Medical History

Thirty years ago

Six doctors recall the birth of the NHS

British Medical Journal, 1978, **2**, 28-33

Aneurin Bevan's first memorandum to the Cabinet on the NHS asked for an urgent decision on one of the fundamental principles of a State service: how should the hospitals be run? There were other important principles—clinical independence, a salaried service for GPs, the relationship of private practice to the NHS—but the structure and financing of the hospital service was not only a key political principle; it presented a formidable administrative hurdle. All six doctors interviewed agreed that Aneurin Bevan faced more controversy on the principle of who should run the hospitals within his own party than he did with doctors or hospital governors.

Some died unnecessarily

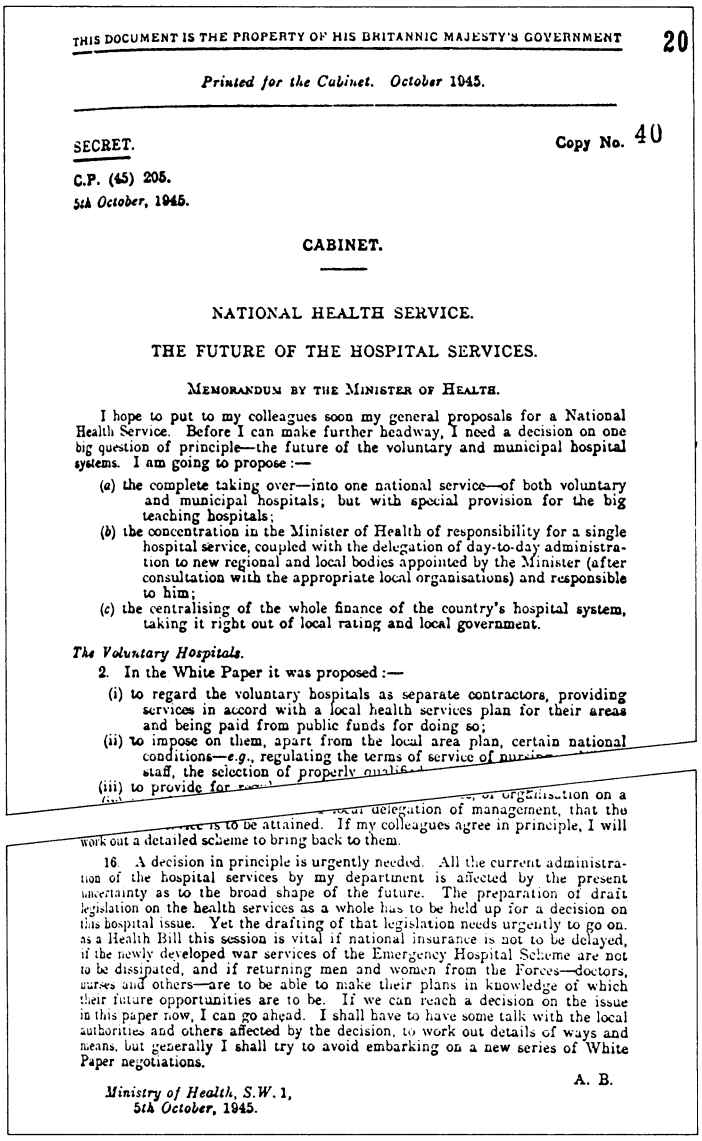
LORD TAYLOR: "The Labour Party being local authority trained thought that the municipal hospitals were wonderful; I suspect that some Labour supporters died unnecessarily because they insisted on going into them for ideological reasons. The Labour Party was in favour of municipalising all the hospitals."

Whatever Bevan's original thoughts, when he presented his Bill he was by then a confirmed supporter of a hospital service run by regional boards separate from local authorities and not run direct from Whitehall.

LORD HILL: "Both in general practice and the hospital service there was a fear that local authorities would gain control. Many local authorities had shown themselves unworthy of converting the poor law hospitals into fine new hospitals. This was where Bevan made his greatest contribution. Herbert Morrison led the campaign for local authorities. Bevan created a unified hospital service with a specially constructed administration for the purpose of resisting the local authorities' desire to own them. He showed skill and courage. That did a great deal to relieve anxieties of consultants."

