we shall not look unsympathetically at any reasonable claims that are put forward, but, of course, we must always keep a balance between the claims of one section and the claims of another.

"I know also that there have been some complaints about the delay in payments, and I hope that you will look at this immediately so as to try and make payments as promptly as possible, and certainly as promptly as your machinery will permit, because there are many professional people who are accustomed to receiving payment at the time the operation was performed and have now to wait a little longer for their bills to be paid.

"We have made, on the whole, as I said earlier, a very good start, but we have yet a long way to go, and I would like to conclude by impressing upon all of us, not only those who are here but those who might read what I say outside, our collective responsibility for the administration of this great Service. It is, I think, correct to say that what we are doing is now being watched by the whole world. This is the biggest single experiment in social service that the world has ever seen undertaken. It is, I think, a great tribute to the vitality and the genius of the British people that we are able to undertake a task of this complexity and magnitude within three years of the end of a great war. It shows that the British people have still got the principles of innovation, and renovation, running through them yet, and that we can pioneer in many directions for the rest of the world to follow. But if we are able to start these things we are being watched as they develop, and the rest of the world will decide whether they are going to imitate us by the extent to which we make a success of what we are doing.

"As I said at the beginning, we are having visiting us now from different countries people who are watching what we are doing, and therefore we have a responsibility not only to the patients, not only to the British nation, but a responsibility to the other nations who are

looking to us to set them a good example.

"Therefore, I wish your Association every success. I thank you for the co-operation you have already given; I implore you to continue it and even to increase it, so that in a few years' time we shall be able to look back upon a good job well done, and be able to hand down to future generations the best instrument of social welfare that the genius of mankind has yet been able to devise."

Source: Executive Councils Association (England) National Health Service, *Record of Proceedings at the First Annual Meeting, October 7th and 8th, 1948* (Preston, Executive Councils Association, 1948).

Notes:

1. Bevan was addressing representatives of the Executive Councils Association in the Hall of British Medical Association House on 7 October 1948. He was introduced by the Chairman, Mr. F.T. West.
2. See above, XIV, n. 3.
3. See above, XIV, n. 2.
4. There were in 1948 about 17,600 general practitioners in England and Wales, and 19,600 in Great Britain. Bevan was perhaps giving a figure for England and Wales, which is therefore something of an overestimate. Webster, *Problems*, p. 122.
5. See above, XIV, n.4.
6. The original Estimate for the part year 1948/49 for the pharmaceutical service was £11.5m. The outcome was £17.5m. The cost of the pharmaceutical service doubled in the first full year of the service, 1949-50. Webster, *Problems*, pp. 222-3.

XVI

HOUSE OF COMMONS, 17 FEBRUARY 1949

I think I am entitled to start off what I want to say by a protest,[1] and that is a protest against the absence of the Leader of the Opposition.[2] There is no obligation on the part of the Prime Minister to be here. Anyone who has been present during the Debate - and a very large number of hon. Members opposite have not been - will know by now that, while the Opposition is in need of the sustenance that may be afforded by the Leader of the Opposition, I am in no need of the support of the Prime Minister.

We really have reached the point where we should ask the Opposition to try to prevent the Leader of the Opposition from so grossly misbehaving himself as he does on many occasions. Last week he made a statement, and as usual - it has become so much the practice now that we have noticed it - he was egged on by the Conservative press in blatant, provocative, sensational headlines about extravagance in the Health Service. He came down to the House and said that these Supplementary Estimates are indications of extravagant expenditure and maladministration. He then said, "We will examine them" - having declared the verdict first. If he had used that language after having had the three days' Debate on the Estimates, there would have been some sense in it. But he told us today that he will consider at the end of the examination whether a Vote of Censure will be moved on us.

If indeed it is the case that this Supplementary Estimate is evidence of gross mismanagement and financial maladministration, then there is no need for the Debate, because the decision has been made by the Opposition. He said it at the very beginning. Whatever the Opposition may do about a Vote of Censure when the three days' Debate on the Supplementary Estimates is over, I am entitled to ask for a verdict on the Supplementary Estimate tonight. Obviously, after being asked for a Debate, and after being asked for it in so provocative a manner, the House and the country are entitled to receive a verdict as to what is the opinion of the Members of the

House upon what has been done. Therefore, I hope that the Opposition, after I have sat down and if I have not convinced them of the error of their ways, will go into the Division Lobby against the Government.

The right hon. Gentleman the Member for the City of London[3] accused me of having miscalculated through incompetence. He was out of the Chamber when the hon. Member for South Hendon[4] accused me of having deliberately provoked a Supplementary Estimate by Machiavellian cleverness in order to put the Opposition to the embarrassment of having to decide whether or not they would vote against it. I am not sure, therefore, whether I am to answer to a charge of duplicity or of ignorance - but I cannot be guilty of both. The trouble with the right hon. Gentleman, may I say with all respect, is that he has generally a most amiable presence, but it is always a foolish spectacle for a weak man to use strong adjectives. It is certainly foolish for him, because it creates a sense of melodramatic anti-climax to wind up so pathetic a speech by the kind of peroration that is usually reserved only for highly dramatic moments.

I say with all sincerity that I regret the atmosphere in which the Debate on this Supplementary Estimate was begun by the Opposition. The House of Commons - and I am not now speaking of any particular part of the House - ought not to allow Supplementary Estimates to go by without examination. That is the duty of the House of Commons. Indeed what I object to is not that a Debate has been requested. What I object to is the utter incompetence of the Opposition in the examination of a Supplementary Estimate and, what is much more serious - and I hope the country will take notice of it - the indifference of the Opposition. The benches opposite have been empty, or almost empty, all the evening. I have here a long list which was taken every quarter of an hour of the attendance of hon. Gentlemen opposite. I have the advantage that my Parliamentary Private Secretary counted the number present. He takes an interest in this matter. These are extracts: Conservative, 19, Liberal, 2, Labour, 72; Conservative, 35, Labour, 57. I regret to say that for a considerable period the Liberal Benches were a complete blank.[5] I am not complaining about the number of Conservative hon. Members present now. I was discussing the numbers present throughout the evening, and I say that, in view of the highly sensational way in

which this Debate was launched, the absence of hon. Members of the Opposition this evening is a disgrace to the House of Commons.

It has been difficult to find out from the Opposition what it is that the Minister of Health is accused of, on this Supplementary Estimate. Is it that the Opposition say that they do not mind that the money has been spent, but that there was a miscalculation? Is it the arithmetic that they quarrel about, or the policy? It has been hard to find out what they are complaining about. Are they saying that it would have been all right to have spent this money in this way if it had gone in the original Estimate, or is it that they object to the spending of the money at all? It is very necessary for us to know which of these two positions is being taken up by the Opposition.

If it is that this represents a grave miscalculation, there was no need for this Debate to proceed after what I thought - and I think most hon. Members will agree - was the very excellent opening speech of the Parliamentary Secretary. The Parliamentary Secretary broke the Supplementary Estimate into its constituent parts, and showed, one by one, how the additional expenditure arose. There was one part of his speech to which no attention has been given, and that was that, when we put in the Estimate seven months before the money started to be spent, I was still in negotiation with practically all the professions, with the chemists, with the dentists, with the ophthalmic opticians and with the British Medical Association, negotiations with whom had not then ceased. Further, the Spens Committee on specialist remuneration had not reported. All these negotiations were proceeding, but it was necessary, because of the financial procedure of the House of Commons, to put an Estimate in.

How was I to know at that stage what would be the outcome of these negotiations? I want the Committee to recollect this point, because it is a very serious matter. When Ministers, whoever they may be, are in negotiation with sections of the community, it is a very serious matter if a Minister in the middle of those negotiations is subjected to pressure lobbies and log-rolling by the sections concerned. He is engaged, or should be engaged, in defending the public interest against the sectional interest with which he is negotiating.[6]

The hon. Member really should go back to his school days. It is therefore vital, if the public interest is to be properly protected, that

he should not disclose his hand. Suppose I put into the Estimates assumptions that could have formed the basis of a negotiation by those professions, I should immediately have been helpless. If these figures of dental expenditure and if these figures of expenditure on the ophthalmic opticians and the chemists had been put into the Estimates by me, my negotiations would have been hopelessly destroyed from the very beginning. It was absolutely essential not to do so. I think every man who has had any experience of negotiations knows very well that if they could read in the Estimates what I estimated I was going to spend upon those services they would know at once what to ask for and what to expect. It is essential, therefore, that in such circumstances the Minister of the Crown, whoever he might be, whatever party he represents, should be able to - did the right hon. Gentleman say "deceive the House"?[7]

How on earth could I deceive the House when I did not know what the figures were going to be? All I could do was to put in figures based upon the past basis of remuneration. How on earth could I? If I had put in figures based upon a prospective settlement, that itself would have vitiated the negotiations. And these are the people who call themselves competent administrators! The fact is that we had to wait. For instance, there is a Whitley machinery established now, and before the Whitley machinery there is an application from the nurses for an increase in salary. I do not know what may happen to those negotiations. I do say now, however, at this moment, that I do know that a slight increase in nurses' salaries is essential. I know that. I do not know how much. Therefore, when I put my Estimates in I have to put them in based upon past remuneration and if, in the meantime, in between the Estimate being presented to the House of Commons and the Vote being spent, there is an increase, there must be a Supplementary Estimate unless there is a fall in expenditure in some other place. That is not the consequence of any maladministration. These are the ordinary accompaniments of our constitutional practice for making up our Budget. It is therefore really quite foolish for hon. Members opposite to adopt the line they have adopted and to suggest either that false figures were put into the Estimates or that any miscalculations have occurred. I am astonished at the line some hon. Members have taken.

The fact is that I consider, without I think much immodesty, that

the launching of the National Health Service has been one of the greatest pieces of civil administration in the history of all civil Government in peace time, and what shocked me last Thursday was the frivolous irresponsibility of the behaviour of the Opposition, and especially of the Leader of the Opposition in saying what he did, because this hospital administration and health administration is carried on in this country by 11,000 devoted volunteers drawn from all parties in the State. What the Opposition were actually doing was accusing all those bodies of maladministration.[8] The hon. Member for Denbigh,[9] who could not give us factual evidence, charged one hospital with maladministration. I cannot even get the name of the hospital from him. It may be that when I find the name, the majority of the members of the management committee may conceivably be members of the Conservative Party. These bodies responsible for the administration of the Health Service over the last year have given more selfless dedicated service in bringing this great scheme into operation than has ever been known in the history of peace-time government.

What we should have had from the Opposition is some commendation of the work of these men and women, and not, as we have had from them, the suggestion that in nine months already evidence of maladministration and financial irresponsibility has arisen from the administration of the hospital services. I think it is a little hard; indeed, one of the reasons why the Opposition are now running away is because they have already found out that what the Leader of the Opposition said last Thursday is almost as unpopular among Conservatives in the country as it is among Socialists.

Furthermore, the Opposition are in a greater difficulty, because as time goes by it will be necessary for us to evolve inside the administration of the Ministry of Health and inside the whole health service proper principles of administration such as those referred to in what I thought was the most thoughtful speech that came from the Opposition; I refer to the speech of the hon. Member for Chippenham,[10] who put this whole matter in its proper perspective. Nobody suggests that the hospital authorities should be permitted to spend whatever amounts of money they like. The service has got to be in operation at least one year before there are any comparative statistics available to show which particular management committee is not

behaving itself properly.

As I understand and envisage the operation of the administration of the hospital system of the future, it will go something like this: we shall have global budgets determined for the regional hospital boards and the management committees of hospitals. Those global budgets will be worked out on principles with which hospital administrators are already quite familiar. Within those global budgets the management committees will have discretion to spend what they wish on this or that item of administration. If they spend more on one, they spend less on another. What would be undesirable would be if no management committee or board of governors could repair a pane of glass without first of all having the consent of the administration, because there bureaucracy would arise.

What we are trying to do is to work out a system of resilient administration with as little bureaucracy as possible, with as much local self-government as possible, and yet at the same time protect the public purse against extravagant administration. I believe we shall do it. In fact, I am convinced we shall do it. We shall show the world how we can centralise financial responsibility and decentralise day-to-day administration in a great service of this sort. I seriously suggest to hon. Members that it is not possible until we have, first of all, at least one year's experience behind us. That is the main answer to the charges made by hon. Members opposite who are so anxious to denigrate the Health Service.

Let them read the newspapers of the last fortnight or three weeks - the newspapers that support the party opposite. Their leading articles have been full of it. There was the case of the "Evening Standard" tonight. All their newspapers have been full of this misrepresentation, and, therefore, I at once give the hon. Member for Chippenham his reply. That is how we conceive that the hospital administration of the future is going to work. That does not mean, of course, that where a hospital management committee is spending money extravagantly on a particular item and is neglecting its duty to the patients, it will be permitted to keep on with that neglect merely because it is not spending more money than the total. It will still be necessary for the central administration to protect the patient against the misbehaviour of any management committee or regional hospital board.

But what we have to do is to try to prevent the very thing we are charged by hon. Members opposite with having done - having a great bureaucracy. The fact is - it is a fact which other nations of the world cannot understand, and we ought to italicise it here because it is something of which we should be very proud - that the National Health Service is not administered by bureaucratic officials; it is administered, as I have said, by 10,000 or 11,000 volunteers of the various executive committees involved. What has been a source of intense pleasure to me is that I have never had any difficulty at all in getting volunteers. I have always had very many more than I could make proper use of.[11] We need not argue that. It is also common ground, and has been for some time, that the voluntary hospital system was financially failing. Indeed, ever since - the hon. Member should really learn the facts of life before he speaks - I took office in 1945 we have been making grants to voluntary hospitals in order to keep them alive.[12] We had this all out when the Bill was before the House. The amount of money we are finding with which to keep the voluntary hospitals, vastly exceeds all the money in their Endowment Fund. Once again, the hon. Member does not know what he is talking about. If he wishes to have the figures, and if he puts down a Question for that purpose, I will give him the figures, and then on this matter he will be for ever silent.

One of the items of expenditure which has produced this Supplementary Estimate was the increase in the remuneration of student nurses. I was asked by the right hon. Gentleman how many hospital beds would be brought into use by this expenditure. How can I tell? I cannot tell until I know what the wastage is going to be, and what is going to be the effect of increased pay on student nurses. I cannot tell what is going to be the effect on recruitment in the nursing field of having raised the standard of remuneration of domestic staff. But I want to point out to the Opposition that this is a profession in which we were having great difficulty to recruit girls because of the bad way they had been treated by the Opposition. It is a matter of pleasure that the Parliamentary Secretary has been able to announce that not only have we reversed the tendencies of the last 10 years or so, but in the course of last year we have actually added 6,000 to the number of nursing staff.[13] Of course we are not using all the beds that we have in our institutions, but if this

increase had begun earlier these beds would now be occupied by patients.[14] I suggest that the Opposition should organise a little school and take some of their back benchers into that school. I have already informed the hon. Gentleman that there are many more hospital beds in existence today than there were before the war. There are many more beds occupied than before the war, but the need is very much greater now than it was before the war, and that accounts for the fact that some beds are still empty.[15] It is because in London it was the practice to take all the interesting cases into the teaching hospitals and the chronic sick into the L.C.C. hospitals. As the hon. Gentleman wishes to be taught, I will give him another answer. It is this: the teaching hospitals of London have, for reasons obvious to everybody, always been more attractive to nurses and, therefore, it was very much more difficult to get nurses in the local government hospitals. Those two facts combined resulted in what the hon. Gentleman has described, and that is why the committees responsible for reorganising the hospitals have insisted that the teaching hospitals should take their proper proportion of the chronic sick. If there are any more questions, I shall be delighted to answer them.

It was obviously impossible for us to know to what extent spectacles and dental operations would be required. I have been accused of not having made use of the statistical information that was available, but there was no statistical information available. The National Health Insurance statistics have not been of any use since 1939. How did we know what was going to be the demand? But I will point out to hon. Members that, both in this field and in many other fields, whenever we have been able to relieve in any way the burden of suffering of the people of Great Britain, the burden has always proved to have been heavier than we ever thought it would be.

The same thing is true in the housing field; the same is true of pensions. It is an unhappy fact that past conditions concealed a vast amount of inarticulate misery and pain. As these great services come into operation that darkness is now moving into twilight; and before very long will move into the light of day, and we shall see exactly what it is. In so far as these figures represent relief of genuine need, everybody ought to be proud of them; but in so far as it is suggested that they represent abuse, point out where the abuse

is. If there is abuse, let us co-operate in getting rid of it. But first identify the abuse, and do not merely make generalisations that smear the whole service.

