CHAPTER V.

THE DEVELOPMENT OF THE HEALTH SERVICES.

55. We propose to devote this chapter to a consideration of the medical aspects of the Health Insurance Scheme in their relation to the various other health services organised or supported by the State which we have described in the preceding chapter. For this purpose we have felt justified in assuming that the various health services of a public character will continue to expand both in their scope and in the range of persons to whom they apply; and that while the limitations of finance to which we refer in Chapter VI may prevent development in the near future, yet, as time passes, these may become less restrictive. It also appears to us that we may accept as a principle which should govern any such developments, the desirability of bringing into closer relationship the various services directed towards the prevention of sickness and the improvement of health, and that the organisation of the services should be such as to facilitate those developments which from time to time may become possible.

56. Medical benefit has been in operation for 13 years; of the other branches of medical service some preceded, others followed its introduction. In all these activities we have found, speaking broadly and with full consciousness of its limitations, such a contribution to the health and well-being of the community that we feel sure that a steady expansion in these services will mark our future social history. We will first devote some space to a consideration of what medical benefit is and what its practical results have been, as from the point of view of our reference that benefit must occupy the central position in a survey of the health services.

SECTION A.—MEDICAL BENEFIT.

Scope of Medical Benefit.

57. Medical benefit is defined under Section 10 of the 1924 Act as "medical treatment and attendance," which "includes the provision of proper and sufficient medicines and of the prescribed medical and surgical appliances, but does not include treatment or attendance in respect of a confinement."

58. So far as the supply of drugs is concerned, there is, subject to a safeguarding provision directed against extravagant prescribing, no limit in nature or cost to what the doctor may in his discretion prescribe. But as to the service he gives, the scope of the benefit has in practice been limited to such treatment as may reasonably be regarded as within the competence of

a general practitioner. The definition given in the Regulations now in force is as follows:—

> "The treatment which a practitioner is required to give to his patients comprises all proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess." (Clause 8 (1) of Part I of the First Schedule to the Medical Benefit Consolidated Regulations, 1924).

59. We were so much impressed by this limitation—imposed as it was by regulations and not explicitly in the Act itself—that we examined the official witnesses of the Ministry of Health on the point at some length. We were told (*Brock*, Q. 995) that the apparently narrow view taken was based on the advice given to the Insurance Commissioners by their legal advisers at the inception of the Scheme. This was to the effect that the provisions of Section 24 of the 1924 Act (Section 15 of the 1911 Act) were not consistent with any other view. The Act gave every duly qualified medical practitioner a right to come upon the medical list, and it contemplated that every insured person would have one medical attendant but not more than one at a time, and that if the insured person did not himself choose a doctor, he might after a certain time be allocated to a doctor by the local Insurance Committee. Thus the effect of the provisions of the Act was that the insured person was entitled to receive from one doctor, and from one doctor only, the whole of "medical benefit" whatever that phrase might mean. In these circumstances it appeared to the legal advisers and to the Department that the scope of medical benefit must be construed as limited to services within the competence of the average general practitioner. Further, though the medical lists included a certain number of men with special experience, whose competence in certain directions was therefore above the average, it was felt that if all doctors were to receive the same rate of remuneration, as practical considerations were found to require, a uniform obligation and a uniform content of service were implied; and that it would not be equitable to require one man, because he happened to possess some special skill, to render a wider range of service than was required from the majority of his fellow practitioners engaged under the insurance contract.

60. Though this limitation of the service has been from time to time commented upon (see *Brock* and *Smith Whitaker*, Q. 1080-1101) and though on all sides a fuller conception of medical benefit has been urged upon us by witnesses, no attempt to challenge it in the Courts has ever been made during the 13 years of its operation. We may fairly assume, therefore, that it is valid on legal grounds and we recognise the general and

administrative reasons for the restrictions contained in the Regulations.

Evidence Supporting Extension.

61. That an extension of the scope of the service is widely desired has been made abundantly clear to us in evidence. Witnesses appearing before us on behalf of the Ministry of Health and the Scottish Board of Health, informed us that " the trouble that has always been brought home to us about medical benefit is that the absence of a specialist service is treated as a reproach " (*Smith Whitaker*, Q. 24,024). " Informed public opinion in Scotland in relation to health services . . . is, broadly speaking, that . . . the present insurance service, as far as it relates to health, is defective, and that the present medical service is merely a general practitioner service; and that in order to get the full benefit of the Scheme . . . it is imperative . . . to extend that service to include . . . all proper aids to diagnosis, all second opinions in the way of experts . . . and certain services which we might broadly describe as curative . . . as electrical treatment, light treatment, and so on " (*Leishman*, Q. 24,328). The British Medical Association (App. XLVII, 19-20, Q. 14,972-14,974) state that " the medical provision made for all persons included in the Scheme should be as far as possible complete." " It is desired to make all such services and benefits (i.e., the various services provided by the Public Health and Education Authorities) an integral part of the Insurance Scheme . . . and to extend the provision so as to include complete consultant and specialist advice and treatment, full laboratory facilities for clinical purposes, residential institutional treatment . . . dental advice and treatment, such ancillary help as can be given by nurses and masseurs, and an ambulance service. . . . The Association is of opinion that all these benefits should be equally available to all insured persons alike, regardless of their membership of any particular Society."

62. The Medical Practitioners' Union (App. XLVIII, 13, Q. 15,345-15,346) hold that " it is right and proper that the provision of medical services by the State should extend until the widest possible benefits of preventive and curative medicine are available for those persons who, without State assistance, would be unable to obtain them." The Society of Medical Officers of Health (App. LVI, 10, Q. 16,993-16,994) urge that " a commencement should be made to give medical benefit its true meaning by including (*a*) facilities to the medical profession for laboratory diagnosis; (*b*) specialist advice and treatment; (*c*) dental treatment; (*d*) treatment in general hospitals and other like institutions; (*e*) further accommodation for the treatment of tuberculosis, especially surgical tuberculosis;

(*f*) treatment in convalescent homes; (*g*) home-nursing when required; (*h*) all other necessary medical advice and treatment." Dr. Harry Roberts, a practitioner in the East End of London with a large insurance practice, gave similar evidence which impressed us both by its quality and as representing the considered views of one who is in close daily contact with the problem in its most difficult form. He refers (App. LI, 14, Q. 16,117) to " the limitation of provided medical treatment to such as is assumed to be within the range of an average general practitioner " as being " one of the principal limitations of utility of the present medical service."

63. Other medical bodies and practitioners have spoken before us to the same effect, and it is evident that the weight of the professional evidence is in favour of a removal of the restriction which seems to be inherent in the arrangements under the present Statute.

64. Turning to the non-professional witnesses we find the same trend of opinion very strongly indicated. The Hearts of Oak Benefit Society (App. IV, 254, Q. 3544-3546) recommend the inclusion of a specialist medical service as part of medical benefit, and (App. IV, 284, Q. 3549-3551) the provision of at least 50 per cent. of the cost of dental benefit for all insured persons. The Ancient Order of Foresters (App. V, 37-44; 46-49) and the Independent Order of Oddfellows (Manchester Unity) (App. VII, 53-61) make similar recommendations.

65. The Joint Committee of Approved Societies state (App. XIV, 24, Q. 8723) that they " desire to see the benefit given by the Act of 1911 fully conferred upon the insured, i.e., adequate medical attendance and treatment and not the restricted form of (domiciliary) medical benefit defined by the Regulations." The National Conference of Friendly Societies, representing over four million insured persons, urge (App. XXVI, 22, Q. 10,913-20) that " until a public medical service can be instituted medical benefit should be extended to include the provision of specialist and consultant services." The National Association of Trade Union Approved Societies submit (App. XCII, 94) " that the term ' medical benefit ' should mean everything that medical and surgical science can command for the prevention or cure of sickness." The evidence from Insurance Committees and their representative bodies is to the same effect. Witnesses giving evidence before us on behalf of the Central Departments also agreed as to the desirability of extending the provision so as to include a specialist and consultant service if the difficulties of finance could be overcome. (See *Kinnear*, Q. 23,682-23,686; *Leishman*, Q. 24,337-24,340.) Finally we may quote an extract from the Annual Report of the Chief Medical Officer of the Ministry of Health, 1924 (p. 163). In concluding his survey

of the insurance medical service and speaking of the work of the insurance practitioner he says :—

> "The work is carried out under certain disadvantages, chief among which is the lack of co-ordination between the services of the insurance doctor and those of workers who have devoted intensive study to special provinces of the great territory of medical practice. The inclusion of such consultant services becomes more and more requisite year by year and is one of the most pressing of present needs. When the insurance medical service shall have been completed by being brought into organic relation with other branches of medical work as part of a comprehensive scheme of medical services, and not until then, will its full capacity for public usefulness be made manifest."

66. We have devoted some space to this question, not only because we think it is of the highest importance in the Scheme as it stands and in relation to the various and widely different proposals for extension and reform which have been put forward, but also because we feel that it raises a cognate question of great difficulty. If medical benefit were thus extended for the present insured class, we are forced to consider the position of those persons of moderate means who are somewhat above the present income limit for insurance purposes but to whom the payment of a specialist's or consultant's fees is nevertheless a serious matter. It is assumed, probably rightly, that such persons can reasonably be expected to meet charges for general practitioner treatment, and are therefore properly excluded from the Scheme in its present form. But in respect of major operations and similar services, for which it is usually necessary that the patient should be an inmate of a hospital or similar institution, it might with reason be contended that the claim which could be advanced on behalf of some of these persons to be protected by some form of State insurance against the risks involved is scarcely, if at all, less valid than the claim of certain of the insured population, and that to provide a full specialist service for the insured, while leaving these adjacent classes to their own resources would bring about a position difficult to justify on grounds of public policy. This point of view was put before us by the National Association of Trade Union Approved Societies, who submitted "that if the difficulties connected with the collection of contributions can be surmounted, medical benefit should be available to persons not employed within the meaning of the Act, whose total income does not exceed £350 a year, and that medical benefit other than general practitioner treatment should be provided for persons whose income exceeds £350 a year, but does not exceed a higher figure to be determined later. . . . ." (App. XCII, 102.) We desire to emphasise in the present discussion of the scope of medical benefit the problem of specialist services for the non-insured of moderate means, because it is one to which we have felt it necessary to have regard in a later chapter of our Report.

