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HEALTH FOR ALL
The Government's Health Plan

JOAN S. CLARKE,
Secretary,
SOCIAL SECURITY LEAGUE

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6d.

Published by
THE SOCIAL SECURITY LEAGUE
33 Bruton Street :: London, W.1
SOCIAL SECURITY LEAGUE

To promote the Principles of the Beveridge Report.

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Health for All

By JOAN S. CLARKE

It is comforting to go to the doctor. Also flattering. Here is somebody who has spent seven years or so studying the human body and who is prepared to concentrate all his knowledge on oneself alone. The patient is of prime importance. The doctor seems infallible, a great wisdom filling his surgery. At the next visit this atmosphere of mutual understanding is revived. The doctor has confidence in his own judgment, but he can carry it into effect only if the patient has equal confidence. It is essential if treatment is to be effective that the patient shall regard the doctor as omniscient—at least pro tem. This doctor-patient relationship, so dearly cherished by patients and doctors, has grown up through centuries of medical practice. This is the relationship which both are keen to preserve and which the Ministry of Health has set out as one of the cardinal principles of its new health plan.

Under the new scheme every citizen will be entitled, without further payment, to whatever medical, surgical, dental, or vision treatment he needs. He will also be entitled to free hospital treatment. These services will be provided out of public funds to which citizens will contribute through taxes, rates and social insurance contributions. For the first time the Government will be responsible, acting through the Ministry of Health or the Local Authorities, for seeing that first-class medical services are available for every citizen, rich or poor. Doctors will be free to choose whether or not they will join the scheme whole-time or part-time and how they will be paid. They will, of course, continue to treat their patients as they think best, and both doctors and patients will be able to choose or to reject each other as freely as they do today.

I. WHY NOT STAY AS WE ARE?

All the good points in our present-day medical services can and should remain in the future scheme. Those who are now getting first-class medical care will go on getting it. But though many people in Great Britain get the finest medical care in the world, this does not apply to all Britons. The wives of manual workers come off particularly badly. As housewives they are not insured and so cannot be
"panel patients"; they must pay a fee every time they see a doctor. Many a housewife postpones treatment till she is seriously sick just because she dare not spend the family income on herself instead of on food and rent. Even relatively minor things like spectacles and false teeth are still not available to everyone. It is quite common to meet people in poor districts whose dentures are ready but who cannot have them till the payment is completed. Before the war, too, many people found it impossible to have false arms or legs because they could not buy these and were unable to persuade a charity to provide them.

Today there are three ways of securing the advice of a general practitioner. Each way is conditioned by finance, and not at all by physical needs. Little more than half of the population is insured under the National Health Insurance Acts. These Acts cover mainly employed persons earning less than £420 yearly unless they are "employed by way of manual work" where the income limit does not apply. Insurance does not cover the wives and children of insured workers. The wives, unless they are pregnant, are left out of public schemes altogether. The children can see the school doctor for certain specified ailments, but only at the school or clinics. He is not allowed to visit them in their homes.

Hospital treatment is not usually covered by insurance, so hospital patients must pay for it, unless they are voluntary contributors in a hospital saving scheme. Even dental and eye treatment are only available for insured people if the Approved Society they are in happens to be relatively rich. So insured persons get different services in return for the same insurance contributions. Hospital treatment, convalescent treatment, artificial limbs and vision treatment are all additional benefits and can be received only from Approved Societies whose funds have shown a surplus.

People who are not insured have to get their medical treatment how they can. Unless they are paupers they have to pay the doctor each time they go to see him. It is often thought that poor people are all insured and that so-called private patients are the rich citizens only. This is of course untrue. Only employed persons are insured in National Health Insurance. Many poor persons work on their own account but, not being insured, have no right to the free services of a doctor. This, of course, is one of the reasons why sick persons stay away from the doctor. Their efficiency is reduced and they spread disease, but they cannot embark on a course of treatment because they cannot pay for it.
Lastly, the Poor Law provides a free medical service from the rates for those without incomes. Doctors working in this service do not usually do so full-time. They see pauper patients as well as ordinary paying and panel patients. "The parish doctor," as he is commonly called, closes the gap in our Medical Services. No citizen in the community need be without the services of a doctor because of total lack of cash.

