and the Approved Societies as agencies for the administration of the health and cash benefits, respectively. So far as Approved Societies are concerned, this is not so much one question as a whole group of questions calling for careful consideration from many different angles.

General Satisfaction with the Scheme.

28. All these grounds of criticism, as well as the suggestions received by us in connection with various details of the Scheme and our proposals for its modification and extension, are dealt with in the succeeding chapters of our Report. In this place we have restricted ourselves to a summary mention of these points in order to give a preliminary view of the problems before us. We can, however, say at once that we are satisfied that the Scheme of National Health Insurance has fully justified itself and has, on the whole, been successful in operation. The workers of this country have obtained under it substantial advantages, in particular by securing the title to free medical attention and medicine whenever and as soon as these are required, and by the proportionate diminution, to the extent of the cash benefit granted, of their anxiety as to the loss of wages during illness. Furthermore, the Scheme has, on the whole, been satisfactorily administered, notwithstanding the difficulties and antagonisms at the outset, and the peculiar and urgent problems which arose when vast numbers of men left insurable employment for the theatres of war and their place in the industries of the country was taken by women entering insurance, consequently, for the first time. The contributions have been collected and the benefits provided with a marked degree of efficiency. We are convinced that National Health Insurance has now become a permanent feature of the social system of this country, and should be continued on its present compulsory and contributory basis. At the same time, if the Scheme is to be made of the fullest advantage to the health and well-being of the nation, there are, in our opinion, various modifications and extensions that could, with advantage, be made, as and when opportunity offers and funds become available.

CHAPTER IV.

THE RELATED SCHEMES OF SOCIAL WELFARE.

General Nature of the Evidence.

29. In the very brief summary contained in Chapter II we have described the Health Insurance Scheme viewed as a self-contained system, and have intentionally refrained from looking beyond its borders. Our reference, however, permits and, indeed, requires us to examine the relationship in which the Scheme stands to those other activities of the State which are concerned with the promotion of the health of the nation. We take the view that any element of those other schemes which reacts in a substantial way upon the working of the system of Health Insurance appropriately comes within our purview.

30. Accordingly we have received and considered evidence relating to the various Public Health services as exemplified in the schemes of Maternity and Child Welfare, the arrangements for dealing with infectious diseases, tuberculosis, and venereal diseases, and the work of the Port Sanitary Authorities. All these services have a very direct bearing on National Health Insurance inasmuch as, by removing conditions prejudicial to the health of the community, or by the provision of remedial measures, they tend to diminish the volume of sickness and so to reduce expenditure on sickness and disablement benefits. We have also taken notice of the problems of the Poor Law medical service in its relation to medical benefit, and have considered the extent to which the cash payments provided as sickness and disablement benefit require to be supplemented by the grant of relief under the Poor Law. We have, further, heard evidence as to the system of medical inspection in factories, which is administered by the Home Office; and of medical inspection and treatment in schools, which is supervised by the Board of Education. To a less extent we have considered the Unemployment Insurance Scheme. The main features of that scheme are, of course, outside our reference. But the problems created by the inequality in the rates of cash benefits under the Health and Unemployment Insurance Schemes and the possibility of devising measures to secure from the Employment Exchanges certification of genuine unemployment as evidence for the excusal of arrears under the Health Insurance Scheme, have to a limited extent brought the Unemployment Insurance system under our review.

31. The Ministry of Health have submitted to us (in App. CIV) a statement as to the services concerned with the public health, maternity and child welfare, infectious diseases, tuberculosis, venereal diseases, port sanitation and medical relief and

maintenance under the Poor Law. It will be seen that in that statement there is furnished an account both of the central and the local administrations of these services, and that the costs to the Exchequer and to the local rates are given separately. The Scottish Board of Health have dealt with the corresponding problems in Appendix CV. In Appendix CIX the Board of Education have given an outline of the School Medical Service, and in Sir T. M. Legge's statement (Appendix XLII) will be found an account of the system of medical inspection in factories. We have thought it advisable to supplement most of this material by oral examination, being satisfied in our minds that the inter-relationship of all the health services is one of the most important questions before us.

32. Inasmuch as the descriptive statements referred to above are published in full in the Appendix to the Minutes of Evidence taken before us, it is not necessary to enter into the matter here in any elaborate detail. It may not, however, be out of place to furnish a short summary of each of these services similar in scope to that already given in Chapter II in the case of the Insurance Scheme; and to comment in passing on one or two points of interest which have emerged.

The Central Control.

