### Summary and Conclusions

The present analysis has necessarily been confined to State differences in insurance status at a time when the system had been in effect for only 4 years. These differences, nevertheless, result from factors which may be expected to continue to operate as long as the present eligibility and coverage provisions remain unchanged. Although the specific proportions of workers uninsured in the various States may change, the relative standing of the States in this respect is not likely to be greatly altered.

The wide differences among the States in the proportion of the labor force who work in employments covered by old-age and survivors insurance result chiefly from the fact that self-employment and agricultural employment are excluded from coverage. In the States where relatively high proportions of the labor force are in excluded employments a high percentage of workers have only short periods of covered employment. Evidently, the number of workers who shift between covered and noncovered employments in those States is greater, in relation to the total number of workers with wage credits, than in States with a higher proportion of the labor force in covered employment. Probably this situation reflects in part the extent to which low-income farmers and farm laborers take advantage of the seasonal character of their farming to supplement their incomes by occasional covered employment.

This type of short-term employment is one of the chief factors responsible for lack of insured status. As a result, interstate differences in the proportion of workers with wage credits who are uninsured at any given time follow the same pattern as do variations in the amount of noncovered employment. Extension of coverage to employments now excluded would greatly reduce the differences among the States in the proportion of workers who are insured. There would remain, however, the variations caused by differences in the amount of seasonal work performed by persons, particularly housewives and students, who are not regularly attached to the labor force, and also the differences caused by variations in amount of unemployment, intermittent work, and low wage rates.

# A National Health Service: Report of the Council of the British Medical Association*

ON FEBRUARY 17, the British White Paper on a National Health Service was made public. On February 18, the British Medical Association issued a brief statement indicating that, while it was clearly too early to give a considered judgment, "the White Paper provides a framework within which we believe it to be possible to evolve a good comprehensive medical service, though its worth to the public and its acceptability to the profession will depend on clarification and on negotiations on many important points . . . Our immediate reaction is one of cautious welcome." [1]

A detailed "draft statement of policy," a report of the Council of the BMA to the Association's Representative Body, was issued in the *British Medical Journal* of May 13. This report is to provide a basis for discussion at meetings of the whole medical profession, nonmembers as well as members of the Association, throughout the country. Professional opinion is invited in the form of resolutions and instructions to representatives at the annual representative meeting of the Association on July 18.[2]

The Council's report reaffirms the position taken by the BMA over a period of years. In 1930 and again in 1938 the Association issued proposals for a comprehensive medical service in *A General Medical Service for the Nation*. In 1942 a draft *Interim Report*, summing up for submission to the profession various suggestions for improving the medical services, was issued by the Medical Planning Commission, made up preponderantly of representatives of the Association, the Royal Colleges, the Society of Medical Officers of Health, and the Medical Women's Federation. In September 1943, before the White Paper was issued, the Representative Body adopted a statement of principles which should govern future health services.[3]

Preparation of a final report of the Medical Planning Commission, based on the recommendations received from the profession concerning the draft *Interim Report*, was postponed by "the appearance of the Beveridge report, with its serious medical implications."[4] Out of the Commission came a smaller representative committee which entered into discussions with the Ministry of Health, but without power to negotiate.

A negotiating body is to be set up at the next meeting of the Representative Body. It will be composed of 30 members—16 appointed by the BMA, the remainder representing other professional societies.

An editorial in the same issue of the *British Medical Journal* as the Council's report, urges that "between now and the moment when negotiations begin . . . doctors both individually and in groups will give as much time as they can spare from their daily work to an intensive study of the White Paper and to any other published matter that has a bearing on it, and more especially to the report of the Council to the Representative Body."

Stressing the importance of the Council's document, the *Journal* declares, "Out of many admirable statements in the Council's report we

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[1] The complete statement was carried in *Social Security Bulletin*, Vol. 7, No. 3 (March 1944), pp. 12–18. For some comparisons between the British White Paper and health service proposals of the Medical Association of South Africa, see "A Health Service Plan for South Africa" in the May 1944 issue, pp. 18–21.

[2] At the request of the Government, the meeting was postponed to avoid additional strain on the transportation facilities.

[3] Reprinted, with an analysis of the White Paper in relation to the principles, in the Supplement to the *British Medical Journal*, March 18, 1944, pp. 47–53.