**SHEEP AND GOATS.**

One suggestion for reform is to extend National Health Insurance to include the wives and families of all insured workers. This, of course, would not take in self-employed persons, so a further proposal is that all those whose incomes are lower than £420, a year, no matter how they make a living, shall be included in some kind of National Health Service. But there would still be difficulty about knowing where the upper income line ought to be drawn. It is unsatisfactory to divide a universal service like medicine into two halves, one half for the rich, the other for the poor. The poor always get the idea that the rich are getting something better. Therefore the Government have now accepted the principle of bringing everybody into one all-in Medical Service in future.

Discrimination between patients has always been one of the unattractive features arising from National Health Insurance. Doctors have both panel patients and private patients; private patients pay a fee for each visit, but panel patients, i.e., the insured, do not pay anything when they see the doctor. He receives a yearly minimum of 10s. 6d. for each panel patient on his list whether the patient receives treatment or not. Doctoring is expensive, so practitioners need to supplement their incomes as far as they can by the fees they get from private patients. They must attract more private patients and they must make them comfortable when they come. Provisions, therefore, often differ for private patients and for panel patients. Some doctors allow private patients to sit in the dining-room while they are waiting, whereas panel patients come in at a side entrance and wait in the passage or in the back hall. This distinction has an unfortunate effect on panel patients, who often feel that they are not getting a fair deal—even though of course the doctor’s skill and attention is given to them as fully as it is to private patients. It is well known, too, that doctors vary their fees according to the wealth of the patients attending them. So that they can treat a poor woman for 1s. or 2s., doctors
charge wealthier patients one guinea or two guineas. This may be reasonable. Doctors may even devote excessive attention—more than necessary—to those patients who can pay big fees as long as the doctors' incomes depend not only on the number of private patients they can attract but also on the number of wealthy private patients.

Doctors are not more mercenary than any other citizens, but they are put in a position where they need costly premises and equipment, where to some extent their skill is judged by the look of their house and the size of their car. All these factors impel them to get money from their patients where they can. Also doctors usually buy their practices. A young doctor just setting out on his career has to find several thousand pounds before he can put up his brass plate and await patients. If he happens to have no private income he must borrow this money and he usually does so from organisations which exist for this purpose. For the first years that he is in practice, therefore, he is obliged to make money over and above his daily needs in order to pay off the heavy burden of debt which he has incurred. It is difficult for him to save enough out of the insurance money to do this, and whether he likes it or not he is obliged to concentrate heavily upon the private side of his work. Also, he has already had a long and costly medical education. His parents have already paid out some £2,000 on his education and maintenance until he is at least 23. It is on the top of this long financial drag that money to buy a practice must eventually be found.

BETWEEN ALL STOOLS.

One way and another the whole population is already covered for general practitioner treatment, but there is no link between the general practitioner and the hospital services. The general practitioner, sitting in his surgery by himself, is absolutely isolated. He certainly needs the backing of the great pool of medical and scientific knowledge which has been built up. He cannot provide the best of everything for his patients. Even if he could afford to buy an X-ray plant he is not trained to operate it. Even if he can buy it and work it he rarely has the space in his surgery to accommodate it, or the time to devote to developing films. For all this kind of supplementary treatment and diagnosis the doctor must send the patient off to whatever Harley Street consultants or voluntary hospitals or municipal hospitals or private or public clinics are suitable and available. In some country areas patients may have to make long and complicated journeys to receive the kind of hospital services which Londoners, for example, find close to their homes. The
patient loses time and courage; the doctor loses not only interest but often the benefit of conversation with the specialist to whom the patient goes. The British medical services are individually first class, but they are not knit together into any integrated pattern. There are endless chances for the patient to fall between all stools. It is nobody’s job to keep him in good health and it is certainly nobody’s job to see that the best types of medical treatment are at his elbow when he needs them.

II. THE NEW HEALTH PLAN.

The Ministry of Health’s White Paper sets out to solve these problems. It is based on excellent principles. First, there is to be a publicly provided Medical Service available for every single citizen in the country, with no exceptions. The Service will be provided partly out of taxes, partly out of rates and partly out of Social Insurance contributions. There will be no need for any citizen to put his hand in his pocket when he sees the doctor. The Service will be there for everybody. Secondly, every type of medical service will be included. Not only will all citizens have a right to treatment from general practitioners, but all citizens will have an equal right to treatment from specialists of every type. Even operations by first-class surgeons will be included, as well as all other forms of hospital treatment. All this without the least stigma of charity, for the new Service is to be one great service for the whole nation. Its emphasis will be on health, not cash. The general practitioner will therefore be closely linked with all types of modern medical treatment and diagnosis. He will be able to move his patients through the long assembly line of medical and surgical treatment until real health is restored.