Although the newspapers and hon. Members' letters are full of complaints from this or that person about this or that doctor, dentist, optician or hospital, I would remind hon. Members that only malice is news. Remember the vast majority of people who are really satisfied with the service but never mention it at all. This service was not launched in harmonious circumstances. In fact, no medical service in the world has ever been launched in harmonious circumstances. As our example here is followed by other nations - and they will follow it - we shall read of the difficulties that other Ministers of Health will be going through; and I venture to suggest that it may be that even the Conservative Party will have a few fleeting moments of pride about their Ministers of Health, because they will find that those other Ministers of Health might not be able to get this great scheme into operation so easily.

I could, of course, have emerged from this examination perfectly clear of any charges of arithmetical inexactitude. All I need to have done was to have failed as an administrator to have emerged successfully as an arithmetician. And why? Who suspected before 5th July last that in six months, before the end of 1948, these figures would have emerged? Who would have said that we would have in the service many more general practitioners than we ourselves thought would have come in? Who would have suspected that 95 per cent. of the population would have registered with general practitioners by the end of the year?[16] Who would have said that by now even in the most obdurate of all the professions - I do not want to make too strong a statement - the profession whose ethical standards as a profession are not as high as they might be, the dental profession, we should have got 92 per cent. of the dentists in?[17] As these people came into the service, naturally the expenditure went up. But that mounting expenditure was an expression of an administrative success, because if they had not come in I would not have had a deficit: I would have had a surplus, and I would then be praised by the Opposition for being a financial success and a failure as Minister of Health. It is just because all these services expanded so quickly, so harmoniously, and so fruitfully that we find ourselves

with this deficit.

Although this financial burden is great, we must nevertheless set off against it the enormous sum of misery we have already alleviated, the general hopes we have already created, and the good health that already starts to flow from what we have done. Why do not right hon. and hon. Gentlemen opposite start ceasing to be so sour? Why is it that as the health of the population goes up, their spirit goes down? The Tory Party used to represent itself as a jocund party.[18] They do not understand now. I will give them a clue: "How jocund did they drive their teams afield." However, that has all gone now. Pale and miserable lot, instead of welcoming every increase in the health of the nation, the buoyancy of the nation and the vitality of the nation, they groan at it. They hate it because they think it spells electoral defeat.

I have sympathised with hon. Members opposite this evening because they have had a really difficult task. They began by attacking this scheme. Especially in 1947, their hopes were raised because they thought that the economic difficulties into which the country was getting over the balance of payments would result in the jettisoning of the health scheme. Right hon. and hon. Gentlemen opposite have spent most of their time saying how much they approved of the health scheme. I am perfectly entitled to rejoin by saying how much they tried to stop its birth. They always hoped that it would be shipwrecked on the initial difficulties of launching. Indeed, not only did they hope that, but they connived at it.

We have only to go back to 1947 and 1948 to see what the Conservative newspapers were doing and how the Tories were conspiring with some of the most reactionary elements in the medical profession at that time. Mark this, they voted against the Second Reading and they voted against the Third Reading. It is a convention of Parliamentary practice that if one votes against the Bill on Third Reading, one objects to it in principle. One very rarely votes against a Bill on Third Reading if one does not object to the Bill root and branch. That is what hon. Members opposite did. As the scheme has gone on and grown in popularity, they have been trying to forget that dreadful past and they are trying to pretend that they were for it all the time. The Conservative Party has always been in favour of reform in the abstract and against every reform in particular, and

exactly the same thing has happened on this occasion.

Later on, when we had negotiations with the dentists and the other professions, we met with hostility. I met with pressure in the House, and every Thursday I was pressed as to why I did not come to an agreement with the dentists and why I did not come to an agreement with the doctors. Instead of supporting Ministers in the negotiations with the professions, the Conservative Party organised itself into a series of pressure lobbies in the Press, pressure lobbies all over the country against every single thing. What they are now saying to the country is, "We were never against it. It is quite true that we voted against it, it is quite true that we agitated against it, it is quite true that we plotted against it, but we were really in favour of it all the time." They say, "You must not read our intentions from what we have said, because we really mean the opposite of what we are doing." Therefore, when the Conservative Party tells the country to vote against us, they do not really mean it, they mean that the country should vote for us.

Really hon. Members opposite ought not to have started this Debate. I say that as this great scheme unfolds itself, it will be necessary for anybody who occupies this position to have the support of the House of Commons in seeing to it that the money which is spent upon the health services is spent where it is intended the best good should be done, and that is not upon doctors. That is for the hon. Member for Denbigh, too, because the hon. Member was organising himself into a small pressure lobby for the doctors.[19]

I say it is necessary that the money be not spent upon the most articulate members of the community who might be the chemists, the doctors, the dentists or the ophthalmic opticians, or it might be even the health workers, because each one of these sections is highly organised and is able to bring pressure to bear upon Parliament and upon Ministers. As the hon. Member for Chippenham said, inevitably there is only a limited amount of money to be spent at any time on all our social services. Therefore, I say in all seriousness - because this I think we share with the Opposition - if it is spent prodigally in one direction, it is not there for another. I am anxious that the money be not spent on the persons who can organise themselves into loud pressure lobbies, and get their columns in the Press, but on the patients who have to make use of this Service.

I end by saying that I welcome the discussion which has taken place. I believe it has shown the hypocrisy of the Opposition. I believe it has shown the soundness of the Service. The best thing the Opposition can do is to resign its position, or admit it is wrong, or walk into the Lobby and vote against the Estimate.

Source: House of Commons Debates, vol. 461, cols. 1448-61, 17 February 1949.

Notes:

1. Bevan was defending a Supplementary Estimate of £52.8m for the part year 1948/49. Webster, *Problems*, p. 137.
2. Hon. Members: "Where is the Prime Minister?"
3. R. Assheton, Conservative M.P., City of London.
4. Sir H.V.H.D. Lucas-Tooth, Conservative M.P., Hendon South.
5. Morris-Jones and Brigadier H.R. Mackeson, Conservative M.P., Hythe, protested about Bevan's categories and tactics.
6. Col. A.D. Dodds-Parker, Conservative M.P., Banbury, "what about the second front now?".
7. Assheton accused Bevan of deception.
8. Hon. Members: "No".
9. Morris-Jones.
10. D.M. Eccles, Conservative M.P., Chippenham.
11. C. Osborne, Conservative M.P., Louth, pointed out that these volunteers had previously worked in the voluntary hospitals.
12. D.L.M. Renton, National Liberal M.P., Huntingdon, attacked Bevan for taking over the assets and endowments of voluntary hospitals.
13. Osborne claimed that beds were being used wastefully.
14. Osborne interjected: "60,000 empty beds".
15. H.N. Linstead, Conservative M.P., Putney, asked why the socialist London County Council had such severe problems in recruiting nurses.

16. See above, XIV, n.2.
17. See above, XIV, n.4.
18. Hon. Members: "What?".
19. Morris-Jones accused Bevan of inaccuracies.

XVII

HOUSE OF COMMONS, 9 DECEMBER 1949

It may perhaps be for the convenience of the House if I speak at this stage, because the speeches - and I make no complaint about it - have tended to repeat themselves. Hon. Members are, of course, speaking under difficulties. They are difficulties that are inherent in the proposal to take powers to do something, when what is intended to be done is not in fact before the House. This is always the case in every Statute where it is found necessary to take power to make regulations of a detailed character. Everybody, I think, who has experience of this matter will agree that we have found it almost impossible to escape that necessity.

I know that the hon. Member for Northern Dorset[1] has expressed, as I have done on many occasions when sitting on the back benches, deep distrust of conferring on a Minister the power to make regulations which would not be subject to amendment. In the course of this Parliament, we have altered that procedure in one or two instances in order that there might be an instrument of discussion rather less restrictive than merely a discussion on a Prayer to annul a regulation. Therefore, I sympathise wholeheartedly with those who say: "Here we are giving this power blindly, and we do not know how it is going to be used."

I have been asked a number of questions as to how I propose to use this power. I say frankly that if I could give the answer there is no excuse for my not having had the regulation ready. I do not myself yet know all the answers. Before this can be made into a practical scheme, it will have to be discussed with representatives of chemists and doctors to see how it is to be worked out.

The proposal to have a charge up to 1s. creates no administrative difficulty at all. The administrative difficulties arise out of the necessity of exemption. I am not myself displeased that we have had this discussion this morning. I am not displeased that hon. Members have been brought up against the administrative difficulties of carrying out principles which many people have so glibly proposed.

We have had, in the course of the last year, a large number of allegedly erudite letters written by professional men and journalists in the daily newspapers advocating charges of various kinds on the National Health Service and pointing out how large sums of money could be saved if these charges were made. All the time they have assumed that there is an economy in transferring a charge from the State to the individual. That in itself is not an economy at all. I am not suggesting that it is. It is not an economy merely to transfer a charge; a proper economy is a more efficient way of giving the service. I have read some of these letters and communications with a good deal of quiet pleasure because I knew that the time would come when the legislature would be faced with the working out of some of these principles.

The same problem arises on the next Amendment, although in that case it will be rather easier when we are asked to distinguish between foreigners and our own nationals. We have had that argument raised, and the newspapers supporting the Opposition have been carrying headlines for almost 15 months on this particular matter. When we come to make a distinction and go from the easy realm of abstract principle to that of practical discrimination, all kinds of administrative problems arise. I can quite see that, in some instances, the cost of administration would exceed the economy, so I am not at variance with a good deal of what has been said this morning.

I want to answer the charge that this proposal was only made in consequence of a demand for economy. If that were the case, how do hon. Members who have made that charge explain that these are powers only to deal with the pharmaceutical services? If indeed the Government wanted to take power to make a charge to the citizens for the use of the Health Service, then we would have general power for making a charge. We have not done that. What we have done is to say that we want to take power to make a charge in respect of the pharmaceutical service alone. Why have we done that? This is a complete answer to the hon. Member for Thurrock.[2] It is because our experience has gone to show that it was this very vital part of the service in which the general practitioner was most involved and where the greatest load had fallen, and that the service was inclined in some respect not to give the standard of service we wanted from

it. It is quite incorrect to say that it was the purely financial aspect of this matter that weighed most with me when I accepted this tentative proposal. In fact the exaggeration we have had this morning -[3] I am bound to say that my hon. Friend is an innocent Parliamentarian if he imagines for a single moment that any Minister is going to stand at this Box and give a detailed description of the internal communications that take place between the members of the Cabinet and himself; he really is more than ingenuous. There is a principle of collective Cabinet responsibility.

What I am saying is that on the face of it the proposal does not bear out the sinister interpretation placed upon it by the hon. Member for Thurrock, because we are in fact confining the power to make regulations to withholding free sales up to a certain amount - not to impose a charge. This is not a power to impose a charge. This is to restrict the free service on the pharmaceutical side up to 1s.[4]

Let us look at the actual facts. It is not the National Health Service that would be making a charge to the patient. It is the National Health Service that would be saying to the patient: "Where a doctor has given you a prescription that costs more than a shilling, the National Health Service will pay the cost above a shilling, but up to the shilling you will pay." We could quite as easily restrict the new service in another direction.

Nor it is true to say, as the right hon. and gallant Member for the Scottish Universities[5] said, that we are putting the National Health Service contributor in a worse position than he has been in since the beginning of the National Health Service Act. That is not true. What is actually happening at the present time is that the National Health Service is giving him a far wider range of services than he had under the National Health Insurance Act; therefore, even if this were imposed, what would be left to the National Health contributor would be a far wider range of service than was ever available before.

What is true is that in certain cases where the National Insurance contributor is having his bottle of medicine free, he will now have to pay up to 1s. for it. All the rest of the service which he gets is infinitely more valuable than that "bob," and he will have a far greater service than before. If he had to choose between the two, ask him which he would prefer.[6]

We have had the experience, as I said earlier, that it is on this

particular side of the service that the greatest burden has fallen. In those circumstances, we had to ask how that burden could be mitigated, and we came to the conclusion that if we could in some way reduce the queues at the surgeries and the unnecessary expenditure at the chemists' shops, it would be a good thing.

It is not correct to say it is only on the side of bottled medicine that some of the abuse has taken place - it is aspirins, bandages, and so forth, costing less than a 1s., which in a large number of cases could have been purchased by the patient without having to call on the general practitioner, or without making a second call on a doctor for a prescription. That is where the abuse arises. It is no use my hon. Friends telling me that this is not the case, because this proposal has not, in fact, been received with much indignation, as it is generally accepted that there is an awareness of the abuse which has been taking place.[7]

If my hon. Friend can tell me how to visit it on the doctor, I will gladly consider the position, but we must presume, until it is proved to the contrary, that it is not in the interests of the patient to have too many prescriptions. We cannot go beyond that at the moment. We do know, however, on the purely subjective side, that this proposal would have met with far greater indignation had there not been this awareness of abuse. We thought, therefore, it would give rise to easement on the general practitioner's side in the early stages of this scheme. I am not suggesting that this ought to be a permanent feature of the National Health Service.

My hon. Friends need not be apprehensive about this matter, because I am as deeply concerned with maintaining the Socialist approach to this service as any one on this side of the House. Therefore, as far as I am concerned, this is put forward only for the purpose of a temporary easement, if it be practicable, and there will then be a residual financial advantage, the extent of which no one knows, because we do not yet know what the exemptions will be. What is practically certain is that the figure of £10 million was based on the assumption that there would be no exemptions, and that any exemptions will reduce that amount, although to what extent no one knows at the moment. All I can say is that the House will have an opportunity of discussing the regulations before they are put into effect.[8]

It is impossible to have the regulations in a form in which Amendments can be made. I want the House to be quite clear about this. These are not the only regulations which are made under a Statute. A whole series of regulations concerning the assistance board have been made, and there is no reason why these regulations should be in a different position from those regulations which are infinitely more important. I see no reason why we should have an extra-Parliamentary procedure for what amounts to a very small aspect indeed of the whole administration.

A lot of exaggeration has gone on that is not revealed in comparison with the figures involved. We are speaking here of a service involving £340 million a year, of which this figure of £10 million is but a small proportion. We must keep our sense of proportion, because we shall then see that what we are considering is not a considerable retreat from the position we have taken up, but merely a mitigation of the burden which has fallen on the general practitioner service at the present time.[9]

No, Sir. They will be regulations requiring the negative Resolution procedure, but that does not affect the situation seriously because I will so arrange the dates that before the regulations are put in operation, an opportunity will be given to the House for a Prayer, so that as far as Parliamentary procedure allows we shall refer the matter back to the House of Commons before any incidence falls on the citizens of the country.

There is already some evidence, as a consequence of the publicity which has been given to this aspect of the service, of a reduction in some cases of the burden on the general practitioners. There is a growing consciousness that people ought not to abuse the service in any particular. I am convinced that, as the service develops, there will be a growing sense of responsibility, and that discipline of this sort will not eventually be necessary in the service as a whole. I hope, therefore, that with those assurances and those explanations the House will permit me to have the powers for which I am now asking.[10]

Certainly; I am giving consideration to it. As I have said, I am not anxious to burden myself with a complicated administrative machine if I can achieve the same results by other means.

Source: House of Commons Debates, vol. 470, cols. 2258-65, 9 December 1949.

Notes:

1. Lt-Col. C.F. Byers, Liberal M.P., North Dorset.
2. L.J. Solley, Labour M.P., Thurrock.
3. P. Piratin, Labour M.P., Mile End, asked whether Bevan originated the idea of the prescription charge.
4. Solley quotes the official report, 24 October 1949, col. 1021, where Attlee stated that the charge would not be more than 1s.
5. Walter Elliot, Conservative M.P., Scottish Universities, and a former Minister of Health. Bevan was answering the charge that insured workers were worse off than under the National Insurance Act 1911, under which medicines were free.
6. Byers and Elliot challenged Bevan's assertion about the degree of disadvantage experienced by insured workers compared with their position before 1948. T.C. Skeffington-Lodge (Labour M.P., Bedford) introduced a digression on the by-election in Bradford South.
7. S. Tiffany, Labour M.P., Peterborough, asked whether there was abuse by both doctors and patients.
8. Byers asked whether amendments to the regulations would be accepted.
9. Lucas-Tooth asked whether the regulations would require an Affirmative Resolution.
10. Somerville Hastings, Labour M.P., Barking, asked whether Bevan might avoid the prescription charge by finding other ways of correcting abuses. Hastings was a veteran of the Socialist Medical Association.