[4] *British Medical Journal*, May 13, 1944, p. 663.

would pick upon the following as summing up succinctly the attitude of most medical men to reform: 'To agree upon the objects of national reconstruction in the field of health is not necessarily to approve the methods or the timetable proposed.'"

The medical profession is opposed to the time chosen to introduce these reforms. "To introduce legislation in wartime, with the younger generation of doctors away, would seem to betray the promise made by the Prime Minister not to legislate during the war on controversial mattexs.

"From the point of view of the general practitioner," the editorial continues, "the key proposal of the White Paper is the establishment of health centers, to be built, owned and administered by the major local authorities—namely the county councils and the county borough councils. For rewarding the staff of these centers the Government favors payment by salary. The practitioner will enter into contract with the local authority and the Central Medical Board. If in fact such a proposal is accepted and acted upon, then it is difficult to see any other fate for the future general practitioner than that of a whole-time salaried servant of the State, to which the profession is unalterably opposed.

"The threat to the other key structure in our medical services is the threat to the voluntary hospitals . . . if the Government pays in full for the services of the voluntary hospitals, this will necessarily involve loss of autonomy and status." The real threat, however, as the profession sees it, is "whether the medical profession is to be socialized." Resistance of the doctors to a whole-time salaried medical service should not be interpreted as opposition to the White Paper, nor should the doctors refuse to negotiate. "It is necessary to be clear-headed in opposition, and wholehearted in cooperation in reforms agreed to be necessary."

The Council's report is divided into three sections—Some General Considerations, Some Criticisms, and Some Positive Proposals. The first two sections are summarized briefly here, since they reaffirm general principles on which the BMA is already on record. The "positive proposals" are only slightly condensed.

### *General Considerations and Criticisms*

The Council agrees that the country's full resources should be brought to bear on reducing ill-health and promoting good health in all its citizens. They add, however, that "It is a medical rather than a health service with which the Government appears to be really concerned—a service which is 'an essential part of any wider proposal for social insurance which may be put into operation.'"

Health is not mainly a matter of medical services; among the principal factors which determine a people's health are sanitation, provision of public water, housing, nutrition, conditions in factory and office, facilities for recreation and education, and here as in the field of health education is ample room for improvement by the State. "Investigation and research are the life blood of medical practice . . . ," and here "The State's attitude may be judged by the fact that its official annual contribution to this work is a mere quarter of a million pounds!"

Today there are overlapping of organization, incoordination of effort, and gaps in service which should be remedied by cooperative action between the State and the profession, and "*not* by the assumption of the State of control of an expert field and those who work in it. The record of the State in health and medical matters contains little to justify the suggestion that either the Ministry of Health or local authorities are sufficiently equipped with knowledge and experience to assume so vast and so potentially dangerous a responsibility." The medical profession "will resist any control by the State, either political or administrative, which is inconsistent with their intellectual and professional freedom."

It is not sufficient, the report continues, to promise that there shall be no interference or no regimentation. The plan must of itself by its provisions guarantee that there shall be no risk of such interference or regimentation.

"The Government's scheme is based on the principle that a comprehensive medical service should be available as a right, and irrespective of means, to all who want it, such service being paid for from insurance, taxation, and rates. The attitude of the profession is that the service should be available to all who need it, but that it is unnecessary for the State to make provision for those who are both willing or able, indeed prefer, to make it for themselves. Freedom is involved.

"This is not merely or mainly a financial issue. It is true that under the Government's plan—the so-called 100% plan—private practice will be diminished, as will income from this source. This of itself may be a serious matter for some members of our profession. What is even more important is that a profession which derives its emoluments wholly or mainly from State resources is likely bit by bit to be controlled by the State which provides its emoluments. Here lies the greater danger both to the profession and to the public."

### *Positive Proposals*

The Council's positive proposals, with its statement of general considerations and criticisms, are offered as "a framework within which negotiations with the Government could take place."

*The central body.*—The profession favors central administration by a corporate body, with the Minister generally responsible to Parliament for its work. It believes, however, that neither a corporate body nor a department can of itself prove satisfactory unless the arrangements are such that "subject to the responsibility of the Minister to Parliament, responsibility for medical policy and medical advice is borne by the medical profession. Accordingly the Association lays less stress upon the type of central body than upon the machinery set up for this purpose."