Thirdly, these services will not be provided haphazardly, as now. It will be the responsibility of statutory bodies to see that they are all available for every single citizen, no matter whether he lives in towns or in the remotest part of the country. These are the major principles. With them goes the principle of free choice. Both doctors and patients can freely choose whether they will take advantage of the service or whether they will stay outside. Doctors can practice in the public service full-time or part-time or not at all. Patients can choose their doctor as they do now, and can use the public service or remain private paying patients exactly as they like. Even if they go to hospital they may not be obliged to go into the public service sections of the voluntary hospitals. They may still be able to go into paying beds and paying wards if they want to pay out cash.
1. PATIENTS:

How will all this work out in practice? Suppose that the White Paper plan becomes law, what shall we have to do when we are sick? What major changes will there be? Citizens who fall ill will at once be aware of the change. They will not have to pay a doctor’s bill unless they want to. They will have paid already through insurance contributions and taxes. In the future we shall be grouped roughly into those who want to pay for their doctors as private patients and those who don’t. Those who choose not to pay their doctor will need to find out straight away whether the doctor they have attended in the past has decided to enter into the public scheme. Maybe he has decided to stay out and have private patients only. If so, his former patients will have to choose between continuing to pay him, or leaving him and choosing another doctor who has arranged to work in the new scheme. But if the doctor is in the scheme, then his patients can go to him as before, continuing their personal relationship with him, all without having any bill to pay. They may find, though, that the doctor is not in the old surgery he used to work in. He may have decided that isolated individual work is not as satisfactory as some form of group practice.

The doctor may have decided that he can work best in a Health Centre. In this case the patients will find him in a spotless consulting room provided by the local authority. There will be teams of nurses, clerical workers, social welfare workers and whatever else is necessary. There will, we hope, be X-ray apparatus on the spot and facilities for heat and light treatment and for massage. There will be other doctors working in the same building and our doctor will have the advantage of calling in his colleagues to discuss a special case if he wants another point of view. If this doctor is in a Health Centre his special relationship with his former patients and with any new ones he may get will remain as firm as before. There will be a list of doctors kept at the Centre and a list of the patients who attend each one. There will be no question of the patients being compelled to see another doctor, nor of Centre doctors treating anyone who happens to be handy. From a patient’s point of view the Health Centre will mean that, if additional examination or specialist treatment is necessary, a good deal of it can be procured on the spot without the patient setting off elsewhere. There will also be the great advantage of being seen in first-class, modern, hygienic rooms. This would seem a necessity for all health work, but in fact we know that many private doctors have been unable for various reasons to provide first class and properly equipped surgeries in which to see their patients today.
2. DOCTORS:

Doctors can choose whether they will co-operate with the new scheme or whether they will stay outside. If they decide to co-operate they can again choose how much work they will do inside the public service and how much in private practice outside the scheme. They can set their mark at any point between non-co-operation and full-time public service. If they enter the service full time they will of course receive a suitable full-time income. This income from public funds will be reduced in proportion to the number of private patients which each doctor decides to take.

Doctors can also choose how they will be paid. Some doctors would like to have a proper salary with pension rights attached. Many doctors working in hospitals or for the public health service are already salaried and would be very reluctant to change back again to the hit and miss remuneration of private practice. However, the British Medical Association has set its face against full-time salaried service. They tell us that the very notion is gravely injurious to the work and happiness of the general practitioner. The Association is particularly afraid that the Health Centre proposals\(^1\) in the White Paper are a disguised method of persuading doctors to accept full-time salaries. It is difficult for the layman to see why the B.M.A. is so afraid. The average citizen respects the medical profession so much that he cannot believe that doctors will work well only if good work adds pound upon pound to their personal incomes. Also we know that doctors work appallingly long hours now which should eventually be shortened, not lengthened, in a full-time service.

The Ministry of Health, however, knows the B.M.A.'s views and has handled the whole problem by giving the doctors free choice as to how they will be paid. If doctors do not want salaries they need not have them. In this case they may be paid, for their public work, by capitation fees, a method which the B.M.A. prefers. "Capitation" is the way the National Health Insurance doctors are now paid. They receive a fixed minimum sum each year for each patient on their lists. The assiduous doctor who can add more patients to his list up to a maximum can add to his capitation fees and so to his total income. Capitation fees, however, put doctors into competition one with another, and make it difficult for doctors to co-operate fully without at least some of them trying to pirate each others' patients. A scientific pooling of service and knowledge will be very difficult to achieve if capitation is retained. However, true to the principle of free choice, the Ministry of Health does not suggest that any pressure be put on the doctors to be

\(^1\) See page 16
salaried rather than paid by capitation fees. Doctors can choose whether they will be salaried full-time or part-time, or paid by capitation fees for full-time or part-time service, or by a mixture of salary and capitation fee, or partly by any of these means and partly by fees from their own private patients.

