THE LEGAL ASPECT OF THE NATIONAL HEALTH SERVICE IN ENGLAND

By PROFESSOR W. FRIEDMANN, LL.D. (London), DR.JUR. (Berlin), LL.M. (Melbourne).

Delivered at a meeting of the Medico-Legal Society held on Saturday, 25th September, 1949, at 8.30 p.m., at the British Medical Association Hall, Albert Street, East Melbourne.

WHEN I was asked to address this Society, I naturally thought that a talk on the British National Health Service might be the most interesting topic, not only because in itself it is an experiment and an innovation of vast magnitude and significance, but also because there is now in the Commonwealth Statute Book a National Health Service Act assented to on 21st December, 1948, which is only an outline but which quite obviously is in its general purport framed on the model of the British Act.

However, when I came to study my material more closely, I felt that I had accepted this somewhat light-heartedly because when I left England the National Health Service had just become effective and had not yet operated for more than a very short time. Meanwhile, of course, a wealth of experience has been collected and many supplementary regulations have been issued, and I felt very uncomfortable—and I still feel somewhat uncomfortable—about giving you even an outline of the legal aspects of the health service, conscious of the all too many things which I do not know about it.

Very fortunately, providence has intervened in the person of Professor Kennedy of Durham University, who is not only at this moment visiting this country at the invitation of the Victorian Government, but who is also very experienced because he is in the midst of the National Health Service, and I very much hope that he will be able to cover what are some of the bare points which my talk will leave, with some solid flesh.

Now all I can promise and attempt to do is to give you an idea of the general organization and outline of the health service and perhaps to indicate briefly some of the legal problems that have arisen or might arise.

As far as I can make out, or at least insofar as the number of legal cases which have come to the public is nil, I have not been able to discover any significant decision connected with any problems, say, the doctor-client relationship or the public law aspects of this new national health service. This does not mean, of course, that they have not arisen, but that they have not so far come before the ordinary courts.

Let me first say one word about the background of the national health service of Britain. It is, I think, most essential to realize that in certain respects the background is a very different one from what it would be in this country. First of all, it would be impossible I think to understand the structure and legal and general organization of the National Health Service without being conscious of the long and far-reaching tradition of local government in Britain. Like the new Education Service, the new Health Service is the transformation of a more systematic, comprehensive and national pattern of many of the activities which have for many years been carried out in the regional and local level, which have been carried out by local authorities and through the active participation of citizens. This is the first essential to grasp because of course, as we know, in this country the background and tradition of local government is a very much weaker one.

Secondly, the British National Health Service has been introduced and operates in a country which is not, I hesitate to say, blessed or cursed with a federal system of government. In any case, it does make a very great difference whether you have a federal system or not for the distribution of powers, and some of the most difficult and intricate questions which may arise here about the distribution of powers, as well as the co-operation, if it is established, between the Comonwealth authorities and the States, do not, of course, arise in Britain.

On the background of local government from which this service has arisen I should like to say a few words. There is a somewhat complicated and, in many ways, archaic network of local authorities and so far attempts to rationalize it, which have been frequent in recent years, have not led to any result. The most effective authorities, however, for administering services, especially for education and health, are the county councils, or the equivalent in status, the borough councils, which are units expressing in terms of local government the administration of the major cities, although a number of other minor cities also

have that status because of their antiquity or historic record and so forth.

You have there units which have a long tradition of carrying out local services, but moreover the Ministry of Health in Great Britain has taken over a great number of the duties and responsibilities carried out by other authorities, especially in the nineteenth century, and has for some time past exercised supervision over health services as well as housing. This is a coincidence of these two responsibilities which can only be explained historically. The National Health Service Act found these two structural foundations ready on hand, a Ministry which has carried out supervision over health in a number of fields—and there was, of course, a very vast and highly developed network of local authority hospitals alongside private hospitals—and it found regional and local authorities with great experience in carrying out health as well as other social services. This Act is one of a series of Acts. It is a system of socializing a number of services, which has two parts, namely, one is transferring to public ownership certain existing industries and the other, of which this one is a part, is to create a network of authorities which between them will embody the programme of comprehensive social security and social services.