It recommends that the central body should be concerned with all civilian health and medical functions of central government, and exclusively with these; and that the central body, whether department or corporate body, should be advised by a statutory body, predominantly medical in composition. The medical members would be elected by the profession. Members of the Council would serve 3-year terms and should be free to appoint their own chairman and, jointly with the Minister, their own secretariat. The main function

of this statutory Council (similar to the Central Health Services Council of the White Paper) should be to consider and advise on any general medical questions affecting the country's health, the Minister to seek the Council's advice on medical questions before him and to be under an obligation to refer to the Council any draft regulations (other than those relating to the terms and conditions of service of medical practitioners) or conditions of grant. It should have the right to call upon the Ministry to supply any reasonable and proper information, and to tender advice on its own initiative and publish its advice, without modification, after the lapse of sufficient time for its consideration by the Minister.

The Council should not be concerned with terms and conditions of service, including remuneration, which should be negotiated directly between the Minister and the medical profession through a permanent body or bodies established for this purpose. If the Central Medical Board, proposed in the White Paper, is established as the body to enter into contract on the Minister's behalf with the medical profession, the Board should have no power to require practitioners to seek permission before entering new public practice, or to require young practitioners to enter any particular form of public practice, or any other similar powers.

*Local administration.*—No satisfactory form of local administration is likely to be achieved until a radical reexamination and reorganization of local government has taken place. Any local machinery decided upon for the administration of the health services should be regarded as provisional.

The Government proposal of joint health authorities covering areas conterminous with existing major local-authority boundaries and composed solely of the nominees of constituent major authorities would lead to an even greater division of local responsibility rather than to its concentration. Despite the White Paper provision for local advisory bodies (the Local Health Services Councils), the proposed joint health authorities would not be sufficiently informed or advised on the problems before them. Although these disadvantages would be removed somewhat by adequate representation of the medical and associated professions and the voluntary hospitals in the membership of the joint health authorities and by devising areas not necessarily conterminous with existing local authority areas but appropriate for hospital and medical purposes, substantial disadvantages would remain. The voluntary hospitals could not achieve real partnership by a minority representation on the body owning the local authority hospitals. The division of local health responsibility could be remedied only by concentrating all health functions in joint health authorities. Many members of the public health service would suffer a severe contraction of interest and responsibility, involving not only loss of status for the doctors but the future discouragement of able practitioners from entering this branch of medical work.

Pending the reform of areas and functions of existing local government authorities, regional councils for national hospital and medical areas, not necessarily or usually conterminous with local authority boundaries, should be established by law in place of the joint board structure proposed in the White Paper. These councils should comprise representatives chosen by local authorities, the medical profession and other vocational interests, and voluntary hospitals. Their function should be to advise the Minister on the planning of all hospital and health services in the region and on the disposition of centrally provided moneys. This planning should culminate in a scheme or schemes approved by the Minister for execution within the area covered by the council.

Local authorities should continue, for the present, to own their institutions and to administer their health services, but should be required to conform to the general plan prepared by the regional council and approved by the Minister. Similarly, the voluntary hospitals would conform to the general plan, receiving their moneys either wholly from the Minister on the advice of the regional council, or partly from the Minister and partly from local authorities in accordance with the plan laid down by the Minister.

In relation to each county and county borough council a medical advisory committee should be established, elected by the local profession and with statutory functions and powers analogous to those of the Central Health Services Council. There should be effective liaison between the medical advisory committee and the Central Health Services Council. Each county and county borough council should be required by law to consult such medical advisory committees and to co-opt representatives of the committee to their public health hospitals and similar committees.

*Voluntary hospitals.*—Such a local administrative plan would go some way towards securing real partnership between local authorities and voluntary hospitals. Financial arrangements would need consideration. However arranged, it should be possible for voluntary hospitals to receive as contracting parties a proper payment even up to the full cost incurred by them without losing their identity or status. The financial arrangements should secure that it is reasonably practicable for these hospitals, with such help as may be available to them from voluntary sources, to maintain and, when necessary, extend their existing services.

*General medical practice.*—The terms and conditions of service, including remuneration of general practitioners, should be negotiated centrally between the Minister and representatives of the medical profession. These terms and conditions should guarantee the professional freedom of doctors and freedom of choice as between doctor and patient. They should provide for a method of remunerating doctors which relates the remuneration to the work done or the responsibility accepted. This method should obtain both in separate and in group practice. If health centers are established, the terms and conditions of service, including remuneration, for practitioners working in the centers should be similar to those affecting other general practitioners except for differences related to the different expenses involved.