LORD TAYLOR claims some credit for Bevan's firm line. Although he was Herbert Morrison's Parliamentary Private Secretary at the time—Morrison was Lord President of the Council and Deputy Prime Minister—Dr Stephen Taylor, as he then was, urged the regional hospital board solution on Bevan. An active member of Political and Economic Planning, which had advocated regionalisation of the hospitals before the war, he lobbied for this policy within the Labour Party. "Morrison called me Nye's PRO. I helped convert Nye to the idea of parallelism instead of the old hierarchical system of the municipal hospitals. This has been the saving grace of the

Sir George Godber, Lord Hill, Dr Derek Stevenson, Lord Taylor, Dr John Thwaites, and Dr Solomon Wand were all doctors who were actively concerned with the introduction of the NHS. This article is based on their recollections given in interviews with a member of the *BMJ*'s editorial staff.



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5th *October*, 1945.

CABINET.

NATIONAL HEALTH SERVICE.

THE FUTURE OF THE HOSPITAL SERVICES.

MEMORANDUM BY THE MINISTER OF HEALTH.

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

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

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

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

The Voluntary Hospitals.

2. In the White Paper it was proposed :—

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

(ii) to impose on them, apart from the local area plan, certain national conditions—*e.g.*, regulating the terms of service of nurses staff, the selection of properly qualified

(iii) to provide for

local delegation of management, that the

work out a detailed scheme to bring back to them.

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

A. B.

Ministry of Health, S.W. 1,
5th *October*, 1945.

The extract of the Cabinet Minute is reproduced with the permission of the Controller, HMSO.

Mr Aneurin Bevan, Minister of Health, 1945-51, was responsible for introducing the National Health Service Bill in 1946. It received the Royal Assent in November 1946 and came into effect on 5 July 1948.

hospital service. We had transplanted into the municipal hospitals the basic staffing principles of the voluntary hospitals."

EMS a catalyst

The development of the Emergency Medical Service before and during the war acted as a catalyst for change in the hospital service.

DR DEREK STEVENSON: "Yes, the war produced some fine hospitals in the EMS. The voluntary hospitals could not survive on contributions: something had to happen on the hospital side."

LORD HILL was even more definite: "Voluntary hospitals were uneven and many had difficulty raising money. Most teaching hospitals could have gone on indefinitely. The local authorities had converted some poor law hospitals into good hospitals but some remained unchanged. The crucial factor was creation of the EMS—co-ordination under duress. There was no going back. Unified in management and control and the old labels were forgotten."

LORD TAYLOR was dogmatic: "The EMS was really the precursor of the NHS for hospitals, just as the 'panel' was the precursor of the general practitioner service. Born out of necessity by the Ministry of Health, which expected thousands of civilian casualties from blitzed cities, the EMS was created by co-ordinating voluntary and municipal hospitals and building some new ones. The EMS, paid for by the Government, was administered by regional medical officers. Initially, all specialists were evacuated from the cities but when they returned retained their interests in peripheral hospitals. This improved the spread of specialist services."

LORD TAYLOR was scathing about the standards of municipal hospitals, a factor which clearly influenced his strong support for regionalisation. "The voluntary hospitals provided a high level of medical care for the time, but their distribution was patchy and there were too few of them in the places of greatest need. The advantage was that they had a parallel system of staffing—the doctors were equal and most were honorary. The rest of the country was covered by municipal hospitals. By and large these were a disgrace. They were the former poor law hospitals staffed by medical superintendents, and masses of juniors in a hierarchical system, so the senior doctors never saw patients and spent their time administering. Starved of money by local authorities, corrupt in that councillors would get admission for their friends, the quality of medicine practised in them was, as a rule, very low."