The Value of Medical Benefit.

67. We come now to the question of the value of medical benefit within the limitation we have just discussed. Such as it is, it has been available for 13 years. It is now provided for about 15 million people and costs the Insurance Funds about £9¼ millions a year, of which about £7¼ millions goes to the doctors and nearly £2 millions on the provision of drugs and appliances. We are told that the number of persons attended in a year may be taken at roughly 7½ millions, the attendances at 52 millions, and the number of prescriptions at between 40 and 50 millions. This service is provided by nearly 15,000 doctors and over 10,000 chemists. These figures sufficiently indicate the enormous volume of the work under the State scheme initiated in 1912, and the social results may, we think, be inferred. The benefit indeed has set up a "new model" in medical provision for the workers, with which the club practices and Friendly Society arrangements of pre-insurance days are scarcely comparable either in extent or quality.

68. As to the quality of the insurance medical service we will restrict ourselves to a citation of some representative extracts from the evidence, prefacing these quotations with the remark that the general acceptance of the system during the last 13 years, the absence of any substantial volume of criticism of it apart from the question of scope already referred to, and the wide demand for its extension, are in themselves evidence of a favourable kind.

Independent Order of Oddfellows (Manchester Unity).—"The present system of providing medical benefit through panel practitioners should be continued" (App. VII, 59).

Independent Order of Rechabites.—"It can almost unreservedly be said that our relations with the medical profession have been most cordial, and recorded cases of complaint have been very few indeed" (App. VIII, 25). "The present panel service deserves more commendation than it sometimes gets" (Q. 4130).

Mr. Alban Gordon.—"I am not prepared to contend that it (the Insurance Medical Service) does not possess as high a standard of efficiency as can reasonably be expected within the bounds at present set" (App. XIII, 32).

The Coventry Insurance Committee.—"The general practitioner service is adequate, and the Committee have only dealt with 15 complaints against doctors since 1912. It is believed that the dispensing service is adequate and popular—practically no

complaints arise " (App. XXXIII, 24 and 26). " In the majority of cases the doctors take very great pains to give a willing and conscientious service " (Q. 12,297).

Ministry of Health Inquiry Room.—" Surprisingly few complaints against the medical service are received, although the object of these visits (i.e., of visitors to the Inquiry Room) is to bring forward an insurance grievance. . . . With very few exceptions those persons who speak to the detriment of the insurance medical service have never been under the treatment of a panel practitioner " (App. XLI, 14).

The Standing Committee of Scottish Insured Women.—" The Committee regards medical benefit as the most important benefit under the National Health Insurance Act " (App. XLVI, 18).

The British Medical Association.—" In the year 1922 both the Representative Body of the Association and the Conference of representatives of Local Medical and Panel Committees declared that the measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Act system has been sufficient to justify the profession in uniting to ensure the continuance and improvement of an Insurance system.

(*a*) Large numbers, indeed whole classes of persons are now receiving a real medical attention which they formerly did not receive at all.

(*b*) The number of practitioners in proportion to the population in densely populated areas has increased.

(*c*) The amount and character of the medical attention given is superior to that formerly given in the best of the old clubs, and immensely superior to that given in the great majority of the clubs which were far from the best.

(*d*) Illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case.

(*e*) Speaking generally, the work of practitioners has been given a bias towards prevention which was formerly not so marked.

(*f*) Clinical records have been or are being provided which may be made of great service in relation to medical research and public health.

(*g*) Co-operation among practitioners is being encouraged to an increasing degree.

(*h*) There is now a more marked recognition than formerly of the collective responsibility of the profession to the community in respect of all health matters."

The Association add that " all these are immense gains, and though it is possible that some of them may not be wholly due to the establishment of the National Health Insurance Scheme, they have certainly been hastened and intensified by that system " (App. XLVII, 5 and 6; Q. 14,613-14,615).

Dr. Harry Roberts.—" In my experience there can be no question as to the enormous advantage to insured persons resulting from the medical provisions of the Insurance Act " (App. LI, 5; Q. 16,136).

The Retail Pharmacists' Union.—" Taking into consideration the enormous number of prescriptions dispensed, and bearing in mind that in no sense is an insured person obliged to go to any particular chemist, the number of complaints against the chemists' service has been almost negligible " (App. LXV, 21). " From every point of view the arrangements for the supply of drugs and appliances through chemists have been successful. . . . Insured persons have benefited very greatly by the arrangements for medical benefit " (App. LXV, 79, 81).

The General Council of Panel Chemists (Scotland).—" The relationship between practitioners and pharmacists is one of mutual respect and confidence and helpful co-operation. The matters . . . . needing amendment are relatively few and are mentioned with a view to their elimination so that a service already on the whole satisfactory may be brought still nearer to the ultimate ideal " (App. LXIX, 28).

The Sons of Temperance Friendly Society.—" The medical service rendered by panel practitioners is considered generally satisfactory so far as it may be given within the definition of range of service " (App. LXXXIX, 41). " The medical service has improved very much upon what it was originally . . . I believe the medical profession as a whole are doing the best they can for insured persons " (Q. 21,534).

The National Association of Trade Union Approved Societies.—" The Medical Profession as a whole has rendered competent and conscientious service to insured persons " (App. XCII, 76; Q. 22,039).

69. Adverse criticisms of the system have naturally been received (see e.g., National Medical Union, App. XLIX and Scottish Medical Guild, App. L), but the examination of witnesses did not convince us that, in the system taken as a whole, there is anything seriously amiss apart, of course, from the limitation of the scope of the benefit, with which we have already dealt. Some reference was also made by certain witnesses (Joint Committee of Approved Societies, Q. 8026-8028, 8040-8041) to the standard of the Insurance Medical Service in London, which was stated to compare disadvantageously with that throughout the country as a whole. We questioned the representative of the London Insurance Committee on the subject (Q. 22,842, 22,899-22,900), but we were not able to obtain any specific evidence as to the foundation on which this general impression of the inferiority of the service in London was based. We may, however, refer in this connexion to the statement of Mr. Brock

(Q. 1051) as to the special conditions in certain districts such as Chelsea and Kensington, and to the very interesting suggestions of the British Medical Association as to possible explanations (Q. 14,623-14,658).

70. We also think it desirable to direct attention to the criticisms made by the Incorporated Society of Pharmacy and Drug Store Proprietors on the pricing of drugs, which are submitted in Appendix LXVI, paragraphs 11-16, and Q. 18,275 to 18,312. This criticism caused us some concern, especially as none of the other professional bodies directed our attention to these matters. We took opportunity later to examine the representatives of the Ministry of Health on the question. (See *Brock* and *Smith Whitaker*, Q. 23,872-23,890.) The representatives of the Incorporated Society appear to have exaggerated the defects in the Drug Pricing procedure, and we are glad to be reassured that the arrangements are as satisfactory as can be expected in dealing with the widely varying systems of supply of drugs and in adapting the tariff to the fluctuations of the commercial market.

71. We may complete this part of the subject by a reference to the volume of individual complaints dealt with under the elaborate machinery set up for that purpose. The following quotations from the evidence of the Federation Committee of the English, Scottish and Welsh Associations of Insurance Committees may be taken as fairly representing the position :—

> " All reports of the Services Sub-Committees have since April, 1920, been sent by Insurance Committees to the Ministry and during that period about 1,700 cases have been investigated, the number for 1923 being 411, representing 3·4 per hundred doctors or per 100,000 insured persons " (App. XXXVI, 116). " Complaints against chemists are very rare indeed " (App. XXXVI, 118). " While there are instances of dereliction of duty in individual cases, the insurance medical and pharmaceutical services can in the main be regarded as efficient " (App. XXXVI, 122).

Private and Insurance Service.

72. We turn now to a subject on which there has been, and may still be, a certain amount of public misgiving. We refer to the suggestion frequently made in the early days of the scheme and still heard occasionally, that doctors and chemists deliberately give to insured persons a service inferior to that given to their private patients. We have questioned many witnesses on this matter, e.g., see *Brock*, Q. 1051-3; *Ancient Order of Foresters*, Q. 4111; *Cheshire Insurance Committee*, Q. 12,465; *British Medical Association*, Q. 14,620-14,622; *Roberts*, Q. 16,101. We are glad to say that, except for some rather contradictory evidence given by witnesses from the National Conference

of Friendly Societies (Q.11,004-11,011), we have found no support for this allegation. On the contrary, there has been a great body of evidence not only from the interested parties—the doctors and chemists—but from Societies and representative bodies showing that no such distinction is made. There is, we need hardly say, no justification for such a distinction in the Act or the Regulations, and any practitioner or chemist deliberately differentiating between insurance and private patients in this way would be subject to disciplinary action. As this is a matter which from time to time engages the attention of the public, a few general observations may, perhaps, be permissible.

73. The assertion that doctors are comparatively inattentive to their insurance patients—a statement more common in unrestrained conversation and in letters to the Press than in formal evidence—is peculiarly difficult to test, inasmuch as, in the nature of things, it almost necessarily rests on vague impressions or sporadic and unrepresentative incidents. It is, perhaps, proper to observe that in a service comprising 15,000 doctors it is impossible to postulate that all will, at all times and in all circumstances, maintain a superlative standard of efficiency and care. It must needs that offences come. The medical profession, like every other craft and calling, can claim no immunity from the intrusion of undesirable and unworthy elements. Nor does this imply any disrespect towards an honourable profession; it is merely an acknowledgment of their common humanity. Isolated cases of negligence and carelessness, therefore, prove nothing; such occur in private practice also. Even if it were established statistically that there were proportionately more causes of complaint in insurance practice than in private practice, this, again, would in itself prove nothing. The causes of complaint might be due to the industrial or social peculiarities of certain areas or to the idiosyncracies of certain doctors, and these might manifest themselves irrespective of the arrangements under which the doctor was giving his service. As against the rather vague suggestions that have been made, it is only right to refer to one other consideration put in evidence before us, namely, that there is a growing tendency among practitioners to be more scrupulous to avoid giving offence in the case of insurance patients than in the case of private patients, since the former are, in a sense, protected by the machinery under the Act for the investigation of complaints. (*Brock*, Q. 1051.) We suggest, finally, that the only satisfactory evidence available is that which expresses the views of those who have seen the operation of medical benefit at close quarters and who, having seen it in bulk, are unlikely to be unduly influenced by any random deviation from the general standard such as is apt to sway the judgment of those less intimately informed on these matters. Of such a character are the views we have already quoted.

