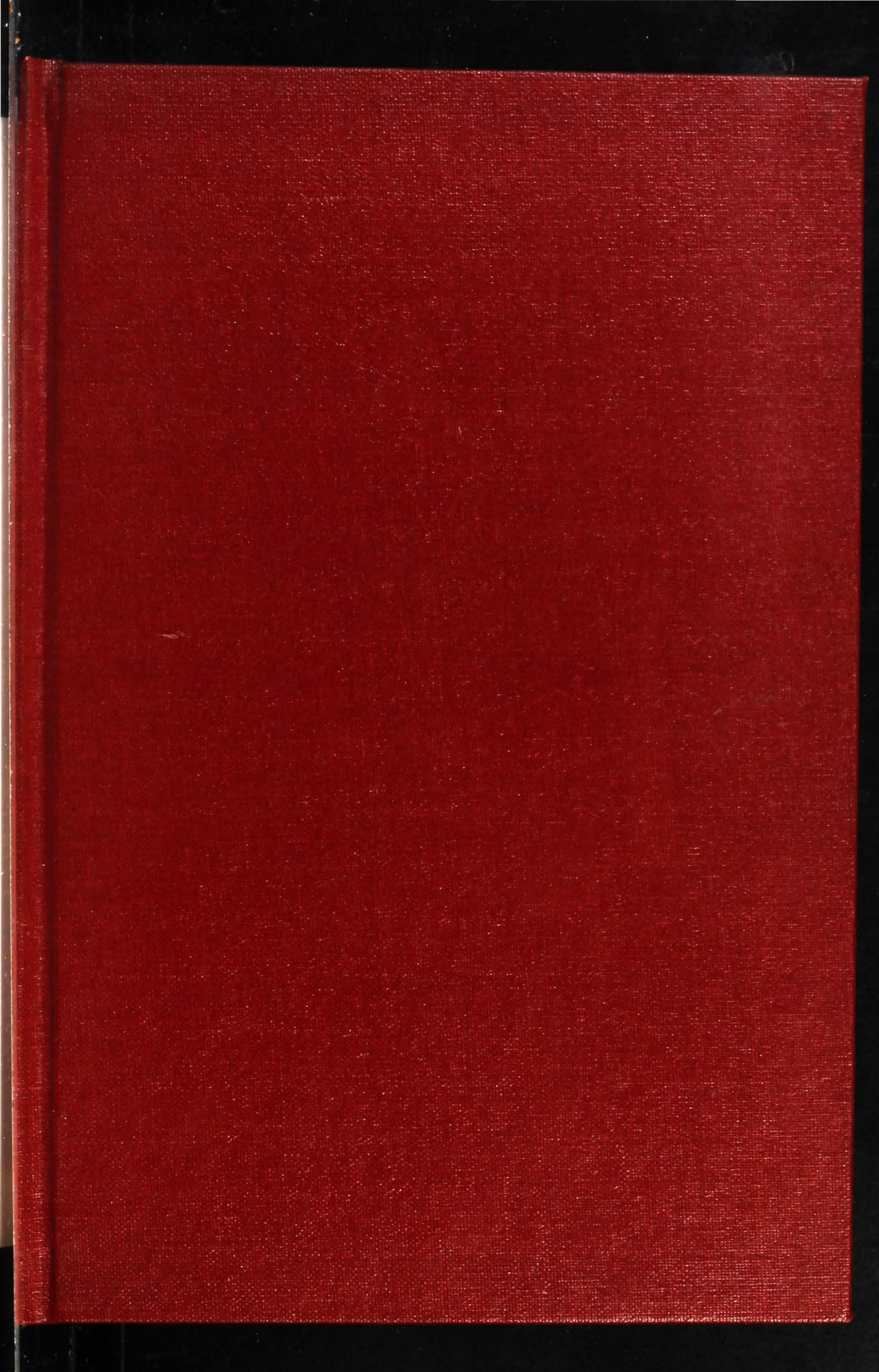

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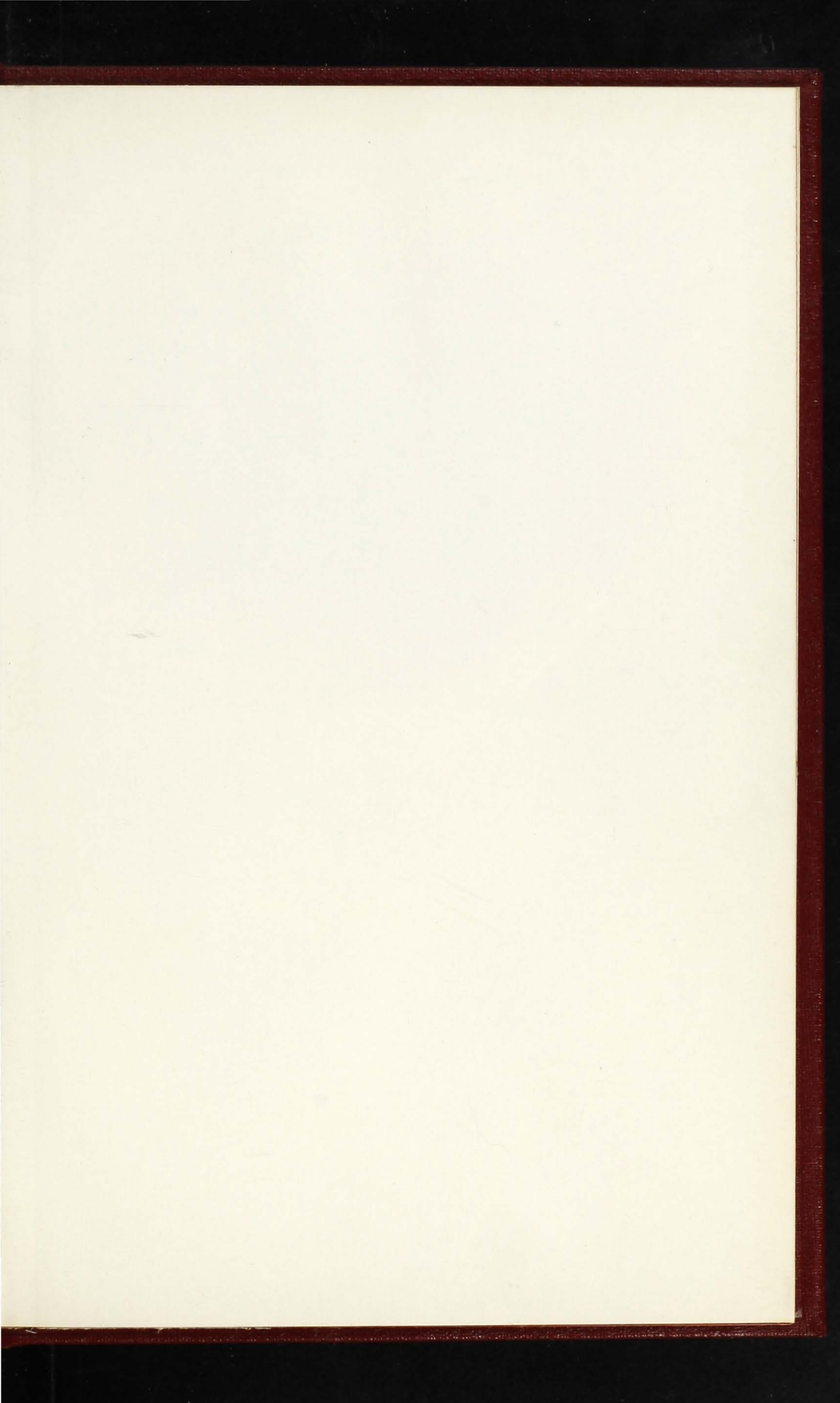

NHS revisited

Barbara Castle
fabian tract 440 30p

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this pamphlet is based on the text of the Nye Bevan Memorial Lecture given by Barbara Castle at Oxford in December 1975.

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January 1976 ISSN 0307-7535 ISBN 7163 0440 6

NHS revisited

There could hardly be a more appropriate moment for me to be giving the Nye Bevan Memorial lecture and it must have been with remarkable foresight that months ago I chose the title " NHS re-visited " for this talk. Because on the face of it the way things have been going in recent months it might have seemed as if there could soon be no NHS to visit at all. The outbreak of industrial action by junior doctors and consultants—action which even a few years ago would have been unthinkable with its almost reckless disregard of the needs of patients—was merely the climax to a wave of unrest in the NHS which had already built up to breaking point by the time I took over responsibility for the Service some 20 months ago. During that period I have been inundated with talk of " crisis ", of " breakdown " and of abysmally low morale in the NHS. So I have been forced to try and analyse the causes of this wrecking mood and to ask myself some pretty fundamental questions about where the NHS now stands and where it is going.

the recent past

This mood is all the more remarkable because the year 1974-75 was one of considerable advance for the Service. It was the year in which expenditure on the NHS rose to 5.4 per cent of the GNP—the highest percentage in its history. In the first full year after Nye launched it on its way in 1948, we were only devoting 4 per cent of GNP to it in the United Kingdom. The percentage fell to 3.5 per cent in 1955—and there was no talk of " demoralisation " at that time: perhaps because there was a Conservative government in office. So in 1949 the NHS budget for Great Britain was £441 million. Since then expenditure in real terms has more than doubled so that today it has risen to £4,500 million. Last year's peak figure was due to the Labour government's authorisation of no less than £750 million of extra money in the form of Supplementary Estimates, £700 million of which went to finance record increases in pay at every level of the Service: nurses, radiographers, therapists, chiropodists, work engineers, laundry workers, porters—the lot. And the process was completed in April of this year when GPs, consultants and juniors also received a record increase of 30 per cent or more. So pay throughout the entire Service was more than brought into line with pay outside and the injustices of the Conservatives' statutory pay policy were corrected.