The operation is generally this. One of the Ministers of the Cabinet, which may in some cases be the Minister of Fuel and Power or the Minister for Education, is responsible at the top of the pyramid. He is responsible for general policy and he is in his turn responsible to Parliament. The Act says: "It shall be the duty of the Minister of Health . . . . in accordance with the following provisions of this Act."

Now, the Minister then is at the top. He is responsible for general policy. He has, we shall see, a number of direct powers of interference and supervision. He is assisted at the central level—and that is again part of the general operation of this Act—by a Central Health Services Council, called briefly the Central Council, composed of eminent members of the various colleges of surgeons, physicians, dentists and so forth and by some other people with administrative experience or other distinction in public life. That council, as well as a number of specialized councils with different specialized services, advises the Minister on general questions of policy. Now that is the top. Next you get what are called the Local Health Authorities. The Local Health Authorities are, in fact the major local

authorities, county councils and borough councils, which, as I have just said, have constituted and still constitute the backbone of the administration and provision of health services throughout the country. The Act lays down in particular their duties, the establishment of health centres, the care of mothers and young children, midwifery, health visiting at home, home nursing, vaccination, inoculation, ambulance services and aftercare. That again is a systematization of a number of activities which have been carried out, but without this general comprehensive pattern, for a long time past.

You have then, thirdly, the Area Executive Councils, which are normally created for the district of each local health authority, although there are provisions that both Local Health Authorities and Executive Councils may be formed, not just for a single county or borough but, if it is expedient in the opinion of the Minister, for combinations of districts. Obviously that is determined by, to some extent, density of population or by existing medical authorities.

Now the main task of these Executive Councils is the provision of a general medical service. That is probably the part of greatest interest, especially to doctors, and is termed General Medical Service. This has been the most controversial and publicized part of the whole scheme, which is best described, not quite accurately as we shall see, as the nationalization or socialization of the medical profession.

There are in connection with these Executive Councils special commitees for the arrangement of general medical services and they are called—and I think the same term is used in the Canberra Act—the Medical Practices Committees. These committees are in charge and it is their responsibility to establish a panel of medical practitioners—and parallel provisions have been made of course in regard to dentists—available for the National Health Service and qualified to be in the National Health Service.

Now so far it has, I think, been the general impression, probably rightly, that the whole problem has been for the Minister of Health, Mr. Bevan, and for the public authorities to get hold of sufficient practitioners willing to go on the panel and form part of the National Health Service, and let me make it quite clear in case there should be any doubt, there is no compulsion to do so—no legal compulsion. Anybody is free to join or not to join the National Health Service. Of course, there is a degree of indirect compulsion of an economic kind insofar

as the National Health Service and the General Medical Service provided by the nation is a counterpart to the claim of the citizens to free medical treatment which in its turn is part of the general scheme of social services which has been introduced in Great Britain since 1946. Obviously in the long run only a minority of people could afford to remain outside the panel because the vast majority of citizens will prefer or be compelled or have no alternative other than to make use of the free health service rather than to continue with privately paying their doctor.

However, there is no compulsion. It was a gamble in that sense. The Act was passed and it remained then to be seen what proportion of the practitioners, medical and dental, would join the service and while that was an open question, of course the success of the political and general fate of the Act depended entirely on the Government succeeding in getting the strong proportion of the profession into the service. Well, as you probably know, there were some protracted difficulties over a number of questions; some of these we might be able to discuss later. I do not want to do it now, in order not to affect the pattern too much; but in the end the majority of practitioners, and I think the majority of the dentists, have joined the panel so that the service functions more or less on the lines as anticipated.

Now the Executive Councils have the function of testing, examining and admitting qualified practitioners to the panel; as I say, whereas hitherto it may have been the problem of whether there were enough people, that may not always be so. The power extends just as much to the exclusion of persons who are not regarded as sufficiently qualified or otherwise fit to be included in the panel.