74. When we contrast the attitude assumed in 1912 by the medical profession and by considerable bodies of public opinion towards the medical service proposed under the Insurance Act with the body of testimony which we have now received, we can say confidently that adverse forecasts have been falsified and that medical benefit has proved in practice a successful and most valued factor in the advancement of the health of the nation.

75. Before passing from this general discussion of medical benefit as it is at present provided under the Insurance Scheme, we may mention that in Chapter X we make important proposals for an immediate expansion of the scope of the benefit so as to cover expert out-patient services. Much of what we have said here, and especially our review of the relative evidence, should be borne in mind in considering the proposals in question. We have preferred to survey the evidence at this point in connexion with our general examination of the Health Services, though it is, of course, equally relevant to the specific proposals which we later put forward for immediate adoption. It is obviously unnecessary to traverse the same ground twice. The same point should be kept in mind in connexion with those other problems of a medical character, i.e., dental benefit, maternity services and medical benefit for dependants, which are discussed in this Chapter in general terms and in Chapter XII in their more immediately practical aspects.

SECTION B.—THE ADDITIONAL TREATMENT BENEFITS.

76. From medical benefit we pass naturally to the various ancillary services which are or may be provided under the additional benefit schemes of the Insurance Act. Under additional benefit schemes (putting aside for our present purpose increases in the rates of cash benefit) provision may be made for in-patient treatment in hospitals (which includes nursing homes) dental treatment, ophthalmic treatment, convalescent home treatment, nursing and the supply of medical and surgical appliances other than those provided as part of medical benefit.

The General Arrangements.

77. Before we proceed to the details of these benefits it may be well to describe briefly the general arrangements under which they are provided. It is important in the first place to observe that at the present time there are two groups of additional benefit schemes in operation. One group is consequential upon the first valuation of all societies and branches made as at the end of the year 1918. The second group follows on the valuation of some societies and branches made as at the end of the year 1922. The schemes of the former group expire in July,

1926, when they will be replaced by new schemes operating generally until July, 1931. The schemes of the latter group came into force in July, 1925, and will expire in July, 1930. Thus, at the moment there are two sets of schemes in operation, covering different periods, and the terms of the two groups of schemes and the conditions enunciated in their schedules relating to the treatment benefits are not strictly comparable. In the later schemes efforts have been made to remove certain difficulties, and to avoid certain undesirable features which presented themselves in the actual working of the schemes. The details and figures hereinafter referred to are those applicable for the most part to the schemes as in operation in the year 1924. A scheme of additional benefits is contingent on the realisation of a disposable surplus by an Approved Society at one of the periodic valuations of assets and liabilities conducted by the Government valuers. A society which finds itself in this position may frame a scheme of additional benefits to be provided out of the surplus and submit it to the Department for approval. The schemes are applicable to all members of the society of five years standing and are current generally for a period of five years. So far as the scheme provides for an increase in the normal cash benefits, it is administered by the Approved Society as part of its normal work. In the case of those schemes which aim at providing treatment for the members, the arrangements for making payment in respect of the provision of the services covered by the scheme are made by the society either directly or through the agency of some institution or organisation. The member makes his application to the society, and receives his document of title stating the amount which the society will pay in respect of the particular service required.

78. It is important to observe that the additional benefits referred to consist not in the provision of treatment, services or appliances but in payment of the whole or part of their cost, as is indicated in the statutory description of the benefits. Subsection 5 of Section 75 of the Act provides, that "Additional benefits shall be administered by the society or branch . . except that where the benefits are in the nature of medical benefit, they shall be administered by and through the Insurance Committee." Though the construction to be put upon the words "where the benefits are in the nature of medical benefit" is not free from difficulty, the Departmental view, taken under legal advice, has been that any additional benefit which involves mere payment of money is not an additional benefit in the nature of medical benefit, notwithstanding that the money may go to secure service of a medical nature.

79. Whilst expressing no opinion on this point we think that it is highly desirable that the organisation of services which are

akin to medical benefit should be entrusted as far as possible to the bodies which are responsible for the administration of that benefit.

Criticism of the Additional Benefit System.

80. Many of the criticisms made on the provision of treatment benefits as additional benefits under the Act are directed to the fundamental characteristics of the system under which insured persons are grouped in Approved Societies. That subject is dealt with later in Chapters VIII and IX. Other criticisms are expressed on the following grounds.

81. These benefits are not given by all Societies, and even among the societies giving them there is it is stated not merely no uniformity in the additional benefits given, but there is also a wide and undesirable variety in the treatment, services and appliances included, and in the arrangements for part payment by the recipients. In other words, there is neither unformity in the selection of benefits nor in the content of the same benefit as given by different societies with the result, it is said, that there is widespread confusion in the minds of the members as to what precisely their rights are. Further, we are told that the arrangements made between societies and professional bodies are wanting in authority and uniformity, and in some cases are accompanied by undesirable conditions.

Here we need only point out that the promotion of an additional benefit to the rank of a normal benefit would remove many of these features since in that event its administration, as in the case of medical benefit, would be placed in the hands of the Insurance Committees or their successors.

We will now take the various additional benefits which are in intention of a medical nature and consider for each its present method of operation.

Dental Benefit.

82. For dental treatment as an additional benefit about £332,000 (including unspent balances carried forward from previous years) was available in England alone in the year 1924 and nearly the whole of this amount was spent in that year. In some Societies the benefit included extractions and fillings but not dentures, in others the position was reversed. There was also great divergence in the proportions of the cost borne by the Society and the member respectively. Some Societies paid the whole cost, other half, others again even less. A very wide latitude was allowed under the first schemes to Societies in the arrangements made regarding the scope of the benefit, the scale of charges, the proportion payable and the agreements with selected groups of dentists.

83. The evidence we have received from Societies shows that this is a very popular benefit, and it has been urged on us from many quarters that it should be made a normal benefit available for all insured persons on uniform terms. The Hearts of Oak Benefit Society state that, although they did not originally include dental treatment as one of their additional benefits, it was found necessary at a later date to diminish the additional cash benefits in order to meet the demands of the members for dental assistance (App. IV, 256). The Ancient Order of Foresters submit that " the provision of dental benefit, probably more than the provision of any other treatment benefit, would have the effect of conserving benefit funds so far as the drain due to sickness and disablement benefits is concerned " (App. V, 49). The National Conference of Industrial Assurance Approved Societies accept the view that it is desirable that a measure of dental treatment should be available to all members of Approved Societies, and make proposals for increasing the Central Fund so as to enable all Societies to make this provision (App. VI, 22). The Joint Committee of Approved Societies remark that " the only treatment benefit which would seem to justify an effort to secure it upon a national basis is probably dental benefit " (App. XIV, 28). The National Conference of Friendly Societies state that " there is a general desire throughout the Societies associated with the Conference that at the earliest date dental benefit should be made one of the normal benefits under the National Insurance Act with a possible restriction of the cost of full dentures to fifty per cent " (App. XXVI, 16). The United Women's Insurance Society have submitted to us some interesting figures and diagrams to illustrate the effect on the benefit fund of an adequate provision of dental treatment over a period of years (App. XXIV, 22-51), and urge that " dental benefit should take its proper place as part of an all-embracing medical service."

84. We have received professional evidence on this subject from the British Dental Association (App. XIX), the British Society of Dental Surgeons (App. XX), the Public Dental Service Association of Great Britain (App. XXII), the Incorporated Dental Society (App. XXVIII), the Ivory Cross (App. LXVIII), and the East of Scotland Dentists' Panel (App. LXXVII) as well as from the British Medical Association (App. XLVII). Finally, the official view is that the provision of dental treatment as a statutory benefit is most desirable if the money can be found. An official witness stated that " something like three-quarters of the industrial population, probably, are suffering from dental defects of one sort or another, and I think the experience of those Societies that have provided dental treatment as an additional benefit does give ground for hoping that systematic dental treatment would lead ultimately to a reduction of sickness benefit claims . . . ." (*Brock*, Q. 23,914). The general effect of this evidence is to emphasise the value

to health of timely, continued and effective dental treatment, the need for making the benefit generally available on uniform lines, and the adequacy of the number of qualified dentists to deal with the whole insured population. Considerable divergence of view exists regarding the possible methods of organising the service and also regarding the scope of the benefit in the immediate future, when heavy arrears of work would have to be overtaken and while financial conditions remain adverse. But the evidence as a whole leaves no doubt in our minds that any system of public medical services cannot be regarded as complete until it includes the provision of adequate dental treatment in a generally available form.

85. The British Medical Association admit that dental treatment should be an exception to the general principle urged by them, that any form of specialist treatment should be available only on the recommendation of the general practitioner (App. XLVII, 22-23; Q. 15,003-15,005, 15,109-15,111). We think this is sound in view of the more stringest qualifications now required for the dental profession and the character of dental trouble itself. At the same time, it in no way debars the general practitioner from considering dental defects in their relation to the general health of his patients.

86. The wider and more uniform provision of this benefit has, as we have said, been pressed upon us from many quarters. We have accordingly felt obliged to examine very closely its claims to be made a statutory benefit available to all insured persons in the same way that medical benefit is. The discussion of this question will be found in Chapter XII where it takes its appropriate place in the examination of the order of priority of certain proposals in themselves desirable in greater or less degree.