It was also the year in which the expert manpower employed in the Service had reached its highest peak. In 1948, when Nye launched his new Service, he was only able to mobilise about 35,000 doctors and 160,000 nurses to provide the generalised health care of which he dreamed. In the last few years there has been a great spurt in the recruitment of doctors and nurses to the NHS. The numbers of doctors in the NHS in England and Wales increased by 5,000 between 1970 and 1974—rising to a total of 55,000. And the expansion of places in Medical Schools has led to a 22 per cent increase—from 2,700 to 3,300—in the numbers starting

training over the same four years. The numbers of nurses in England and Wales has increased by 15 per cent in this period to over 320,000.

Despite these remarkable advances, the mood of crisis—as against the reality—continues. If we are to analyse its cause we must go back into history.

the original aims

First we must ask: what was it that Nye Bevan set out to achieve ? What were the problems he was confronted with ? How far did he succeed ? It is important to remember that the creation of a NHS formed part of the comprehensive provision visualised by William Beveridge when in 1942 he outlined his social insurance proposals for helping to deal with the five giant evils : ignorance, disease, squalor, idleness and want. That man was nothing if not apocolyptic ! If people were to be armed to fight the giants, he argued, they needed enough cash to live on in adversity, but they also needed comprehensive health care and the state must shoulder the responsibility of providing it. Nye took up this challenge enthusiastically. It fitted perfectly into his instinctive urge to unify society, a theme he constantly harped on. But he also harped on the fact that you cannot unify society unless you universalise its major benefits. The Service, he told the House of Commons on the 2nd Reading of his Bill establishing the NHS, " will keep many people alive who might otherwise be dead. It will relieve suffering. It will produce higher standards in the medical profession. It will be a great contribution towards the well being of the common people of Great Britain."

Up to that time the common people had had to manage as best they could on a patchwork of health care provision, part government, part municipal and part voluntary. Those lucky enough to be at work under a contract of service were covered by compulsory health insurance up to a level of incomes equivalent today to £1,850 a year or about £35 a week and so became the " panel " patients of a GP. But their wives were not covered ; nor were their children. The self-employed were not covered: nor were those who had never been fit to work, or those who had been too old when health insurance came in: nor the " middle class ". And if they had to go into hospital, the patchwork became even more unreliable. Go-ahead local authorities had good municipal hospitals which could afford to employ specialists. Elsewhere voluntary hospitals had to be provided by charitable funds where specialists provided their part time services free. In these cases the availability of a specialist could depend on the amount of private practice in a locality because the specialist had to earn his bread and butter privately before he could afford to give any time to charity.

What Nye did was to weave this variegated provision into a comprehensive system

of health care for everyone " from the cradle to the grave ", a system financed and therefore regulated by the State. Everyone became entitled to go on the list of a NHS family doctor and through him had access to treatment in a nationally financed network of hospitals run by 14 regional hospital boards, whose members were appointed by the Minister of Health, and 36 Boards of Governors of teaching hospitals. The whole ethic behind the new Service was that every citizen had an equal right to the best medical care available, which he paid for when he was well—through his taxes—and which he received free when he was sick, and therefore least able to pay. Or, as Nye put it in his second Reading speech: " One of the first merits of this Bill is that it provides a universal health service without any insurance qualification of any sort. It is available to the whole population and not only is it available to the whole population freely, but it is intended, through the health service, to generalise the best health service and treatment." It was a revolutionary new formula unparalleled in the non-Communist world, and it was met with howls of anger from the Tory Opposition and the BMA. Despite the fact that the idea of a comprehensive health service had been in the air for some time—even a Commission set up by the BMA during the War had advocated it—when the time came neither the Conservative Party nor the medical profession wanted to face the implications of what a comprehensive health service means. It was Nye's genius that, having talked and thought his way through the paper plans he had inherited, he saw clearly that certain implications were inescapable.

the principles

First if it was to be comprehensive the Service must be nationally financed ; or, as Nye said: " without insurance qualification of any kind." And who, looking at the systems in other Western countries today, can doubt that he was right ? The simple fact is that any health service, if it is to embrace everyone, must be financed by taxation. If it is linked to any insurance principle, whether public or private, it must leave someone out. That is why, even though the UK is a member of the EEC, with free movement of labour and supposedly equal treatment of labour between member countries there is still no complete reciprocity of health treatment between our respective nationals, since the health insurance schemes of the rest of the community are not completely comprehensive in the people they cover.