Agreements—the content of which should be centrally negotiated—should be entered into between the general practitioner and a body or bodies set up by the Minister expressly for the purpose. Such body or bodies

should include ample representation of the profession. The proposed Central Medical Board, but without the proposed powers of compulsion, would be appropriate for this purpose, acting either directly or through local committees of the Central Medical Board, analogous to the existing Insurance Committees under national health insurance. General practitioners are unwilling to enter into contractual relationship with local authorities.

*Health centers.*—The establishment of health centers as a national policy should be preceded by from 3 to 5 years of scientific trial and experiment, organized in contrasting areas under the aegis of the Central Health Services Council. This trial should be undertaken in consultation with the local medical profession and should include clinical, administrative, and financial experiments. The ultimate decision on the policy of establishing health centers, including the types, should await the result of such experiments.

*Compensation.*—The adoption of the proposal in the White Paper to compensate practitioners who enter health center practice for loss of capital value of their practices would adversely affect the capital value of all general practices. It would reduce the number of potential buyers and so lower the capital value of existing practices and would give a financial impetus, unrelated to the public interest, to the development of health centers out of all proportion to any case there might be for the establishment of such centers.

If this view is accepted, the question of compensation must be approached as a general, not a partial, issue. In any case, the final decision must await the results of the health center experiments, though it does not follow that the form or forms of health center finally approved will necessarily involve compensation. The approval of the "diagnostic and special investigation" type of health center, for example, would not, of itself, raise any compensation issue.

The uncertainty already caused by the White Paper proposals would, however, be aggravated by the absence of definite decisions on compensation. It is recommended that compensation formulas, standards, and amounts, relevant to both capital values and professional premises, should be calculated and agreed now, pending decisions whether compensation is involved by the forms of general medical practice ultimately approved.

*Rural practice.*—Problems peculiar to rural general practice will need special consideration. Any plan should include extension of the system of cottage hospitals suitably equipped, an increase in the provision of maternity beds, and the provision of radiological and pathological facilities. The terms and conditions of service of rural practitioners should take into consideration the relative sparseness of population and the time and cost incurred in travel.

*Hospital and consultant services.*—The position of voluntary hospitals is dealt with elsewhere in the report, and the report was prepared for recommendation to the Representative Body before the publication of the report of the Interdepartmental Committee on Medical Schools. Certain principles affecting consultant and specialist services may be put forward, however. In general, consultant services should be associated with hospitals and hospitals should be responsible for a complete consultant service, both institutional and domiciliary. The individual general practitioner should, so far as is practicable, retain the right to select the consultant he desires.

The terms and conditions of service of consultants, like those of general practitioners, should be negotiated centrally between the Minister and representatives of the medical profession. There is much to be said for placing the individual consultant or specialist in contractual relationship with the hospital or hospitals which appoint him. It has, however, the real disadvantage that general practitioners will look in one direction for contractual purposes, and consultants and specialists in another. This point needs further consideration.

*Private practice.*—The future of private practice depends primarily on the proportion of the community to which this service is made available irrespective of means and as a right. Before the profession can consider any modification of its attitude on this issue (summarized earlier in this article), it needs fuller information on several points, including the general social security contributions, the administrative and professional arrangements, and the machinery for ensuring the continuance of private practice for patients who wish it.

For general practice, the points to be considered include the mode of distinguishing between health service patients and private patients, and the procedure to be adopted by citizens intending to utilize the service for a particular item, or items, of medical service. For consultant and specialist practice, the profession needs fuller information on the procedure proposed for persons seeking consultative service in the consulting rooms of consultants and specialists, and in private wards, wings, and blocks associated with general hospitals.

Whether or not the whole community is covered by this scheme, persons who wish private medical service should be absolutely free to obtain it from any doctor of their choice, and every practitioner should be free to render such service on a private basis with access to hospital facilities at every level, should such be necessary. This is an issue of the freedom of the public rather than of the interests of the profession.

### *Statement of the Minister of Health*

In a speech at Croydon on May 17, Mr. Willink, British Minister of Health, commenting on the Council's draft statement, declared that, however much he might disagree with certain points, the report was "just the kind of thing we want and expect to see—full, constructive, detailed, well-marshalled criticism and review . . .

"As to this, plain speech is best. For instance, I do not believe that the interests of a great new social service which we all have at heart, or indeed the interests of one of the oldest and most respected professions, are best served by the preposterous accusation that the responsible Government of this country, in promoting this great measure, is really only scheming to gain control of the medical profession or to control medical certification, or that the inspiration of the new service is 'political rather

than medical,' whatever that may mean.

