The Future of Medicine in Great Britain: A Review of the Medical Planning Research Report*

The December and January issues of the Bulletin carried summaries of recommendations made by British governmental and nongovernmental organizations to Sir William Beveridge and his Interdepartmental Committee on Social Insurance and Allied Services, and of the Beveridge report.[1] The report summarized here,[2] which appeared almost simultaneously with the Beveridge report, represents the proposals of a group of young medical practitioners concerned with the future of medicine in Great Britain and the pattern of the post-war society in which the new medical services must be built.

THE INTERIM GENERAL REPORT of Medical Planning Research represents a synthesis of the proposals offered by some two hundred young medical practitioners, approximately half the membership of an organization formed in 1941 to plan for the future of medicine in Great Britain. Membership in the voluntary organization was solicited through the medical press, and all who cared to take an active part in its work were invited to join as actual contributors of recommendations or as critics of the plans proposed by other members. The members who prepared drafts of recommendations on which the present interim report is based are, for the most part, doctors who have been practicing less than 21 years or others connected with the health services who are not more than 45 years of age.

Like the Draft Interim Report of the Medical Planning Commission, issued by the British Medical Association several months earlier,[3] the report of Medical Planning Research (M P R) is intended not as a blueprint but as a basis for discussion and criticism. The present draft is a synthesis of many documents, none of which was written for publication. The aim of the small editorial group responsible for the draft was to select the most constructive proposals and those most calculated to attract constructive criticism. Since many of the members of M P R are in service with the armed forces on distant fronts, it is proposed to allow at least 6 months for examination and detailed criticism of the present interim report by members and other interested persons before a final report is prepared. By withholding the names of the contributors, M P R believes that it will be possible for doctors and others serving in the armed forces to contribute to the discussion of post-war health services without conflicting with service regulations. "Medical opinion is on the move," the report says, "and no desire to suspend judgment can alter this fact. It is important, therefore, that men in the services should make their contribution now . . ."

The Draft Interim Report issued by the British Medical Association dealt with the various proposals advanced for improved organization and enlargement of the scope and content of the medical services provided the British people by the State. Within that framework it made an exhaustive analysis of what should be done to make "available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional." In much the same field, the Society of Medical Officers of Health presented an interim report concerned mainly with proposals for administrative reorganization of the health program.[4]

M P R, on the other hand, starts with the thesis that proposals for the future of medicine

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[1] Otey, Elizabeth L., "British Proposals for the Future of Social Insurance and Services," *Social Security Bulletin*, Vol. 5, No. 12 (December 1942), pp. 11-21; and Ring, Martha D., "Social Security for Great Britain—A Review of the Beveridge Report," *Social Security Bulletin*, Vol. 6, No. 1 (January 1943), pp. 3-30.

[2] "Medical Planning Research; Interim General Report," Supplement to *The Lancet*, Vol. 243, No. 6221 (Nov. 21, 1942), pp. 599-622. An American edition will be available from Medical Administration Service, 1790 Broadway, New York City, which, jointly with *Medical Care*, is issuing the report in pamphlet form.

[3] Medical Planning Commission, *Draft Interim Report*, London: British Medical Association House, 1942, 45 pp.

[4] "A National Health Service; Interim Report of the Society of Medical Officers of Health," *Public Health*, Vol. 55, No. 12 (September 1942), pp. 199-202; see also the editorial, "Medical Planning—The Society's Report," in the same issue, p. 197.

must recognize two groups of problems connected with, but not strictly a part of, medical planning. First, since the group considers medical organization as very largely determined by the pattern of the society in which it exists, they examine the probable pattern of post-war society "to see the framework inside which the new medical services will have to be built." The second group of problems they see as "environmental planning for health and happiness," which demands "a study of the special measures which should be taken . . . to achieve the highest measure of positive mental and physical health."

M P R's approach to post-war problems parallels closely that of Sir William Beveridge and of Political and Economic Planning (P E P).[5] All three documents assume a concerted effort of the British people to abolish want, by maintaining a subsistence income for all segments of the population through maintenance of employment at high levels; by State responsibility for meeting part of the living costs of large families through adequate allowances, without means test, to families with young children; and by an expanded contributory social insurance program which will provide benefits for all persons whose incomes are interrupted by sickness, unemployment, or death of the family breadwinner.