So as Secretary of State for the Social Services I have to negotiate reciprocal agreements with the other members of the Nine in order to ensure that our self-employed, when they visit the Continent, get the same automatic health coverage as *their* self-employed do when they come here—and so far we have only been able to negotiate such agreements with Denmark and West Germany. As for the United States I found when I paid a visit there last Easter that the dramatic increase in unemployment had caused a major crisis in their health care system because workers who

had negotiated collective health insurance arrangements with their employers found they were without cover when they were out of work and the Administration was considering emergency legislation to meet the problem.

The second essential Nye grasped was that he could not universalise the best hospital treatment throughout the country if the hospitals were left to the caprice of charity or the uncertainties of local finance. In his brilliant biography of Bevan, Michael Foot records a conversation Nye had with Lord Moran, the powerful President of the Royal College of Physicians, whom he BMA dubbed " Corkscrew Charlie " because of the remarkable alliance he struck up with Nye. Nye asked Lord Moran how he could attract first rate consultants into the peripheral provincial hospitals. When Moran replied that consultants would go there if they got an interesting job and if their financial future were secured by a proper salary, Nye paused and then said: " Only the State could pay those salaries. This would mean the nationalisation of hospitals " (Michael Foot, *Aneurin Bevan,* Davis Poynter, 1973). And nationalise them he did. An irate member of the BMA described this as " the greatest seizure of property since Henry VIII confiscated the monasteries."

The third essential Nye grasped was that health care starts with the family doctor. And here again the British Health Service is unique. Lloyd George's health insurance scheme had led the way and already when Nye took over, two thirds of the doctors in practice had joined the scheme. Here again Nye wanted to secure universal coverage—not by conscripting doctors, but by persuading them.

Knowing their dread of a whole time salaried service, he retained the ingenious and sensitive formula which had operated under National Health Insurance. General practitioners would not become employees of the State but in contract with the new Executive Councils of which half the members would be representatives of the profession. And they would be paid by capitation fees. But he fought stubbornly for two things. There must, he said, be a small element of basic salary to help the young doctor who was just starting up and had not yet built up his practice. And secondly the sale and purchase of practices must be abolished. That was evil in itself, he said, because it meant that patients were bought and sold as well. But above all it made nonsense of the proper distribution of doctors he was determined to secure. He told the House of Commons: " Proper distribution kills by itself the sale and purchase of practices."

Looking back it is astonishing how much furore that single proposition aroused.

The reaction of the medical profession to all this was characteristically confused. The medical profession's whole *raison d'être* is to heal the sick and its professional pride is rooted in its demand that it must be free to do so without any political or

other barriers being placed in the way. But before the NHS was created one of the most obvious barriers to clinical freedom was the financial one: the inability of many patients to pay the doctor's fee, or to afford the drugs he wanted to prescribe, or to have access to hospital and specialist treatment on equal terms. As a result many family doctors forwent their fees when they knew their patients could not afford to pay. I remember my own GP during the war boasting to me that, if anything, she treated her panel patients better than her private ones. And many specialists, despite their charitable work in voluntary hospitals, were uneasily aware that innumerable people were not getting the treatment they needed. So it was clear to them that the establishment of the NHS removed the obstacles to clinical freedom in its highest sense—as well as guaranteeing a good, regular income to doctors in poorer areas who had made so many financial sacrifices before.

That was why, in their rational moments, many doctors recognised that a comprehensive health service would be good for them and good for medicine. The BMA's wartime Commission had said as much. But when it came to applying the principle in practice, the mood changed.

the BMA and the NHS

Before Aneurin Bevan ever came on the scene the BMA was mobilising against the wartime Coalition government's tentative proposals for a comprehensive service. This was rushing things too much, said the BMA. Nothing should be done until a Royal Commission had examined the whole field: a familiar delaying device. And the *British Medical Journal* denounced the White Paper as "the mailed fist of bureaucratic control carefully wrapped up in the velvet glove of political diplomacy" (Foot, *op cit*).

The story of Nye Bevan's ensuing battle with the medical profession as Minister of Health is an epic one. He met them endlessly, argued with and listened to them: and then produced the plan he had become convinced was essential to achieve his aims. But though he was quite clear about what must be the governing principles, his judgement as to how they should be applied was eminently practical. That was why he resisted the pressure from his own back benchers to introduce a whole time salaried service for GPs. "I do not believe the medical profession is ripe for it," he told the House, "and I cannot dispense with the principle that the payment of a doctor must in some sense be a reward for zeal and there must be some degree of punishment for lack of it" (Hansard, 30 April 1946, col. 55). It is clear, too, that the deal he did with Lord Moran to allow NHS doctors to earn fees from private patients, and NHS specialists to have private beds in hospitals, was influenced by his sense of immediate realities. His main task, as he saw it, was to attract top specialists to the Health Service at a time when hospital buildings were inadequate,

re-building had had to be postponed and the very survival of the Service was still in doubt. But he never compromised on his main aim. " No society can legitimately call itself civilised " he wrote " if a sick person is denied medical aid because of lack of means " (Foot, *op cit*).