87. In closing this review of the evidence on the dental service we may refer to an important change made in the arrangements in July, 1925. Sir Walter Kinnear in reply to Q. 23,915 said: "Under the additional benefit schemes for dentistry at the present moment the insured person has a right to go to any dentist he chooses who is willing to do the service on the scale of fees agreed with the Societies generally. We do not allow Societies to select particular dentists. There is free choice of dentist. That is a development which has taken place during this year of course." He added (Q. 23,916) "I think the scheme is very much better than the one that was in vogue at the early part of this year."

Ophthalmic Benefit.

88. The official evidence indicates that next to dental treatment ophthalmic benefit is most in demand. (Ministry of Health App. I,B, 212.) For the year 1924 in England alone nearly £82,000 was available for it and of this sum about 37 per cent. or

£30,000 was spent in the year. It is not a costly benefit, the average charge per case being, we are told, about 15*s*. While there is a general consensus of opinion as to its value we have encountered, especially in the professional evidence, a strong conflict of opinion as to the method by which it should be provided. The British Medical Association (App. XLVII, App. C; Q. 15,006, 15,116-15,117, 15,145-15,154), the Council of British Ophthalmologists (App. LXIII, 2-3; Q. 17,777-17,778) and the Ophthalmic Benefit Committee (App. LXIV, 3-7; Q. 17,940 and 17,955) insist that in any case of ocular disorder or visual defect the benefit should only be available on the recommendation of a medical man basing their contention on the intimate connexion between the state of the eye and the general health of the body. They submit that the training of the general practitioner fits him to determine whether this recommendation should be made, and that for the purpose of dealing with any cases requiring special advice or treatment there is a sufficiently large number of medical men with training or experience in ophthalmology adequately covering the whole country. On the other hand the Institute of Ophthalmic Opticians (App. LX, 14-21; Q. 17,491-17,495, 17,506-17,507, 17,510), the Joint Council of Qualified Opticians (App. LXI, 27-32; Q. 17,628, 17,677-17,689, 17,694-17,697) and the British Optical Association (App. LXII; Q. 17,717 and 17,723) have urged that direct access to the optician should be allowed as in the case of the dentist, and have supported their argument by drawing attention to the training now required by these organisations and by citing the evidence of medical men. They also contend that "the medical practitioner's knowledge of optics is not so thorough as that of the optician" (J.C.Q.O., Q. 17,660), and while admitting the superior skill of the ophthalmic surgeon state that the number of such surgeons would be inadequate for coping with the work. We feel that this is a very contentious matter, on which it is difficult for laymen to pass judgment. But we understand that the Ministry of Health, acting on the advice of their medical advisers, have taken the view that the medical practitioner must intervene and in this conclusion we think we must concur. For a full statement of the views of the Ministry of Health on this difficult problem we refer to the reply by Dr. Smith Whitaker to Q. 23,956.

89. We are also informed that it has been clearly laid down by the Ministry and accepted by the medical profession that any work which might be involved in recommending a case as proper for the receipt of this benefit is included within the scope of the obligation already imposed on insurance practitioners towards the insured persons on their lists, and that consequently no question of any increased cost to the insured person obtaining the recommendation can arise (*Ministry of Health*, App. I, C, 67). Where such a recommendation has been granted or forwarded to the approved society, it is for that body to decide what steps shall be

taken to give effect to it. If the insurance practitioner advises a further medical examination of the patient's eyes the proper course is for the latter to consult a medical practitioner with special experience of ophthalmic work, who would diagnose the defect and provide such treatment as might be required. This would in the great majority of cases take the form of the testing of sight and prescription of the necessary glasses. It was claimed by witnesses representing various bodies of opticians that this work was within the competence of a qualified optician; and we are prepared to admit that where no doubt can exist that the defect is merely an error of refraction the task of prescribing the requisite glasses should not be beyond the skill of an optician who has undergone the course of training and passed the examination required by certain of the opticians' organisations which gave evidence before us.

90. In this connexion, however, two difficulties arise. In the first place, in contrast with the position in medical practice and dentistry, there is not in this country any State registration of opticians and it is open to anyone to test sight and supply spectacles, however, unfit he may be to undertake the work. Secondly, in a proportion of cases, which may be no higher than 5 per cent., eye trouble may be due to some cause other than a mere error of refraction and may be a symptom of serious disease, and it is essentially a task for the qualified medical practitioner to differentiate between cases of this kind and cases of mere refractive error. It was admitted, even by medical witnesses who appeared before us to support the case of the opticians, that, other things being equal, it would be preferable, for the purpose of testing eyesight, to have recourse to a properly qualified eye-specialist rather than to the most highly qualified optician (*Joint Council of Qualified Opticians*, Q. 17,660). It is true that there has hitherto been a shortage of medical practitioners specially qualified in ophthalmic work and this, no doubt, has contributed to the result that the testing of eye-sight has very largely fallen into the hands of opticians. We are informed, however, that the British Medical Association has compiled a list of approximately 600 doctors in all parts of the country who possess special ophthalmic experience and who are willing to undertake this work for insured persons at a moderate fee. It is not within our province to consider the arguments for or against the prohibition of the testing of eye-sight by persons other than medical practitioners. But as to the provision to be made for insured persons as part of the Health Insurance Scheme, we consider that a satisfactory solution could be found in connexion with a proposal which we make in Chapter X directed to the provision of a specialist medical service as part of medical benefit. Such a specialist service would include ophthalmic specialists whose services would be at the disposal of insured persons requiring them, and the function of the optician would thus in the case of insured persons, be limited to the making-up of the spectacles prescribed by the eye-specialist.

91. We may perhaps be allowed here to make one observation, even if it relate to a matter somewhat beyond our legitimate frontiers. In the case of midwifery and dentistry, we have recently seen the State compelled to make arrangements for limiting the practice of these professions to those possessing the requisite professional qualifications. In each case it has been necessary to provide for the inclusion in the Register at the outset of most, or of all, of those previously in practice, whether qualified or not. Such a situation, even if inevitable, may lead to not a little friction and professional unhappiness in the transitional period. The larger the volume of unqualified practice, the greater will be the difficulty of establishing matters on a satisfactory basis, and if in the case of any calling within the range of medical services it may ultimately be necessary in the public interest to prescribe the conditions of entry, much may be gained by taking the necessary step while the problem is still easily manageable. While expressing no opinion on the question, it is perhaps a matter for consideration whether problems similar to those which led to the Registration of Midwives and to the Dentists Act of 1921 are not in process of being engendered elsewhere. Two such examples which occur to us are those of the opticians and the masseurs.

Hospitals and Convalescent Homes.

92. Nearly £538,000 was available in England in 1924 for this benefit, but only about 40 per cent., or £220,000, was expended in the period. Payments under this heading do not necessarily relate to specific applications by members, but may, in schemes consequent upon the first valuation, take the form of an annual payment to a hospital or home for the purpose of securing treatment of members therein. The benefit is limited to in-patients. The payment of travelling expenses, in whole or in part, is included within its scope. A common method of administration is for the hospitals to send periodically to the societies concerned lists and particulars of members who have received treatment and for the societies to pay the hospitals at an agreed rate, frequently 25*s*. or 30*s*. a week per patient.

93. We have received evidence as to these arrangements from the British Hospitals Association (App. LVII), the Sheffield Joint Hospitals Council (App. LVIII), and the Middlesex Hospital (App. LIX). Attention is directed to the fact that the treatment of insured persons by insurance practitioners is incomplete because it is not satisfactorily linked up with provision for treatment in hospitals. It is represented that while any payment made by societies with additional benefit schemes

is welcomed, nevertheless owing to various causes no payment is made from insurance funds in respect of a large proportion of those insured persons who receive treatment. Even in the case of those for whom insurance payment is made, the amount contributed is only a part of the average cost per occupied bed per week. No payment at all is made in respect of the general out-patient work which the witnesses urge " is of great economic value not only to the State as a whole but also to Approved Societies in particular, by enabling members to return to their work more quickly after illness or accident " (British Hospitals Association, App. LVII, 7). In connexion with this last point we examined witnesses to ascertain whether insurance practitioners were evading their proper work by sending their patients unnecessarily to the out-patient departments of the hospitals. But we are assured that this is not so to any extent, and that " the tendency is for the out-patient department to become more and more consultative, and patients appreciate the value of the benefit of treatment by the consulting staff of the hospitals " (British Hospitals Association, App. LVII, 10). We are told that, whereas in the past patients attended at the out-patient department almost entirely of their own volition, the number coming now on the advice of their medical attendants is about 50 per cent. of the total.

94. The contention of the hospitals is, therefore, for a fuller measure of financial assistance in respect of all insured persons using the hospitals in any way. At the same time they are opposed to any encroachment on their voluntary status, and the British Hospitals Association suggest that "there should be no contract to treat, but . . . that the important role filled by the voluntary hospitals in supplementing the work of the panel practitioners and in furnishing the additional services . . . should be recognised by practical assistance from insurance funds " (App. LVII, 14).

95. The figures of costs submitted by the Sheffield Joint Hospitals Council in App. LVIII are of interest. It appears that, in 1923, in respect of three general hospitals in Sheffield, the total cost of providing services to patients (3,221 in-patients and 15,269 out-patients) who were insured persons was £28,870, while the total amount received from insurance funds was only £4,300. In considering these figures it must, however, be borne in mind that, had there been no Insurance Scheme, the hospitals would still have borne the cost and would have been without the substantial relief which the Insurance Funds have brought. Further, the insured persons, like other citizens, make voluntary contributions to the funds of the hospitals through subscriptions, collections, club arrangements and the like; and they receive from the hospitals no preferential treatment over the rest of the population.