Patterns of Post-War Society

Part 1 of the M P R report deals with the changes that are likely to occur in the social pattern and the changes that are considered essential for maximum health of mind and body. Underlying the proposals is the assumption that the controls necessitated by a war economy have come to stay and that "post-war industrial production will have to be planned nationally, first to meet the needs of the people and only then the luxuries." In wartime, personal wealth—in the form of goods and services received—is reduced to the lowest level compatible with efficiency in waging the war. All surpluses above the minimum needed "to keep citizens physically fit for their war work, and mentally content to go on doing it" are devoted to the war effort, through a series of industrial, social, and financial controls, including allocation of raw materials, control of production, rationing, and price fixing. The war has taught that the limiting factors to national efforts are not finance, but rather the amounts of raw material, machinery, and labor a country possesses and the power to cooperate in using them. After the war, Britain can be nationally richer by the machinery and manpower freed from military purposes, but unless that wealth is used it will be only a potentiality. And if, after the war, the desires of some groups of people to revert to a free economy are realized, the story of 1918–39 will be repeated.

Action for the future, the report maintains, must be based on available real resources and priority of needs. Such resources will be greater after the war than during it. "There is no need for a return to pre-war poverty, slumps, or unemployment, if we are prepared to impose certain disciplines on ourselves. By continuing to sacrifice some freedoms, which we have willingly sacrificed in war, we can gain greater freedoms than we possessed before. . . . A planned health service is an A–1 priority. The best that the medical and allied professions can provide must be available for everybody. Provided this does not encroach on other A–1 priorities we need not count the cost. Since the productive wealth of Britain has never been greater, we can plan if not prodigally at least boldly."

The report holds that Britain must have a long-term planned population policy after the war. Children must be made an economic asset to all classes of the population, rather than a liability; in existing circumstances, children are "a bad cash investment" for all but agricultural laborers. The report recommends a universal system of adequate family allowances for all children and for young people up to the age of 25 if they continue at school. At the same time, there must be a universal system of free education for all children up to age 18, with emphasis on vocational training in the last 4 years. There should also be free university or technical school training for those who can profit most from it, and provision for adult education.

To make children a social asset to all classes of the population—only slightly less important than the economic factor—calls for a planned housing policy, "so that homes and their surroundings may be suitable for the happy and healthy growth of families of three or more children"; nursery schools, to permit mothers to continue at work; and an educational campaign to popularize fam-

[5] Political and Economic Planning, *Planning for Social Security*, London, Planning No. 190, July 14, 1942.

ilies of three or more children. Such a campaign will be of use, however, only when all the material factors working against large families have been dealt with. Concurrent with steps to encourage parenthood, it will be necessary to study the results achieved, by establishing a demographic research department in a national social research council, and to consider also public education on contraceptive technique.

Along with measures for planning and controlling the population trend, methods of controlling the distribution of population must be introduced, and radical measures taken to correct the distribution of the past which was "unplanned for strategic safety, industrial efficiency, transport of products, transport of labour to and from work, community life, and health and happiness of the workers, the managers, and the families of both. . . . The undoing of the work of the nineteenth century and the first forty years of the twentieth is the biggest task which will face the people of this country after the war."

Important as all these other proposals are, however, M P R sees poverty, "by which is meant lack of enough money to purchase the necessities of life," as the major cause of ill health and unhappiness. Only by a concerted attack on the problem of poverty can the goal of positive mental and physical health be achieved.

The immediate causes of poverty in Great Britain are well known, the report says. They include: unemployment of the chief wage earner, 32 percent; sickness of the chief wage earner, 9 percent; insufficient wages to meet family expenses, which depend more than anything else on the number of children in the family, 21 percent; old age, 22 percent; widowhood or unmarried motherhood, if associated with inability to work because of children, 6.5 percent.[6] The complementary causes of poverty are, therefore, inadequate unemployment insurance and assistance, inadequate sickness benefit, the failure of wages to allow for the size of the family, inadequate old-age pensions, and inadequate widows' pensions and allowances for their children.