XVIII

CABINET DISCUSSION, 3 APRIL 1950

The Minister of Health[1] agreed that the Cabinet should first discuss the question of principle: it was for that reason that he had refrained from discussing in his memorandum the details of any possible charges.[2] Ministers had in fact considered this question already, in the discussions in the Economic Policy Committee in October 1949, about the reduction of Government expenditure (E.P.C. (49) 34th and 35th Meetings); and he had been under the impression that they had then satisfied themselves that the principle of charges should not be applied generally throughout this Service.[3] A large proportion of the total expenditure on the Service was incurred by the hospitals, and there would be great difficulties in recovering a "hotel" charge from the occupants of hospital beds. For a wide range of hospital treatment, particularly in Scotland, no charge had ever been made even before the introduction of the National Health Service. And the deduction of sickness benefit which was already made after the recipient had been in hospital for more than eight weeks was in effect equivalent to a charge. Even if it were now decided that hospital patients should contribute ten shillings a week from the date of their admission to hospital the total revenue raised could not exceed £10 million. And he could not predict how much of this total would in fact be recovered; for he was satisfied that, if such a system had to be introduced, it must be operated by the National Assistance Board and not through a revival of the almoners' functions in the hospitals, and he could not say what criterion the Board would apply in determining the patient's capacity to make such a contribution. In the dental service he did not favour the introduction of charges: he would prefer to proceed by way of closer scrutiny of the dentists' claims, if the Treasury would agree to the appointment of not more than twenty inspectors for this purpose.[4] In the ophthalmic services he was prepared to reduce the choice of spectacle frames provided free of charge, and to increase the charges made for other kinds of frames; and he expected to secure by this means a saving of £1

million.[5] As regards prescriptions he no longer favoured the proposal to impose a charge: he would prefer to seek economies by prohibiting doctors from prescribing proprietary medicines.[6]

He was glad that the Chancellor of the Exchequer accepted the fact that expansions in some parts of the Service were inevitable. He had particularly in mind the need for new buildings and capital equipment in the hospital service. He thought it unreasonable that capital expenditure of this kind should have to be met as an annual revenue charge; and he suggested that, as a matter of accounting, arrangements should be made to spread this type of expenditure over a number of years.

The Minister pointed out that, if a system of charges was to be introduced, amending legislation would be required. This legislation might be criticised by the Opposition, and would be unpopular with Government supporters; and in the existing Parliamentary situation the Government might well find it difficult to pass such a Bill through the House of Commons. The Government's abandonment of the principle of a free and comprehensive health service would be a shock to their supporters in this country and a grave disappointment to Socialist opinion throughout the world. The Government had so far had experience of only one full year's working of the existing system; and he strongly urged that they should not abandon the principle of a free service on the basis of experience over so short a period.[7]

Source: CM(50)17th mtg, 3 April 1950. PRO CAB 128/17.

Notes:

1. The Cabinet was discussing memoranda on the cost of the National Health Service circulated by the Chancellor of the Exchequer, the Minister of Health, and the Secretary of State for Scotland (CP(50)53,56,57). In the order recorded in the Minutes, the meeting was attended by: Clement Attlee (Prime Minister, in the Chair), Herbert Morrison (Lord President of the Council), Hugh Dalton (Minister of Town and Country Planning), Viscount Alexander of Hillsborough (Chancellor of the Duchy of Lancaster), James Chuter Ede

(Secretary of State, Home Department), George Isaacs (Minister of Labour and National Service), Tom Williams (Minister of Agriculture and Fisheries), Harold Wilson (President of the Board of Trade), Hector McNeil (Secretary of State for Scotland), Sir Stafford Cripps (Chancellor of the Exchequer), Viscount Addison (Lord Privy Seal), Viscount Jowitt (Lord Chancellor), Emmanuel Shinwell (Minister of Defence), Aneurin Bevan (Minister of Health), George Tomlinson (Minister of Education), James Griffiths (Secretary of State for Colonies), Patrick Gordon-Walker (Secretary of State for Commonwealth Relations).

2. Cripps opened the discussion by proposing that the NHS should be limited in future years to an expenditure of £392m. Given the limited capacity for saving by economies he invited colleagues to consider other means to keep within the ceiling. He proposed that the Cabinet should accept the principle of the introduction of charges, leaving the details for imposition to be agreed by himself and the Health Ministers.

3. At the Cabinet Meeting on 4 April Bevan reported that he had met Regional Hospital Board chairmen and informed them of the need for economies in the current financial year. He had also instigated monthly statements to monitor hospital expenditure. He hoped in this way to "get to grips at once with any excess of expenditure over estimates". Although one or two of the chairmen of RHBs had complained that this proposed supervision was "bureaucratic", these chairmen had been told that "they must assume that it would continue for the next year or so". CM(50)18th mtg, 4 April 1950, PRO CAB 128/17.

4. On 4 April Ministers expressed concern about the cost of the dental service. They complained that the priority services were collapsing. This generated some support for McNeil's proposal for limiting the scope of NHS dental provision to priority classes. Ministers also pressed for application of the New Zealand experiment in wider utilisation of dental hygienists. The Health Ministers reported on their efforts to reduce the remuneration of dentists and to check abuses. CM(50)18th mtg.

5. On 4 April Ministers also worried about the high cost of the ophthalmic service. The Health Ministers reported that they would reduce the choice of spectacle frames provided free of charge and increase the charges for special frames. Ministers wanted more dental and ophthalmic work to be carried out in local authority clinics. CM(50)18th mtg.

6. On 4 April Bevan reported that "no material reduction could be made in the cost of the general practitioner service". He had informed the BMA on 3 April that the government rejected their appeal for a higher capitation fee. CM (50)18th mtg. Bevan was able to ward off a pay

increase for general practitioners, but his successor, Marquand, agreed to independent adjudication, which resulted in the Danckwerts Award, announced in March 1952 under the Conservative administration. This gave general practitioners a substantial increase, backdated to 1948. Webster, *Problems*, pp. 198-201, 227-31. Bevan also anticipated that economies result from the Cohen Committee, which he wanted to recommend use of non-proprietary drugs where these were available. He was seeking cooperation of the BMA over disciplining doctors guilty of extravagance in prescribing. These overtures were unsuccessful, partly on account of bad relations with the BMA over the pay issue.

7. McNeil agreed with Cripps on the need for charges, but he also proposed restrictions in the dental service and suspension of the ophthalmic service. He was not in favour of the prescription charge. Morrison strongly backed Cripps. He concluded that "In seeking to provide a comprehensive health service for all, the Government had been trying to do too much too quickly". The discussion resumed at the Cabinet meeting on 4 April, where Bevan suggested the establishment of a Cabinet Committee under the chairmanship of the Prime Minister to monitor expenditure on the NHS. He also outlined proposals for economy in the hospital sector. On 4 April McNeil concluded that the scope for economies was so slight that "a substantial proportion of the money required [for savings] must be found either by a reduction of less essential services or by a system of charges". Gaitskell insisted that the £392m ceiling should not be breached. In his view charges or cuts were inevitable. The Prime Minister summed up the discussion at the Cabinet Meeting on 6 April, where it was agreed to establish the Cabinet NHS Committee. It was also agreed that the Budget statement would indicate that it was not possible in existing circumstances to permit any increase in expenditure on the NHS.

XIX

INSTITUTE OF HOSPITAL ADMINISTRATORS, 5 MAY 1950

"As the Chairman said, it is five years since I last addressed your Conference.[1] Looking back over those five years I get the impression that I have lived an awful long time in the course of it. Very many things have happened since then, and if I attempted a retrospective view, then this Conference would last a very long time. In the meantime, the National Health Service that we were then bringing about has come into actual being, but perhaps that is a slight exaggeration, it is coming into being, because there are some people who have a sort of romantic attitude towards public affairs and think that secular institutions have a sort of heroic birth, whereas we know very well that the conception is painful, the period of gestation is unpleasant, and the birth lasts an awful long time. One of the difficulties of course that is an inevitable accompaniment of planning in a democratic community is that our plans are bound to be controversial; no matter how amiable the Minister is who is responsible for them, they are the subject of political controversy, and by that very fact alone their inception is almost certain to be accompanied by a good deal of polemics. In the case of the National Health Service very deeply entrenched emotional attitudes were disturbed. The traditions of the medical profession go back a very long way, and it was too much to hope that so drastic a thing as the National Health Service could be accomplished without very much disturbance. However, I am now reconciled to what happened because as I read the newspapers about what is happening in other parts of the world where similar attempts are being made to launch a National Health Service of a very much more modest kind than we have here and when I read what is being said about it by members of the medical profession, then I realise the controversy which took place between the British Medical Association and myself were a series of comparatively friendly exchanges compared with what is happening elsewhere.

A Service for Patients and the Public

"There is another aspect of this which I think we should keep in mind, especially in a Conference of specialists of this sort. As a great service of this sort is bedded down the most important part of the service tends to be obscured. First of all of course there are a vast number of pressure groups which are concerned; there are the doctors themselves, then there are the nurses, then there are the domestic staffs of hospitals, then there are the dentists who are particularly vocal, then there are the ophthalmic opticians, then there are the various other bodies, and then of course there are the hospital administrators, also an extremely powerful pressure. One after the other takes the stage and makes its presence known until before very long one gets a sort of impression that the National Health Service is being created for them and the poor patient is hardly heard at all. It is necessary for us to remember, because although the thing is obvious that does not make it less important, that the National Health Service has been brought into existence not for any of those pressure groups at all, but for the patients and for the general public, and in our own flash of personal pride and professional jealousy let us all bear in mind that there may be a time when one of us will be a patient and that will restore our sense of values. I am bound to make these reflections because the order paper in the House of Commons tends to be filled with questions about the pressure groups in the National Health Service and the patients are hardly ever heard of at all. Let us keep our sense of proportion. Of course I know very well that no National Health Service is going to be successful if the various people responsible for carrying it out are not reasonably contented. That is obvious. Indeed, it is impossible to take a proper professional pride in one's work if one is conscious of a sense of injustice, and so I do not cavill at the assertions which are made by this or that branch of the National Health Service in establishing its claims. But we have now called into existence a vast piece of conciliation machinery which is operating quite smoothly. That of course is first of all started at the top because they had to get the Whitley machinery into existence and now we are getting right down to the bottom so as to get the consultative machinery established at hospital level because I believe that we can make the Hospital Administration and the National Health Service as a whole a vast co-operative

enterprise.

Reconciliation of conflicting interests

"We do not want, and indeed I think there is no danger of it becoming, at least I hope not, a vast bureaucratic machine, because if it becomes that, then we shall have failed in one of our principal objectives, because the National Health Service is a novel experiment, as I have pointed out before. It is an attempt on the part of British society to reconcile two normally conflicting interests, centralised financial responsibility and decentralised administration at the periphery. Other countries of course are quite unable to understand what we are doing. When I point out to them that the National Health Service is administered by a vast body of voluntary workers they just do not understand it. I know that secretly you also modify it yourselves. There is a natural disposition on the part of the official to believe that the committee is nothing but a nuisance. However, in a democratic community it is a necessary nuisance because that committee, if it does its work, will establish the proper reciprocal contact between the internal administration of a hospital and the nature and taste of public opinion outside. Therefore, although you may be irritated by these interferences with what you consider to be the last word in efficiency, you must realise that there are two types of efficiency, mechanical and quantitative efficiency and democratic efficiency. I am reminded of it every week in the House of Commons.

A Novel Experiment

"We are, as I say, trying to carry out a very difficult and novel experiment which has never been done before. We have no precedent for it in the British Constitution. We have all kinds of types of administrative set-ups and we have created many of them in the course of the last four or five years, statutory Boards that are responsible for administering vast industries, but in the National Health Service we came to the conclusion that a medical Board was an entirely unsuitable instrument for this purpose, because you could not possibly allow the welfare of the patients using the National Health Service to be subject only to the *ipse dixit* of non-elected bodies. Therefore we decided that the only way in which this could

be done and also preserve the principle of central financial responsibility was by making the Minister responsible to Parliament, so that the Minister of Health, whoever he may be at any given time, is responsible constitutionally for everything that you do. I am frightened when I think about it! Everything that happens in the National Health Service among the whole 340,000 or 350,000 working in the various branches, the Minister has to answer for to the House of Commons, and no one can say that the House of Commons is not vigilant in the matter, because I think I am now getting every Thursday a record number of questions as many as 60 or 70 every Thursday afternoon, not only on the health matters of course, which shows the lively interest Members of Parliament are taking in what you are doing. When I get up in the House of Commons I speak with all the assurance of the knowledge of an efficient band of administrators behind me.

Health Service Expenditure

"There is one particular feature of the National Health Service which has come under very special public attention recently, and that is the expenditure. A lot of foolish things have been said by people who ought to know better; in fact I know sometimes they do know better. They have talked about the vast administrative expenses of the National Health Service. Well, we know that it is always necessary to maintain the utmost vigilance in regard to administrative expenses, and it is not enough to say that this or that little piece of carelessness does not cost much money. The important thing about an efficient and prudent administration is not only the money which it saves, which is of importance itself, but that if a piece of carelessness or a piece of extravagance or slackness goes unrebuked or uncorrected, a general air of lassitude soon begins to pervade the whole service.

Self Critical Machinery

"The very good result that follows from preventing a piece of slackness is that that itself pervades the whole administration and it becomes taut and efficient and self-critical, whereas if a piece of extravagance, whoever it is committed by, goes unrebuked or uncorrected, then everything becomes loosened and slackened and

generally unself-critical and inefficient. Therefore, although a lot of nonsense has been talked, we must nevertheless always act on the assumption that when any piece of organisation reaches a certain size, there must always be something wrong with it all the time and that therefore it is our duty to find out where and what that wrong is.

"We shall have to proceed, therefore, both centrally and locally on that principle, that a piece of self-critical machinery will have to be established so that not only now and again in a nervous and desultory manner, but persistently and automatically checks are kept up on the administration of the service.

Uniform System of Accounting

"Now one of the difficulties about the hospital service is that because it 'growed up like Topsy,' it grew up differently, and not only grew up differently, but people used the same name for different things, and that is particularly so too of the accounting of hospitals. Various items of expenditure were included under different heads and so it was a jigsaw puzzle, and indeed some of the voluntary hospitals appear to have had the most extraordinary system of non-accountancy because we have not been able to discover how they added up or subtracted. Therefore we have found it necessary to have a uniform system of accounts kept everywhere so that all of us are describing the same things by the same names. That is an essential condition for any effective control over financial expenditure. After this has been in operation for some time - and I hope you will be getting it within a few weeks - it will be possible to begin the first stage in self-examination, and that is a system of comparative costing.

Comparative Costing a Guide to Investigation

"Now let me be on my guard at once and admit that there is such an extraordinary difference between hospitals and the needs of hospitals and the ages of hospitals that it is not possible to arrive at a refined conclusion and say that hospital has got so much per bed more under a particular heading than that hospital and therefore A must be less efficient than B, because we know that is just not true. If you have a hospital that has just been altered from an old infirmary where you had stone flags, stone staircases and all kinds of ancient

methods, then obviously it is going to be very much more difficult to administer that hospital than an up-to-date one.

The First Need, Uniform Accounting

"What the system of comparative costing will do is to show a red light, and then it will be our duty to find out why the costs are either higher in gross or higher under a particular heading, and then of course the investigation starts. Then comes the reply and an explanation of why the difference occurs, and if the explanation is satisfactory, all well and good, but if the additional expenditure conceals itself, as indeed it may well do, behind an alibi, as though one might say to oneself: 'I know I have an old hospital and therefore I am entitled to be expensive' - if that subjective attitude were to arise, when that subjective attitude expresses itself in quantitative terms, we will be able to examine it and find out as to whether or not the additional expenditure is justified. Therefore, the first condition or the first self-criticism or the first piece of automatic machinery inside the National Health Service will be this method of comparative costing which cannot start until the accounting is on a uniform level. I am extremely grateful to this organisation and to many of the officials who have helped us so much in getting this costing system or accounting system established.

A Staff Ceiling

"Then there will be the second matter we propose to have, because hospitals vary so much not only in their ages, but in the specialities for which they are responsible. We propose to have a team, and a competent team, that is not consisting only of administrative officials, but assisted by men with medical knowledge with a knowledge of hospital administration, to visit the hospitals and they will establish, after examining the hospital on the spot, and agree the staff ceiling.[2] We have to do it in this way because of what I have said, that there is such a variation that no uniform principle can be applicable, and when that ceiling has been established by reference to the actual facts and duties of that particular hospital, then it will not be possible to exceed that ceiling without consent.