There was often local competition between voluntary and municipal hospitals as SIR GEORGE GODBER described: "If you are going to provide a district service—and the district is more important than the region—it has to be based on the family of hospitals that serves the district. The competition was such that you had the medical superintendent at the Nottingham City Hospital saying that he would not have a particular patient in his hospital if the patient had been in the Nottingham General (voluntary) Hospital. There could be a complete failure to provide the right mix of specialists in a district. The best known exception was Middlesex, which staffed its hospitals with whole-time specialists, and there were some others. The LCC had no such integrated system but made much greater use of part-time voluntary hospital specialists. Many municipal hospitals had no outpatients, doing acute medicine, surgery, and obstetrics. There was antagonism between the two systems. We have forgotten all this today."

"We have as good a specialist service as anywhere, except perhaps Canada. General practice has improved, but this has nothing to do with the NHS. Informed people have not thought enough about how to organise the health services, but despite the administration it has been a good service."—Lord Taylor.

Health not an election issue

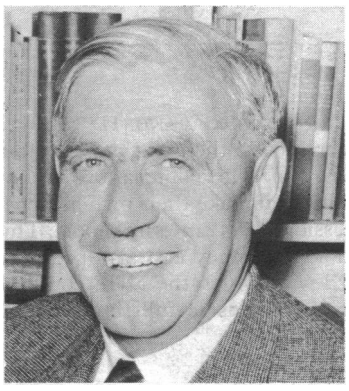
With most of the population dependent upon municipal hospitals it is perhaps surprising that, according to all six doctors, a State health service was not a major issue in the 1945 election.

LORD TAYLOR'S judgment: "Health wasn't something people felt passionately about. The public felt passionately about unemployment, housing, and social security. Never again must there be mass unemployment, never again a lack of social security for all. Of course, all these things indirectly affected health."

DR JOHN THWAITES summed it up: "Health was not a burning issue. Patients were a limited section of the public and they were generally satisfied with care."

The fact that health was not a "burning issue" was largely because it was firmly wrapped up in the Beveridge package, described by LORD HILL as the "equivalent of the 'homes for heroes' pledge after the first world war." Furthermore, the majority of the Conservative Party as well as its Labour and Liberal opponents were committed to a NHS—they had all been partners in the wartime coalition Government that had produced the 1944 Willink White Paper outlining the general features of a national health service. Indeed, during the preceding decade the profession itself had suggested some surprisingly radical reforms in 1930, 1938, and again in 1942 for introducing a State service.

LORD HILL: "The Medical Planning Commission [drawn from the BMA and the royal colleges] produced an interim report in



Lord Taylor (Dr Stephen Taylor) was a general practitioner and Labour MP for Barnet, 1945-50. He was also Parliamentary Private Secretary to the Deputy Prime Minister and Lord President of the Council, 1947-50.

Lord Hill (Dr Charles Hill) was Secretary of the BMA 1944-50. He then entered politics as a Conservative MP and later became a cabinet minister.

1942* which showed how far doctors themselves had gone in preparing the way for the NHS. Plans had included a NHS available to all on a 100% principle; the building of health centres for GPs; the unification of hospitals under regional bodies; the payment of GPs partly by salary; and the disappearance of buying and selling of practices. The BMA's Representative Body accepted the outline but referred back the suggestion of part-time salaries for GPs while rejecting the notion of whole-time salaried service."

On the Willink White Paper LORD HILL explained the profession's delaying tactics. "Willink was too nice for politics. He produced the proposals and we began discussions in private. We made them last, making a hell of a meal of minor details. Everything was referred to a special Representative Meeting—excessive democracy. We suggested co-ordinating existing services, with regional bodies controlling the flow of public money. Then we published Willink's proposals with our comments, provoking Bevan—then a backbench MP—on the issue of parliamentary privilege. We were at fault. I don't know whether the proposals would have become law if the Conservatives had been returned to power: they said they were committed to a NHS."

100% principle

The Beveridge Report proposed the 100% principle—namely, a health service covering everyone in the country—and the profession accepted the principle by a large majority in 1945. But, as LORD HILL observed, "some subsequently regretted it."