The British Medical Association have submitted in Appendix XLVII a full statement of their policy with regard to hospitals. Their attitude, so far as finance is concerned, may be gathered from the following quotation :—

> " The Association recognises a dual policy as regards the voluntary hospitals; (*a*) that the purely charitable side should be continued wherein the whole cost of the maintenance of indigent patients is met by the gratuitous contributions received by the hospital, and on whose behalf the services of the honorary medical staffs are given gratuitously; (*b*) that other patients who are not indigent may be received for treatment at voluntary hospitals when they cannot pay for, or cannot obtain, adequate treatment elsewhere, and that, for them, payment should be received by the hospital either from the patients themselves or, on their behalf, from the authority or body referring them to the hospital, and that, on account of their treatment, some method of remuneration of the honorary medical staff should be arranged." (App. XLVII, Sub-App. D, paragraph E, 3.)

The implication is that, in respect of insured persons, payment, including an amount for the remuneration of the honorary medical staff, should be made by the societies to the hospitals

On the question of the relationship of the out-patient department to the general practitioner the Association enunciate the general principle that the primary object of the out-patient department should be for consultation, and that only such treatment should be given therein as cannot consistently with the best interests of the patients be properly undertaken by a general practitioner of ordinary professional competence and skill. (App. XLVII, Sub-App. D, paragraph 25.)

96. The National Association of Trade Union Approved Societies have submitted in paragraphs 138-139 of App. XCII, their policy in regard to hospitals. They contemplate a complete system of treatment centres, local or cottage hospitals, county hospitals and national hospitals under public control and supported by public funds, but " would give voluntary hospitals the option of being taken over by the Health Authorities entirely or of receiving grants from public funds conditional on efficiency." " The Local Health Authority should be represented on the Boards of Management, and though remaining on an entirely voluntary basis, such hospitals should work in co-operation with the public hospital."

Provision of Nurses.

97. The amount available in 1924 for this additional benefit was in England about £152,000, of which, however, only 4 per cent., or about £6,000, was spent in the year. Difficulties of administration have been encountered, we are told, owing to the

members of any one society being widely scattered throughout the country, to drawbacks of organisation and " to the general paucity of demand under present conditions for such services " (Ministry of Health, App. I, B, 210). The usual financial arrangement between the Societies and the Nursing Organisations provides for payment being made at the rate of 1*s.* 4*d.* per visit, of which the Society pays 1*s.* and the member 4*d.* We have received professional evidence from the Queen Victoria's Jubilee Institute for Nurses (App. LXXII) and the College of Nursing (App. LXXIII), the former being engaged in the practical work of providing nurses throughout the country, and the latter in the promotion of the better education and training of nurses and in watching their professional interests.

98. The Queen Victoria's Jubilee Institute points out that " there is already in existence a national service which can and does provide skilled nursing for all kinds of illnesses at an economical rate and under proper safeguards—a service which, though not completely covering the country, is capable of being made to do so," and urges " that nursing should be provided for all insured persons, and that in doing so advantage should be taken of the existing organisations." (App. LXXII, 16.) The rates of payment arranged between the Institute and numerous Approved Societies is 1*s.* 4*d.* a visit for the first 30 visits, and thereafter not more than 5*s.* a week, and 5*s.* for a nurse's attendance at an operation. In some cases the Society pays the full amount, in others it pays 1*s.* and leaves the Nursing Association to collect the balance from the insured person.

99. The witnesses who appeared on behalf of the College of Nursing also suggested the need for a wide extension of the nursing service of insured persons in place of the present additional benefit arrangements, which they characterise as " inequitable, fragmentary and wholly inadequate." (App. LXXIII, 9.) In fact, they " urge the provision of a statutory nursing benefit complemental to medical benefit " (App. LXXIII, 3 and 15), and suggest that a sum of 1*s.* per insured person per annum would go far to provide the requisite finance for this complete service. (App. LXXIII, 14.)

100. The Ministry of Health representative makes the following comments:—" The ground is already to a considerable extent covered by the District Nursing Associations, particularly in urban areas. . . . . By undertaking the provision (i.e., as an additional benefit) you are not adding very much really to what the patient can get or what they would otherwise get." (*Smith Whitaker*, Q. 23,968.) " If you were proposing to provide a nursing service for the whole community you might take over the whole of their (the Nursing Associations') organisation and develop it, but if you are going to provide nursing for a section of the community . . . you cannot do it better than by making arrangements with the District Nursing Associations who are already doing the work for so many other people." (*Smith Whitaker*, Q. 23,971).

Medical and Surgical Appliances.

101. The provision of medical and surgical appliances is, we are told, a fairly widely adopted benefit, for which in the period from July, 1921, to December, 1922, the sum of £69,804 was available in England, but out of which only £3,348 was spent, or just over 4½ per cent. Appliance means a medical or surgical appliance other than a dental or optical appliance or those other appliances already prescribed as part of medical benefit by the Regulations. It has been held to cover such diverse articles as a motor ambulance, a bath chair, surgical boots, artificial limbs, trusses and hot-water bottles. For the most part it is not an expensive benefit, though the average cost per case in some societies has been between 30*s.* and 40*s.* Sometimes the whole cost is paid by the Society; sometimes only half above a fixed maximum, for example, £4.

Other Suggested Additional Benefits.

102. We understand that suggestions have been made to the Department from time to time advocating the inclusion of massage, electrical and radiant heat treatment, laboratory facilities, specialist treatment, and spa treatment, in the list of additional benefits (Ministry of Health, App. I, B. 219). We ourselves have received strong representations from witnesses as to the first and last (See Apps. LXVII and XCVI). The Ministry of Health representative, in particular stated—" There can be no doubt as to the value of massage and electrical treatment, particularly for cases of after effects of injuries and rheumatic conditions by which a large amount of prolonged incapacity for work is produced. . . . Such a service might be provided as an additional benefit . . . but it would not be practicable to provide a satisfactory service unless you had security for effective organisation. . . . Such a service would be more economically and efficiently provided as a part of statutory medical benefit." (*Smith Whitaker*, Q. 23,973.)

Tuberculosis.

103. Having concluded our review of the additional benefits of a medical nature we may now pass on to refer briefly to the treatment of tuberculosis. This has been the subject of representations to us from the London County Council (App. LXXXIV), the Joint Tuberculosis Council (App. XCIII) and the Cambridgeshire Tuberculosis After-Care Association (App LXXXIII). Institutional treatment of Tuberculosis was removed from the Insurance Scheme in 1921 and entrusted to

the Public Health Authorities, by whom it has been greatly developed and made available for the whole community. Domiciliary treatment, however, remained as part of the service which the insurance practitioner contracted with the Insurance Committee to give to his insured patients. In this Chapter we need do no more than point out that the removal of the institutional treatment of tuberculosis marked a distinct change in the conception of the responsibility of the State in this matter as in place of provision for a restricted class, who in part paid by insurance contributions for the service provided, there was substituted a provision available for the whole population and supported entirely by rates and taxes. We may quote the following reply to a question we put to the Ministry of Health representative on this question. "An effective scheme for the treatment of tuberculosis cannot be confined to one section of the community, and the placing of the responsibility for the treatment of all sections upon one local authority has had the substantial advantages of (1) preventing local administrative overlapping, (2) simplifying supervision by the Central Department, and (3) enabling due attention to be given in the further development of local tuberculosis schemes, to the needs of other sections of the community, besides the insured, and especially children. Even from the point of view of insured persons this is an advantage as their dependants constitute the larger part of the non-insured section of the community." (*Maclachlan*, Q. 24,092.)

SECTION C.—THE MEDICAL SIDE OF MATERNITY BENEFIT.

104. No survey of the health services under the Insurance Act would be complete if it omitted to take account of maternity benefit. It is true that this is a cash benefit administered directly by the Approved Societies, and that it differs from the additional treatment benefits in that there is no control of the application of the money given. Yet the money does in large part go to pay for the services of doctor and midwife and the underlying purpose of the benefit is to promote the health of mother and child at the critical period of pregnancy and childbirth. Having regard to the great importance of skilled advice and treatment at that time, we feel confident that any development of this benefit will be in the direction of an increase of the service element provided under appropriate conditions of control. Accordingly we proceed to a consideration of the maternity provision and the evidence that we have received in this connexion.

Evidence as to Maternity Benefit.

105. Taking the professional evidence first, we find that the British Medical Association in this as in the general problems

recommends medical unification of the services. "Provision in connexion with maternity and infant welfare" should be made "an integral part of the Insurance Scheme or brought into proper relation thereto" (App. XLVII 19-20). In paragraph 29 of the same Appendix they point out that "attendance in connexion with confinement is expressly excluded from medical benefit, and such public provision as insured women and the wives of insured men can avail themselves of is under other auspices and is not complete in character." They recommend that in addition to a cash payment there should be suitable ante-natal examination and supervision, attendance at confinement and during the puerperal period by a midwife or doctor as the case requires, consultant and specialist service available for difficult cases, provision for institutional treatment where necessary (App. XLVII, 29, 30; Q. 15,118-15,129).

106. The Society of Medical Officers of Health who, as representing the medical advisers of the bodies responsible for the work of the Maternity and Child Welfare Centres, speak with special authority in this matter, say that "the maternity and child welfare schemes have involved local authorities in large expenditure frequently greatly exceeding the total amount of maternity benefit paid in their district." They point out that "These schemes are of the same essential nature as maternity benefit and the only practical method by which this latter benefit can be administered in the interests of the mother and child is by requiring local authorities to administer it through their statutory Maternity and Child Welfare Committees." After reciting the need for the same elements of medical attention as those recommended by the British Medical Association they go on to say that "maternity benefit even in money value should vary according to the necessity of the mother and the medical character of the case" (App. LVI, 9). They conclude with the following recommendations:—

> "Maternity benefit, whether in its present, or in an extended form, should cease to be administered by Approved Societies and be administered both in money and kind by local authorities; which, in their turn, should be made definitely responsible for providing medical attention. The attendance upon maternity cases should not be an obligation upon a panel practitioner." (App. LVI, 14 (10); Q. 16,992.)
>
> "Maternity benefit should provide for all necessary medical attendance in pregnancy and maternity, and medical benefit should be understood to be exclusive of such medical attendance." (App. LVI, 14 (11).)