As a cure the report recommends a social security program for the entire Nation which would provide, in essence: a national minimum wage for men and women sufficient to enable workers to purchase all the basic needs for physical health; a wife's allowance as a supplement to the wages of the husband when the wife is not gainfully employed; family allowances for children; insurance benefits, raised to the national minimum wage level, for unemployment, sickness, and widowhood, with continuation of allowances for wife and children when men are out of work or sick; and old-age pensions at somewhat lower rates than minimum wages and with no requirement that the pensioner shall cease gainful work. A fundamental premise for all payments is that there must be no means test; contributions must be made by all members of the community, and all must have similar rights. "If a means test operates, or if there is any deviation from the minimum rights, the thrifty and industrious will be penalised, and relative poverty will continue to cause misery among those who have done least to deserve it." Moreover, any comprehensive system for the removal of poverty will work only if the community maintains a high level of production.

The present system of medical practice in Great Britain depends largely on the distribution of purchasing power. "Most wage earners contribute compulsorily to an insurance scheme which enables them to pay for medical attention during the time they can best afford it—that is, when they do not need it. The dependants of the insured population, having individually small purchasing powers, pay small fees for the medical care they receive. The middle and upper income groups, a relatively small part of the population, have a much greater purchasing power. In return for larger—and indeed sometimes very large—payments, they receive slightly better medical attention. This Robin Hood system as it has been called has a certain rough and ready justice about it. But it will work only as long as the doctors who treat the poor at low rates are able to make up by treating the rich at high rates. If the rich lose their purchasing power, the doctors who depend mostly upon them (but who serve all classes) will be driven out of business. It so happens that this particular group of doctors—the consultant and specialist group—is of vital importance in the chain of curative medicine."

From the point of view of medical planning, the report asserts, it is necessary to have a flexible system of distributing purchasing power, "capable

[6] The report ascribes these figures to H. Tout, author of *The Standard of Living in Bristol*, Bristol, 1938.

of providing the whole community with everything medical that it needs, but also allowing the rich to pay more if they want to. Under no circumstances are we justified in saying that the rich shall get better treatment than the rest, because they want to pay for it. Only the best must be available for everybody."

Paying for Medical Services

Dismissing as undesirable on one ground or another the present methods of paying for medical services—by direct payment of fees, by the panel or insurance system, by local or national tax revenues, by private insurance arrangements, by assessing against employers the cost of industrial accidents, and by charitable contributions—the report recommends that complete medical and hospital services, rehabilitation, and training should be financed by a single social security insurance contribution payable by all wage and salary earners and persons in receipt of any form of earned or unearned income. This same insurance contribution would carry rights, without means test, to adequate cash benefits in unemployment, sickness, old age, and widowhood; adequate family allowances; and burial allowances. Contributions would be graded to income levels, and each contributor could elect to make his payments weekly, monthly, or quarterly. Additional voluntary contributions would entitle contributors to proportionately higher benefits, and persons already carrying private insurance would be allowed to transfer such insurance to the compulsory system.

Since a sample study of family budgets in 1937–38 indicated that 7.2 to 7.5 percent of the total weekly expenditures of wage earners in Great Britain went for medical care, social insurance contributions, and other forms of insurance, the report maintains that a single social security insurance contribution of not more than 8 percent of income would be no more burdensome than are existing expenditures for like purposes. The proposed program, with its greatly increased benefits and family allowances, would probably make a contribution rate of 10 percent of income acceptable. During periods of unemployment or sickness, contributions would be credited as if paid. Except for medical emergency benefits, receipt of all benefits would be conditioned on a complete record of contributions paid or waived.

In most respects the proposed program parallels closely the recommendations of the Beveridge report in comprehensiveness of coverage, types of insurance benefits, children's allowances, abolition of workmen's compensation as it now operates, and provision of universal medical and rehabilitation services. M P R proposes contributions and benefits at higher levels than does Sir William, but the latter specifically states that the levels he assumes are illustrative and tentative only. M P R postulates the disappearance of public assistance, poor relief, and unemployment assistance with their stigma of the dole and charity; Sir William, on the other hand, considers that public assistance will continue as a necessary part of a social security program to abolish want, since some persons will fail to meet contributory requirements for social insurance benefits and others will have special needs which require supplementation of such benefits to meet subsistence requirements of the family.