It is quite possible that at some future time, perhaps when the service has established itself and there are more trained medical practitioners available, that the boot will be on the other leg.

Now against any refusal to put somebody, at his application and request, on the panel there is a complaint to the Minister—in other words, a Minister functions here as what lawyers know as an administrative tribunal. He has certain judicial or quasi-judicial functions in deciding a question which may be of very vital importance, of course, for the professional future and livelihood of the practitioner concerned. There is also a possi-

bility of getting people off the panel if, either on the report of the executive committee—which, as I said, has a general responsibility for the establishment of the medical services—or at the request of the Minister, it is alleged that a certain person should be removed from the panel.

That is, of course, an even more serious matter, because it involves disqualification, and in that case a greater safeguard for justice is provided in the form of a special tribunal. The tribunal follows the usual form of having a qualified lawyer or barrister of not less than ten years' standing as chairman, a representative of the Local Health Authorities as one of the assessors, and a member from a panel of six of the different branches of the medical profession as the third member.

You have the next most important type of authority, namely, the Regional Hospitals Boards and Management Committees. One aspect of this National Health Service has been that instead of the dual system which existed until then of public hospitals owned and managed by local authorities and private hospitals which were mainly existing on endowments and gifts and collections, but had a certain amount of public support, especially in recent years, you have now only one system, namely, national hospitals, which are in a wide sense the property of the nation, which are managed and supervised by Regional Hospital Boards. These Regional Hospital Boards, as well as the Management Committees which function under them, are separate legal personalities. They are corporate bodies, they can sue and be sued, and they are fully liable in law and they do not enjoy any immunities or privileges enjoyed by the Crown in law. These privileges have now been vastly reduced since the passing of the Crown Proceedings Act in 1937, which has made the Crown liable to be sued in tort.

A number of privileges remain, but these Regional Hospital Boards and Management Committees are public authorities and, again following the operation of this modern British legislation, provide public services in the form of separate corporations with separate management and separate standing so that they will be more easily accountable. To use President Roosevelt's famous phrase, "They are public authorities with the flexibility of private enterprise," and the Regional Hospital Boards and the Local Health Authorities are separate, although forming part of the Crown, and are separate legal personalities.

The Regional Hospital Boards, at present numbering fourteen, are generally grouped around a university with a medical school, or faculty, as it is called in England, so that an appropriate service shall be available for each Regional Hospital Board. These are, of course, of very great importance. It is these boards and the management committees under them which run the hospitals, engage staff, provide equipment, and which are responsible for the admission and care of the patients in the hospitals, for the engagement of specialists, and so forth.

To complete the organizational operation there is what is called the deferred power of the Minister, which consists in his power to dismiss upon an enquiry which is conducted by him or under his supervision, on complaint or otherwise, any Regional Hospital Boards, Board of Governors . . . . and otherwise make necessary provisions.

This, of course, is the main disciplinary weapon of the Minister, and as I have said already there are also, as part of the administrative hierarchy, certain tribunals—in some cases the Minister himself as the ultimate authority, and in some cases the tribunal of three which I have already referred to and which is competent mainly to deal with questions of disqualification from membership of the panel of doctors or dentists.

Well, now, to complete this brief outline I should just like to refer to a few of the many legal problems which might arise from this reorganization. Perhaps, by way of a very general observation, we have here what I think is more characteristic of the modern scheme of welfare state in Australia as well as in Great Britain, an intricate mixture of old private law relationships and old public law relationships. It is over-simplification to speak simply of somebody becoming socialized lock, stock and barrel, and becoming simply a tool in the hands of the Minister. What we find in this case in particular is that, while the framework of the old private relationship between individual doctor and individual patient largely continues, it is interwoven with a new type of administrative supervision.