107. Very interesting evidence on this subject was given by the late Mr. Benjamin Broadbent, who devoted so much of his life to the furtherance of public health work, especially in its bearing on the welfare of mothers and children. He regarded the

maternity benefit of the Insurance Scheme as " a great opportunity missed." " The real purpose which Parliament had in view was undoubtedly to make childbirth safer alike to mother and child. This purpose cannot be fulfilled merely by a grant of money " (App. XXIII, 3; Q. 10,140-10,146). He considered that though the benefit is a real help and is properly utilised in many cases, its cash character and limited scope condemn it and its administration by Approved Societies as unsatisfactory (App. XXIII, 4-9). He held the view that the whole administration of the maternity benefit should be transferred to the Public Health Authority and incorporated with the work of the Maternity and Child Welfare Centres (App. XXIII, 10-12; Q. 10,061-10,066, 10,091).

108. The Incorporated Midwives' Institute (App. LXXIV), while considering that " maternity benefit is a useful institution and should be maintained," are of opinion that " it should not only mean a cash benefit but also, when needed, a treatment benefit directed specially to the condition of pregnancy, that sick pay for four weeks after confinement should be given, and that the benefit should include ante-natal treatment." The Scottish Midwives Association (App. LXXV) support these views and add that " an additional maternity nursing benefit " should be made available under certain conditions. On the fundamental question of the transfer of maternity benefit to the Local Health Authority we were told that these bodies had not considered the matter (Q. 19,781), but in answer to Q. 19,790 a bias towards some form of unification appeared.

109. Evidence from Approved Societies and their representative bodies was generally to the effect that the fees of doctor or midwife tended to absorb the whole benefit and leave nothing over for comforts, extra nourishment and other requirements arising at the time of confinement and that these fees had been increased substantially as the larger benefits (increased for cost of living and by additional benefits) had become available (see e.g., Hearts of Oak Benefit Society, Q. 3490-3491, 3529; Independent Order of Rechabites, App. VIII, 6, Q. 6110-6111; Scottish Co-operative Friendly Society, App. LXXVIII, 2, Q. 20,326-20,327; National Federation of Rural Approved Societies, App. XXIX, 14). Other witnesses advocated a proposal that the fees for doctor or midwife should be made a statutory charge on the general medical fund so as to prevent this absorption of the whole benefit (see Association of Approved Societies, App. XLV, 11-12; Scottish Co-operative Friendly Society, App. LXXVIII, 2, Q. 20,328-20,330). The Standing Committee of Scottish Insured Women recommend that definite provision should be made for the payment of sickness benefit during the four weeks prior to confinement (App. XLVI, 6).

110. The National Association of Trade Union Approved Societies recommend that medical benefit should include treatment and attendance before, during and after confinement (App. XCII, 101), that " benefit sufficient for the full and healthy maintenance of an insured woman and her child should take the place of maternity benefit," " that these provisions should be administered through Local Health Committees " (App. XCII, 130-131). They also draw attention to the fact that although the general death rate has been reduced by one-third, no corresponding reduction has occurred in the rate of maternal mortality, despite the expenditure of £1,500,000 a year on maternity benefit, and they suggest that in the prevention of this evil a solution may be found to the problem of excessive expenditure on disablement benefit in respect of women (Q. 22,057). The Standing Joint Committee of Industrial Women's Organisations make recommendations on the lines of the Washington Convention and urge the expansion of the work of the maternity and child welfare centres (App. C, 17-27). The Sons of Temperance Friendly Society say :—

> " Opinion has been obtained from the Grand Divisions (N.H.I. units) of this Society on the question of this benefit, and it is found that there is general dissatisfaction with the present method, which, instead of providing definitely, in money or in kind, for the direct and special benefit of the mother—and, incidentally, the child—as was intended by the original Act, there is in many cases a demand made upon the financial resources (often slender enough) of the home, beyond the cash value of the benefit. Instances of medical fees up to five guineas, and midwifery fees up to two guineas, have been cited.
>
> " This Society suggests that maternity benefit should be made completely statutory, and should consist of (*a*) a definite cash payment to the woman confined; (*b*) a fee for all needful medical or midwifery services, chargeable to the funds of the Approved Society " (App. LXXXIX, 69-70).

111. The National Federation of Insurance Committees, recommending a complete medical service for insured persons and their dependants, say that this should include maternity services which would be additional to any cash payment that might be available (App. XXXVI, 223, 234). The National Association for the Prevention of Infant Mortality make the following recommendations :—

> " The Maternity Service as a part of maternity benefit should provide, in addition to a cash benefit :—
>
> (1) Ante-natal examination during pregnancy, by a registered medical practitioner, with any necessary report.
>
> (2) Adequate professional attendance during pregnancy, normal labour and the puerperium.

(3) Provision of medical services if and when called in by a registered midwife who has been engaged to attend the confinement.

(4) Consultant service.

(5) Institutional treatment.

The payment of the cash benefit should be distributed over several weeks before and after the confinement and not be paid over in one lump sum. The Association are of opinion that the Medical and Maternity Benefits Services should be regarded as a health service and be grouped with other such services for administrative purposes; that is, under the Public Health Authority" (App. CXXIV, 9 and 10).

112. The Ministry of Health representative, in answer to questions on the subject, gave the following reply: "This is a matter that has been discussed several times with the medical profession in 1919 and since, and I think that the general feeling is that, if the requisite financial arrangements could be made, it would be very desirable to end the present system under which you have the general practitioner responsible for treatment before labour but having no responsibility during labour, the midwife, under an entirely independent authority, giving attendance in labour and calling in a practitioner to attend in labour, if necessary, who would be paid by the local authority; then you have the maternity and ante-natal centre giving assistance in the early stages. There is a great deal of overlapping and probably a good deal of waste, and it would be most desirable, if it could be arranged, to have a scheme that brought the family doctor, the midwife, the specialist, if necessary, and all the services that are available at the maternity centre, under a common scheme and a common control, so that they each played their proper part and were brought into proper relation with each other, helping one another instead of acting at a distance as they do now." (*Smith Whitaker*, Q. 23,896.)

113. Closing this summary of the evidence on this important question, we note that the National Conference of Friendly Societies, to whose advocacy of a radically reformed Health Service we have elsewhere referred, include all the maternity work of the various agencies as part of the material to be incorporated in their proposed unified scheme (App. XXVI, 30-41).

Separation of Money Provision and Treatment.

114. On a review of all the evidence we have heard we have come to the conclusion that the present elements of maternity benefit should be ultimately dissociated from each other, that is to say, any cash payment made on confinement should be separated from the medical, nursing and institutional services of all kinds provided in connexion with the condition of pregnancy. The former should, we think, continue to be

administered by the Approved Societies. The latter would be provided as an integral part of the medical service and would be administered by the appropriate local authority. The general practitioner, the midwife, the nurse, the specialist and the institution would all take their respective parts in the scheme of extended medical services.

SECTION D.—INTER-RELATIONS OF THE HEALTH SERVICES.

115. To complete our review of the health services we naturally pass on to consider the public medical services outside the Insurance Scheme, and this leads inevitably to the extremely important problem of co-ordination of the health services generally. We have already, in Chapter IV, given a brief description of these activities of the Central Government and the various Local Authorities. We may also refer to the detailed accounts supplied by the Ministry of Health (App. CIV), the Scottish Board of Health (App. CV), the Board of Education (App. CIX) and Sir Thomas Legge (App. XLII). Naturally we have not heard on these topics such a range and variety of evidence as we have received on the Insurance medical service. But we have been sufficiently informed of the nature of the arrangements supervised by these Departments, and many witnesses, e.g., the Society of Medical Officers of Health (App. LVI) have directed our attention to these State activities and have emphasised their intimate relation to the problem of the future of public health work in the broadest significance of that term. Here, again, as in the case of medical benefit, we have been impressed by the social value of these various activities, the great advances that have been made *pari passu* with the development of the Insurance Scheme, and the possibilities of expansion that are latent in these schemes if the necessary public funds could be made available. Most important of all, we have been impressed by the feeling that, in any further developments, the need for close co-ordination between the health work within the Insurance Scheme and that outside it, must be continually kept in view both in the administration and in the essentials of professional work.

116. We will refer, first, to the reports of the Consultative Councils of the Ministry of Health and of the Scottish Board of Health, made in 1920. In these reports the greatest emphasis is laid upon local co-ordination of all the health services. The former approach the subject on a theoretical basis and describe what the organisation of a complete health service should be, quite apart from existing systems and commitments. The latter deal with the problem more in the practical sphere, and, taking things as they are in Scotland, indicate the desirable lines of progress. But in both the underlying principles are the same—

a carefully built-up service organised on a single local basis in which all varieties of preventive and curative work find their appropriate place. (For an outline of the substance of the English reports see Q. 24,170-24,172.)

The Professional Evidence.

117. From the evidence we have received from a wide variety of witnesses similar conclusions may be drawn. For example, the British Medical Association say: "It is essential, not only that the attention of all practitioners should be directed continually to the preventive aspects of their work, but that the existing machinery and medical officers of the Public Health Service should be brought into close and organic connexion with the Insurance Scheme." (App. XLVII, 3); and again: "It is desired to make all such benefits and services (i.e., pathological facilities, treatment for tuberculosis and venereal disease and for certain infective fevers, the treatment of certain conditions of children of school age, provision in connexion with maternity and infant welfare) an integral part of the Insurance Scheme or to bring them into proper relationship thereto" (App. XLVII, 20). The Society of Medical Officers of Health point out that their service, "primarily concerned in the preservation of health generally, has from the beginning recognised the impossibility of adequately discharging its function in dissociation from measures for the restoration of health to individuals." "It has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health, and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it." "The scheme . . . is, to a great extent, isolated from the other schemes of the State in operation and doing essentially similar work . . . the relationship of such work to that done by local authorities should be of a most intimate nature." "Centrally it is true that the administrations are amalgamated in one Government Department, but such an amalgamation is of comparatively little value if the practical and detailed working of each in local areas is ill co-ordinated or impossible" (App. LVI, 1-4). "The need for some genuine co-ordination of all the medical agencies in every area has long been severely felt, and the intricate and costly nature of the provision necessary for the people constitutes an additional reason for a full co-operation of all the institutions and personnel taking part in this work." (App. LVI, 11; Q. 16,934-16,940, 16,972-16,974.)