33. In the first place, it may be observed that unity of administration at the centre is provided for in England and Wales by the single control of all these health services (except the school medical service and the inspection of factories), which is vested in one Department, namely, the Ministry of Health. So far as the schools are concerned, the Department actually supervising the work—the Board of Education—acts in this matter as the agent of the Ministry of Health, and the two Departments have a Chief Medical Officer in common. The Minister of Health, we are informed, has, in fact, in pursuance of a provision in the Ministry of Health Act, 1919, delegated the administrative arrangements to the Board, which continues to act subject to the suzerainty of the Minister. We were assured in evidence that effective co-ordination at the centre has been secured and that the high intentions with which the Ministry of Health was established have, so far as six years allow, not remained without fulfilment. We may quote the following extracts from the Evidence. "There is a very considerable measure of co-ordination by means of frequent consultations between the various heads of the Divisions as well as by reason of there being one Minister and one Permanent Secretary in the Ministry to whom all the heads of the Divisions are responsible." (*Kinnear*, Q.24,199.) "The arrangements for co-ordinating the work of the Ministry are such, I think, as to secure a continuance of this process as opportunity arises." (*Kinnear*, Q. 24,211.)

The Local Systems of Administration.

34. When, however, we turn to a consideration of the local administration of these health services we find a multiplication of local administrative bodies and a considerable division of functions due to some extent no doubt to historical causes. It is true that the work relating to public health, maternity and child welfare, tuberculosis, and venereal diseases are controlled by one local authority and administered under one chief executive officer, namely, the Medical Officer of Health. But there remain under other independent local authorities the school medical service, the Poor Law medical service, the Insurance Service and in certain cases the Port Sanitary service. Further the medical inspection of factories stands outside the supervision of any local authority. The problems raised by the Port Sanitary service appear to be of such a special nature that probably nothing is lost by the existence of a separate authority, though in point of fact the Local Authority in certain cases also acts as the Port Sanitary Authority. Where, however, as often happens, the natural port area covers several municipal areas a joint and specially constituted authority is necessary. The administration of the school medical service stands, of course, in the closest relationship to the educational work of the local Education Authority, under whose direct control it is placed. The systems under which medical provision is made locally for the sick poor and for the insured population are entirely separate from each other, both in administration and in the financial arrangements which they require, the one being supported by the local rates and the other by the contributions of the workers and their employers supplemented by grants from the Exchequer. Each, however, must be locally managed and in respect of each the present method of administration must shortly come under review, the first in connexion with the pending reform of the Poor Law, and the second as a consequence of recommendations which we have decided to make and to which we refer at some length in a later chapter. The question naturally arises whether in the course of developments in these directions, an opportunity will arise to effect a measure of local unification which in the circumstances would be considerable in its scope and consequences. We note the possibilities in this respect, though it does not fall to us to consider them in any detailed manner.

35. We now proceed to give a very brief outline of the various services under review.

Tuberculosis.

36. The national scheme for the treatment of tuberculosis is administered locally by the Councils of Counties and County

Boroughs, who submit to the Minister schemes for the treatment of persons suffering from tuberculosis at or in dispensaries, sanatoria and other institutions. The Local Authorities in this matter deal with all classes of persons, insured and uninsured. In addition to the service given in the tuberculosis dispensaries and the sanatoria and hospitals, home-visiting by tuberculosis nurses and health visitors, and extra nourishment for tuberculous patients receiving treatment at home, are provided. Schemes are in operation in every County and County Borough, and the total number of approved tuberculosis dispensaries in England is 454, under the charge of 353 Tuberculosis Officers. The number of residential institutions is 458, containing nearly 21,000 beds. Of these beds 13,000 are in institutions belonging to Local Authorities and 8,000 in institutions belonging to voluntary bodies. The gross expenditure on all this work was in 1922-23 about £2,600,000, of which about £1,600,000 was met from Exchequer grants, the remainder being, in large part, borne by the local rates. At present the distribution of the burden between the Exchequer and the Local Authorities is on the basis of an annual State grant of £315,000, in addition to an annual grant of 50 per cent. of the approved net expenditure incurred by Local Authorities. Provision is also made for the treatment of ex-service men suffering from tuberculosis, attributable to or aggravated by service in the War, and, through the Ministry of Pensions, arrangements are made for defraying the cost of treatment so given.

Venereal Diseases.