First of all, as I said already, there is no direct or legal compulsion. It took many months of protracted negotiations before an agreement between the B.M.A. and the Minister was reached on the terms on which they would recommend their members to join. It was free to any one individual to join all the same, but the power of the sole professional organization, which has in Britain as well as here certain disciplinary powers,

is a very great one. In the end an agreement was reached. That means the vast majority of the doctors and dentists are members of the service. Those who are not carry on as before. As far as I can see, there is no difference whatsoever in their legal relationship and social relationship to their clients. I understand, but again I can only go on information that I have had, that there is a gradually decreasing number remaining outside—mainly specialists who can afford, or perhaps find it preferable, to do so.

Those who join, and that is the vast majority, join on certain conditions which have been laid down in several supplementary regulations. I have not been able to obtain in time some of the regulations I should have liked to have had for this talk. There are quite a few regulations concerning the terms, not only of remuneration but of other matters. It is specifically laid down in the Act that a doctor or dentist who joins the service does not have to take patients assigned to him. It remains a matter of choice. The patient chooses from people in the panel, which means in the vast majority of cases that he or she continues to choose their former doctor, and the doctor has the same liberty of action as before, except that regulations lay down the maximum number of patients, which I believe at present is 2,000.

It is possible, but not obligatory, to receive a minimum salary, which would really be in the nature of a guaranteed minimum salary paid by the state, or to depend alternatively entirely on capitation fees. All doctors on the panel have liberty to take on private patients. There, I think, one can imagine certain difficulties, which depend, of course, to some extent on the personality of the practitioner concerned, but which might produce a certain conflict between the old former type of private doctor and patient relationship and the new public position.

It is, for example, possible that a doctor treats a patient in a clinic in a public hospital according to facilities available and who might also have the use of a private nursing home for private patients. It may be, and probably arises in a very small number of cases, that there are some doctors who would say to a panel patient, "Well, I shall operate on you, but I shan't have any facilities for another fortnight. However, if you choose to come to me as a private patient I can operate on you to-morrow." If that were done on any large scale, it would probably bring into operation the disciplinary machinery. A complaint would be made to the Executive Council, the Executive Council would

make a decision or recommendation which would go to the Minister, and eventually that matter might come before the tribunal, which would finally decide. As far as I can understand these cases have not happened very often so far.

As far as the individual relationship between doctor and patient is concerned, I should think very little has changed, except that the fee is paid according to a standard laid down in a Ministerial regulation and that the fee is paid on behalf of the patient by a public authority. The standard of treatment and the liability for negligence is, I think, just the same as it was before.

Once you come to the individual relationship of doctor and patient, whether he is on the panel or not, whether in the National Health Service or otherwise, I would say there will probably be a somewhat greater responsibility on the public authority for any cases of negligence, and that for two reasons. There is now a far greater number of directly owned public hospitals and full-time public doctors, specialists, nurses and other qualified personnel. Lawyers here have a problem—also familiar to doctors—which has come before the courts on a number of occasions: how far any hospital, either public or private, is liable for negligence in operation or treatment of patients by practitioners. The general law has been that there is no liability because a doctor in that capacity exercising his independent professional skill cannot be construed as a servant of the hospital, whereas the case of nurses and other personnel, and of doctors in their administrative rather than in their medical professional capacity, is quite different. It seems to me that there must almost inevitably in the new set-up be a greater degree of responsibility for admissions of patients, the priorities established and in various other matters just short of the actual operation or treatment performed, of an administrative rather than of a professional character. I have always thought it very irrational, and cannot see why this distinction should be made, or why the master-servant liability should not operate in that case. There seems to be a confusion of two different things: whether a certain activity requires professional skill, or the social question whether it is performed on the master-servant basis, that is to say, by a full-time employee on behalf of an employer. I do not know what difference this may make – perhaps quantitatively there will now be more classes where public authority will be liable, but I have not become aware of any cases on that

subject. There is also the possibility of extended liability of public authorities because of the intended use of health centres and of public hospitals for patients by private practitioners and for medical treatment altogether by private practitioners.