The Lay Evidence.

118. These are professional opinions. From the lay side come similar recommendations. For example, Mr. Alban Gordon says in paragraphs 36-41 of Appendix XIII.—"The unification

of central control which took place when the Ministry of Health was established was unaccompanied by any corresponding unification or co-ordination of existing medical services locally . . . At every stage medical benefit overlaps with one or other of the large number of existing forms of medical service . . . and this duplication of effort between the Insurance Act and existing medical services is a grave source of weakness and expense." The National Conference of Friendly Societies, representing four million State insured members and a total voluntary membership of 7,400,000, has submitted to us the interesting and important conclusions contained in paragraphs 34 to 41 of Appendix XXVI from which we quote the following:—

> "Few will deny that it is highly wasteful and inefficient to allow six or more separate organisations for medical services (all paid for wholly or mainly out of public funds) to exist side by side, as they do to-day, with consequent overlapping, friction and duplication of expense.
>
> "This becomes all the more marked when it is remembered that for one-third of the entire population there is, in addition, a general practitioner service provided in the form of medical benefit under the Insurance Act.
>
> "Notwithstanding all these various medical services, there exists little or no provision for specialists' and consultants' services for the fifteen million insured persons, whilst for the twenty millions or so dependants of insured persons there is no general medical service except that of the Poor Law.
>
> "Owing to lack of means, it is impossible for the poorer classes to obtain the services of doctors on fee-paying terms, and for this reason it was deemed necessary to introduce a system of compulsory insurance to include free doctoring. It is submitted that the need is equally great to-day for similar provision for the remainder of the population below an income limit of, say, £250 a year, including the dependants of such persons, as well as those of insured persons.
>
> "If this were done by merely extending medical benefit on its present basis to dependants of insured persons, it would:
>
> "(*a*) Greatly intensify the overlapping of services already referred to;
>
> "(*b*) Be extremely costly, because a large number of panel practitioners would be, in effect, working full-time on payment basis devised for part-time work;
>
> "(*c*) Leave out of the scheme at least one and a half millions of persons including not only the destitute, but a number of non-insured persons, such as hawkers, small shop-keepers, &c.

"It is, therefore, suggested that the best way of organising the provision of medical treatment is to merge *all* existing forms of public medical service (including medical benefit under the National Health Insurance Acts) into one National Medical Service, thereby creating one unified organisation for the prevention and cure of disease. Under this system, the service would be provided for all persons below a given income limit."

119. We naturally questioned the official witnesses of the Ministry of Health on this problem and received replies indicating generally that closer co-ordination was regarded as desirable. For example:—"Reference has already been made to the general arrangements which have been or may be made for co-ordinating the work of public health services with the Insurance Medical Service. Any effective arrangements for such co-ordination should tend to diminish disease and sickness." (*Maclachlan*, Q. 24,226.)

"As regards the Poor Law Service I understand that it is not considered that further progress in the direction of co-ordination with the Insurance Medical Service is likely so long as the present division of work between the various local authorities is maintained." (*Maclachlan*, Q. 24,027.)

"If provision in one area of two services providing identical assistance for different, although only slightly different classes of the population is regarded as overlapping, then it is present in a very substantial degree." (*Maclachlan*, Q. 24,037.)

"The Maternity and Child Welfare Service provides many forms of assistance which a slightly different class of woman may get from the Poor Law Service. The same would hold good I think as regards tuberculosis." (*Maclachlan*, Q. 24,038.)

"The present arrangements are not, however, regarded as permanent. The ideal to be aimed at is a single Public Health Authority in each area, responsible for the whole of the public health services, but this can only be attained in connexion with a general reorganisation of local administrative areas and a consequent revision of the functions of the local authorities." (*Maclachlan*, Q. 24,155.)

"It cannot be said that there is any general or complete co-ordination between the medical work of Poor Law authorities and other health services." (*Francis*, Q. 24,165.)

"Is there any sound reason why the provision of medical attendance for sick persons who are destitute should be in the hands of a separate local authority?"—"I know of none." (*Francis*, Q. 24,166.)

"Would you agree that it would be a great advantage if the whole of the health services in any area, whether for the insured or uninsured, destitute or not destitute, were in the hands of the same authority? Would it be in accordance with the views

of the Ministry that in any reorganisation of the local administration of the Insurance Medical Service this end should be kept in view?"—"The answer to both parts of the question is yes." (*Maclachlan*, Q. 24,169.)

120. This large volume of representative evidence leads us to the general conclusions that whatever may be the changes which are made in the Insurance scheme in the near future, the trend of the development will be towards a unified health service, and that in determining future changes full account of this tendency should be taken.

SECTION E.—SOME GENERAL CONSIDERATIONS.

121. We do not feel that it is for us to explore in any detail the problems of the future to which this principle of unification must necessarily give rise if it is accepted. That there will be many and difficult questions so ensuing must be evident to all who look with any wide view at the diversity of services of a medical nature now provided or supervised by the State. Such problems as the nature of the services, the manner in which they should be inter-related, the range of persons for whom they shall be available, the financial arrangements by which they will be supported, the appropriate division of the work between the central and local authorities—all these are problems which confront the students of our social system and to which, we think, a solution must ultimately be found.

122. But though these matters cannot be dealt with at the moment, and are perhaps in any case beyond our Terms of Reference, we are glad that our proceedings have afforded the opportunity to many witnesses to state their views thereon. Such general expression given from a number of different points of view, e.g., that of the Medical Profession, that of the Approved Societies and Insurance Committees, that of persons so peculiarly interested in these developments as the Medical Officers of Health, that of independent observers and critics, cannot but be a valuable contribution to the consideration of these difficult problems and should be of assistance to those who at some future date will attempt their solution. We who approach these matters from the point of view of the medical benefit provided under the Insurance Scheme, need only consider one or two matters of somewhat more limited range.

Central and Local Co-ordination.

123. In the first place we may mention the question of co-ordination of effort in and between the Central Departments. On this point we have examined the official witnesses of the Ministry of Health which, as we have pointed out in Chapter IV,

already controls most of the health services. We have also considered the statement submitted by the Board of Education on the school medical services; and Sir Thomas Legge of the Home Office has described to us in considerable detail the medical services in the factories. We are told that co-ordination is effectively secured between Departments by consultation and other official machinery (see *Brock, Maclachlan and Francis*, Q. 24,025-24,196). Similarly, we are told that within the Ministry of Health itself the various branches are maintained in effective relationship (*Kinnear*, Q. 24,197-24,201). We are glad to be reassured on this point, but we would suggest that, as the various national schemes are advanced along the lines of their natural development, it will be essential to secure at each stage the utmost degree of co-ordination at the centre.

124. In the second place there emerges prominently the problem of the multiplicity of the local authorities whose work we have described in Chapter IV. Here again, approaching the question from within our Reference, we have to consider the future of the Insurance Committees, with their related bodies, the Local Medical Committees and the Panel Committees. A full account of the duties of these three groups of bodies is given in Appendix I, Section C, to our Minutes of Evidence. We will turn first to the Insurance Committees.

The Insurance Committees.

125. If, as we think, there is to be a concentration of local health functions in the hands of a single Authority, the powers and duties of the Insurance Committee would naturally pass to that Authority. We have come to the conclusion that a change in this direction may justifiably and conveniently be made in the immediate future, the functions of the Committees being transferred to the appropriate municipal and County Authorities. In view of the importance of this proposal we devote a large section of Chapter XII to its discussion and to a review of the evidence directed to the activities of the Insurance Committees. Here we need only say that though Insurance Committees and their staffs have done their work well, and at the outset some advantage undoubtedly resulted from the attention and energy which specially instituted bodies could devote to the launching of the new scheme, yet owing to a variety of causes, there is not now work of a quality or volume to justify the continued existence of this separate organisation. That, of course, is not the main argument from the point of view expressed in this Chapter. We would urge unification as the ultimate aim even if the work of Insurance Committees were in fact substantial. But it is not; and we are thus spared the necessity of advocating on one principle the disappearance of a system which justifies its existence on another.

The Local Medical and Panel Committees.

126. Passing now to the consideration of the Local Medical Committees and the Panel Committees, we would observe in the first place that these bodies have proved a valuable element in the medical side of the Insurance Scheme. The principle of having in each area a representative body of medical men, to whom professional questions are referred and by whom many of the administrative problems affecting the insurance practitioners are considered, has evidently been acceptable to both lay and professional opinion. It might be held that the same results would be obtained by the presence of elected or co-opted medical members on the local administrative bodies. But we think—and evidently the framers of the Scheme thought also—that something more than this was desirable; and that to secure the full co-operation of the Medical Profession, so necessary to the scheme of medical benefit, the independent position given by the two statutory and purely professional Committees was essential. It is true that in most cases the two Committees have the same personnel, and indeed we are told that the Ministry has in many areas recognised the Panel Committee as the Local Medical Committee. Yet each represents a distinct idea, the former the effective voice of the practitioners in contract with the Insurance Committees, the latter the combined experience and opinion of all types of medical men in the area whether "on the panel" or in the most exalted specialist practice. Under such an extension of medical benefit as we recommend in Chapter X and even more so in any larger developments of the future, the two Committees will necessarily tend to coalesce and become, if they are continued, the single expression of professional wisdom in the area. We do not doubt that they will be continued in any immediate developments, and equally we see in them the hint of a local professional committee working side by side with the single local health authority in all parts of the country.

Availability and Finance.

127. Much of the evidence we have received on the general subject with which we are now dealing has been directed towards two highly important problems, namely, the classes of persons for whom the public and insurance medical services should be available, and the manner in which the costs of such services should be met. At one extreme are those who would limit the services strictly to the necessitous and finance them from public funds, leaving the rest of the population to make their private arrangements. At the other are those who advocate the provision of a complete service for the whole population without distinction of class or means, the cost being defrayed entirely from Exchequer grants and local rates.