37. Treatment centres for venereal disease are established throughout the country at which all persons may obtain treatment free of cost under conditions of secrecy. Facilities for the diagnosis of venereal disease by laboratory methods are made available free of cost not only to the medical officers of the Treatment Centres, but to medical practitioners in general. A gratuitous supply of approved arsenobenzol compounds is made to medical practitioners who possess one or other of certain specified qualifications; and propaganda as to the dangers of venereal disease and the necessity for treatment is conducted. These schemes are carried out by the Councils of Counties and County Boroughs with the aid of a Government grant of 75 per cent. of the approved expenditure, the remainder being borne by the rates. There are in England and Wales about 194 of these treatment centres. The annual expenditure of Local Authorities on this service is about £420,000. The propaganda work is undertaken by the British Social Hygiene Council on behalf of the Ministry of Health, and involves an expenditure of about £6,700 a year, the whole of which is borne by the Exchequer. The Local Authorities also carry on propaganda work.

Maternity and Child Welfare.

38. Maternity and Child Welfare schemes are conducted by County Councils and County Borough Councils and the Councils of certain of the larger County districts. Amongst the services for which the schemes provide are included the salaries and expenses of inspectors of midwives, health visitors and nurses engaged in maternity and child welfare work, the provision of midwives for necessitous women in confinement, and the expenses of Centres, *i.e.*, institutions providing any or all of the following activities: medical supervision and advice for expectant and nursing mothers, and for children under five years of age, and medical treatment.

39. The expenditure on these services is met by a 50 per cent. grant from the Exchequer, the balance being found from the rates; and the grant is made on condition that the work of the agency is co-ordinated, as far as practicable, with the Public Health work of the Local Authority. The total Exchequer grant paid to Local Authorities and Voluntary Agencies was in 1922-23 about £785,000. The total expenditure on the whole service amounted to about £1,530,000 in 1922-23.

Port Sanitation.

40. The primary object of the Port Sanitary Service is to protect this country and British shipping from the introduction of grave infectious diseases which are endemic in certain parts of the world but are not ordinarily found in this country, for example, plague, cholera, yellow fever and in a lesser degree typhus fever and small-pox. Constant inspection and supervision of shipping is carried out to this end, and in the course thereof, all cases of ordinary infectious disease which are discovered are also dealt with. Efforts are likewise made to secure healthy conditions on board ship. The other main branch of port sanitary administration is the inspection of food entering the country in bulk.

41. The total annual expenditure of the Port Sanitary Authorities in England and Wales amounts to about £90,000, and an Exchequer grant is made amounting to 50 per cent. of the approved net expenditure.

Infectious Diseases.

42. The control and treatment of acute infectious diseases, such as scarlet fever, diphtheria and small-pox, is carried out in the main by the local sanitary authorities without assistance from Government funds. Broadly speaking, the functions of the sanitary authorities in respect of infectious disease are:—

(1) To receive from medical practitioners in their district notification of cases of certain infectious diseases. Inquiries

are then made to discover the source of infection and to ensure that all precautions desirable to prevent the further spread of infection are taken. Occasionally these inquiries disclose an urgent need for wide investigation and prompt action, as for instance where there is reason to suspect that water supplies, milk supplies, or oyster layings have become contaminated. The Medical Officer of Health is prepared to assist a medical practitioner in the diagnosis of a dangerous disease, such as smallpox, if requested.

(2) To provide facilities for the isolation and treatment in hospital of persons suffering from acute infectious diseases who cannot be properly isolated and treated at home. The powers of Section 131 of the Public Health Act, 1875, to provide isolation hospitals are permissive and not mandatory, and some districts are still without any means of isolating cases of infectious disease. Provision is made in the Public Health Acts and in the Isolation Hospitals Acts for the formation of Joint Boards or Joint Committees for the purpose of providing and maintaining hospitals for the common use of two or more sanitary districts, and the Minister of Health has, in some instances, made regulations under Section 2 of the Public Health (Prevention and Treatment of Diseases) Act, 1913, authorising a County Council to provide an isolation hospital for the whole or part of the County.

43. In the year 1921-22 expenditure on the provision and maintenance of isolation hospitals amounted to about £4,320,000, of which only about £4,200 was met out of Exchequer grants.

The School Medical Service.

44. Passing now to the school medical service we find that the authorities responsible for this administration are the Local Education Authorities which are the Councils of all Counties and County Boroughs and of certain non-County Boroughs and Urban Districts. These Authorities exercise their powers in all cases through statutory Committees appointed for the purpose. All school children are medically examined at entrance to school, at the age of 8, and at the age of 12, on the basis of a model schedule issued by the Board of Education, which is in general use in nearly every area. Any children who appear at any time to be ailing are also submitted to medical examination, and any child in whom a defect is found is reinspected subsequently. In such cases the parents are informed and are advised to have the defect remedied, and school nurses follow up the cases to see that the necessary treatment is provided. The parents are expected, if able to do so, to provide the treatment themselves, but where they are unable, for any reason, to secure the necessary treatment, the Local Education Authority provides treatment for the following types of defect: minor ailments, defects of vision, defects of teeth, enlarged tonsils and adenoids and crippling defects.