But all the accommodations he made to allay the fears of the medical profession did not protect him from the fury of the BMA—the body that now argues that his agreement to allow pay beds in NHS hospitals was one of the conditions on which doctors agreed to participate in the NHS. For two years after he announced his concessions on this, the BMA still fought his proposals tooth and nail—Dr Guy Dain, chairman of the Council of the BMA having dismissed the concessions as meaningless. The language used against Aneurin Bevan as the row went on is an immense consolation to me at the present time. Dr Alfred Cox, a former medical secretary of the BMA, described Nye's proposals as " uncommonly like the first step, and a big one, towards National Socialism as practised in Germany " (Foot, *op cit*). The BMA launched a Defence Fund. The *Daily Express* ran headlines: " No future for Us in Britain: Doctors Turn to Empire." The Tory Opposition excelled itself, its front bench spokesman, Mr Richard Law, claiming that the proposals were "likely to lead to a great increase in maternal mortality." And of course the uproar was blamed on Nye's personal qualities as a negotiator. He retorted sweetly: " Yet we are to assume that one of the reasons why the doctors are taking up this attitude is because of unreasonableness on my part. It is a quality which I appear to share in common with every Minister of Health whom the BMA have met " (Hansard, 9 February 1948, col. 37).

In the end Nye won because he kept his nerve, insisting that the Service would start on time despite the doctors' repeated refusals to cooperate. He relied on his belief that public opinion would rally to his support ; and it did. The doctors began to waver and at the eleventh hour he broke down their last remnants of resistance by accepting Lord Moran's suggestion that he should embody in amending legislation his oft repeated pledge that a whole time salaried service would not be introduced. After a few more protests and struggles the BMA climbed down and on 5 July 1948, the new Health Service opened its doors ; dead on time. About 90 per cent of General Practitioners joined overnight. Within a matter of months 97 per cent of the population had enrolled in it and have remained in it ever since.

Nye's epic struggle to get the Service launched inevitably left its mark. The BMA never forgave the Royal Colleges for the part they played and this has had its repercussions on the profession's relations with the Government even up to today. The structure Nye hewed out was right for the time, but it had obvious imperfections. It left health care divided between three separate instruments ; the hospitals, the general practitioners and the health services of the local authorities. Democra-

tic control of health care was reduced by putting the hospitals under appointed boards. The teaching hospitals were left as sovereign empires under their own Boards of Governors and with special privileges.

And there were other flaws of which Nye was well aware. There was not enough money to carry through his grand design as he would have liked ; to provide free dental and optical services or to establish the health centres to which he attached so much importance in raising the standards of the medical profession as a whole. The problem of family planning was swept under the carpet: Nye did not want a religious war on his hands at the same time. Not least the existence of pay beds remained an anomaly in a Service dedicated to the principle that no one should be denied equal medical aid for lack of means. Nye himself always admitted it was a concession he had felt compelled to make, describing it in his book, *In Place of Fear* as a " defect in the Service which was seen from the beginning."

Nonetheless the principles and the structure of the NHS stood the test. Patients did not rush to abuse free medicine. Doctors did not find they had become slaves. In 1953 the Conservative government set up an independent Committee, the Guillebaud Committee, to examine the rising costs of the NHS and how they might be controlled. When the committee reported in 1956 it gave the NHS a clean sheet, saying there had not been the vast increase in costs which some people seemed to think there had been and adding the following: " We are strongly of the opinion that it would be altogether premature at the present time to propose any fundamental change in the structure of the NHS " (Report of the Committee of Enquiry into the cost of the National Health Service, Cmnd 9663, HMSO, 1956).

the NHS record

How far has the National Health Service succeeded in the ultimate aim of improving health ? It is of course impossible to know what would have happened if we had left the pre-1948 health services to struggle on as before. It is also impossible to isolate those improvements in health which are due to more and better living conditions generally—better diet, better housing, a cleaner environment through less smoke pollution and so on.

Nevertheless a national health system has led to dramatic improvements in certain fields. New vaccines and treatments have totally transformed the impact of diptheria, polio, whooping cough and measles. Deaths from these diseases have fallen from 1,394 in 1948 to 33 last year. Advances in the detection and treatment of tuberculosis have reduced deaths from nearly 22,000 in 1948 to about 1,250 last year. The National Health Service made it possible to exploit these developments quickly and effectively and made them available to the poor as well as the rich.