Unit Costing

"Then of course there is a third method which is only in its beginnings. The Nuffield Trust and the King Edward's Fund are helping us to find out whether it is possible to have a system of unit costing so that we can have a more refined check still.[3] Now these are necessary for any efficient organisation. It is absolutely essential that we should realise their importance now, because I have given a pledge that for the year 1950/1951 there will be no exceeding of the financial ceiling that has been laid down in estimates. Now a lot of foolish things have been said about the supplementary estimates. They have been regarded by some people as pieces of self-evident evidences that the finances of the National Health Service are not under effective control. That is a very silly thing to say because it was not until at least one year's experience had been obtained that it was possible to find out what the expenses would be. Indeed, as I tried to explain to the House of Commons, and I think it is being understood now even by some newspapers, the estimates which are laid down for the year 1950/1951 are the first estimates based upon a full year's experience of the National Health Service. All the other estimates necessarily had to have an element of conjecture in them and it is a fact that the pre-requisite for the study of human behaviour is that human beings should first of all be allowed to behave, and it was not possible to know what would be the hospital expenditure under the new conditions, it was not possible to know what would be the dental or optical expenditure or the pharmaceutical expenditure until people had had long enough in the enjoyment of them to show how they proposed to behave. Now our estimates for 1950/1951 are based on much surer foundations, and they are your estimates very largely, and therefore, I am entitled to expect you to live within them. Therefore the next year, 1950/1951 is an extremely important year. We have first had to start the National Health Service, the State has found the money for it, and now we have to show that our administrative machinery is sufficiently gripping to enable us to say with some degree of predictability what the National Health Service is likely to cost. Therefore, we must have economies, and we must have economies in order to have extensions, because if the National Health Service is to live within its estimates, then any improvement in any particular part of the Ser-

vice must necessarily come out of economy in another part, or we should be a stagnant Service, and we do not want that, do we? There are a lot of things we want to do, and if we cannot exceed the gross estimate, then we shall have to have economies here and there in order that the Service may be bettered in one or two directions.

The Role of the Hospital Administrator

"This is where you play the most important part of all, because no matter how vigilant or enthusiastic the hospital management committee may be, they will be completely helpless unless the hospital administrators are up to their job. Therefore, the responsibility that rests upon you is very great indeed. Everybody knows, every amateur knows, that ultimately his efficiency depends not upon the eloquence of his perorations, not upon even the substance of his exordium, but upon the efficiency of his instruments. Therefore, hospital administrations will depend finally and ultimately upon the efficiency and zeal of those responsible for the day to day administration in the hospital, and that is you. I know you have got some difficulties; I know that hospital administrators are subject to intimidation. The matron crackles her starches and it has a very great result. At the same time the medical staffs produce an air of sacerdotalism in the hospital which is very intimidating for the secular mind. You have to stand up against it. Sometimes when you are listening to their importunities it will be just as well to close your eyes because we know that professional people are perfectionists, that they never have got enough; the sky is the limit as far as they are concerned, but the limit is slightly under the sky as far as exchequer is concerned. I know that hospital administration is an arena in which the contending giants fight and you ultimately have to make the final decision. The hospital unit, although it is the place where the professions show their skill, is essentially a secular unit, because it is where the public are being served, and therefore it is a secular decision and not a professional decision in the hospital organisation of this country. We have said, and it is not to be modified in the very slightest, that we put the apparatus of medicine at the disposal of the profession and then the profession uses it as it thinks fit, but in the organisation of the apparatus of the hospital, the secular voice must

have its say. Therefore I know and I am very conscious of the fact that you will have very great financial, physical and psychological difficulties too, but I am quite sure you will be equal to them. When you gather here every year, or even more frequently, where the professions are not present, you can fortify your moral courage. I again emphasise that next year is an exceedingly important one, because if at the end of the year we can show, and I am sure we shall, that this vast apparatus that we have called into existence in so short a time is entirely within our management and control, then we shall have won the most important fight in the development of the National Health Service.

The Service Relieving much Suffering

"Before I sit down, may I just say this. We hear so much of what is wrong and we hardly ever hear of what is right. It is inevitable because only misfortune is news, and we hear all the time about this little defect and that little defect and that piece of maladministration, but you know better than I do that the National Health Service as a whole is responsible for the relief of an enormous amount of human suffering and very many young people are getting benefit from it. We are being watched by practically the whole of the world to see whether this National health Service is going to be a success. We know it is going to be a success. This is a non-political organisation and I am the very last person to introduce political colouration into a gathering of this sort, but the last General Election could not pay a higher tribute to the success of the National Health Service because all political parties clamoured for equal responsibility for its inception. We start off with an enormous amount of goodwill behind us and therefore that is an augury for more success in the future."

Source: *The Hospital*, June 1950, pp. 429-34.

Notes:

1. Bevan was addressing the Annual Conference of the Institute of Hospital Administrators held at Caxton Hall on 5 May 1950. He was introduced by the President of the Institute, Mr. B. Lees.

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CABINET DISCUSSION, 9 APRIL 1951

3. After the Chancellor of the Exchequer had explained his Budget proposals the Cabinet reverted to the question, which they had discussed at their meeting on 22nd March, of the level of Government expenditure on the social services.[1] One of the assumptions on which the Chancellor had constructed his Budget was that, in pursuance of the Cabinet's decision of 22nd March, expenditure on the National Health Service would be subject for the time being to an upper limit of £400 million. Before that decision was taken expenditure on the Health Service in the financial year 1951-52 had been estimated at £423 million; and, in order to keep it within the upper limit approved by the Cabinet, the Health Ministers had agreed to effect economies in the hospital administration totalling £10 million and to introduce charges for dentures and spectacles which, in the coming year, would produce £13 million. In a full year these charges would produce a much larger revenue; but the saving on the hospitals' service was non-recurrent and the revenue from charges would be needed in future years, if the total expenditure was to be kept below the upper limit of £400 million, in order to offset increasing costs in all parts of the Service.

The Minister of Labour[2] said that he had always been opposed to the introduction of charges for dentures and spectacles. In his view it would be undesirable in principle, and politically dangerous, for the Labour Party thus to abandon the conception of a free Health Service. Now that he was aware of the details of the budgetary position he was able to add the further argument that this step was not financially necessary. In a Budget of over £4,000 million it should not be difficult to find so small a sum as £13 million in some other way which would not breach the principle of a free Health Service. He was specially disturbed at the prospect that this inroad on the Health Service would be justified by the argument that the money to be saved was needed for the increased defence programme. He himself believed that shortages of raw materials and machine tools

2. In August 1950 hospital authorities were informed that specialist review teams would visit all hospitals to fix establishments for each category of staff. This initiative was largely abortive. Webster, *Problems*, p. 301.

3. Separate investigations into unit costing were undertaken by a committee of RHB Treasurers, by the King's Fund, and by the Nuffield Provincial Hospitals Trust. Webster, *Problems*, p. 256.

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would make it impossible in practice to spend effectively all the money which was to be allocated under this Budget to the defence programme; and in this view he had the support of the President of the Board of Trade and the Minister of Supply. The Defence Estimates for the coming financial year totalled £1,250 million; and of this the estimated cost of defence production amounted to £510 million. These were large figures and must be subject to a substantial margin of error. He believed that, within that margin, the Chancellor could have found the savings which he proposed to secure by introducing charges under the Health Service. The Minister reminded the Cabinet that such charges could not be imposed without fresh legislation. Believing, as he did, that such charges would involve a serious breach of Socialist principles, and having on numerous occasions proclaimed in public speeches his opposition to such a course, he did not see how he could be expected to vote in favour of such a Bill. If the Cabinet reaffirmed their decision that these charges should be imposed he would be obliged to resign from the Government.

The Chancellor of the Exchequer[3] said that it was his special duty, in framing the Budget, to determine how the necessary revenues should be raised to meet essential Government expenditure and also, in present circumstances, to form a judgment on the figure of the Budget surplus at which the Government should aim in order to keep inflationary tendencies in check. The Budget which he had outlined to the Cabinet was a carefully constructed and integrated plan for regulating the national finances over the coming year; and it would be difficult for him to modify at the last moment any essential feature of that plan. The Cabinet should, in particular, be content to leave it to his judgment to determine the size of the Budget surplus at which he should aim. He believed that the estimates of defence expenditure were as reliable as any such estimates could be: he could not accept the suggestion that he should frame his budget on the assumption that the out-turn of this expenditure would be something less than the estimate. He had taken the view from the outset that some part of the rising cost of the defence programme must be met by reductions in other Government expenditure; many of his efforts to secure such reductions had been frustrated; and he had now reached a point at which he could not make any further conces-

sions. The Cabinet had agreed, on 22nd March, that expenditure on the Health Service should be subject for the time being to an upper limit of £400 million; he was satisfied, from his consultations with the Health Ministers, that the cost of the Service could not be kept within that limit without the imposition of charges; he believed that, of the various charges which might be made, these would be the least unpalatable politically; and in all the circumstances he felt obliged to ask the Cabinet to maintain their earlier decision.

A long discussion ensued. The following is a summary of the main points made in it:-

(a) The Minister of Labour and the *President of the Board of Trade*[4] thought that the Government would find great difficulty in persuading their supporters in the House of Commons to accept departure from the principle of a free Health Service. They considered that some Government supporters would abstain from voting in favour of the legislation authorising the imposition of these charges; and they pointed out that, if only a few Government supporters abstained, the Conservative Opposition, by voting against the Bill, could bring about a major Government defeat. In that event the Government would face a General Election in circumstances which would enable the Conservative Party to pose as the champions of a free Health Service. *The Home Secretary*[5] also feared that there might be considerable Parliamentary difficulty in securing the passage of this legislation.

On the other side it was pointed out that, so far as concerned legislation, the principle of a free Health Service had already been breached by the National Health Service (Amendment) Act, 1949, which authorised the imposition of a shilling charge for prescriptions. This legislation, which the present Minister of Labour had himself introduced, had encountered no substantial opposition from Government supporters. It was not until it had been passed into law that the Government had decided not to proceed with their plan for making a charge for prescriptions.

The preponderant view in the Cabinet was that the Government, if they remained united on this issue, would have no substantial difficulty in persuading the Parliamentary Labour Party to support legislation authorising charges for dentures and spectacles supplied under the National Health Service.

(b) The Minister of Labour said that, in a Budget totalling over £4,000 million, there must be tolerances which would allow the Chancellor, if he wished, to forego his insistence on a saving of only £13 million on the Health Service. By the exercise of ingenuity, means could surely be found to avoid having to impose these charges. Thus, for the coming financial year, the relatively small amount required might be obtained by increasing the contribution made to the Health Service by the National Insurance Fund. Alternatively, the Chancellor might reduce by £13 million the Budget surplus at which he was aiming.

The Chancellor of the Exchequer said that he was not prepared to adopt either of the courses suggested by the Minister of Labour. They would both be inflationary in effect. Moreover, if he had such a sum at his disposal, he would certainly wish to consider to what purpose it could most usefully be applied. He was by no means satisfied that, even within the social services, the Health Service had the first claims on any additional money that might be available.

(c) Several Ministers expressed the view that, if the Minister of Labour resigned from the Government on this issue, an acute political crisis would develop. With their present Parliamentary majority the Government could not afford any diminution in their voting strength in the House of Commons. And, if the Government fell, as a result of divided counsels within the Cabinet, the Labour Party's prospects at the following General Election would be very gravely prejudiced.

After a prolonged discussion the *Foreign Secretary*[6] said that it seemed clear that the Cabinet would not be able to reach an agreed conclusion at that meeting. He therefore proposed that the discussion should be resumed at a further meeting later in the day. In the interval he would see the Prime Minister (who was in hospital) and would report to him the course which the discussion had so far taken.[7]

The Cabinet -

Agreed to resume their discussion at a meeting later in the day.

The Cabinet resumed their discussion of the level of Government expenditure on the social services.

The Foreign Secretary said that during the afternoon he and the Chief Whip had seen the Prime Minister in hospital and had given

him a full account of the Cabinet's discussion at their meeting that morning. The Prime Minister had asked him to convey to the Cabinet the following expression of his views. First, he had pointed out that in all Cabinet discussions of Budget proposals there must be a substantial measure of give and take between Ministers. The Chancellor of the Exchequer had particular responsibility for the national finances; and no other Minister ought to claim that any particular estimate should be treated as sacrosanct. It would be a most unusual thing for a Minister to resign on a Budget issue: so far as he was aware, the only Minister who had ever taken this step was Lord Randolph Churchill, whose political fortunes had never recovered thereafter. Secondly, a Minister who found himself in disagreement with a particular part of the present Budget proposals should consider, not only his personal position, but the effect which his resignation would have on the present and future fortunes of the Labour Party. Thirdly, the Prime Minister had said that it would be folly for any Minister to provoke a political crisis at the present time, for there could hardly be a worse moment for a General Election. As the summer went on, the conditions might become more favourable - the meat ration might be increased, the weather might improve and there might be some change in the international situation. But a General Election at the present time with a Labour Party torn by divided counsels, would prejudice the fortunes of the Labour movement for years to come. Fourthly, if the Government were forced to face the electors in these circumstances, they could hardly hope to win the election; and, after such a debacle, the Conservatives might remain in office for a long period. If the situation arose, the responsibility for bringing it about would rest with any Ministers who resigned from the Government at the present juncture. For all these reasons the Prime Minister urged his Cabinet colleagues to give solid support to the Budget proposals put forward by the Chancellor of the Exchequer; and, in particular, to adhere to the decisions which they had taken, as a Cabinet, on 22nd March regarding the future level of expenditure on the National Health Service.

The Minister of Labour said that he was not surprised to hear that the Prime Minister took this view. He had, however, discussed the matter with the Prime Minister before 22nd March; and he had then made it clear that he would not be able to share collective

responsibility for a decision to abandon the conception of a free Health Service. This was, for him, a question of principle. He had given five years to building up the Health Service; he had proclaimed it on many public platforms as one of the outstanding achievements of the Labour Party in office: he had, in particular, upheld the conception of a free Service as the embodiment of Socialist principles. It was too much to ask him now to go into the division lobby in support of a measure authorising the imposition of charges for dentures and spectacles provided under this Service. In saying that he must resign from the Government if the Cabinet persisted in this decision, he was not speaking lightly or without consideration of the possible consequences which the Prime Minister envisaged. But a Minister must be free to resign if he felt that he could not conscientiously share collective responsibility for decisions which his Cabinet colleagues wished to take. This Cabinet had taken many decisions which he had not wholly approved; but, when it became clear that these represented a preponderant view in the Cabinet, he had been prepared to take his share of responsibility for them. But, latterly, he had come to feel that he could bring more influence to bear on Government policy from outside the Cabinet than he could ever hope to exercise within it; and, when a Minister reached that position, it was time for him to go.

The President of the Board of Trade said that he wished at this stage to make his own position clear. In the Cabinet's earlier discussion that morning he had said that he supported the view of the Minister of Labour that it would not be possible to persuade all Government supporters to vote in favour of legislation authorising the introduction of charges under the Health Service. He now wished to make it clear that, if the Cabinet maintained their decision to introduce these charges, he would feel unable to share collective responsibility for that decision and, like the Minister of Labour, would feel obliged to resign from the Government.

In the course of a long discussion Ministers dwelt upon the grave consequences which would follow if resignations from the Cabinet caused a serious division in the ranks of the Labour Party. This might well precipitate a General Election, at a moment most unfavourable to the fortunes of the Party, and in circumstances in which the Party's chances of success must be rated very low. But

worse than that, it might undermine the authority of the Party's leaders and weaken the electoral prospects of the Party for many years to come. From a wider point of view it was also argued that the Labour Party had given an example to the world of stable and progressive Government in the difficult period of transition after the end of the war and in the dangerous period of international tension which had followed it; and it would be a tragedy if at this juncture the inspiration of its leadership in world affairs were cast away.

The Minister of Labour said that he could not accept responsibility for these consequences, even if they turned out to be as serious as some of his colleagues had feared. It was not he who had taken the initiative in proposing charges under the Health Service. The political crisis, if one developed, would have been provoked by those who had made this proposal. Other Ministers, on the other hand, held that any Ministers who resigned from the Government at the present time would be responsible for the political consequences which were likely to follow; and, in their view, this was a very heavy responsibility.