"The provision of supporting specialties on an adequate scale was the big achievement of the first few years. But we should have given the regional boards more autonomy and redistributed the funds better. It took four years—until the Danckwerts award—to put the injustices right for GPs over their remuneration."—Sir George Godber.

One of those who did was DR SOLOMON WAND. He believed that the service should have been free to the great majority but that people in the top income group, who could afford to pay for themselves, should be permitted to make their own arrangements, as proposed in the profession's 1942 interim report. This modification would have saved some money and also provided an independent sample standard with which the NHS could be compared. It was also a safeguard against a full-time salaried service. DR WAND remembered the profession's fears that changes were being pushed through too quickly: "I had the feeling that he [Bevan] wanted to be the architect of the finished structure. That is why he went for the lot. That was the biggest mistake and we urged him to go slowly. He should have done it step by step."

Yet Bevan as a skilful politician was prepared to compromise. LORD HILL: "There was a public belief that Bevan was a dangerous demagogue and it took some time for the medical profession to realise that here was a man of great intelligence, imagination, and skill. He knew that he had to compromise to get the NHS bill through—for instance, by letting the consultants do private practice in National Health Service hospitals."

"The greatest achievement was a unified hospital service. We underestimated the increase in public demand and expectation. It is doubtful today whether the country could guarantee to give a comprehensive service without charge. In 1948 we estimated the annual cost at about £150 million."—Lord Hill.

Private practice

The decision to allow NHS consultants to do private practice if they wished was, indeed, one of Bevan's crucial concessions to the profession.

LORD TAYLOR: "Nye was determined to bring in private beds and he was absolutely right. He did not want to create in the NHS the pattern of the education services, where there are two services and never the twain shall meet. . . . That seemed folly to him. He argued ad hominem: he felt that he had to have privacy if he went into hospital; it followed that everyone else had the right to privacy if they wanted."

Did Bevan deliberately buy off the consultants so as to split the opposition in the profession? This may not have been his initial intention but the way in which negotiations went suggested this. The structure he proposed for the hospital service, with teaching hospitals remaining separate, suited consultants, as did his concession for "geographical part-time" practice. While a salaried service was anathema to most GPs, consultants had rather a different view.

SIR GEORGE GODBER: "The numbers of consultants were relatively small—the 1950 figure of 5500 consultants was a 50% increase over pre-NHS numbers—and a proportion were salaried posts, with some whole-timers in municipal hospitals already in a State service. Furthermore, the Emergency Medical Service had introduced a lot of doctors to the idea of having their incomes subsidised by the State. Younger doctors were in favour of the NHS. They saw themselves with a guaranteed income without having to scrape around for private practice, particularly at a time when their numbers were going to be increased. Pathology,

Sir George Godber (Dr George Godber) was medical officer at the Ministry of Health during 1939-50. He later became chief medical officer.

*The final report never materialised.

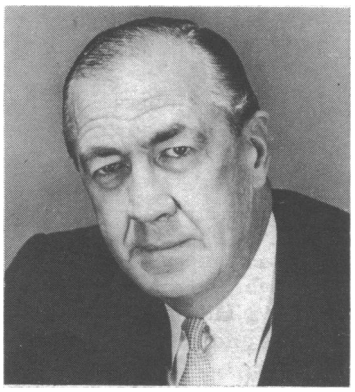
for example, was becoming more popular. But Bevan's acceptance of the part-timer was one of his most important concessions. And the inflation of junior staff made it easier for those who wanted to do private practice."

DR STEVENSON: "Consultants were told that they could virtually carry on as before, there would be more of them, and they would have a regular salary."

Divided profession

The impression of a divided profession was, if anything, enhanced by the belief that the BMA represented GPs while the consultants were led by the royal colleges.