45. The School Medical Service thus keeps the whole school population under constant medical supervision, brings to the notice of parents defects from which their children are suffering and urges the necessary remedies. Further, it provides certain definite forms of treatment itself. Each Authority has a School Medical Officer in charge of the work, with one or more medical assistants for the ordinary duties. In addition the Authorities employ specialist officers, either whole-time or part-time, for certain branches of the work, such as dentistry, care of the eyes, and operative treatment.

Medical Service of the Poor.

46. Coming now to the Poor Law Medical Service, we find that the regulations of the Central Authority require that every Board of Guardians shall provide an outdoor medical service and an institutional medical service for the destitute poor. For the former purpose there is appointed in each district a medical officer, whose duty it is to attend, and supply medicines to, all poor persons requiring medical attendance within the district at the order of the Guardians or the Relieving Officer. These medical officers are general practitioners and are usually on the insurance panel. For the purpose of institutional medical service there is the staff of medical officers and nurses attached to the workhouse infirmaries. There are at present in England and Wales 635 Boards of Guardians managing 629 workhouses, 597 of which include at least some accommodation for the sick. There are also 71 separate institutions for the sick and 16 institutions for defectives. The total number of Poor Law beds provided expressly for physical or mental infirmity may be taken as roughly 129,000, of which 37,000 are in separate hospitals and infirmaries and 13,000 in separate institutions for mental cases. The total number of persons suffering from sickness, accident or bodily infirmity in receipt of Poor Law medical relief on 1st January, 1925, was about 310,000. The estimated expenditure by Boards of Guardians in 1923-24 on persons suffering from bodily infirmity was about £7,000,000, of which over £6,000,000 was borne by the rates, the remainder being met from the small Exchequer grant and other receipts.

Medical Inspection in Factories.

47. The arrangements for medical inspection in factories and workshops are made directly by the Home Office, and Local Authorities have no place in the scheme. From Sir T. Legge's

statement (Appendix XLII) it may be inferred that, while this long-established system works successfully, he feels there may be room for some closer relationship between the medical work of his Department and the other medical activities of the local bodies and of the insurance practitioners. But while the problems of ill-health in factories have, no doubt, some relation to the general sanitary conditions of the area and to the work of the ordinary practitioners, we understand that there are strong arguments for retaining the existing close connexion between the medical and the technical inspection of factories. In reply to questions on this matter, Mr Brock expressed the view of the Ministry of Health as follows: "It was felt that the practical difficulty of transferring medical inspection of factories to the Ministry arose from the impossibility of divorcing it from the general work of factory inspection. In practice it would be very difficult to separate the medical side from questions of Workmen's Compensation and from the lay factory inspection as distinct from the medical inspection." (Q. 24,183). "I think the medical inspection of factories involves so many questions of a technical and not wholly medical character that it would be very difficult to separate it from the general provision for factory inspection." (Q. 24,184.)

The Contributory Pensions Scheme.

48. As to the relations of the Health Insurance Scheme to the arrangements under the Widows', Orphans' and Old Age Contributory Pensions Act recently passed little need be said. The provisions for the joint stamp and joint collection of contributions are matters of machinery. On the benefit side the two schemes stand quite apart. The age limit for contributions and cash benefits under the Health Insurance Scheme is to be lowered from 70 to 65 as from January, 1928, and the weekly contribution payable is accordingly reduced by 1d. in the case of men and $\frac{1}{2}d.$ in the case of women. Medical benefit, as before, does not cease when the insured person's rights to cash benefits under the Act are terminated at 65, but continues throughout the remainder of life.

Workmen's Compensation.

49. The payment of benefit to persons in receipt of compensation under the Workmen's Compensation Acts is dealt with in Section 16 of the National Health Insurance Act of 1924. If the weekly value or weekly rate of the compensation received is equal to or exceeds the weekly rate of Health Insurance benefit to which the insured person would otherwise be entitled, no benefit is payable. If it is less only the difference is payable. Lump sum compensations are to be translated into weekly

equivalents for this purpose. The relief to the insurance funds thus resulting is allowed for in the actuarial calculation of the contribution. The system appears to work well and has the feature that it continues to place upon the employers the full financial responsibility for industrial accident and disease.