"Nor am I impressed by the suggestion that the Government ought not to be replanning the nation's health services in time of war. Was this an obstacle to the construction of our educational system? I should have been reluctant to have had to say that the Government had decided not to try to get anything ready in this field for the return of all our young men and women from the Forces, and particularly that we were going to let all our serving doctors come back to a period of confusion and uncertainty as to what their post-war professional opportunities were likely to be."

Nor was it very helpful or fair, he continued, to imply that the public was being misled into believing that health is simply a matter of hospitals and doctors and bottles of medicine, and that it has not occurred to the Government that healthy living depends largely on health education, on good enviroment, on prevention as much as cure. All these things and a lot of other things—good employment, economic security, nutrition, the whole field of social organization and progress—have to be the related parts of a single reconstruction policy. The country has no cause to be ashamed of the strides made before the war in housing and public hygiene and the betterment of living standards, of the millions spent on improving nutrition and food standards and the knowledge of ways of healthier living generally. After the war there will be every cause to be proud of further advances in all these fields.

The British Medical Association has produced in this new document, the Minister said, "a mass of good and fair criticism, a mass of practical points and proposals on the shaping of the new service . . . The doctors have some genuine and important anxieties in all this. They fear that, however good our intentions may be, the new arrangements might unintentionally turn out to have the effect of reducing professional life to some kind of dull uniformity, of discouraging some of the variety of enterprise and individualism, which is, as I know well, the life-blood of a vigorous profession; that the door might be opened to monotony and regimentation and interference with the doctor's primary allegiance to his patients. But I agree assurances are not enough. The way to safeguard these things is not by verbal assurance, nor, I think, by loose phrases about 'bureaucracy,' but by us all sitting down together to thrash out a detailed scheme in which these things will not arise.

"The spirit and intention of the White Paper are far removed from any notion of regimentation and control. But it is possible that the form of administration which the White Paper proposes can be altered and improved to give even surer effect to this intention. If so, I am waiting with a welcome for anybody's constructive suggestions to that end, and I assure you that I shall be anxious to accept anything that can be shown to be a genuine and practical improvement. All that matters is that the new health service, on the need for which all responsible opinion is agreed, shall be so framed as to give the best possible service to the public who use it, and to the people who provide it a fair deal and a career of stimulus and interest.

"I want this to be a service of individual people for individual people. It must be a willing, enthusiastic service. I believe that we are on the threshold of the biggest single advance in the opportunity of health that this or any other country has had the opportunity of making. We want, and expect, the help and good will of all."

# The Public Health Service Act, 1944

*By* Alanson W. Willcox*

ON JULY 1 the President approved the Public Health Service Act (Public Law No. 410), to consolidate and revise the laws relating to the Public Health Service. While the act makes a number of changes in the law, its basic purpose is to bring together into a single and consistent enactment virtually all of the statutes relating to the Service—a body of law which had accumulated over a century and a half, with little system or consistency, with many duplications and a few important gaps, and with an abundance of ambiguity. Since the founding in 1798 of a seamen's health insurance system, there had previously been no comprehensive legislative treatment of the Public Health Service or its predecessors, except as enactment of the Revised Statutes had brought together the applicable provisions as of 1878.

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### *The Surgeon General's Statement*

In commenting on the act at the time of its approval by the President, the Surgeon General expressed his gratification "that the House and the Senate have passed the Public Health Service Act without a dissenting vote. We are conscious of the large obligations imposed by the public trust invested in the Service. This law facilitates the discharge of this responsibility under both wartime pressures and the continuing demands of peacetime."

Dr. Parran continued, "The act again confirms the approval by Congress and the President of a closely knit, highly trained commissioned corps of officers, who are specialists in public health, medicine, scientific research, and related specialists, as the best type of administrative structure to deal with national and international health problems. To this structure has been added the commissioning of nurses, who play such an important part in the war.

"Through its research branch, the National Institute of Health, the Public Health Service has made important contributions to the great advances in medical and public health science during the twentieth century. But knowledge of many diseases remains incomplete; and control of such ailments as mental and nervous disease, heart diseases, and other chronic conditions demands coordinated plans of painstaking and laborious research. The Public Health Service Act gives the National Institute of Health the authority to develop such programs, in the same way that cancer research has been developed in our National