DR STEVENSON: "The BMA tried to speak for consultants through its own machinery. This led to some hostility by the royal colleges. There were some tremendous personalities at that time—Lord Moran, who led the physicians, the PRCS, Lord Webb Johnson (who never saw eye to eye with Moran), and William Gilliat, PRCOG. On the BMA side we had the Birmingham GP, Guy Dain, who was Chairman of Council, and Charles Hill. When the Bill was published in 1946 the two sides formed a joint negotiating committee, chaired by Dain. Some of the meetings got rowdy and when the Bill was almost on the statute book Moran made a determined attempt to take negotiating rights for consultants away from the BMA. Hill decided that the only way to handle this was to link the colleges and the BMA by forming the Joint Consultants Committee. This caused uproar as some didn't see why the colleges should enter negotiations. Anyway the JCC was launched—had it not been the result would have been disastrous for the profession.



Dr Derek Stevenson was assistant director-general Army Medical Service, War Office, 1942-6, and assistant secretary of the BMA, 1946-8. He later became secretary.

"I think Bevan was influenced by the pressure put on him by the three presidents that if only he would give way and make one or two important concessions, then the profession had no case to fight. In that respect the colleges acted as a catalyst in breaking the 1948 deadlock."

The consultants' college leaders were London based and, as SIR GEORGE GODBER observed, while this probably made discussions with the Ministry easier, "they did not realise what would happen when the peripheral hospitals were built up. They thought that they were too big fish to fry."

LORD HILL commented on the profession's negotiating committee: "It did not work too badly. Consultants thought the BMA was too concerned with money and terms of service, but some of them had never received money from public funds. Lord Webb Johnson was a born negotiator, but Lord Moran had no experience and our association was not easy because he did not really comprehend the procedures. However, consultants and GPs came closer together as negotiations went on. Even so, the famous 1948 letter to Bevan from the three presidents calling for a compromise did a great deal of damage to relations —some doctors described it as selling out."

DR WAND said that it was widely regarded by doctors as a "stab in the back."

Meetings of doctors throughout this period were well attended by both consultants and GPs. A surprising feature, DR STEVENSON remembered, "was that in all the two years of fracas money was rarely mentioned. No one knew what GPs would earn until the appointed day—when I believe the average remuneration was set at £1111." On the Ministry's side Dr Stevenson remembered the negotiating power being entirely in the hands of Bevan. "He was the only Minister I have ever known who never turned to his officials for advice [during a meeting]. He was never floored and was a formidable opponent." This sentiment was strongly reinforced by LORD HILL, who said of the BMA: "It had to hold the doctors together. We needed a little more confidence on the part of the profession in its negotiators. Our procedures seemed so democratic and caused delays, but the plebiscite structure was right."

"The Government tried to do too much too quickly. Insufficient details were worked out—for example, about whether there were enough doctors and what it would all cost. The achievement has been the distribution of specialist medicine. The public has access to the best of British medicine and the retention of home visiting is unique. Clinical independence has so far been preserved: doctors must never give it away."—Dr Derek Stevenson.

GPs' worries

The factors that worried GPs were the threat of a salaried service; direction of manpower; clinical independence, including loss of choice (by patient of doctor and vice versa); and the loss of practice goodwill. On the latter deferred compensation was eventually negotiated. The first offer was a derisory £1 million: the final negotiated figure was £60 million. But how many doctors realised that it was only the advent of Lloyd George's 1911 Insurance Act that provided most general practices with the security of income that enabled "goodwill" to be a transferable commodity? It was DR THWAITES who made that point during the interviews, and he also pointed out the extent to which GPs were already providing a comprehensive service before 1948. Only wage earners were covered by Lloyd George's panel scheme, not their wives or children, though many of them belonged to doctors' clubs or friendly societies, some of which had their origins in the nineteenth century. "In the 1930s," said DR THWAITES, "panel doctors started on their own initiative the public medical service. This grew and was successful. It was run on the same lines as the panel—people, who need not be fit

"Politicians promised the impossible and ever since have wasted time and resources in trying to make the impossible seem possible if not today at least tomorrow. The NHS should have been given real regional autonomy, including financial autonomy, with State finance provided through grants."—Dr John Thwaites.

when they joined, paid weekly or monthly and medical attention and medicines were free. It was a locally organised private system, grafted on to the existing State panel scheme, that was run economically, with the prescribing costs deducted from the doctor's pay. He got a capitation fee of about 15s a year for the public medical service and around 9s a year for the panel."