The costs of the proposed social security plan for Great Britain as estimated by M P R are compared, in table 1, with estimates of the costs

Table 1.—*Great Britain: Social security expenditures for 1938–39 and estimated expenditures under the proposed Medical Planning Research program and under the Beveridge plan*

Program	Present programs, 1938–39[1]		Medical Planning Research		Beveridge plan (estimates for 1945)	
	Amount (in millions)	Percent of total	Amount (in millions)	Percent of total	Amount (in millions)	Percent of total
Total	£444.3	100.0	£1,052.3	100.0	£697	100.0
Social insurance	154.0	34.7	822.0	78.1	480	68.9
Sickness benefits	43.0	9.7	82.5	7.8	72	10.3
Unemployment benefits	62.0	14.0	70.0	6.6	110	15.8
Old-age and survivors' benefits	49.0	11.0	351.0	33.4	155	22.3
Family (children's) allowances	......	....	308.5	29.3	[2] 118	16.9
Burial allowances	......	....	10.0	1.0	4	.6
Administration	[3]	....	[3]	....	21	3.0
Medical services	160.3	36.1	230.3	21.0	170	24.4
Hospitals and institutions	75.3	16.9	......	....	......	....
Practitioners' fees and salaries	60.0	13.6	......	....	......	....
Medicines	25.0	5.6	......	....	......	....
Public assistance	130.0	29.2	......	....	47	6.7
Unemployment assistance	36.0	8.1	......	....		
Noncontributory old-age pensions	48.0	10.8	......	....	44	6.3
Other assistance	46.0	10.3	......	....		
Administration	[3]	....	......	....	3	.4

[1] Costs as presented by Medical Planning Research. The Beveridge report gives a total cost of £334 million in 1938–39; see the Bulletin, January 1943, p. 10, table 6.
[2] Includes marriage grants and maternity grants and benefits.
[3] Included with benefits.

for the Beveridge plan in 1945 and with the expenditures under existing social insurance programs in 1938–39.

M P R assumes insurance contributions based on income; Sir William proposes to maintain a flat rate of contributions varied only by age, sex, and income source. M P R would require no employer contributions on behalf of employees and would permit persons in higher income groups to pay reduced contributions to compensate for the medical expenses they might prefer to meet under private arrangements. In that case, they would not be eligible for medical benefits under the insurance plan.

Before the war, according to M P R, the national income of Great Britain was approximately £4.5 billion, and since the war it has increased to about £6.3 billion. The increase, however, does not represent an increase in real wealth since nearly 60 percent of the goods and services produced goes to the war effort, which requires the full time of perhaps 3.5 million persons in active war services and at least as many in the production of munitions. About 1.5 million previously unemployed persons are now working, and the war has drawn a very large number of housewives into gainful employment. The proposed health and social security program would cost less than one-fifth of the present nominal or potential real national income. In presenting a budget for the comprehensive program, the report points out that, even if the cost of approximately £1.0 billion were "a withdrawal from the national income, a total loss as it were, we consider it is not an excessive price to pay for the abolition of poverty, and economic and medical insecurity. But it is *not*, in fact, a withdrawal from the national income but an orderly redistribution within it."

"Our proposed social security contributions would yield about 300 million pounds. The remaining 700 million would have to be met by direct contribution from the Exchequer. It is worth noting that between 1926–38, 63.5 percent of all state income maintaining payments (under national health insurance, and unemployment, war and other pension schemes) was met out of taxation and not by the contributors. We propose that the figure should instead be 70 percent. It is worth reiterating here the reasons why the whole sum should not come directly from the Exchequer; we consider that there should be a direct link in the minds of everyone between contributions paid and benefits received . . . The finding of this 700 million presents considerably less difficulty than the financing of the British national war effort; 11 million per day are being spent directly on war purposes; 700 million per annum is something under 2 million per day."