From the doctors' point of view the new scheme has very great advantages. Young doctors entering the service will not have to find large sums of money to buy practices, and they will be able to start straight away on their medical careers with their income clear and with no burden of debt. This means that young doctors coming fresh from hospital will not have, as so often happens now, the edge of their enthusiasm blunted by money worries, by overwork, and lack of leisure. One of the great problems which doctors now face is the need to be twenty-four hours on call for their patients. Panel doctors who do not respond to calls from their patients at any time of the day or night, or who leave their practices without a substitute or an address where they can be found, are subject to severe penalties. The doctor's time and soul are never properly his own. In future, doctors who decide to go into Health Centres will be able to arrange with other doctors to be on night duty in turn and will be able to find ways of securing that their leisure is really leisure. Today a doctor with a large practice in a busy district has little chance and little energy left at the end of the day for reading, for keeping up with modern medical knowledge, and certainly not for doing any kind of personal research. Even if he goes to the cinema he may see a call for him flashed upon the screen at any moment. The slavery of the G.P. will end when the new health plan begins to work.

It is, of course, important to emphasise that doctors entering the new service will continue to exercise their own judgment in the actual treatment of their patients. There is no question of "regimentation" or routine medical treatment being instituted. Doctors will have every opportunity of working as individually as they do now, but with the great advantage that assistance will be handy when it is wanted. Nor is there any pressure on doctors to choose Health Centre practice. Those who prefer to do so will be able to link up with other doctors in some sort of group in much the same way that several partners now share practices. Alternatively, doctors can enter the scheme without taking advantage of any of the possible opportunities for co-operation. These doctors can keep on their own private surgeries, submitting, just as they do now, lists of those public patients who attend them. Doctors' private surgeries will not be liable to inspection, and doctors will be able to
continue as they are at present, taking a proportion of public and private patients in whatever way will maximise their income.

The scheme will, of course, only be effective if the majority of general practitioners co-operate. This was the difficulty that the New Zealand Government had to face in 1938. The New Zealand Social Security Act provided that all insured citizens could have free general practitioner treatment; but when citizens paid their social security tax and went off to their doctors for treatment, they found that most doctors were not co-operating. The New Zealand Branch of the B.M.A. seriously embarrassed the New Zealand Government. It was not until 1941 that a satisfactory working arrangement was evolved between doctors and the State.

In Great Britain exactly the opposite happened in 1911. Lloyd George wanted to introduce the National Health Insurance Act and the doctors protested vigorously. Doctors' speeches and articles of 1911 make all the arguments which doctors are now putting up against the new Health Plan. Lloyd George was told that he was interfering with the patient-doctor relationship, that he was restricting the professional freedom of doctors, that he was reducing the incentive to good work. However, he went ahead with his plan and a few weeks before the Act came into operation the doctors in their hundreds began to change their minds and to sign the panel list. In 1944 the doctors are repeating the arguments which they made thirty years ago against the very service which they now defend.

3. HOSPITALS:

The British hospital tradition is founded on the voluntary system. The care of the sick was originally the job of the churches and religious orders. Then special institutions developed and were financed from legacies from wealthy people, or from thank-offerings of those who had received some kind of blessing, or from donations of wealthy citizens. We all know the great voluntary hospitals—Guys, Barts, the Manchester Royal Infirmary. Over the last hundred years local authorities have also begun to provide hospitals out of the rates. They are now allowed to do this not only for paupers but for any citizen. Municipal hospitals differ administratively from the voluntary hospitals. First, they pay their specialists. It is only the voluntary hospitals whose honorary specialists are unpaid. Secondly, municipal hospitals are run—apart from patients' payments—entirely from public funds. Voluntary hospitals, however, receive no public funds at all and depend on legacies, charities, and contributions from private citizens. Each volun-
tary hospital is an independent unit. Its board of management is
entirely free to run the hospital in any way it thinks fit. Municipal
hospitals are dovetailed as far as possible one with another inside each
area and are run by locally elected public representatives. These
municipal hospitals, because they are run from public funds, are
obliged to find beds for any sick persons needing hospital treat-
ment. Voluntary hospitals are under no such obligation and can
choose their cases. This has meant that in the past municipal hospitals
have had the majority of chronic and old cases while the voluntary hos-
pitals, especially the teaching hospitals, have tended to select the most
medically interesting cases.