DR WAND remembered pre-NHS general practice in Birmingham. "Families were bigger and helped each other. Only the lower-paid workers were covered for general practitioner care through the Insurance Acts. Their dependants and the rest of the community had to pay for their care or be looked after under the poor law arrangements. To help them the Birmingham Public Medical Service was started. Regular subscriptions were collected monthly. There was a special rate for families and those entering in old age. A fee could be charged for out-of-hours calls, but this was often waived. Patients needing hospital care could go to the voluntary or municipal hospitals and not have to pay. It was easy to get beds. One did not hear of the acute sick failing to get treatment. The earnings of the GP were generally low. In an area like Birmingham industrial injuries were a major problem and a well-known industrial medical officer, Donald Stewart, persuaded some industrialists of the need for an accident hospital and an appeal to industry resulted in the establishment of the pioneering Birmingham Accident Hospital."

Dr John Thwaites was a general practitioner in Brighton, and a member of the BMA Council, 1942-51. He later became deputy editor of the *BMJ*.

War service

One of the difficulties for the profession in the run up to the NHS Bill was that so many doctors had been in uniform. This had disrupted both hospital and general practice, and as DR THWAITES described the position: "The whole thing [plans for a NHS] seemed unreal: half the doctors were away."

DR WAND: "Many doctors who had served in the armed Forces (and a large number had no knowledge or experience of practice as it was before the war) became adjusted to the administrative and hierarchical structure in the forces, and were in favour of a full-time salaried service.

"Despite these wartime experiences, GPs soon became fearful of the prospect of Government control, which was the risk of a full-time salaried service. A Government monopoly could mean the end of private practice and we were frightened of bureaucratic control of medicine. The coalition government's first proposal put to us was for a salaried service. The Labour Party favoured a full-time service, with the Socialist Medical Association in the van, but Bevan had the guts to realise that if that went through it would be a disaster."

DR THWAITES put it this way: "You have to tie up the salaried service proposal with the one that doctors should no longer own their practices. The value of the ownership of goodwill was part of the independence: it was a legal entity. Initially Bevan had not wanted to compensate GPs. But sale of goodwill was a financial asset to doctors on retirement: they had no pension."

"Pragmatic and sensible" tripartite system

The NHS's tripartite system—hospitals, GPs, and MOHs—was much criticised over the years and the 1974 reorganisation was, in part, motivated by its defects, so why did Bevan set it up?

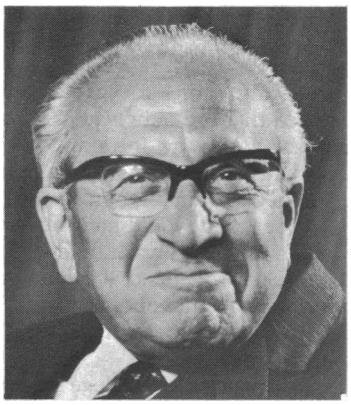
LORD TAYLOR had no doubts: "It was done because it was pragmatic and sensible. The tripartite system gave GPs autonomy through LMCs, freeing them from the tyranny of regional hospital boards and hospital administrators. Local authorities were left with preventive services and medical officers of health had an identifiable job that was not too much or too vague. GPs could work in hospitals and the unifying factor was the patient."

LORD HILL confirmed the last point: "I asked Nye where was the co-ordination between the three parts and he replied: the patient. The tripartite system was the best which he could get. His reputation depended on getting agreement. Nye had to produce the NHS and to do so to get the acquiescence of the profession."