Beside these grave consequences, the issue which now divided the Cabinet seemed relatively small. Was there not some compromise on the basis of which agreement might still be reached? The Cabinet then discussed various possibilities. Thus, would it be possible to postpone for six months the introduction of charges under the National Health Service? During the interval Ministers should be able to resolve their doubts on the question whether the money allocated to the increased defence programme could in fact be profitably spent; and they would then be able to see more clearly whether the proposed economies on the Health Service were in fact essential. Postponement would also have the advantage that the discussion could be resumed at greater leisure under the Chairmanship of the Prime Minister himself. Alternatively, would it suffice for the Chancellor in his Budget speech to say merely that expenditure on the Health Service would be kept for the time being within an upper limit of £400 million, and that the Government were considering what steps would be necessary to ensure that this limit was not exceeded? Would it not be possible to secure economies in the administration of the Service without resorting to charges? Or could the necessary savings be secured by imposing a charge for

prescriptions, and abandoning the proposed charges for dentures and spectacles? This would have the advantage that no fresh legislation would be required. And in 1949 the present Minister of Labour had accepted the view that a charge for prescriptions would not involve a breach of the principle of a free Service.

The Chancellor of the Exchequer pointed out that none of these alternative courses would give him a sufficient assurance that the necessary savings would in fact be secured. Other Ministers testified that the Cabinet Committee on the National Health Service had exhaustively considered all practicable alternative methods of reducing expenditure on the Service, and had satisfied themselves that this expenditure could not be kept within an upper limit of £400 million without recourse to charges. They were also satisfied that the charges now proposed, for dentures and spectacles, were the most practical and the least unpalatable of any which could be introduced. The Cabinet reluctantly came to the conclusion that no compromise solution could be found along these lines.

In the course of further discussion *The Minister of Labour* indicated that, if he resigned from the Government, he would feel obliged to make it clear that his differences with his colleagues had not been restricted to this question of charges under the National Health Service. He was also gravely concerned about the economic consequences of the increased defence programme. While he supported the policy of rebuilding the armed strength of the western democracies, he was concerned about the pace and volume of their rearmament programmes. He believed that, by trying to do too much too quickly in response to United States pressure, the western democracies were in grave danger of undermining their economic strength. The United Kingdom Government would in his view make a double mistake if they allowed the increased defence programme, not only to distort the national economy, but to do this at the expense of the social services.

Further appeals were then made by a number of Ministers that the solidarity of the Government and the Labour Party should not be breached by resignations on this issue. *The Minister of Education*,[8] in particular, made it clear that in his view Ministerial resignations were too high a price to pay for an economy of £13 million on the Health Service. He felt sure that it must be possible to resolve the

differences within the Cabinet by some means which would not involve Ministerial resignations; and he hoped that the majority would not press their view to a point which would make these resignations inevitable.

After further discussion *The Foreign Secretary* said that he must bring the issue to a decision. He read out the conclusions reached by the Cabinet at their meeting on 22nd March, viz., that for the time being expenditure on the National Health Service should be subject to an upper limit of £400 million; that charges should be imposed for the supply of dentures and spectacles under the Health Service; and that the Health Ministers should draft the necessary legislation and make such advance preparations as were required to bring the scheme of charges into operation on 12th April. He asked each member of the Cabinet to state whether he was still prepared to adhere to those decisions. *The Minister of Labour, the President of the Board of Trade* and *the Minister of Education* said that, for the reasons which they had indicated in the course of the Cabinet's discussion, they were not in favour of re-affirming those conclusions. The remaining members of the Cabinet all indicated that they favoured re-affirming those conclusions.

The Minister of Labour said that in these circumstances he would have to resign from the Government. He would submit his resignation to the Prime Minister in the course of the following day; and he presumed that he would thereafter make a personal statement in the House of Commons, possibly on 11th April.

The Cabinet -

(1) Reaffirmed their decisions of 22nd March regarding the limitation of expenditure on the National Health Service and the introduction of charges for dentures and spectacles supplied under that Service.

(2) Authorised the Chancellor of the Exchequer to announce these decisions in the course of his Budget speech.

(3) Invited the Minister of Labour to reconsider his position, and expressed the earnest hope that he would not find it necessary to resign from the Government on this issue.

Source: CM(51)25th mtg., 9 April 1951, PRO CAB 128/19.

Notes:

1. The Cabinet was meeting to conclude its discussion of the Budget statement. In the order recorded in the Minutes, the meeting was attended by: Herbert Morrison (Secretary of State, Foreign Affairs, in the Chair), Ernest Bevin (Lord Privy Seal), Hugh Dalton (Minister of Local Government and Planning), Viscount Jowitt (Lord Chancellor), Emmanuel Shinwell (Minister of Defence), Tom Williams (Minister of Agriculture and Fisheries), Harold Wilson (President of the Board of Trade), Hector McNeil (Secretary of State for Scotland), Hugh Gaitskell (Chancellor of the Exchequer), Viscount Addison (Lord President of the Council), James Chuter Ede (Secretary of State, Home Department), Aneurin Bevan (Minister of Labour and National Service), George Tomlinson (Minister of Education), James Griffiths (Secretary of State for Colonies), Patrick Gordon-Walker (Secretary of State for Commonwealth Relations).
2. Bevan.
3. Hugh Gaitskell.
4. Harold Wilson.
5. James Chuter Ede.
6. Herbert Morrison, who succeeded Bevan as Foreign Secretary in March 1951 owing to the latter's illness.
7. Attlee was in St. Mary's Hospital.
8. George Tomlinson.

XXI

HOUSE OF COMMONS, 23 APRIL 1951

Mr. Speaker, it is one of the immemorial courtesies of the House of Commons that when a Minister has felt it necessary to resign his office, he is provided with an opportunity of stating his reasons to the House. These occasions are always exceedingly painful, especially to the individual concerned, because no Member ought to accept office in a Government without a full consciousness that he ought not to resign it for frivolous reasons. He must keep in mind that his association is based upon the assumption that everybody in Government accepts the full measure of responsibility for what it does.

The courtesy of being allowed to make a statement in the House of Commons is peculiarly agreeable to me this afternoon, because, up to now, I am the only person who has not been able to give any reasons why I proposed to take this step, although I notice that almost every single newspaper in Great Britain, including a large number of well-informed columnists, already know my reasons.

The House will recall that in the Defence debate I made one or two statements concerning the introduction of a Defence programme into our economy, and, with the permission of the House, I should like to quote from that speech which, I assumed at the time, received the general approval of the House. I said:

> "The fact of the matter is, as everybody knows, that the extent to which stockpiling has already taken place, the extent to which the civil economy is being turned over to defence purposes in other parts of the world, is dragging prices up everywhere. Furthermore, may I remind the right hon. Gentleman that if we turn over the complicated machinery of modern industry to war preparation too quickly, or try to do it too quickly, we shall do so in a campaign of hate, in a campaign of hysteria, which may make it very difficult to control that machine when it has been created.

> "It is all very well to speak about these things in airy terms, but we want to do two things. We want to organise our defence programme in this country in such a fashion as will keep the love of peace as vital as ever it was before. But we have seen in other places that a campaign for increased arms production is accompanied by a campaign of intolerance and hatred and witch-hunting. Therefore, we in this country are not at all anxious to imitate what has been done in other places." [OFFICIAL REPORT, 15th February, 1951; Vol. 484, c. 738.]

I would also like to direct the attention of the House to a statement made by the Prime Minister in placing before the House the accelerated armaments programme. He said:

> "The completion of the programme in full and in time is dependent upon an adequate supply of materials, components and machine tools. In particular, our plans for expanding capacity depend entirely upon the early provision of machine tools, many of which can only be obtained from abroad." [OFFICIAL REPORT, 29th January, 1951; Vol. 483, c. 584.]

Those cautionary words were inserted deliberately in the statements on defence production because it was obvious to myself and to my colleagues in the Government that the accelerated programme was conditional upon a number of factors not immediately within our own control.

It has for some time been obvious to the Members of the Government and especially to the Ministers concerned in the production Departments that raw materials, machine tools and components are not forthcoming in sufficient quantity even for the earlier programme and that, therefore, the figures in the Budget for arms expenditure are based upon assumptions already invalidated. I want to make that quite clear to the House of Commons; the figures of expenditure on arms were already known to the Chancellor of the Exchequer to be unrealisable. The supply Departments have made it quite clear on several occasions that this is the case and, therefore, I begged over and over again that we should not put figures in the Budget on account of defence expenditure which would not be realised, and if they tried to be realised would have the result of inflating

prices in this country and all over the world.

It is now perfectly clear to any one who examines the matter objectively that the lurchings of the American economy, the extravagant and unpredictable behaviour of the production machine, the failure on the part of the American Government to inject the arms programme into the economy slowly enough, have already caused a vast inflation of prices all over the world, have disturbed the economy of the western world to such an extent that if it goes on more damage will be done by this unrestrained behaviour than by the behaviour of the nation the arms are intended to restrain.

This is a very important matter for Great Britain. We are entirely dependent upon other parts of the world for most of our raw materials. The President of the Board of Trade and the Minister of Supply in two recent statements to the House of Commons have called the attention of the House to the shortage of absolutely essential raw materials. It was only last Friday that the Minister of Supply pointed out in the gravest terms that we would not be able to carry out our programme unless we had molybdenum, zinc, sulphur, copper and a large number of other raw materials and non-ferrous metals which we can only obtain with the consent of the Americans and from other parts of the world.

I say therefore with the full solemnity of the seriousness of what I am saying, that the £4,700 million arms programme is already dead. It cannot be achieved without irreparable damage to the economy of Great Britain and the world, and that therefore the arms programme contained in the Chancellor of the Exchequer's Budget is already invalidated and the figures based on the arms programme ought to be revised.

It is even more serious than that. The administration responsible for the American defence programme have already announced to the world that America proposes to provide her share of the arms programme not out of reductions in civil consumption, not out of economies in the American economy but out of increased production; and already plans are envisaged that before very long the American economy will be expanded for arms production by a percentage equal to the total British consumption, civil and arms.

And when that happens the demands made upon the world's precious raw materials will be such that the civilian economy of the

Western world outside America will be undermined. We shall have mass unemployment. We have already got in Great Britain under-employment. Already there is short-time working in many important parts of industry and before the middle of the year, unless something serious can be done, we shall have unemployment in many of our important industrial centres. That cannot be cured by the Opposition. In fact the Opposition would make it worse - far worse.

The fact is that the western world has embarked upon a campaign of arms production upon a scale, so quickly, and of such an extent that the foundations of political liberty and Parliamentary democracy will not be able to sustain the shock. This is a very grave matter indeed. I have always said both in the House of Commons and in speeches in the country - and I think my ex-colleagues in the Government will at least give me credit for this - that the defence programme must always be consistent with the maintenance of the standard of life of the British people and the maintenance of the social services, and that as soon as it became clear we had engaged upon an arms programme inconsistent with those considerations, I could no longer remain a Member of the Government.

I therefore do beg the House and the country, and the world, to think before it is too late. It may be that on such an occasion as this the dramatic nature of a resignation might cause even some of our American friends to think before it is too late. It has always been clear that the weapons of the totalitarian States are, first, social and economic, and only next military; and if in attempting to meet the military effect of those totalitarian machines, the economies of the western world are disrupted and the standard of living is lowered or industrial disturbances are created, then Soviet Communism establishes a whole series of Trojan horses in every nation of the western economy.

It is, therefore, absolutely essential if we are to march forward properly, if we are to mobilise our resources intelligently, that the military, social and political weapons must be taken together. It is clear from the Budget that the Chancellor of the Exchequer has abandoned any hope of restraining inflation. It is quite clear that for the rest of the year and for the beginning of next year, so far as we can see, the cost of living is going to rise precipitously. As the cost of living rises, the industrial workers of Great Britain will try to adjust

themselves to the rising spiral of prices, and because they will do so by a series of individual trade union demands a hundred and one battles will be fought on the industrial field, and our political enemies will take advantage of each one. It is, therefore, impossible for us to proceed with this programme in this way.

I therefore beg my colleagues, as I have begged them before, to consider before they commit themselves to these great programmes. It is obvious from what the Chancellor of the Exchequer said in his Budget speech that we have no longer any hope of restraining inflation. The cost of living has already gone up by several points since the middle of last year, and it is going up again. Therefore, it is no use pretending that the Budget is just, merely because it gives a few shillings to old age pensioners, when rising prices immediately begin to take the few shillings away from them.[1]

It is no use saying "Hear, hear" on the opposite side of the House. The Opposition have no remedy for this at all. But there is a remedy here on this side of the House if it is courageously applied, and the Budget does not courageously apply it. The Budget has run away from it. The Budget was hailed with pleasure in the City. It was a remarkable Budget. It united the City, satisfied the Opposition and disunited the Labour Party - all this because we have allowed ourselves to be dragged too far behind the wheels of American diplomacy.

This great nation has a message for the world which is distinct from that of America or that of the Soviet Union. Ever since 1945 we have been engaged in this country in the most remarkable piece of social reconstruction the world has ever seen. By the end of 1950 we had, as I said in my letter to the Prime Minister assumed the moral leadership of the world. It is no use hon. Members opposite sneering, because when they come to the end of the road it will not be a sneer which will be upon their faces. There is only one hope for mankind, and that hope still remains in this little island. It is from here that we tell the world where to go and how to go there, but we must not follow behind the anarchy of American competitive capitalism which is unable to restrain itself at all, as is seen in the stockpiling that is now going on, and which denies to the economy of Great Britain even the means of carrying on our civil production. That is the first part of what I wanted to say.

It has never been in my mind that my quarrel with my colleagues was based only upon what they have done to the National Health Service. As they know, over and over again I have said that these figures of arms production are fantastically wrong, and that if we try to spend them we shall get less arms for more money. I have not had experience in the Ministry of Health for five years for nothing. I know what it is to put too large a programme upon too narrow a base. We have to adjust our paper figures to physical realities, and that is what the Exchequer has not done.

May I be permitted, in passing, now that I enjoy comparative freedom, to give a word of advice to my colleagues in the Government? Take economic planning away from the Treasury. They know nothing about it. The great difficulty with the Treasury is that they think they move men about when they move pieces of paper about. It is what I have described over and over again as "whistle-blowing" planning. It has been perfectly obvious on several occasions that there are too many economists advising the Treasury, and now we have the added misfortune of having an economist in the Chancellor of the Exchequer himself.

I therefore seriously suggest to the Government that they should set up a production department and put the Chancellor of the Exchequer in the position where he ought to be now under modern planning, that is, with the function of making an annual statement of accounts. Then we should have some realism in the Budget. We should not be pushing out figures when the facts are going in the opposite direction.

I want to come for a short while, because I do not wish to try the patience of the House, to the narrower issue. The Chancellor of the Exchequer astonished me when he said that his Budget was coming to the rescue of the fixed income groups. Well, it has come to the rescue of the fixed income groups over 70 years of age, but not below. The fixed income groups in our modern social services are the victims of this kind of finance. Everybody possessing property gets richer. Property is appreciating all the time, and it is well known that there are large numbers of British citizens living normally out of the appreciated values of their own property. The fiscal measures of the Chancellor of the Exchequer do not touch them at all.

I listened to the Chancellor of the Exchequer with very great

admiration. It was one of the cleverest Budget speeches I had ever heard in my life. There was a passage towards the end in which he said that he was now coming to a complicated and technical matter and that if Members wished to they could go to sleep. They did. Whilst they were sleeping he stole £100 million a year from the National Insurance Fund. Of course I know that in the same Budget speech the Chancellor of the Exchequer said that he had already taken account of it as savings. Of course he had, so that the re-armament of Great Britain is financed out of the contributions that the workers have paid into the Fund in order to protect themselves.[2] Certainly, that is the meaning of it. It is no good my hon. Friends refusing to face these matters. If we look at the Chancellor's speech we see that the Chancellor himself said that he had already taken account of the contributions into the Insurance Fund as savings. He said so, and he is right. Do not deny that he is right. I am saying he is right. Do not quarrel with me when I agree with him.

The conclusion is as follows. At a time when there are still large untapped sources of wealth in Great Britain, a Socialist Chancellor of the Exchequer uses the Insurance Fund, contributed for the purpose of maintaining the social services, as his source of revenue, and I say that is not Socialist finance. Go to that source for revenue when no other source remains, but no one can say that there are no other sources of revenue in Great Britain except the Insurance Fund.