The White Paper proposes major changes. It aims at providing
first class hospital treatment for every citizen who needs it, no matter
where he lives or what his income may be. To this end voluntary and
municipal hospitals are invited to co-operate much more closely and
to work together within a single plan. For the first time hospital facili-
ties will be planned as a whole over areas wide enough for first class
and diversified treatment to be made accessible to all citizens.

New Joint Authorities will take over and run all public hospitals.
Voluntary hospitals, however, will still remain under their own boards
of management. They need not come into the scheme at all unless
they choose. Those which decide to come in will be fitted into the
Joint Authority's plan and will be required to keep to their part of
the bargain by providing the services which they have promised. In
return they will, for the first time, receive substantial public funds as
part of their normal income. They will be paid, first, in proportion
to the public service they will provide; secondly they will receive a
fixed sum (the same as that to be given to the public hospitals) for each
public bed available. Thirdly, teaching hospitals will be given a special
grant, and, fourthly, all voluntary hospitals will get payment in respect
of the specialist services they provide under the scheme.

The receipt of public money will carry with it few conditions.
Voluntary hospitals must, of course, be willing to have their public
sections inspected, and they will also be asked to adopt a uniform
system of accounting for administrative convenience. They, with pub-
lic hospitals, will have to appoint consultants and specialists in accord-
ance with nationally agreed terms. Even voluntary hospitals who choose
to co-operate in the new service need not bring in all their facilities.
They will still be entitled to have private beds and private wards for
paying patients; the rules laid down apply only to the work for which
they are receiving public funds. The voluntary hospitals are afraid
that they will not be able to find additional money from voluntary
sources when the public know that they are entitled to free hospital treatment in return for their Social Security contributions and rates and taxes. It would not seem logical, however, for the voluntary hospitals to receive the whole of their income out of public funds while having no public representatives on their boards of management. The hospitals want to have their cake and eat it. They want full public maintenance without full public accountability. Ultimately they will have to choose between more public money or more autonomy.

4. RUNNING THE SCHEME.

New public bodies will be created to work the scheme. First, there are the Joint Area Authorities composed of representatives of Counties and County Boroughs in districts big enough to provide efficient services of almost every type. Theirs is the responsibility of seeing that every citizen in their area has access to the appropriate service whatever his need. They will take over all public hospitals in their areas and will prepare complete medical plans for their entire areas covering the services of hospitals, specialists and general practitioners.

Parallel with the Joint Area Authorities will be the Local Health Advisory Councils. These will represent the chief medical bodies, the voluntary and medical hospitals, and other related professions like dentistry, nursing, and midwifery. They are entitled to advise both the Joint Authorities and the County and County Boroughs falling within the area; they may also, if they like, make their suggestions or criticisms direct to the Minister of Health. The Joint Area Authority will be obliged to discuss with these Local Health Councils not only the initial health plan for the area but any alterations or improvements they think of later. The Local Health Council will bring the expert’s opinion to bear on these plans. This machinery may result in endless delays in getting anything at all effected while the papers are passed from one body to the other and back again. There must be some over-riding authority vested in the Minister to decide disputes between the experts, and the elected representatives.

The Counties and County Boroughs will be responsible for dental and eye services and for setting up Health Centres. However, they will not have to set up Health Centres unless they wish, so that dull or unimaginative councils may procrastinate a long time before doing this. The White Paper says that in the last resort the public interest must be the deciding factor about Health Centres. Here again it would seem that the Minister ought to have power to speed up backward authorities who refuse to experiment in this way.
Only in Health Centres will general practitioners come into contact with the Counties and County Boroughs. In all other cases they will be employed by a Central Medical Board. This Statutory body will work from London and will have powers of action concerning the appointment, pay and conditions of general practitioners in the public service. Where such doctors decide to work in Health Centres they will have a three-part contract, the local authority as well as the Central Medical Board standing as employer.

There is going to be some difficulty in getting all this machinery to work. The Government is obviously sensible in setting up much larger areas than in the past, but the smaller councils who are losing their hospitals naturally do not like this. Smaller authorities see their whole existence threatened by the creation of larger bodies. They have a vested interest in keeping things—even if obsolete—exactly as they are. Medical services, however, can only be provided effectively over wide areas (or smaller areas of more congested population.) In health administration—as in industry and European Government—the larger unit is the future pattern.