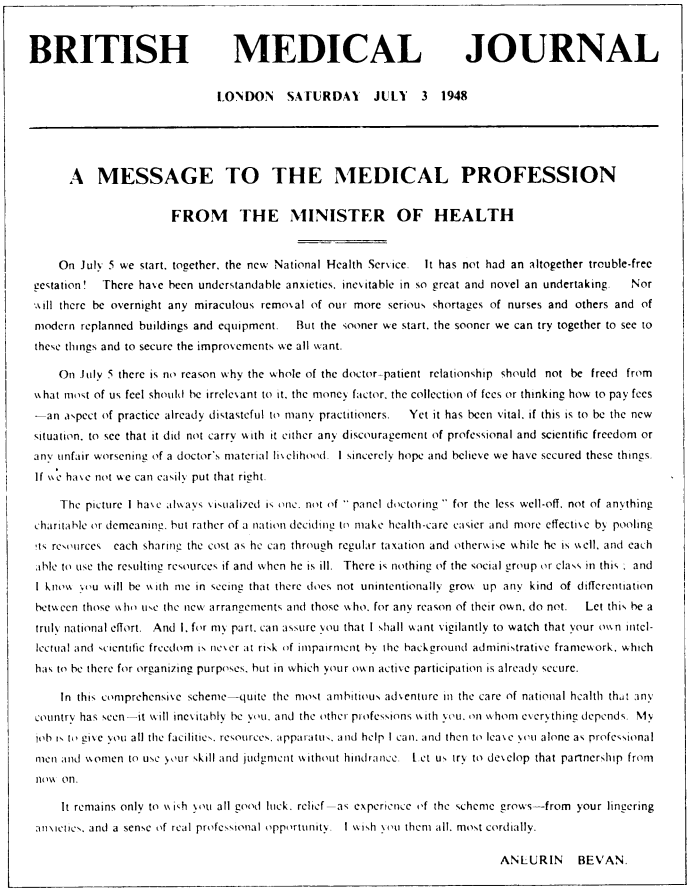
SIR GEORGE GODBER was equally forthright. (His experience was based, among other things, on a detailed two-year survey of hospital services in the Sheffield region, one of a series of national surveys done between 1942 and 1944 and jointly financed by the Nuffield Foundation and the Ministry of Health.) "We would never have got on the road without the tripartite system. There was one entirely new administration to create: regional hospital boards and hospital management committees, with two years to do it in. It was a devil of a job but a triumph. Patients were not aware of the effect of the takeover except that those who paid ceased to do so. In general practice the friendly societies were cut off and executive councils were set up, but this was a minuscule administrative change."

As the first six months of 1948 dragged on and the profession's opposition to the Act—due to start on 5 July—persisted, if less

"Everyone who needs care can get it, but there are far too many long delays in certain specialties. The NHS has failed to educate the public on the cost and responsible use of the benefits. We shall have to think again about making charges. Governments have deprived the NHS of money and treated doctors badly financially. As expected there has been a steady increase in GP's work."
—Dr Solomon Wand.



Dr Solomon Wand was a general practitioner in Birmingham. He was also a member of the BMA Council, 1935-72, and of the profession's negotiating committee. He was chairman of the General Medical Services Committee, 1948-52, of the Representative Body, 1951-4, and of the Council, 1956-61.



BRITISH MEDICAL JOURNAL

LONDON SATURDAY JULY 3 1948

A MESSAGE TO THE MEDICAL PROFESSION

FROM THE MINISTER OF HEALTH

On July 5 we start, together, the new National Health Service. It has not had an altogether trouble-free gestation! There have been understandable anxieties, inevitable in so great and novel an undertaking. Nor will there be overnight any miraculous removal of our more serious shortages of nurses and others and of modern replanned buildings and equipment. But the sooner we start, the sooner we can try together to see to these things and to secure the improvements we all want.

On July 5 there is no reason why the whole of the doctor-patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay fees—an aspect of practice already distasteful to many practitioners. Yet it has been vital, if this is to be the new situation, to see that it did not carry with it either any discouragement of professional and scientific freedom or any unfair worsening of a doctor's material livelihood. I sincerely hope and believe we have secured these things. If we have not we can easily put that right.