I now come to the National Health Service side of the matter. Let me say to my hon. Friends on these benches: you have been saying in the last fortnight or three weeks that I have been quarrelling about a triviality - spectacles and dentures. You may call it a triviality. I remember the triviality that started an avalanche in 1931. I remember it very well, and perhaps my hon. Friends would not mind me recounting it. There was a trade union group meeting upstairs. I was a member of it and went along. My good friend, "Geordie" Buchanan, did not come along with me because he thought it was hopeless, and he proved to be a better prophet than I was. But I had more credulity in those days than I have got now. So I went along, and the first subject was an attack on the seasonal workers. That was the first order. I opposed it bitterly, and when I came out of the room my good old friend George Lansbury attacked me for attacking the order. I said, "George, you do not realise, this is the beginning of

the end. Once you start this there is no logical stopping point."

The Chancellor of the Exchequer in this year's Budget proposes to reduce the Health expenditure by £13 million - only £13 million out of £4,000 million.[3] No, £4,000 million. He has taken £13 million out of the Budget total of £4,000 million. If he finds it necessary to mutilate, or begin to mutilate, the Health Services for £13 million out of £4,000 million, what will he do next year? Or are you next year going to take your stand on the upper denture? The lower half apparently does not matter, but the top half is sacrosanct. Is that right? If my hon. Friends are asked questions at meetings about what they will do next year, what will they say?

The Chancellor of the Exchequer is putting a financial ceiling on the Health Service. With rising prices the Health Service is squeezed between that artificial figure and rising prices. What is to be squeezed out next year? Is it the upper half? When that has been squeezed out and the same principle holds good, what do you squeeze out the year after? Prescriptions? Hospital charges? Where do you stop? I have been accused of having agreed to a charge on prescriptions. That shows the danger of compromise. Because if it is pleaded against me that I agreed to the modification of the Health Service, then what will be pleaded against my right hon. Friends next year, and indeed what answer will they have if the vandals opposite come in? What answer? The Health Service will be like Lavinia - all the limbs cut off and eventually her tongue cut out, too.

I should like to ask my right hon. and hon. Friends, where are they going?[4] Where am I going? I am where I always was. Those who live their lives in mountainous and rugged countries are always afraid of avalanches, and they know that avalanches start with the movement of a very small stone. First, the stone starts on a ridge between two valleys - one valley desolate and the other valley populous. The pebble starts, but nobody bothers about the pebble until it gains way, and soon the whole valley is overwhelmed. That is how the avalanche starts, that is the logic of the present situation, and that is the logic my right hon. and hon. Friends cannot escape. Why, therefore, has it been done in this way?

After all, the National Health Service was something of which we were all very proud, and even the Opposition were beginning to be proud of it. It only had to last a few more years to become a part of

our traditions, and then the traditionalists would have claimed the credit for all of it. Why should we throw it away? In the Chancellor's Speech there was not one word of commendation for the Health Service - not one word. What is responsible for that?

Why has the cut been made? He cannot say, with an overall surplus of over £220 million and a conventional surplus of £39 million, that he had to have the £13 million. That is the arithmetic of Bedlam. He cannot say that his arithmetic is so precise that he must have the £13 million when last year the Treasury were £247 million out. Why? Has the A.M.A. succeeded in doing what the B.M.A. failed to do? What is the cause of it? Why has it been done?

I have also been accused - and I think I am entitled to answer it - that I had already agreed to a certain charge. I speak to my right hon. Friends very frankly here. It seems to me sometimes that it is so difficult to make them see what lies ahead that you have to take them along by the hand and show them. The prescription charge I knew would never be made, because it was impracticable.[5] Well, it was never made.

I will tell my hon. Friends something else, too. There was another policy - there was a proposed reduction of 25,000 on the housing programme, was there not? It was never made. It was necessary for me at that time to use what everybody always said were bad tactics upon my part - I had to manoeuvre, and I did manoeuvre and saved the 25,000 houses and the prescription charge. I say, therefore, to my right hon. and hon. Friends, there is no justification for taking this line at all. There is no justification in the arithmetic, there is less justification in the economics, and I beg my right hon. and hon. Friends to change their minds about it.

I say this, in conclusion. There is only one hope for mankind and that is democratic Socialism. There is only one party in Great Britain which can do it and that is the Labour Party. But I ask them carefully to consider how far they are polluting the stream. We have gone a long way - a very long way - against great difficulties. Do not let us change direction now. Let us make it clear, quite clear, to the rest of the world that we stand where we stood, that we are not going to allow ourselves to be diverted from our path by the exigencies of the immediate situation. We shall do what is necessary to - defend ourselves defend ourselves by arms, and not only with arms but with

the spiritual resources of our people.

Source: House of Commons Debates, vol. 487, cols. 34-43, 23 April 1951.

Notes:

1. Hon. Members: "Hear, hear".
2. Hon. Members: "Oh!".
3. Hon. Members: "£400 million".
4. Hon. Members: "Where are you going?".
5. Hon. Members: "Oh!".

XXII

LOCAL GOVERNMENT MANAGEMENT OF THE HOSPITALS, 12 MARCH 1954

An old problem of local government is how to marry function to area.[1] The technical requirements of the function are apt to exceed either the size of population within a given local authority or its extent in terms of square miles, or both. When the marriage is convenienced by enlarging the local authority, or by singling out the larger local authorities to perform the function in question then it is true the marriage is consummated, but it is often divorced from local government in any acceptable meaning of the term.

I was faced by this difficulty when framing the National Health Service. Not even the larger local authorities provided a gathering ground extensive enough for certain medical specialities. An extreme instance is leprosy, a notifiable disease, but one, fortunately, so rare in this country in its more serious and infectious forms that no unit smaller than the whole country sufficed.

The principle of national financial responsibility also conflicted with local government responsibility for the service. Uniformity of treatment could not be achieved by making the nation the unit of the service, nor, indeed, should it be attempted. But, equality should be the aim and this could not be guaranteed if facilities varied with local finances.

Then again there was the old problem of passing patients from the care of one health authority to another, a transference often necessary for clinical reasons, but one fraught with financial complexities for the authorities concerned.

All these considerations had to be kept in mind when shaping the service and any modification of the existing structure should be able to accommodate them, otherwise we shall not retain the enjoyment of a truly free National Health Service.

Nevertheless, it remains a defect that the principle of election had to give way to that of selection, by the Minister, in the administrative agencies of the service. I found this hard because I am by

experience and conviction a local government man. In my book, "In Place of Fear", written in 1952, I wrote the following on this subject:

> "...Although it is essential to retain Parliamentary accountability for the service, the appointment of members of the various administrative bodies should not involve the Minister of Health. No danger of nepotism arises, as no salaries are attached to the appointments, but election is a better principle than selection. No Minister can feel satisfied that he is making the right selection over so wide a field. The difficulty of applying the principle of election rather than selection arises from the fact that no electoral constituency corresponds with the functional requirements of the service. This is particularly so in the case of hospitals. These are grouped in such a way that most, if not all, the different medical specialities are to be found within a given area.
>
> "A solution might be found if the reorganisation of local government is sufficiently fundamental to allow the administration of the hospitals to be entrusted to the revised units of local government. But no local finances should be levied, for this would once more give rise to frontier problems, and the essential unity of the service would be destroyed."[2]

The idea is for the local authority to act for the Minister on an agency basis, on financial terms which should not present too much difficulty in working out. All staff appointments should be in the control of the local authority, with the exception of the specialists. These could be appointed on the recommendation of a regional advisory body, with adequate representation from the medical and other allied professions. By this means a considerable measure of local responsibility would be restored.

But one qualification must be made. The local authorities should avail themselves of the immense reservoir of voluntary workers in this field; otherwise there would be a danger of merely making a transfer of power from the officials in Whitehall to those in the town hall.

This is not the place to work out all the details of the change. These are many and varied, but we now have a wide experience to

draw on; and, I hope, a more co-operative mood in the medical profession. Now that the fears of the doctors have been largely assuaged there should be a readier disposition to set aside the traditional antagonism between the clinicians and the medical officers of health.

But, in my opinion, success is dependent on a radical reorganisation of the structure of local government. As we all know this is long overdue. The example of the National Health Service is only a special instance of a general case. Unless it can be brought about Ministers, in framing their legislation, will feel compelled, as I was, to improvise other forms of administration. Ardent supporters of local government have no answer if they continue to resist changes which are necessary to meet the requirements of a changing society.

In the proposals which I outline from now on, I must make it clear that I am speaking for myself alone and not for any particular section of political opinion. Arguments about the reform of local government cut across political parties, because it cannot be said that any one party would stand to gain by a change. It is this fact, as much as anything else, which has postponed action where, for so long, it has been so badly needed.

In reforming local government what should be our general aim? We should wish to revive and maintain local government as a form of government which is truly local, and which is so near to the people as to ignite and keep their interest.

This interest by the public is important as a spur and refreshment to the governing bodies themselves and for the creation of an intelligent and educated democracy inspired with civic spirit. Quite apart from its value to the well-being of society and to the individual citizen, it is of incalculable value to the community in any kind of crisis. Because of all these central objectives we must have local bodies which are near enough to the electorate to command interest, which have functions of sufficient importance to attract the best type of councillor and which are strong enough to carry the services they administer.

How do we apply these principles to the actual facts of the present complex of local government? There are two extremes operating in the district councils and the county councils. Within each group there are considerable variations in size, but taking the average unit

in each, there seems little doubt that the present boroughs and district councils are too small for efficiency, whereas the administrative counties are too large for democratic principles to flourish; in my view county administration is a practical example of the way excess of size can turn the administration of an elected body into largely a bureaucratic form. There is little or no spiritual identification by the citizen with the administrative county. The latter is a machine with no organic thrust from the accretions of community living. Its disappearance would involve the dispersal of sometimes highly efficient teams of officials but no emotional disturbance among the electorate embraced by it.

Machines are important but democracy is a way of life as well as a means of living. Efficient machinery can guarantee the performance of material functions but it cannot by this means alone provide the full life; for if efficiency were to be accepted as the sole test the mechanised feeder would replace the domestic table.

This is not to say that I award the palm, even for efficiency, to the majority of county councils. Far from it. But it must be admitted that the abolition of the county as an administrative unit, for local government purposes, would involve the dissolution of a number of devoted and efficient teams.

The second aim we set for our reform was that it must ensure functions important enough to attract the best kind of councillor. This points directly at the all-purpose authority. No one acquainted with local government would seriously contest the proposition that a two-tier local authority system leaves neither with enough functions to achieve viability. The delegation of powers from county to district causes endless friction between the two. The problems of overspill, boundary extensions and the promotion of non-county borough to county borough status; all these, which sorely vex and perplex us at present, would either disappear, be easier of settlement or partly resolved by the change.

In particular, except for the great conurbations, most local government units would embrace both rural and urban areas to their mutual advantage. There can be no doubt that one unit of local government, discharging all the functions now shared between county and district, would attract and keep the very best type of councillor, and give local government in Britain a

much-needed fillip.

The third aim we mentioned was the necessity for strong administration. The all-purpose authority, enjoying diversity of function and based on a large enough population, would be able to command efficient teams of officials, provide them with status and pay them rates of remuneration which would serve to protect them from constant erosion by other forms of employment.

I believe it can be shown that the practical application of these principles would result in the creation of between 235 to 240 all-purpose authorities. With a little patience and industry and a good map anyone can make a rough outline of the scheme. If you take an existing township of substantial size and attach to it an area so that both taken together would comprise a population of more than 50,000 the result is surprising and in the main gratifying. The bulk of the population would be within ten miles of the civic centre. In these days of easy transport this would give an accessibility far in excess of what was deemed tolerable a short while ago.

The rest would be under 20 miles. Less than ten would possess populations of less than 50,000. As one should expect, these occur in sparsely populated districts of Wales and near the border. More than 75 per cent. would have populations exceeding 75,000. I have deliberately not chosen to show how this would work out in particular places because it is not desirable to provoke local argument at this stage.

There would be a substantial increase in the number of education authorities but on the other hand the excepted authorities and divisional executives would disappear. As we all know, there is constant bickering between these executives and the county councils.

The important fact to keep in mind is that the exercise produces local authorities which satisfy the three conditions I mentioned: strength, viability and accessibility.

Of course it is not proposed to split places like Cardiff, Bristol, Manchester, Birmingham and the like, except in some instances to provide rural belts.

In considering proposals of this sort, which are so fundamental and far-reaching it is necessary to avoid too violent a disturbance with local bodies, such as the Charter boroughs, for example. Many of these are much too small to entrust with

the full range of local functions. Nevertheless, they are repositories of historical interest and command strong local sentiment.

Arrangements could be made for them to discharge certain services of a strictly local and immediate character, and also retain the pageantry and ceremony so long associated with them. For these purposes they could spend money provided by the all-purpose authority. In addition there seems no reason why they should not be allowed to require that body to raise from their own citizens a rate to be spent on such matters as they think fit. The parish is the oldest form of local government. There is no reason why it should not find its place in the new arrangement. Indeed, it might get fresh vigour.

Obviously it is not possible to deal with the details of these proposals in one article, nor to answer all the objections that might be brought against them. There are exceptional circumstances, like Greater London, for example, where special provision would have to be made in any scheme for the reorganisation of local government.

The London County Council is not London. But Greater London is clearly too big to be one unit. Even the LCC is considered by many to be too big and remote. It is incontestable that there should be a body which is recognisable as the authority for London. What its functions should be is a subject for argument, but they should not be so extensive as to deprive the rest of local government in the area of viability and status.

Where so many deeply rooted vested interests are concerned it is hopeless to expect the argument to be conducted without prejudice and even passion. Nor are there subjects too extraneous to be mobilised in the service of the controversy. I have been told, for instance, that the end of the county as an administrative unit of local government would mean the end of the county cricket team. What possible connection there is between the two passes comprehension. The county, as an historical entity, existed before the creation of county administration and it would continue to exist after the latter ceased. Yorkshire would still enjoy its centuries-old friendly rivalry with Lancashire.

The issue here is the restoration and preservation of local government as a vital part of our constitutional apparatus and as an indispensable element in the British way of life.

Those of us who have had experience of county and district administration can be in no doubt as to which is local government in all the essential meanings we attach to the term.[3]

Source: *The Municipal Journal*, 12 March 1954, pp. 544-5.

Notes:

1. Bevan wrote this article in response to a request by the journal for his views on local government administration of the hospital scheme.
2. *In Place of Fear*, pp. 91, 188.
3. Jennie Lee confirmed Bevan's concern with the unification of health service and local government administration in her address to the NHS twentieth anniversary celebration. DHSS, *National Health Service Twentieth Anniversary Conference Report* (London, HMSO, 1968), p.11.

XXIII

HOUSE OF COMMONS, 30 JULY 1958

The National Health Service became ten years of age on the 5th of this month and my right hon. and hon. Friends on this side of the House thought that it would be suitable that we should have a debate at the earliest possible moment to commemorate that fact. It also provides us with an opportunity of assessing the achievements of the Service as well as considering its shortcomings and making suggestions as to how it can be improved. I hope that it will not be considered inappropriate that it has been decided that I should open the debate.

I should like to take advantage of this opportunity to say something which it has not been possible to say before: that is, to call attention to the extraordinary achievement for which the Ministry of Health was responsible in launching the Health Service on 5th July, 1948, and to pay a very special tribute to the permanent officials who were at the Ministry at that time, both in London and in Scotland. It is not possible for me to identify the civil servants who were engaged in that work because, if I did, I should be depriving them of the protection of anonymity with which it is our practice to provide the Civil Service.

But there are one or two people whom I can mention with propriety. One is Sir William Douglas, Permanent Secretary at the time, who, unfortunately, has died.[1] The other is Sir Wilson Jameson, the Chief Medical Officer, who, I am glad to say, is still very much alive and at work, although he has retired from the Ministry.[2] The nation was extremely fortunate in having two eminent civil servants of that calibre at the Ministry at that time. I am quite certain that if hon. Members and the nation generally knew how much work they did and what a huge task it was, they would feel very grateful indeed.

On this occasion, I should like to put on public record my personal appreciation of the loyal, efficient and inexhaustible service which I received at the time from the officials at the Ministry of Health. It was no light task. We had not very much time. We had to

be ready with all the machinery on 5th July, because people had to have access to the rights which we said that the legislation would provide. There was, therefore, a very great risk that, unless we did work night and day, we should not be able to be ready in time.

Two main conceptions underlay the National Health Service. The first was to provide a comprehensive, free, health service for all the people of the country at time of need. The second - I shall call particular attention to this later, because it has been somewhat overlooked - was the redistribution of national income by a special method of financing the Health Service.