The intended Regional Health Centres, which were one of the greatest features of this Act, have not to any large extent been created yet, mainly because of the shortage of building material for more urgent priorities. So the Health Centres, which were based on certain experiments carried out and which were intended to be centres which would generally develop prophylactic and social care instead of the more individual medical treatment of the patient, are yet in a stage of planning rather than of execution, although I am told that they have been developed at some of the universities. Insofar as public hospital equipment under the responsibility of the Regional Hospital Boards and Management Committees would be used, there would of course be liability of the boards—and that means indirectly of the state—for the equipment or for other deficiencies which could be classified under negligence.

Then, of course, there is the question of administrative supervision. Every doctor or dentist who is on the panel is to some extent his own master with regard to a private relation with the patient, and in another respect he is, of course, subject to the supervision and authority of the Minister. It does not mean that he is a civil servant. Those who are full-time employees in hospitals now owned by the state or on behalf of the state by the Regional Hospital Boards are, of course, public servants though not civil servants.

One thing that might be of interest is the provision on the sale of practices. There is a very elaborate section in the Act which provides that where any medical practitioner is on the list of medical practitioners undertaking to provide general medical services, it shall be unlawful subsequently to sell the goodwill or any part of the goodwill of the medical practice of that medical practitioner. In other words, upon joining the health service the sale of the medical practice becomes (a) unlawful and (b) subject to fine. That is to say, a contract purporting to sell the goodwill of the practice would be illegal with all the consequences that involves in law and also the subject of criminal prosecution and a fine on conviction. There are a number of provisions which aim at curbing any attempt to get around this provision by obvious devices such as the sale of

buildings and equipment at a price obviously above the reasonable level—in other words, for a disguised sale of goodwill; or by the device of a partnership agreement between medical practitioners where the consideration given in the agreement is obviously of a kind that includes a tacit sale of the goodwill; as well as in the case of an agreement on the respective value of the services where there is a similar provision where a medical practitioner performs services for remuneration considerably less than is considered reasonable, having regard to his services at the time when the remuneration was fixed and subsequently in any part of the business.

There are various other practices which, if it is desired, we can discuss perhaps with any questions which can be asked later. The sale of the goodwill of medical practices has always been a very contentious matter, as a general principle, but it now becomes unlawful as incompatible with a national health service.

There is, however, a fund provided as compensation, to the sum of £66 million, which is available in a similar manner to the fund of about £3 million which upon nationalization of land betterment values was provided to compensate the private owners for the loss of the development of the land. A similar fund is here provided as a lump sum for equitable distribution according to regulations among the persons who lose the goodwill of their practice—in other words, while the sale of goodwill is considered as illegal and as an offence, in future for anybody who becomes a member of the National Health Service it is not implicitly regarded as a legitimate asset, as is quite clear from the fact that compensation is provided.

I am very conscious of the obvious inadequacy of this account to give you even a rough picture of what is obviously a very great and big experiment. I am not able to say anything on the question as to what extent superfluous wigs have been acquired or how people have abused the facilities to acquire spectacles for nothing, or all the other things which we have read in the newspapers. This is the kind of thing which gets into the papers but is obviously the least important.

We should also bear in mind, I think, that in judging the scheme we should differentiate the basic features and the extraneous. For instance, if there are too many patients per practitioner, obviously that is a matter which should be remedied as more trained people become available or as experience is

gained. If the public abuse certain facilities, again in the light of a year or two's experience these things can be remedied.

I would conclude by saying, first, that in Britain this National Health Service has certain foundations in the past practice and experience of local government, in particular; and secondly that I think now is the time when one can only begin to judge its main import and its main deficiencies as experience shows what in it is valuable and what is an excrescence.

I think I had better finish at this stage. I shall of course be glad, as far as I shall be able, to answer any questions on the Act, but in particular I am anxious that somebody who really knows how the National Health Service functions, and whom we are fortunate enough to have amongst us to-night, should not be deprived of this opportunity by my carrying on too long.