Secondly, there has been only a small increase in the proportion of elderly people who are registered blind. To a considerable extent this is because people with cataracts have been found and given early treatment.

Thirdly the National Health Service has provided much better care for mothers before and during childbirth. The ability to plan on a national scale, to get targets and promote good practice, have decimated the risks of childbirth. The chances of a mother dying in childbirth are now about a tenth of those when the health service began. These and many other achievements are a tribute to the thousands of doctors, nurses and many others who have given such devoted service within the National Health Service over the last 27 years.

Above all the NHS has won the deep seated loyalty of the vast majority of the people of this country. Even those who seek to supplement its provision by buying private insurance schemes turn almost in their entirety to the specialist services of the NHS in the major medical crises of their lives. Despite the Health Service's undoubted gaps, Robert Maxwell, in his study of health systems in different countries published last year, *Health Care: the growing dilemma,* concluded that Britain " has achieved high overall health standards for a comparatively moderate slowly rising cost."

today's " crisis "

So why the sense of crisis at the present time ? The Service has not collapsed: it has continued to grow. It has become the largest employer in the country. In England alone there are 700,000 people working for the NHS compared with 400,000 in 1949. There are 20,000 more doctors ; roughly 160,000 more nurses, midwives and health visitors, and over 25,000 more in the other health professions. Of the 10,600 consultants working in the service nearly half have opted to work whole time and about 40 per cent of the rest are known to be working maximum part time. The vast majority of consultants earn the major part of their income in the NHS. The family practitioner service has gone from strength to strength and is the envy of countries like the US where, I was told, it is difficult to get a doctor to visit your sick child at home, however much private insurance you may pay.

Some of the reasons for the talk of crisis have been maturing over the years. For instance, the population served has increased over the last five years by about 1¼ per cent and older people are living longer. The number of people aged 75 years and more is increasing at the rate of 2 per cent a year, which will give us ½ million more over the next 10 years—and the older people grow, the more costly they are to care for. We need to increase our health service spending by ½ to 1 per cent a

year simply to provide the same standards of health service to an ageing population. Secondly, more and more people, rescued from the great killer diseases, are living long enough to get the disabling diseases ; and children who are born disabled now live much longer than before. There is thus a growing minority of disabled people needing costly services and expensive care. Thirdly medical knowledge is expanding and deepening. We can do much more to help people but at much greater cost. Over the last 20 years there have been enormous technological developments in medical equipment. As a result head X-Ray and some radiotherapy equipment cost 13 times more in real terms.

Fourthly medical care is a labour intensive " industry ". Hours of work for health service staffs have been reduced. In hospitals there have to be staff on duty throughout the day and night. It now takes 4½ nurses to cover a 24 hour span of duty which was covered by three nurses in 1948.

Fifthly we are constantly widening the scope of our health services: cardiac pacemakers, renal dialysis, kidney transplantation, genetic counselling are now widely available. One of my first decisions in 1974 was to introduce a free comprehensive family planning service, a decision which should have been taken 20 years earlier. It is the much wider demands which people are making on the service which put it under pressure and it is often these demands which are resented by some critics of the NHS who want to introduce a financial disincentive through a consultation fee.

So despite the growth of our expenditure on the NHS, we are not keeping pace with the demands on it. Hardly any hospitals were built in the first 15 years of the Service and it was not until the late sixties that a substantial hospital building programme was planned. The health centres to which Nye attached such importance hung fire for years because the general practitioners would not work in them. Suddenly their mood changed, the demand grew and the number of health centres leapt from about 20 in 1964 to 566 last year. But the programme was so late in getting off the ground that only about one doctor in seven yet practises in a health centre and the big expansion I planned has run into the country's financial difficulties.

The NHS's difficulties are undoubtedly partly due to the fact that, compared with housing and education, it has not been getting its fair share of national resources in recent years. And the effects can be seen in the age of our hospitals compared with that of our houses and schools. Only about a quarter of our district hospitals have been built since the war compared with roughly half our houses and half our schools. And a major reason for this slower advance I believe, is the undemocratic nature of the structure which Nye set up. It is significant that both education and

housing are the responsibility of local authorities which have responded to the sort of local pressures which cannot be exercised on appointed boards, even when they include representatives of local authorities. Yet the horror of the medical profession at the thought of coming under local government is as strong as ever it was.