As to the first principle, there has always been more medical care in existence than the masses have been able to reach. Many people have died and many have suffered not because the knowledge was not there, but because they did not have access to it. To all the suffering which attends illness, there was always added the bitterness that, if the poor could have had access to the knowledge available, they might have been saved, or at least, might have been helped. It was this situation that the National Health Service was intended to put right. The general availability of the knowledge could be achieved, of course, only by a National Health Service.

I shall not give very many figures, because, if I try to give a comprehensive picture of what the National Health Service is now doing, I should be invading the time that you, Sir, have already allotted to those who wish to raise matters on the Consolidated Fund Bill later. But it is necessary to keep certain figures in mind in order to have an idea of what has been accomplished.

Today, 98 per cent. of the people of Great Britain are registered with general practitioners, that is to say, almost the whole population of the country. There are today 147,676 nurses - or, rather, there were last year; I have not the up-to-date figures for this year - as against 125,752 in 1949. There are today 38,149 part-time nurses, as against 23,060 in 1949, making a grand total of 185,825. There are also more than 30,000 additional hospital beds in existence today.

One of the troubles I had when starting the Health Service in 1948 was that mass radiography had disclosed the existence of early tuberculosis, and applications were made for beds, of course, which were not there and for nurses whom we could not recruit. One

of the chief reasons that we could not recruit them was that, in the voluntary service which existed before, they were so inadequately paid and the conditions were so bad that we could not recruit them in sufficient numbers. Indeed, I myself had to take the unusual step, rather different from that taken by the Government today, of intervening in negotiations to secure an increase in wages for the nurses. Otherwise, we should never have had sufficient nurses to man the hospitals - if I may use an Irishism. Today, of course, the Government have done the opposite; they have intervened to stop the rises.

In addition, we had the very considerable problem of converting old infirmaries which had been workhouses into modern hospitals. One of the most pleasant features of the country today is the extent to which what were buildings of horror are now bright buildings, many of them maternity hospitals. All this had to be done very quickly, and the burden, administrative and physical, was very great indeed.

To turn to the picture today, here are some more figures. In 1947, there were 23,076 notifications of tuberculosis, giving a rate of 552 per million of the population for tuberculosis in all forms. Last year, there were 4,784, representing a rate of 107 per million, a reduction from 552 to 107 per million of the population. Those are very remarkable figures. In the ten years of the National Health Service, new cases in England and Wales have fallen by 38 per cent., and deaths by no less than 78 per cent.

It is perfectly true, of course, that all the credit for this might not go to the Health Service. To some extent, it is due to higher standards of nutrition and better housing - though we were to some extent responsible for that also - and also to new drugs. But the main point still remains: all those drugs and medical facilities would not have been available under the old system. That is the point. The new knowledge would be there, but it would not reach the people needing it.

This must be borne in mind in everything we say about the Health Service, and this is why our medical profession got it all wrong when it started to oppose the National Health Service in 1946. Medical men seemed to believe, or some of them, at least, pretended to believe, that all that nationalised medicine would do would be to interfere in the practice of medicine. I had no such intention at all.

What the Health Service was intended to do was to organise the practice of medicine in such a fashion as to reach the people who needed it most. That, of course, has been done.

The incidence of children's diseases is falling so rapidly that hospital beds are now becoming vacant in great numbers. It must be exceedingly pleasant news for the country that, instead of children being in hospital, they are now going to school in greater and greater numbers, largely due, once more, to the maternity and child welfare services, of which, I am glad to say, the women of Great Britain now take full advantage.

There is no more pleasant sight to be seen in the world than can be seen outside a maternity clinic in Great Britain today, where women of all classes in the community mingle together, taking their children to be weighed and to be examined, to receive their lessons in maternal care, to have advice about what food to give their children, and to listen to the doctors' advice as to what may be wrong with them. That is an exceedingly pleasant spectacle, and, of course, this part of the Service is in great measure responsible for the fact that we can probably boast in Britain today that we have the bonniest children in the world.

There are other vital statistics which are equally remarkable. The infant mortality rate has fallen from 33.9 to 23 per 1,000. The maternal mortality rate has fallen from 1.02 in 1948 to 0.47 per 1,000 today. Those are extremely interesting figures.

We were able to turn our attention, also - I commend this to hon. Members in all parts of the House - to another feature which was quite novel. At the end of a war, the industries and crafts which make artificial limbs and give assistance in other forms to injured soldiers, sailors and airmen are, of course, at their height because they have many unfortunate applicants; but, as the years go by and the number of ex-Service men diminishes, the call for that skill and industry diminishes. The pool of knowledge and skill is lost. But, of course, industry produces far more casualties in the aggregate than does war, and of course, those skills were not generally available or, at least, were available only in a very small degree.

We were able to keep that pool of experience, knowledge and craftsmanship in existence and make it available to the civil population as well as to ex-Service men. That is going on. To take invalid

chairs and tricycles as an example, the number issued from 1949 to 1957 was 109,037. At the end of 1957, 1,647 motor cars made available for disabled war pensioners were in use in England and Wales. However, I shall not give very many figures because they are easily available and it would add too much to the burden of my speech and impose upon the patience of the House if I were to do so.

We can say, therefore, that the National Health Service in the facilities provided to the population as a whole can be regarded as a marked success. Indeed, so successful is it that there is now competition in claiming its paternity. I have found even Conservative Members who have forgotten that they voted against it on every conceivable occasion and for every conceivable reason. It has been said, of course, that the National Health Service had a curious kind of beginning, that all parties were in favour of it. I am bound to say that, when I went to the Ministry of Health, I found no evidence of that.

I will tell right hon. and hon. Members on my word, that the poor people there had realised that the Government of the day had practically abandoned them. The Minister of Health at that time had not even been made a member of the Cabinet, so as to show how unimportant the Government regarded the creation and launching of the National Health Service. As for the hospital system, I must say that I found absolutely no preparation at all for integrating the hospitals with the rest of the Health Service. On the contrary, the opposite was the case. The old voluntary hospitals were to remain.

Of course, opposition was being whipped up, but I was singularly fortunate in my opponents. First, I had the Conservative Party, and no one could be luckier than to have that at that time. Then, of course, we had the Association of Voluntary Hospitals, which was bitterly opposed to the taking over of the hospitals, and that was led by no less a distinguished person than Sir Bernard Docker. Who could be luckier than that? He described the National Health Service Bill as a mass of "mechanism in which the patient will get caught and mangled" and as providing for "the mass murder of the hospitals." I remember meeting a deputation led by the good knight. After listening to him and to his case I knew that the way ahead was quite clear.

I was also fortunate in another matter, very fortunate indeed, and that was that we had in the London County Council a Labour Council. Therefore, although reluctantly - and one can understand that - it was prepared to hand its hospitals to the nation. I tremble to think what would have happened if, instead of there being a Labour majority at County Hall, at that time there had been a Conservative majority led by the present Minister of Housing and Local Government.

So we were able to take over the hospitals without too much friction from those who were responsible for them. Of course, in addition to all that I had the singular advantage of being opposed by the present Chancellor of the Duchy of Lancaster.[3] He led his men up the hill and he led them down again. Therefore, with all those advantages in our favour we were able to go ahead, and with the Health Service on its therapeutical side I am quite certain that there is general satisfaction, although, of course, there will be some criticism, and I propose to make a little criticism myself.

It is when we come to the financial side that I am getting a little worried because, as I said to the House just now, the second principle was to bring about the redistribution of the national income by means of the method of financing the Health Scheme. I rejected the insurance principle as being wholly inapplicable in a scheme of this kind. We really cannot give different types of treatment in respect of a different order of contributions. We cannot perform a second-class operation on a patient if he is not quite paid up.[4]

One of the reasons why there was such a rush by the people of the country to enlist in the Health Service in 1948, just before the launching of the Service, to sign on with the doctors, was that the propaganda of the British Medical Association had conveyed the impression to the country that it was an insurance scheme. It was the singular benefit of the lucidity of the Chancellor of the Duchy, because to mobilise opposition he convinced the country that from 5th July 1948, it would be paying for something that was not to be there. He converted the country to the quite mistaken belief that there was an insurance scheme. Therefore, they all joined up to get their money's worth. As a recruiting sergeant for the National Health Service he was successful.

Very large numbers of people today still believe that their weekly

contributions are in respect of the National Health Service. That arises partly because of the confusion of the terminology - National Insurance and National Health Service and the old National Health Insurance. All that language is very confusing for people not expert in it. Therefore, today there are very many people who think it is an insurance scheme.

I refused to have the insurance principle not only for the reasons I have already given, but for another reason, and that is that the whole idea of insurance is inapplicable, because if everybody is in it, it is no longer insurance. Insurance, by its very nature, assumes a group, a group within the community. If all the community is in it, it is not insurance: it is a tax, unless the amount of the contributions is related to a variety of benefits, and we could not relate it to a variety of benefits for the reason I have given. The insurance scheme was inapplicable.[5]

Next, and equally important, was the fact that we had found group insurance to be highly undesirable, whether in respect of occupation or in respect of vertical groupings of the community; and we discovered that with the National Health Service. Hon. Members with experience of industrial areas will know that additional medical benefits which were available to the better-off members of the working class were denied to those who needed them most.

Miners, steel workers, textile workers were unable to obtain additional benefits from the National Health Insurance whereas the better-off members of the 20 million insured were able to get them because the incidence of sickness and unemployment was less among those than amongst the others. So we found group insurance, occupational insurance to be highly undesirable. Occupational insurance is particularly undesirable, because medical benefits for the workers engaged would follow the fortunes of their industry and the funds available would expand and contract with the sales or lack of sales of their products.

For all these reasons and very many others we rejected the principle of insurance and decided that the best way to finance the scheme, the fairest and most equitable way, would be to obtain the finance from the Exchequer funds by general taxation, and those who had the most would pay the most.[6] It is a very good principle. What more pleasure can a millionaire have than to know that his

taxes will help the sick? I know how enthusiastic they have always been in following that up.

The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutical.[7]

We shall see how civilised hon. Members opposite are. To them, the financial principles are much more important than the therapeutical principles. They have been engaged in trying to reverse the redistributive aspect of the Service, and one of their chief supporters in that is the man who tried to stop it coming into existence at all, that is to say, the Chancellor of the Duchy of Lancaster. I am sorry not to see him in his place. I was hoping that he would be there on the Front Bench. As it is the National Health Service that we are discussing the saboteur in chief ought to be present to hear the results of his handiwork.

What has happened since then? I have certain figures here which, I think, the House will find quite illuminating. In this case, the then Chancellor of the Exchequer, my right hon. Friend the Member for Bishop Auckland[8] - I must give him credit for this - accepted the principle of financing the National Health Service from the Exchequer with enthusiasm, because he entirely agreed with my point of view about this. But, of course, there was one particular item which even he could not deny himself. That was that portion of the contribution of the old National Health Insurance which had been used for medical benefits. The Treasury could not forgo putting its fingers on that. I do not blame them too much, and it did not matter to me at all.

The Treasury said, "All right, if the Treasury is to carry the full cost of the National Health Service, we will take that portion of the National Health Insurance contribution which was used formerly for medical benefits." From one point of view, that was perfectly just. In other words, if in future the provision of all medical benefits was to be financed from the Treasury, it seemed quite reasonable that the portion of insurance contributions formerly used for that purpose should be an appropriation-in-aid for the Treasury.

That amounted to something in the nature of £40 million to £41 million. As a matter of fact, it was fairly constant. It was in 1949-50, £40.8 million; in 1950-51, £41.5 million; in 1951-52, £42 million; in 1952-53, £40.9 million; in 1953-54, £41.2 million; in 1954-55, £41.2

million; in 1955-56, £41.3 million; and in 1956-57, £41.7 million. In other words, we had a contribution there which was almost constant because it represented an appropriation-in-aid, but it did not represent a contribution to the cost of the National Health Service.[9] I hope that hon. Members will get that clear in their minds. It had nothing to do with the National Health Service. It was not paid to the National Health Service. It was an appropriation-in-aid taken from the Insurance Fund by the Treasury. There was no organic, financial or administrative link between National Insurance and the National Health Service. I want to make that point as strongly as I can, because unless that is seen in its full significance, no one will appreciate the dishonesty of the Government in the way in which they have used this purely historical accident as a justification for undermining the redistribution principle of the National Health Service.

For instance, the Chancellor of the Duchy of Lancaster, in a speech the other day - I think it was on 5th March - when he sought to justify an increase in National Insurance contributions in aid of the National Health Service, spoke about a flat rate contribution from the National Insurance Fund to the National Health Service as a principle adopted in the 1946 Act. It was not in the Act at all. There is no reference in the 1946 Act, so far as my memory serves me, to any relationship between National Insurance and the National Health Service.

But, of course, he wanted to make a case, so what he did was this. He expressed as a percentage of the total of National Health expenditure the £40 million to £41 million taken as an appropriation-in-aid. In other words, he made a retrospective judgment and said: "That being the percentage there, all we are doing is bringing it up." As I have tried to show, so far as we were concerned, it was constant and although expenditure on the National Health Service went up by £200 million, the appropriation-in-aid remained the same. In other words, there was no organic link between insurance and National Health. It has been created in the mind of the Government in order to justify a tax on the poor.

I will show exactly how it has been done. Whereas the contribution was about £40 million to £41 million over those years, it has now been raised to £95 million for England and Wales only. What has happened is this. By assuming this link, instead of increasing taxa-

tion to provide the additional money, the Government have called for the money from the National Insurance Fund, and they can only call for it from the National Insurance Fund by a poll tax, because it is no longer an insurance contribution. It is, in fact, a transfer of the burden from the shoulders of the rich to those of the poor. The reason why I resent it today is not only because it is inimical to the second important principle of the scheme but because, if it is persisted in, it would appear to justify a gradual transfer of the whole of the cost of the National Health Service to the shoulders of the poorest members of the community.

Let us just consider, for example, these figures for England and Wales. I am sorry to weary the House with them, but it is necessary that they should be on record so that we shall understand what has happened. In England and Wales, the appropriation-in-aid was constant at about £37 million, £36 million, £36.7 million, £36 million - the same each year; it does not change at all. But then it went up. In 1957-58 it went up to £57.9 million, and the estimate for 1958-59 is £95 million. So we have there a complete picture of the transfer of the cost of the National Health Service.

I am speaking now about the perfectly unjustified transfer of the burden from the well-to-do to the poorest, because the poorest have to pay those contributions. I say that it is entirely unjustified, and more particularly so because the cost of the National Health Service to the present Government is a smaller percentage of the national income than it was in 1950. In other words, when the burden has become less for the nation it is made heavier for the poorest. That seems to me to be an entirely unjustifiable attitude of approach. Of course, the party opposite would make even more inroads on the Service if they thought that it was politically expedient to do so.[10] Certainly, on the Service. In addition, hon. and right hon. Members opposite have imposed charges.

The party to which I belong put on some small charges in 1951, intending that they should last for four years. When the party opposite came in, it made them permanent and increased them, until now they represented a payment of nearly £35 million for England and Wales alone. But that procedure was so unpopular that the party opposite did not go very far with it. It did the other thing; it got itself out of its financial troubles by increasing the tax on the Insurance

Fund. The figures as percentages of the national income are 4.2 in 1949 and 3.9 in 1956. Therefore, as we grow richer and more able to bear the burden, the more and more the party opposite throws it on the shoulders of the poorer members of the community.

I want to give another example, which I hope will appeal to the House, of the way in which the Treasury is nibbling away at the Service in every respect. In, I think, 1947-48, it seemed to me a very good idea to establish a college of a very unusual type. That was a college for the teaching of teacher-midwives. We in this country have always been very proud of our maternity service, which I think is the best in the world. But we had to increase the numbers rather rapidly. In particular, I wanted to provide a very quick increase of midwives for the Commonwealth, and especially for the backward areas. In the Commonwealth, and especially in the Colonial Empire, doctors are very thin on the ground. In the rural areas, particularly, they practically do not exist.

It seemed to me and to my medical advisers at the time that the quickest way of providing efficient help for these areas would be to provide them not only with midwives - and that we could not do in sufficient numbers - but with teacher-midwives to teach others as the quickest and cheapest way of helping, because if one could get a trained midwife to preside at births in these areas an enormous amount of mischief would be stopped. We set up the college. It is at Kingston-on-Thames and is a very small affair.