The picture I have always visualized is one, not of "panel doctoring" for the less well-off, not of anything charitable or demeaning, but rather of a nation deciding to make health-care easier and more effective by pooling its resources: each sharing the cost as he can through regular taxation and otherwise while he is well, and each able to use the resulting resources if and when he is ill. There is nothing of the social group or class in this; and I know you will be with me in seeing that there does not unintentionally grow up any kind of differentiation between those who use the new arrangements and those who, for any reason of their own, do not. Let this be a truly national effort. And I, for my part, can assure you that I shall want vigilantly to watch that your own intellectual and scientific freedom is never at risk of impairment by the background administrative framework, which has to be there for organizing purposes, but in which your own active participation is already secure.

In this comprehensive scheme—quite the most ambitious adventure in the care of national health that any country has seen—it will inevitably be you, and the other professions with you, on whom everything depends. My job is to give you all the facilities, resources, apparatus, and help I can, and then to leave you alone as professional men and women to use your skill and judgment without hindrance. Let us try to develop that partnership from now on.

It remains only to wish you all good luck, relief—as experience of the scheme grows—from your lingering anxieties, and a sense of real professional opportunity. I wish you them all, most cordially.

ANEURIN BEVAN.

fiercely, Aneurin Bevan finally promised to introduce his Amending Act, prompted by the controversial presidents' letter. The Act would prevent a salaried service being introduced for GPs without another Act of Parliament, a considerable concession to the profession.

LORD HILL listed the profession's achievements at the end of the two-year battle: "No full-time salaried service for GPs; freedom to practise without State interference; freedom of choice by patient and doctor in general practice; a planned hospital service with its own administration; and adequate medical representation on the administrative bodies."

With these achievements and with the public clearly behind the scheme the BMA accepted the NHS. On 5 July 1948 it started, with the vast majority of doctors signing on.

Postscript

And what did the patients do with their new Health Service?

DR WAND: "It was chaos on the appointed day. The amount of work was already high and it shot up. Even so, many didn't realise they could have treatment for nothing. We did not, however, have to take on any extra partners."

But LORD TAYLOR remembers a practice that did: "On the appointed day two Irish GPs in Sheffield found that they had 17 000 patients between them. They immediately took in three partners. This was the general standard of medicine in big cities and the NHS improved matters for people living in them. The maldistribution of doctors we complain of now is nothing to what it was."

DR THWAITES on the South Coast recalls that things changed very little—except that most of the patients stopped paying. "Our practice had been very busy in the war and the amount of work did not appreciably increase after the appointed day."

SIR GEORGE GODBER succinctly observed: "The hospitals started with administrative chaos in some cases. In one the only accounts were the stubs of the cheque books."

Introduction of the NHS

Timetable

1942

Coalition Government publishes Beveridge Report.

Interim report of Medical Planning Commission (representatives of BMA and royal colleges) published.

1944

February: Government issues White Paper on a national health service.

1945

March: Willink Plan produced but not published. Plan prepared by Willink, then Minister of Health, to meet objections to 1944 White Paper.

August: Labour Government took office; Aneurin Bevan appointed Minister of Health and subsequently discusses (but does not "negotiate") intentions with interested organisations while drafting NHS Bill.

1946

March: NHS Bill has first reading in House of Commons.

November: NHS Bill receives Royal Assent.

1947

January: Poll of profession produces majority against negotiating details of Act.

January: Royal colleges express willingness to negotiate separately for consultants.

January: Special Representative Meeting of BMA agrees to negotiate on regulations for the Act.

1948

January: BMA recommends rejection of Act by all practitioners.

February: BMA polls profession again. An 84% response gives 9 to 1 majority rejecting NHS, with 88% opposing acceptance of service in it.

March: Royal college presidents write to Bevan suggesting an Amending Act that would prevent whole-time salaried service for all doctors being introduced by regulation.

April: Bevan promises Amending Act and drops universal basic salary for GPs in favour of capitation system.

May: Third poll of profession with a 77% response. Two-thirds of GPs still opposed it but only a small majority opposed serving in it. BMA Council and Special Representative Meeting accept NHS.

5 July: NHS starts.

1949

May: First reading of NHS (Amendment) Bill in House of Commons.

December: NHS (Amendment) Bill receives Royal Assent.