"Running the Show"

The latter half of the report discusses in considerable detail the principles of administration which should govern the medical service organization and the detailed functions of the health service and its medical personnel and regional and local units. The establishment of the national health services as a corporate body and not as a Government department is urged, to divorce administration from politics and "day-to-day or even year-to-year inquisitions in Parliament" and to permit bold planning and initiative. The Government would turn over to the National Health Corporation grants from the social security fund to be spent for health services for individuals. Environmental services, such as sanitary control, are primarily the concern of nonmedical technicians and should be under separate control.

The home doctor of the medical service should receive his remuneration in three parts: a basic salary with additions for special qualifications and length of service; a capitation fee depending on the number of persons on his list; and fees for special clinics or other special work and private fees for patients who elect to be outside the service. The doctor, according to the plan, would not have to "buy his way" to practice and thus incur heavy debts which cripple the early years of practitioners. He must be free to give up practice if he desires, free to refuse to accept a patient, free (within limits of efficiency) to increase his practice by his own efforts, and free from "undue bureaucratic interference, whether medical or lay." Unless doctors are free, they lack the sense of responsibility on which the doctor-patient relationship depends. If they fail to carry out their statutory obligations they must be subject to statutory discipline but not the "inroads of officialdom."

Other "musts" for effective service are adequate remuneration from the outset of the medical career, adequate housing and equipment, regular holidays, periodic leave for refresher courses,

opportunities for acquiring and utilizing special skills, professional contact with other general practitioners and specialists, and adequate insurance protection for sickness and old age.

The home doctors or general practitioners would be attached to small local health centers affiliated with local medical or hospital centers at which specialists' and in-patient services would be provided. On a regional basis, key general hospitals, convalescent homes, and special hospitals would be established, all with adequate staffs. Medical health officers or "social doctors" would be attached to each medical center to act as health advisers to all local authorities within the area and to advise the home doctors on environmental factors in health and disease. The first duty of the social doctor should be the organization and maintenance of vital statistics and medical intelligence service; he would take over the recording of births, marriages, deaths, infectious diseases, and statistics for health centers and hospitals. He should have a statistical staff and mechanical equipment for transferring data to punch cards and should also supervise a small corps of social workers for home visiting.

The M P R proposals for organization and administration of the health services are similar in some respects to those made by the Society of Medical Officers of Health. Both reports underline the inadequacies of present provisions for preventive and curative medical services in Great Britain and the failure of a fee-for-service form of payment to meet the needs for medical, dental, nursing, and hospital care. The Medical Officers of Health, however, propose administration of "the new medicine" as a Government service answerable to Parliament through a Cabinet minister. The health officers' report also differs from that of M P R in proposing full-time salaries as the only form of remuneration for medical personnel.

The new role of medicine as envisaged by both groups—a role which is also advocated by the Medical Planning Commission of the British Medical Association and other medical groups in their report—is that of a public service with far greater emphasis on prevention than has hitherto been possible. The new medical services proposed by all three medical groups would include complete general medical service, with hospital, institutional, maternity, consultant, specialist, nursing, dental, ophthalmic, and auxiliary services available to the entire British population without direct charge. Persons would pay for these services for themselves and their dependents when they could best afford to pay, through insurance contributions which would be waived when earnings were interrupted by sickness, unemployment, or old age. M P R sums it up as follows: "It is agreed that the best possible health services both curative and preventive, shall be available to everyone. It is agreed that the nation as a whole can afford to pay for these services. It is also agreed that lack of capacity to pay shall not deprive anyone of the best."

As justification for its comprehensive social security proposals, M P R declares, "We recognize that such comprehensive proposals carry with them a theoretical risk of excessive pampering and paternalism. These dangers have been put forward as an argument against most social reforms in the past hundred years; yet the same people who have put them forward, have often argued that a leisured class, existing on unearned income, is a cultural and social necessity. We consider that the conduct of British people in all social classes in the present war suggests that the virtues of courage, enterprise, and vigour (and indeed a certain number of vices) occur independently of the income level and the measure of financial security. We regard the theoretical risks involved in social security as well worth running."