Besides all this, the concept of health care has been changing rapidly. For years the main emphasis was laid on the role of the hospitals, which Nye described as the " vertebrae " of the system. Now we realise how much can—and should—be done to keep people out of hospitals and institutions and in the community. But this growing realisation meant that Nye's tripartite structure had become out of date and reorganisation was inevitable to integrate the hospital and other health services. Unfortunately the new managerial type structure introduced by my Conservative predecessor, Sir Keith Joseph, was about as complicated as it could be. In place of Nye's simple structure of Regional Hospital Board and HMC, Sir Keith loaded the Service with three expensive administrative tiers: Regional Health Authorities, Area Health Authorities (AHAS) and district management teams, with my Department as a fourth tier and the Community Health Councils stuck on at the bottom to give a semblance of democracy. Since the medical profession insisted on having a full voice in all three tiers, some doctors are now overloaded with committee work meanwhile the rest feel far more remote from management than they did before.

This single factor has done more than anything else to stoke the medical profession's sense of frustration at the present time. Yet the new structure had just been elaborately erected and manned when I took over responsibility for it as Secretary of State and it would have been irresponsibly disruptive, as well as costly, for me to have attempted to *re*-reorganise it radically. All I could do was to try to strengthen the democratic element by increasing the representation of local authorities on RHAS and AHAS, and by taking steps to introduce representatives of the staff for the first time. I have also taken steps to increase the influence and authority of the CHCS. Any more radical democratisation or streamlining of the structure will have to await the decision on devolution and the possible role of elected English regional government.

The second cause of the recent sense of frustration is, of course, money. First there was the explosion of anger over pay in the Service last year, which had fallen behind under our predecessors' statutory pay policy. It took twelve months for the Labour government to disengage from that policy and in the meantime the habit of striking swept through the hospitals into services like nursing where it had never been known before.

Suddenly men like consultants who had previously considered themselves as pro-

fessionals on professional type contracts began an agonising re-appraisal of their role in society, demanding industrial-type contracts with clearly defined hours of work and payment for overtime—just as the juniors are doing at the present time. Yet they recoiled at the idea that they should lose their professional freedom and status and have to account for their movements as industrial workers do.

the economic climate

The real cause of the present malaise in the NHS is that the Service is having to adjust itself to economic stringencies and new social attitudes, just as the rest of the country is having to do, and the most powerful men in it have not been trained or conditioned to make that economic and social adjustment. God and Mammon are at war in them. So their sense of frustration is expressing itself in a clamant insistence that the Service is " under-financed " with the covert suggestion that a Health Service financed overwhelmingly out of taxation can never respond to the growing health standards of a modern society. Whether they realise it or not they are questioning the whole basis of Nye Bevan's dream. But they have no clear idea of an alternative. They just believe instinctively that large sources of extra money are available for health care if only the government would allow private money to play a larger part in the financing of the NHS. It is essential that this belief should be probed and exposed for the myth it is. That is one of the reasons why the government has agreed to set up the Royal Commission for which the profession has clamoured for so long.

pay beds

And that is why the profession finds the phasing out of pay beds so provocative. The clash over this represents the conflict between two diametrically opposed points of view: those on the one hand who believe the time has come to complete Nye's vision of a Health Service where no one shall be debarred from getting the best available treatment because he cannot afford to pay, and the medical profession on the other which believes that more health care will have to be financed privately, not less. The independence of the profession is not at stake because I and the government have announced that we are ready to renew in the legislation the pledge Nye gave that the right to private practice will be preserved. Only in future it will have to operate outside NHS hospitals. In other words for the first time it will have to stand on its own feet. And that is why the phasing out of pay beds is more than an egalitarian gesture. In accepting the compromise which allowed pay beds to operate within the comfortable cocoon of NHS hospitals, buttressed by all the specialist services these hospitals could provide in an emergency, Nye enabled doctors to evade the test of just how much people are prepared to pay for private medical care when they have to pay for all of it. The experience might be a shock, for the

British people are well aware that in the NHS they get better value for money than they can get anywhere else.

Can the Health Service continue to maintain and develop its high standards if it is purely publicly financed ? It was Enoch Powell who, as Minister of Health, said that a " free " Service unleashes practically unlimited demand. So it does and there is nothing wrong in making demand articulate. It was Enoch Powell who used the word " rationing " in relation to health care. But in all countries health services are rationed: even in the wealthy United States. The only question is by what means. Is it to be by money or by a concerted national effort so to plan and organise the resources of a NHS that we provide the highest practicable level of care for everyone ? Sir Rodney Smith, the President of the Royal College of Surgeons, recently wrote that professional independence is at risk. And he defined that independence as " quite simply the right of a doctor to treat his patients in accordance with standards dictated by knowledge and conscience alone, and without interference from others " (*President's Newsletter,* Royal College of Surgeons of England, May 1975). But, as Nye stressed, the biggest interference with professional independence and clinical judgement can be the patient's inability to pay. That, too, can lead to rationing. Just because of its proud ethic, the medical profession ought to be the government's natural ally in trying to solve these moral dilemmas of our society.