128. Between these extremes lie those who would retain the insurance principle as a means of raising part of the necessary funds and would weave it, in some way not very clearly defined, into the financial web. For example, the British Medical Association contemplate a line drawn horizontally across the structure of society. Above that line everything is to be left to private effort, except those services which are of a public health character in the strictest sense. Below that line they would admit a comprehensive service embracing all medical elements and incorporating all the activities of the local authorities which stand at present apart from the insurance service. The service which would thus be limited so far as concerns those for whom it would be available, although in its content of the widest scope, would be financed from a combination of public and insurance funds. The principle governing the limits within which such a service would be available is enunciated in the following words: "The medical provision should be available for those persons, and only for those persons, who would be unable to obtain it without the help of an Insurance Scheme . . . the medical provision made for such persons should be, as far as possible, complete." (App. XLVII, 8; Q. 14,689-14,708, 14,806-14,817.) In other words, the witnesses who appeared on behalf of the British Medical Association, contemplate a unified and complete service resting in part on insurance funds which should, however, be restricted to the poorer classes of the community.

129. On the other hand, such a scheme would be broader than the present scheme of Health Insurance, as it would ignore the distinction between those employed under a contract of service, and those working on their own account who are at present outside the scope of the Acts. This scheme would, moreover, include the dependants of both these classes. We questioned the witnesses closely as to the income limit at which the line should be drawn, but did not receive any very definite suggestion on the point. They apparently contemplated something substantially higher than the present destitution test for the complete medical attention given by the Poor Law authorities, but lower than the present insurability limit for non-manual workers (£250 a year), with the further proviso that dependants should only be included if the person on whom they were dependent had an income substantially below that figure. The general effect of these proposals would be to exclude from the scheme instituted by the State a substantial number of the present insured class but to bring within the scheme a greater number than those so excluded, consisting of the dependants and of the various classes of persons of small means at present outside the existing insurance scheme. To this enlargement of the sphere of "contract practice," there appeared to be no objection on the part of the British Medical Association, assuming that a sufficiently low income limit should be conceded in defining those for whom the health service should be available. They do not appear to have contemplated the possibility that in some areas the proportion of the population who would be embraced within the scheme under any income limit likely to be acceptable to the industrial classes, would be so large as to afford a strong argument on grounds of public economy for the replacement of the contract system by a whole-time salaried service.

130. The National Association of Trade Union Approved Societies appear to have accepted the insurance principle, and indeed, desire to extend it in several important respects (*see* App. XCII, paras. 102-104). The National Conference of Friendly Societies approve, as we have indicated above, a complete reorganisation of all health services on a public basis financed entirely from rates and taxes.

131. Mr. Alban Gordon makes the following statement:—

> "My own personal predilection would therefore be in favour of abandoning altogether any attempt to base a National Medical Service on insurance funds, to abolish medical benefit altogether, relieving the Insurance Act contributions proportionately, and to finance a National Medical Service out of taxation, national and local. The incidence of such taxation would, in the long run, be very much the same as that of the contributions under the National Insurance Act, the remitted or substituted portion of which would, therefore, counterbalance that increase in general taxation.
>
> "At the same time it cannot be denied, from the point of view of political expediency, that it might be unwise to hand back to the insured persons and their employers a sum of eight million a year, which they are now paying without complaint, only to re-levy the same sum in the form of increased taxation in some other direction which might be strongly resented. Furthermore, the insurance funds now contain an exceedingly large sum of money by way of accrued surpluses on the first two quinquennia, a large portion of which is proper to be used for medical and allied purposes. Some of this might well be utilised as a capital sum to defray in whole or in part such expenses consequent upon the inauguration of the National Medical Service as are of a capital nature, e.g., primary health centres, such as are contemplated in the Dawson Report, additional hospital accommodation, and conversion and improvement of existing hospital buildings, &c." (App. XIII, 46, 47.)

The "Means Test."

132. In connexion with these views we may give a brief outline of the operation of what is called the "means test" as it appears in the various health services. In the Insurance system

the £250 limit applies to non-manual workers: for the manual workers there is no limit whatever. But so far as medical benefit is concerned, Insurance Committees are empowered to prescribe an income limit applicable to all insured persons for whose medical benefit they are responsible. Where such an income limit is prescribed in any area, persons above that limit must make their own arrangements for receiving medical benefit, receiving the appropriate payment from the Committee's Medical Benefit Fund in aid of their own expenditure. We are not aware that any Committees have exercised this power, so that a well paid manual worker would, under the present system, receive medical benefit on the capitation system and thus be quite free of any means test.

133. Another restriction of a similar type is to be found in the requirement that a voluntary contributor with over £250 a year is not entitled to medical benefit at all, either under the capitation system or under that known as "own arrangements," and pays a reduced contribution accordingly. Whether this restriction is effectively administered we do not know, but in any case voluntary contributors form a very small class. This provision—although it then related to a lower income limit—was inserted in the Act of 1913 to meet the objections entertained by the Medical Profession against extension of the sphere of contract practice to persons who, though initially within insurable limits, might later pass beyond the range of income for which voluntary insurance was, in their view, designed. It may suffice to accord mention, in passing, to the somewhat similar provision governing the medical benefit of exempt persons.

134. These restrictions are significant as embodying in a very definite form the means test, even in a system which is in part—and so far as the voluntary contributor is concerned in a very large part—maintained by the contributions of the beneficiaries.

135. The medical service provided by the Poor Law authorities is an extreme form of the application of the means test. Closely akin is the medical *treatment* provided by the Education Authorities for school children though medical *inspection* is provided for all, just as elementary education itself is, irrespective of means. The treatment of physical defects and diseases is subject to strict inquiry into means and to proved inability of the parents to provide it themselves.

136. As exemplifying the opposite principle we may take the whole group of services which deal with what is known as "public health," e.g., sanitation, provision for dealing with infectious diseases, venereal disease and tuberculosis and the Port sanitary service. The cost of these services is defrayed out of rates and taxes and no consideration in any form is given to the means of those most directly affected. The

Maternity and Child Welfare service is subject in certain aspects of its work to a means test, but in other branches it is generally available to all who may care to make use of its facilities.

137. On a general survey of these instances it is possible to recognise a guiding principle running through the differences. Certain of the services are conducted not only in the interests of the individual but perhaps even more fundamentally for the general well-being of the community. Others again are of a much more personal kind and in these the interests of the individual constitute the sole end, and not merely an end incidentally promoted in seeking the public good. In the latter class of case where the interests of the individual are the dominant consideration, payment may legitimately be required of the individual if his financial circumstances so warrant. On the other hand, in the former type of case where in any event the general interests of the public would dictate the expediency of not leaving the individual unattended, it might be inappropriate to call upon the individual to defray the whole, or indeed any part of the cost incurred in respect of the service rendered to him. But we may suggest that this distinction, like the general distinction between public health and the health of the individual, from which it arises, is one on which, as time goes on, it must become increasingly difficult to insist.

General Conclusion.

138. We have mentioned these problems in a general way because, although they are not of immediate practical importance, we feel sure that sooner or later they must be faced. Having indicated our views on the need for effective co-ordination of all the health services, whether at the centre or in the local administration, it is sufficient to leave particular problems, and especially those of a financial character, to be solved in the light of the developments of that considerable period which must elapse before full effect can be given to the general principles we have enunciated. In the circumstances of that time, financial considerations may have emerged, and social conditions may have changed, in a way that is difficult to forecast, and anything we may say now must necessarily be thus qualified. But, if we may venture to pronounce on this matter, we are of opinion that the difficulties of a composite support to a completed medical service from insurance funds as well as from grants and rates would be so considerable alike in their financial, administrative and social aspects that some more practical solution must be sought. In particular we feel sure that the wider the scope of these services, the more difficult will it be to retain the insurance principle. The ultimate solution will lie, we think, in the direction of divorcing the medical service entirely from the insurance system and recognising it along with

all the other public health activities as a service to be supported from the general public funds. Consideration would have to be given to the question of the classes of society for whom the service would be available and whether it should be so available on a free basis or with payments by insurance or otherwise. These, however, are problems which need not—perhaps cannot—be solved now, but may be fitly left over for those who, unlike us, will approach at close range to the great question of the Public Health Service of the future.

CHAPTER VI.

THE FINANCIAL BURDEN OF THE EXISTING SOCIAL SERVICES.

139. In the preceding Chapters we have described in a general way the various health activities of the Central Departments and the Local Authorities, their relations to each other, and the lines along which, as we think, development should take place. But we have hinted that, in connexion with the various proposals for the extension of the Health Insurance Scheme which have been brought to our notice, serious regard should, in our opinion, now and for some time to come, be given to the present financial and industrial position of the country. Our proposals, because they are thus conditioned, may appear to be of a restricted nature to the numerous advocates of substantial development. We therefore, at this point, think it desirable to make a brief reference to these conditions and to indicate why in our opinion they necessarily limit present progress.

The Burden of Unemployment.

140. The serious conditions prevailing in many of our industries and the grave embarrassments under which the central and local finances of the country are alike labouring, are too well known to call for elaboration here. But lest we should be thought wanting in a proper appreciation of the value of a large advance in the public arrangements for promoting the health of the community, we think it desirable to emphasise the factors which on any statesmanlike review of the problem before us point to the expediency of a policy of caution. In the foreground there obviously stands out the question of unemployment, which for a period of almost five years has doubtless been the gravest feature in the life of the community. The number of the unemployed is now about 1,200,000 and for the past two years has varied very little. The figure has been as high as 2,000,000. Even at 1,200,000 it is 11 per cent. of the working population registered at the Employment Exchanges. The maintenance of this huge number of workers and their dependants is a national burden, the responsibility for which has been accepted by the State and it is being borne at a cost of about £50 millions a year to the community (of which £13 millions is paid from the Exchequer). In 1913, the corresponding figure was only £2 millions and in 1920-1 £14 millions. Even though the contributions of employed and employers to the Unemployment Fund make up a large part of the sum required, it is nevertheless true that the