Maintenance of the Poor.

50. Turning to the maintenance aspect of the Poor Law, we have had evidence as to the supplementing of the cash benefits under the National Health Insurance Scheme by Poor Law relief. The Scottish Board of Health submitted a statement showing the numbers of persons in certain industrial parishes who applied for Poor Relief to supplement National Health Insurance Benefit and other resources, and stated that, from information based on the Census records, "The indications are that for both sexes, 5·9 per cent., and for men, 7·3 per cent., of the insured persons drawing benefit applied for poor relief (App. CV, 51). The evidence furnished to us by the Ministry of Health indicates that while "no records are available of the number of applicants for, or recipients of, Poor Law relief who are insured persons, it can only be stated that the proportion must be a substantial one." The evidence from this quarter also indicates that in the two Boroughs of Reading and Halifax it was reported that 9·3 per cent. and 3·4 per cent. respectively of the persons in receipt of Health Insurance Benefit on a certain date were also in receipt of Outdoor Relief (Appendix CIV, 69). The Association of Poor Law Unions of England and Wales informed us that "an insured person in receipt of sickness benefit comes to the Guardians for help simply because he has some dependants. He is thrown out of work and there is nothing coming in except his sickness or disablement benefit. In a case like that they are bound to come for Poor Law assistance unless they have some other resources" (Q. 21,673).

51. This evidence raises the fundamental principle involved in the question whether these benefits should be adequate for maintenance, or whether their supplementation by private insurance in the case of the provident and by the Poor Law in the case of the thriftless or unfortunate is to be regarded as a permanent and desirable element in the system. The present rate of 7*s.* 6*d.* a week for disablement benefit is obviously not sufficient for the maintenance even of the single man. It was probably never intended to be, but was merely a basic sum such as the contribution could provide, giving an assured though small weekly payment which could be supplemented by private savings, voluntary insurance, and in other ways. The sickness benefit of 15*s.* is very near the margin for the single man and insufficient for the man with dependants. It is true that the

grant of additional cash benefits, which may raise the former rate to 10*s*. and the latter to 20*s*., may make such supplementation less necessary. But these additions are not universally operative, and many Societies do in fact give their members cash benefits at the basic rates only.

The Unemployment Insurance Benefits.

52. In this connection we may be permitted to refer to certain disparities between the Health and the Unemployment Insurance Schemes. In the latter the standard rate of benefit is 18*s*. a week, and additions of 5*s*. are made for the wife and 2*s*. for each dependent child. It is difficult, in our opinion, to justify a less generous provision for the invalid than for the man in good health, whose circumstances certainly involve smaller expenditure. It is equally difficult to justify the existence of two State schemes side by side, one of which recognises the needs of dependants and the other does not, in circumstances of hardship closely similar. Both schemes are designed to alleviate the distress arising from the cessation of income due to causes beyond the worker's control, and the question whether these causes are to be sought in ill-health or in the failure of employment has no bearing on the needs of dependants.

It has been suggested to us by the National Association of Trade Union Approved Societies that, as a consequence of the higher rate of unemployment benefit there may be a temptation to apply for that benefit rather than for sickness benefit, even though the applicant may be incapable of work, and so fulfil the statutory condition for the latter. (Appendix XCII, 109.) In such a case he would, of course, be really disentitled to receive unemployment benefit. We have received no direct evidence on the point and, in any case, such evidence would probably be difficult to obtain. We do not doubt that this question, which primarily affects the administration of Unemployment Insurance, is fully in the minds of the officials of the Ministry of Labour.

Certification of Unemployment.

53. It has been suggested to us that the machinery of the Employment Exchanges should be utilised to certify genuine unemployment with a view to excusal of arrears under Health Insurance. We are impressed with this possibility, and have received evidence from the Ministry of Labour on the subject (App. CII, Q. 23,290 to 23,395). The question arises whether, in a period of widespread unemployment, arrears of contributions due to this cause should penalise the insured person in respect of benefits granted under the Health Insurance Scheme. While it is true that the Prolongation of Insurance Act and the present Arrears Regulations make a temporary and partial provision for

this difficulty, we are inclined to think that some arrangement to excuse arrears in respect of genuine and, as far as possible, officially certified unemployment should be part of the permanent scheme, and we deal with this problem in Chapter XIII.

54. We have in this chapter merely attempted to indicate broadly the nature and extent of the territories lying along the borders of Health Insurance. We reserve for a later chapter our detailed consideration of certain questions which arise from a consideration of the relations of the Health Insurance Scheme to these other activities of the State.