It has turned out 267 students in the short time it has been in existence. Seventy-five of these have gone to the Commonwealth. The numbers of students from the Commonwealth are: Australia 5, Burma 3, Canada 2, British West Indies 5, India 7, Malaya 7, Singapore 3, Hong Kong 1, Sarawak 1, Ghana 2, Sierra Leone 2, Uganda 1, Nigeria 7, Southern Rhodesia 3, Sudan 1, and Ceylon 1, making 51 in all. I do not hesitate to say that I do not believe that there is a single service of more value for so little money as that. Nor do I think that there is a service which has a better public relations aspect for this country, because these teacher-midwives go out and teach midwives there so as to increase the number available. I am certain that they are ambassadresses for this country in a very singular sense.

We had a little assistance to finance this college in the first instance, but now the college is threatened to be closed because the

Treasury will not find £3,500 in a year in subvention.[11] This is a characteristic example of the relationship between the spending Departments and the Treasury about which I have protested over and over again. I do not object, but, on the contrary, admit that it is necessary that there should be some global relationship between what the Treasury is prepared to spend and what the Service is entitled to get. It cannot get what it likes, but I insist that when the Treasury has decided that it is able to afford certain money for certain purposes it should leave the spending of the money to those who know most about it and about how they can get the most good for the Service. What happens over and over again is that some minor official at the Treasury wipes the dust from his eyes and looks at all these items and sees how he can nibble them away. Out of a vast expenditure of £600 million, the Treasury goes poking away, trying to nibble at that £3,500.

At present, these students are paying fees, and now they will have their fees increased. Whereas we ought to be finding more money and not less for this college, I am now told by those responsible that the college may close down unless some financial assistance is given - that modest sum of £3,500 a year. I am not attacking the Minister. I do not believe that he is responsible for it. If he is, he should be ashamed of himself. Indeed, he should resign if that is his view of the Service; but I am sure that this is not his disposition, and I am making this speech today about this matter in order to enable him to exercise the necessary leverage with his colleague. If he wants further assistance, I shall be delighted to give it to him.

One of the difficulties about the National Health Service is that there have been far too many Ministers. They have followed one after the other, not only to their mutual embarrassment, but to the dismay of the nation as a whole. I was at the Ministry from August, 1945, to January, 1951, - a very long term - and my right hon. Friend the Member for Middlesbrough, East[12] was there, but for a short time, unfortunately, because the electorate deserted us at that time. The present Minister of Labour's tenure of office was disastrous, although he became educated before the end.[13] Towards the end, he became really a defender of the Service, although he started off as its most advertised executioner. He said so himself from the Front Bench opposite. He was there from May, 1952, to December,

1955.[14] Yes, I beg the pardon of hon. Members. He was there - and was a most unfortunate choice. Then, from December, 1955 to 1957, the right hon. Member for Thirsk and Malton was the Minister, a very short term.[15] The next one, unfortunately, fell ill,[16] and now the right hon. and learned Member for Hertfordshire, East occupies the office.[17] I hope that it will not be for long - not for any personal reasons. I hope that he also will be deserted by the electorate before very long.

I make this point because if we have a succession of Ministers in an important Department like this two things happen. By the time they have acquired a jealousy for their position and a knowledge of it they are sent away. They also do not acquire in that office sufficient stature to be able to stand up against the importunities of the Treasury. It is necessary for them to be senior, experienced, long-standing Ministers to be able to get their own way. I am not talking about the global sum spent on the Service, but about its internal administration. They can stand up against this nibbling by the Treasury only if they are men of stature in the Government, men of experience and long standing. Therefore, I think that great mischief has been done to this Service by the continual changing of occupiers of the office of Minister of Health.

One or two features were introduced into the National Health Service in 1948, which I always regarded as concessions to the pressures of the moment for reasons which I think were at the time perfectly proper. For instance, we wanted to bring an end to these nursing homes, expensive places not properly looked after in my opinion. We could do that only by persuading surgeons to stay at the general hospitals, and that could be done only by having pay-beds at the general hospitals. So we made a concession; it was that there should be pay-bed blocks and that the consultants should take paying patients into hospital.

I know from what I have heard from different parts of the country, because I receive letters about this every week, that this position is in some respects and in some cases seriously abused. Apparently the middle classes cannot help preying upon the middle classes. The consultants, if they can get a paying patient into the hospital, jump the waiting list and get him in, and there is no justification for saying that in every instance they go in for medical reasons,

because they go in for financial reasons. This is a serious abuse.

I am not saying for a single moment that it is universal, that it has amounted to so grave an abuse as to impair the Service, but I do say that it has caused great grief. I hope, therefore, that hospital management committees will pay more attention to this and will ensure that patients are admitted to hospital for medical reasons first, and that people should not be able to buy their way in ahead of those who need hospital more than they do. Unless we can put a firm administrative foot on this practice, we shall find a kind of Gresham's Law operating in the National Health Service by which the worst practices will drive out the better.

Again, the administration ought to stand up for the better consultants against the others. It ought to discourage these consultants having financial advantages over their colleagues by getting fees, whereas their colleagues apply a medical test and a medical test only. So I hope that this kind of thing will stop, because if it is stopped the whole climate of the Service will be much happier, and certainly the hospitals will be much more wholesome. If it is not stopped, then I am afraid - despite the fact that some of the consultants may take me to court - that I shall send their names to the Minister. We will see what happens, and I shall not even try to claim qualified privilege.

Many other things could be said. For instance, I could pay some attention to the mental health service, but that would take me too far afield, although we know it is very necessary indeed that more money should be spent on it. Some of our mental hospitals are in a disgraceful condition, and there is every justification for the Minister asking the Treasury for more capital moneys to be spent on this aspect of the National Health Service.

Before I sit down, I want to say how especially happy I was to pay some attention to the deaf for the first time in the history of public administration in this nation. Deafness is a most disabling disability. It is worse than blindness; it is stupefying. Large numbers of people could not attend their work, could not take part in normal social intercourse, because of this terrible misfortune. How many there were we did not know. An estimate was made. I was told that the figure was probably between 130,000 and 150,000. It turned out to be far more than that. The number of Medresco hearing aids

issued between 1948 and 1957 amounted to 580,000. I am not saying that at any given moment 580,000 people are wearing them, although as one moves about one sees many people wearing them and leading perfectly normal lives.[18]

When people are talking about the cost of the National Health Service, I hope they will keep such facts as that in mind; because not only does the Service rescue people from a kind of twilight life, but their rehabilitation is of an enormous economic advantage. People are able to go about their normal vocations and to lead happy and contented lives, rescued from what was a near death.

Also, when people are talking about the cost of the National Health Service as expressed in these figures, I hope they take into account the fact that the Service has a column - a secret, silent column, which never appears in the balance sheet. That comprises the enormous number of people who are back at work and who would not be there had they not received hospital treatment. It is not only that the hospitals are providing more beds, but the turnover is much greater there. People are getting back to work more quickly. These are assets that are unassessable and require imagination to be seen. It is that function which the House of Commons must perform.

I hope, therefore, that as we celebrate the tenth anniversary of the National Health Service, more and more people in this House will become its guardians, because it is regarded all over the world as the most civilised achievement of modern Government.

Source: House of Commons Debates, vol. 592, cols. 1382-98, 30 July 1958.

Notes:

1. Sir William Scott Douglas (1890-1953), Permanent Secretary to the Ministry of Health, 1945-1950.
2. Sir Wilson Jameson (1885-1962), Chief Medical Officer to the Ministry of Health, 1940-1950.
3. Dr. Charles Hill.
4. R.G. Cooke, Conservative M.P., Bristol interjected in favour of insurance. Bevan retorted that the American experience indicated what

happened to health care under insurance.

5. Sir Frederick Messer, Labour M.P., Tottenham, pointed out that the insurance principle introduced qualification for service.

6. Hon. Member: "There is nothing wrong with that, either".

7. W.S. Shepherd, Conservative M.P., Cheadle, "More". Bevan retorted that he was more civilised than that.

8. Hugh Dalton.

9. Shepherd pointed out that £2,000m was spent on drink and tobacco. Bevan replied that the rich were not known for abstinence.

10. Hon. Member: "On the Service?".

11. Hon. Member: "Shame".

12. H.A. Marquand.

13. I.N. Macleod.

14. As Edith Summerskill (Labour M.P., Fulham West) reminded Bevan, he had omitted to mention H.F.C. Crookshank, who was Minister of Health from September 1951 to May 1952.

15. R.H. Turton.

16. D.F. Vosper.

17. D. Walker-Smith.

18. See above, V, n.6.

NOTE ON
"STUFFING THEIR MOUTHS WITH GOLD"

Arguably Bevan's best-remembered and most frequently reiterated remark relates to his dealing with consultants, whose compliance with the new health service was sufficiently generously rewarded for Bevan to have concluded "I stuffed their mouths with gold". Understandably this colourful, pointed and not inappropriate comment has become an obligatory component of accounts of the establishment of the NHS hospital service. Yet this quotation is not contained in any speech or writing included in this collection or its notes, and I have not located anything like it in the original documentation relating to the period of Bevan's ministerial career. This omission calls for a brief note of explanation.

The ubiquity of references to the quotation in sources of all kinds is self-evident. Indeed the BBC programme marking the thirtieth anniversary of the NHS was called "Stuffing their Mouths with Gold".[1] Neither has the growing tide of learned commentary on the early NHS overlooked the attractions of Bevan's epithet.

Despite its current vogue the Bevan quotation seems not to appear in the early literature on the National Health Service emanating from Ross (1952), Eckstein (1958), Lindsey (1960) and Stevens (1966). Its general entry into the historical imagination seems to begin with a widely-quoted review by Julian Tudor Hart of the second volume of the Foot biography. Tudor Hart noted that consultants' support for the service was won not only because Bevan (in his own phrase) "choked their mouths with gold", but also because he was offering the means to higher standards of professional work.[2] Tudor Hart was the source for Navarro, who concluded that Bevan "choked [the consultant's] mouth with gold" by establishing a hierarchical order within the medical profession with consultants at the top and general practitioners at the bottom.[3] Of the more recent books on the NHS, the quotation is afforded most prominence by Honigsbaum, who makes it the basis for a chapter assessing the relative extent of Bevan's concessions to consultants and general

practitioners.[4]

Of the major biographies Campbell follows the predictable line, concluding that consultants were rewarded with power and income, hence Bevan can be said to have "stuffed their mouths with gold".[5] Significantly this remark is not cited in Michael Foot's massive biography. Indeed he confirmed that "I did not hear Nye say that myself, and certainly Moran did not repeat it to me in the lengthy and instructive talks I had with him on the subject".[6] This recollection, together with the absence of substantiation for the quotation, might lead us to question its authenticity. However, it is possible to trace the source with a degree of confidence.

In fact, all of the above studies which cite Bevan's remark are either directly or indirectly indebted to Brian Abel-Smith's authoritative *The Hospitals 1800-1948: A Study in Social Administration in England and Wales* (London, Heinemann, 1964). This book was not primarily concerned with the National Health Service, but chapter 29 contains an excellent and succinct discussion of the Bevan scheme, under the heading "Bevan Decides". In describing the generous settlement won by the consultants, Abel-Smith notes: "As Bevan remarked to a friend: 'I stuffed their mouths with gold'."[7] This comment from 1964 - four years after Bevan's death - seems to have been the first occasion upon which reference was made to the celebrated quotation. Abel-Smith slightly varied the quotation in a personal communication which is given as the source by Tudor Hart. Some elaboration was given in the BBC programme in 1988, when Professor Abel-Smith observed that he was at dinner with Bevan in 1955 where Bevan commented: "ultimately I had to stuff their mouths with gold". Professor Abel-Smith now confirms that "Bevan made the stuffed with gold remark over a dinner at the House of Commons given to celebrate the publication of the Guillebaud report which vindicated Bevan on the charge of extravagance. Six of us were present if I remember right."[8] This would seem to locate the quotation precisely at the very end of 1955, or January 1956.

Thus the small mystery is solved. Bevan's remark is authentic, but it was made from the safe haven of the Guillebaud Report. Once absolved of blame on the serious charge of wasteful stewardship of health service resources he was able to admit to a certain generosity to consultants. The concessions won by consultants were tangible

and substantial. On this question it is not possible to improve on Professor Abel-Smith's admirable summary: "While the negotiating committee under the aegis of the British Medical Association was awaiting a summons to Whitehall, Bevan was dining with Lord Moran (President of the Royal College of Physicians) at Prunier's restaurant in St. James's Street. Thus the top doctors obtained *à la suite* terms in the Health Service: part-time payment for loosely defined sessions, the secret disposal of Treasury funds to those of their number whom Lord Moran and his two colleagues thought more meritorious, the lion's share of the endowments of the teaching hospitals to pay the costs of their researches, and the right to private practice - much as before. The consultants had gained regular remuneration without any loss of freedom and were being trusted to use this freedom responsibly".[9] In the light of this seemingly excessive generosity to consultants, how was Bevan so easily acquitted of the charge of profligacy? As already indicated, abandonment of the principle of full-time salaried service for the higher professions was a painful compromise for the Labour government. In the case of dentists the fee-for-service method of payment was initially extravagant, but the excesses were rapidly eliminated. The capitation method adopted for general practitioners was primarily due to their skill in determining the outcome of the Spens enquiry and the Danckwerts award. By 1945 it was universally accepted that the tradition of consultants serving hospitals on an honorary basis was obsolete. All doctors in local authority hospitals were paid on proper professional scales. Junior appointees in voluntary hospitals were also salaried. Extension of such an arrangement to all medical staff in hospitals was inevitable. No doubt Bevan anticipated that the majority of consultants would take up full-time contracts and be paid by salary. Although in the event full-time contracts were in the minority, the problem over generous terms of part-time contracts and distinction awards was in essence confined to about 4,000 part-time consultants, many of whom were located in the London area.[10] This distinction awards system was anathema to the Treasury, but it was a bearable expedient because greatly more economical than any salary scale likely to be adopted for the consultant class. Consequently, the majority of consultants were employed on a modest flat-rate salary and the rest were exposed to Lord Moran's lottery, all of

which served the Treasury interest. Since consultant numbers could be held down, part-time contracts and distinction awards remained a tolerable luxury. Also, since the majority of routine hospital care was undertaken by low-paid specialists, junior doctors and nurses, the whole system of payment for front-line hospital treatment represented a remarkable economy. Bevan may therefore be excused his wry remark. In effect liberal distribution of "glittering prizes" to the consultant élite purchased their compliance with the NHS and this brought in the entire support structure. Unfortunately the severe imbalances of remuneration soon became institutionalised and although recognised as a major injustice they have never finally been erased.

Notes:

1. BBC 4, September 1988.
2. J. Tudor Hart, "Bevan and the Doctors", *The Lancet*, 1973, ii, 1196-7, 24 November 1973.
3. V. Navarro, *Class Struggle, the State and Medicine. An Historical and Contemporary Analysis of the Medical Sector in Great Britain* (Oxford, Martin Robertson, 1978), p. 41.
4. Honigsbaum, *Health, Happiness and Security*, p. 143.
5. Campbell, p. 168.
6. Personal communication from Michael Foot, 24 April 1990.
7. Abel-Smith, *The Hospitals*, p. 480.
8. Personal communication from Brian Abel-Smith, 30 April 1990.
9. Abel-Smith, *The Hospitals*, pp. 486-7.
10. Although there were initially 1,310 whole-time and 12,372 part-time consultant appointments on 31 December 1945, these contracts were held by only 5,200 persons. Ministry of Health, *Report for 1950*, p. 4 and Appendix III.

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"...despite our financial and economic anxieties, we are still able to do the most civilised thing in the world – put the welfare of the sick in front of every other consideration." 9th February 1948

"This is the biggest single experiment in social service that the world has ever seen undertaken." 7th October 1948

"The NHS is regarded all over the world as the most civilised achievement of modern Government." 30th July 1958

"The undertaking to provide all people with all kinds of health care...creates an entirely new situation and calls for something bolder than a mere extension and adaptation of exisiting services." 13th December 1945

"I believe it is repugnant to a civilised community for hospitals to have to rely upon private charity." 30th April 1946

"...the hospital service of Great Britain, if it is to be efficient, must be fully integrated." 6th April 1946

"...the defence programme must always be consistent with the maintenance of the standard of life of the British people and the maintenance of the social services..." 23rd April 1951

"If we are to carry out our obligation and to provide the people of Great Britain...with the same level of service, then the nation itself will have to carry the expenditure..." 30th April 1946

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