5. WHO PAYS?

The new Health Plan will be paid for partly by the Social Security contributions which will be required from all of us, partly out of taxation and partly out of local rates. The exact amount of the Social Security contribution is not yet known. Sir William Beveridge suggested a rate based on 4s. 3d. for an earning man and proportionately less for women and younger people. Certainly the Government is unlikely to introduce a higher contribution. This sum would, according to Sir William Beveridge’s suggestions, give title to every form of medical and rehabilitation service as well as a right to the full range of cash benefits—unemployment, sickness, disablement, old age, widowhood and marriage, funeral and maternity grants. Certainly 4s. 3d. sounds a highish weekly payment. On the other hand, citizens should work out for themselves what they pay on the average in doctors’ and dentists’ and oculists’ bills, in hospital subscriptions and fees, and in additional expenses at the time of sickness, childbirth or bereavement. In future all these ad hoc payments and possibly a good deal of voluntary insurance will be unnecessary. The single Social Security contribution will give full coverage. Private citizens who fear that the new Health Plan will be expensive should imagine a future in which they will have no doctors' bills, no dentists' bills, no dragging anxiety that
they might need an operation or hospital treatment and not be able
to afford it.

Just over one-third of the finance for the new scheme will come
out of the Budget—that is to say, out of money which comes in to the
Chancellor of the Exchequer from income tax, surtax, death duties
and various forms of indirect taxation. Sir William Beveridge esti-
\med that the cost of a comprehensive medical service would be £40
millions yearly more than the Government estimate, but even to provide
services on the scale which he envisaged the total additional tax burden
would be very slight. Mr. Nicholas Kaldor, the economist, has calcu-
lated that the additional sum to be raised for the Beveridge provisions,
including medical services, is the equivalent of only 6d. in the £ on
income tax and 1d. in the pint on beer. This, of course, does not
mean that these sums would be extra to the present level of taxation.
It simply means that whatever level taxation sinks to after the war the
equivalent of 6d. in the £ on income tax and 1d. in the pint on beer
would have to be added if we want a proper Social Security scheme.
However, as the Government’s estimates for the first years of the scheme
are lower than Sir William Beveridge’s we may find that we have to
contribute even less.

The last third of the scheme will be financed out of the rates.
The effect of this is slight, as the Government estimate that only
an additional £8 million yearly need be raised locally. This would
be considerably less than 1d. rate over the country as a whole.
Therefore, at a trifling cost we can free ourselves from the burden of
doctors’ and dentists’ bills. We can give security of income to doctors
and dentists and other health workers and, finally, we can create a
nation-wide service which will not only cure illness but which will
prevent a great deal of sickness from ever occurring at all.

THE FUTURE

The Government plan will not suddenly create a Utopia of health
—many difficulties must be overcome before it can operate at all—but
it will provide a solid base from which a real Health Service can de-
velop. The Social Security League supports the Plan both as an end
desirable in itself, and as an instalment of a full Social Security scheme.
Constructive Health Services are a necessary complement to cash main-
tenance during sickness; adequate Social Security benefit is essential to
meet minimum needs, but it cannot reach the actual cause of need—
sickness—nor can it do the positive job of restoring earning power.
Sir William Beveridge said in his Report, “Primarily, Social Security
means security of income up to a minimum, but the provision of an income should be associated with treatment designed to bring the interruption of earnings to an end as soon as possible." Conversely, medical treatment cannot be fully effective if the patient is being undermined by poverty and by the knowledge that he lacks sufficient income to maintain his family. Adequate sickness benefit, payable for the whole duration of sickness, is an integral part of a wide Social Security scheme which should run parallel to the Health Plan. The Beveridge Report shows clearly how these services must be linked—Half the project is now before us in the Health White Paper—the other half, furnished by Sir William Beveridge, has lain dormant for 18 months. But even the Health Plan is not yet on the Statute Book. Strong opponents are rallying all their forces to attack it. The Ministry of Health have done their part in putting forth a scheme. They will find it difficult to carry this forward into law unless citizens show that they really want the New Health Plan.

July, 1944.

NOTE.—On 5th August, 1944, The British Medical Association published the results of its questionnaire to 53,000 doctors of whom 25,000 responded. Of these 68% approve of Health Centres.