without medical care. To-day voluntary hospitals, although still formally regarded as charitable institutions, derive a large part of their income from patients' payments. In many parts of the country the old Poor Law institutions have made way for modern municipal hospitals which are open to all citizens in their area, either free or at comparatively low charges. The maternity and child-welfare services of local authorities have become an accepted feature of the community's life and are used by the large majority of mothers. Most dramatic perhaps, the local milk and food schemes for poor mothers and their infants have been replaced by the National Milk and Vitamin scheme for all mothers and all children under five without consideration of income. Yet the divisions between the different sections of what should long have become a national health service have remained.

The great variations in the standard and extent of the services from one area to another are perhaps the most outstanding feature of the present situation. Voluntary effort is necessarily haphazard, and it is to-day rarely possible for charity to finance the very costly services of modern hospitals. The public services are based on "permissive" legislation. Poor local authorities cannot easily afford to provide all the services they have power to provide, and backward local authorities may see no reason to do so. Practising doctors very naturally settle where they can find paying patients, and the poorest districts are often ill-provided. Specialists tend to live near teaching hospitals, where they work in an honorary capacity, and to practise in the Harley Streets of big towns, where they find their living. As a result, there are areas without the necessary specialist services and without well-staffed hospitals equipped with an adequate number of beds. In short, the distribution of our medical resources is not determined by need, but partly by accident and partly by economic factors.

This situation was tolerated by successive Governments before the war, although many professional and lay bodies, including the Labour Party, repeatedly called for a unified health service covering the whole population. It became intolerable when the country was threatened by large-scale air attack. The Emergency Hospital Service, instituted by the Government in 1939, provided an object lesson. At a moment of crisis, when highest efficiency and co-ordination of all available resources became vital, all previous objections were swept away and large-scale planning was accepted as the obvious solution, at least in this branch of the health services.

During the war the future health services of the country became one of the issues in all the discussions for a better post-war Britain

and many lay and professional bodies published detailed plans. The Medical Planning Commission, a body widely representative of the medical profession, expressed itself in favour of health centres, and the Labour Party, in its "National Service for Health", demanded a comprehensive free service for every citizen. The Beveridge Report, which was welcomed so widely and enthusiastically, included as one of its assumptions the existence of such a service, and in 1944, by then eagerly awaited, the Coalition Government's White Paper on a National Health Service appeared. Some of the most progressive provisions of this document are understood to have been whittled down in secret discussions between the Minister of Health, Mr. Willink, and the British Medical Association. But the General Election intervened, and a new start was made when Labour came to power.

In the spring of 1946 Mr. Aneurin Bevan submitted his National Health Service Bill to Parliament, together with a Summary of the Proposed Health Service, in which the Government's intentions were outlined in greater detail. The Bill itself was mainly concerned with the general structure of the service, and made it the duty of the Minister of Health to fill in the details by statutory regulations, subject to the control of Parliament, thus ensuring elasticity and speedy decisions. The main principles and provisions of the Bill remained unaltered during its passage through Parliament, and in November the National Health Service Act, 1946, received the Royal Assent. By 1 April 1948, provisionally fixed as the "Appointed Day", Britain's National Health Service should be in operation.

MAIN PROVISIONS OF THE ACT*

It will in future be the duty of the Minister of Health "to promote the establishment of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness".

This comprehensive service will include (1) every kind of general and special hospital care, maternity accommodation, in- and out-patient service, treatment at specialist clinics, and the advice and service of specialists wherever necessary at health centres and in the patients' homes; (2) general practitioner services provided by

* The Act applies to England and Wales only, and so do all facts and figures contained in this pamphlet. The National Health Service (Scotland) Bill is before Parliament at the time of writing.

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Extract from '*A Guide to the National Health Service Act 1946'* Published by the Labour Party, Ca.1946.

doctors and dentists of the patient's choice, either from publicly equipped health centres or from the practitioners' surgeries; (3) supplementary services such as midwifery, maternity and child welfare, health visiting, home nursing, priority dental care for mothers and children, domestic help where needed on health grounds; and (4) the provision of spectacles, dentures and other appliances, as well as drugs and medicines, at hospitals, health centres, clinics, pharmacists' shops, and wherever else is found appropriate. Special school health services, which are already provided for under the Education Act, 1944, are not included.

Every citizen who wishes to use this service will be able to do so free of charge, without insurance qualifications or waiting periods. There will only be some charges for certain additional amenities, supplementary foods, blankets, the renewal or repair of appliances, and domestic help. The service will be financed partly from the Exchequer, partly from local rates, and partly from insurance funds.

By making the service comprehensive and by placing it at the disposal free of charge at the moment of need to every man, woman, and child in the country, the Act implements the main principles of the Labour Party's health programme. Health, like peace, is indivisible, and a health service which includes only some branches of medical care and excludes others would constantly defeat its own ends. The abandonment of the insurance idea in relation to medical care is another step forward which involves a great principle. Medical need will now be made the only criterion which determines what the citizen will get. The inclusion of the whole population in the service, without consideration of income, ends one of the controversies with those who were opposed to the so-called "100 per cent principle". Some doctors and others wished to preserve as much as possible of private practice, and proposed, therefore, that an income limit should be fixed in order to compel approximately ten per cent of the population who were "willing and able to pay" for their medical care to stay outside. This would have involved nothing less than the imposition of a means test on the remaining ninety per cent for the use of the service, and it would have undermined the whole of the Government's social-security system, which is all-inclusive and of which the health services form a part. Even more important, it would have perpetuated the idea that there will be one service for the well-to-do and another for the poor, and thus weakened the confidence of the public in the new service from the beginning. Nobody who does not wish to do so will be compelled to use the public service, and no doctor or other professional person will be compelled to work

in it, but the objective will be to make it the best that medical science can offer when it is supported by all the material and administrative resources of the community.

The Act outlines the administrative structure within which all the manifold parts of the service can work in co-ordination. The Minister will discharge his responsibilities through three main channels:

(1) He will appoint new Regional Boards to administer, on his behalf, the hospital and specialist services over wide regions. Individual hospitals will be administered by local Hospital Management Committees set up by the Boards. Teaching hospitals will not be subject to the Regional Boards, but have their own Boards of Governors. The blood-transfusion and the bacteriological-laboratory services which were created during the war will remain the Minister's direct responsibility. He is also empowered to conduct research and to give financial help to voluntary research agencies.

(2) The county and county borough councils will be the future local health authorities. They will be responsible for the local clinic and supplementary services, and it will be their duty to provide, equip, and maintain the health centres. Their arrangements will require the Minister's approval and form part of the plan for the region as a whole.

(3) New Executive Councils, normally one for the area of each major local authority, will be created to organise the services of general practitioners, dentists, and pharmacists both in health centres and outside. Half of the members of these Councils will be nominated by the local authority and the Minister, the other half by the local practitioners concerned.

An advisory body, the Central Health Services Council with various standing committees of experts on particular subjects, will be created by the Minister for his own guidance on professional and technical issues arising in his work.

This, in very broad outline, is the structure of the new service. In the following sections its individual parts will be considered in greater detail.

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