If the NHS is to be strengthened we must find a way of entering into a new, less bitter dialogue between the medical profession and government. For if the suspicions and resentments could only be broken down the medical profession would find it could play a great constructive part with government in getting even better value for money in the NHS and making our resources go further in planning the best use of our medical manpower, helping to design more cost effective buildings, working out the right health priorities on which to concentrate, reconciling clinical judgments with economic restriction ; not as civil servants, whole time conscripts or state slaves, but as free men fulfilling the ethic by which they seek to live. This is the real answer to the problem of rationing. In this way alone can we realise Nye's dream.

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Cover design by Dick Leadbetter. Printed by Civic Press Limited (TU), Civic Street, Glasgow G4 9RH.

ISBN 7163 0440 6 ISSN 0307-7535

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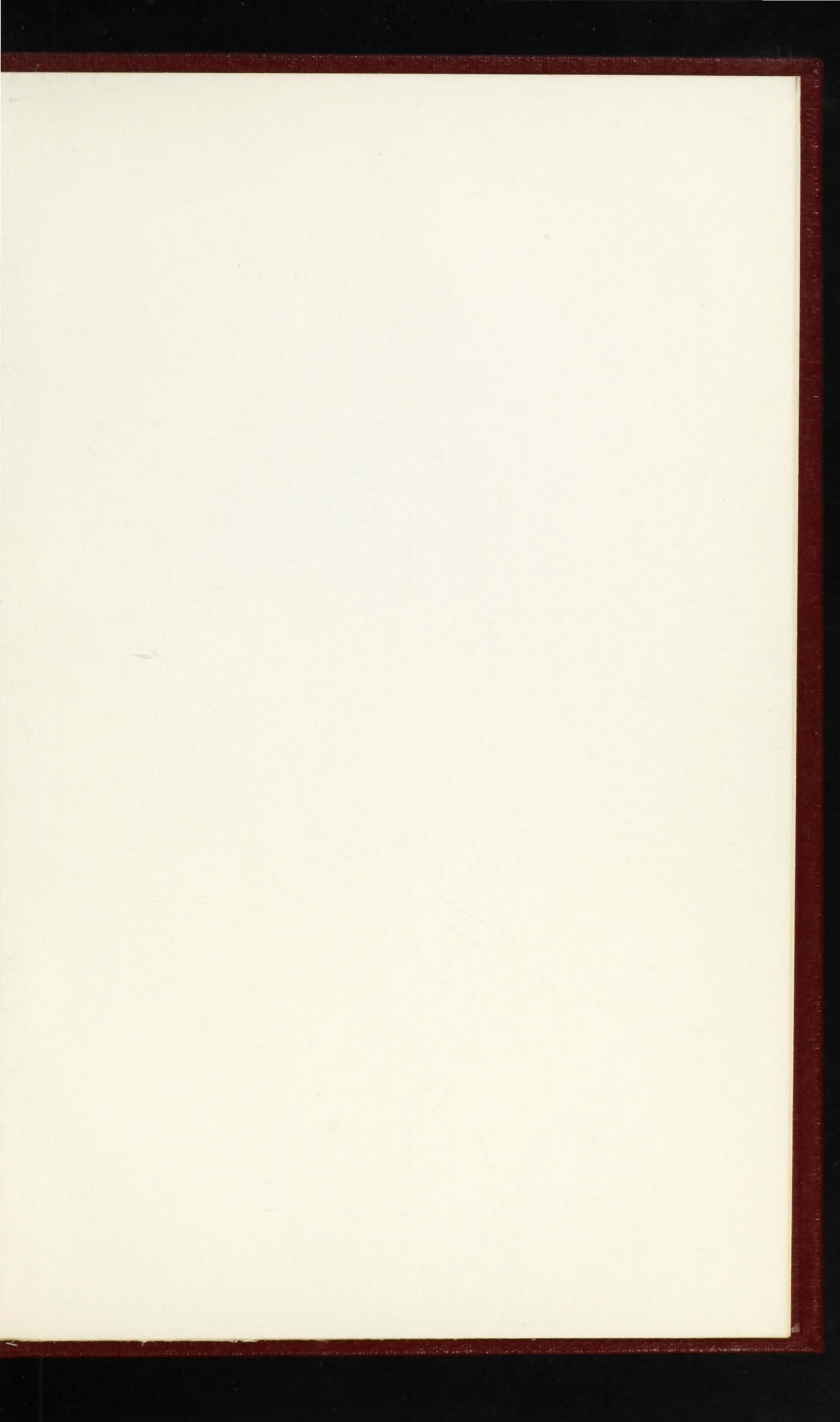

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