from an increase of contribution or of the Exchequer grant (neither of which changes, as we have previously stated, can in our opinion be contemplated as possible in the near future), by which any general extension of the present statutory benefits can be provided for all insured persons. In Chapter X we recommend that the scope of the present medical benefit should be extended to include a specialist and consultant service, and we are satisfied that under the pooling scheme suggested above it would be possible to introduce this extension at once. When it is recognised that one effect of the partial scheme of pooling which we recommend will be to enable this important extension of the benefits of National Health Insurance to be provided at once for all insured persons, much of the opposition which might otherwise have been aroused against our proposal will, we trust, be allayed.

CHAPTER X.

PROPOSALS FOR EXTENDING MEDICAL BENEFIT.

260. In Chapter V of our Report we have described in general terms the changes in the medical aspects of National Health Insurance which we regard as ultimately desirable; and on the other hand we have indicated in Chapter VI the reasons which in our opinion make wide and costly amendment undesirable and indeed impracticable in the near future. In this and the following chapters we propose to deal with various matters which we consider are of immediate practical importance, the attainment of which is, moreover, within the financial bounds which we have regarded as prescribed for us by the general circumstances of the time. It would in our opinion be regrettable if, for reasons of financial stringency, we could propose nothing beyond a series of minor amendments. But in fact we are able —without suggesting any increase in the contribution or the Exchequer grants—to propose several fundamental changes which we think will be beneficial to the insured population at large, and in addition a considerable number of amendments, not individually of great importance, but in their cumulative effect conducive to a real improvement in the general working of the scheme. Questions relating to Approved Societies have already been considered in Chapters VIII and IX. With certain larger matters apart from these we deal in this and the next two chapters. A large number of other questions of varying degrees of importance, the consideration of which has been forced on us by the evidence or by our general review of the Scheme, are dealt with in Chapter XIII.

261. The first of the questions to which we now turn is that of the extension of the scope of medical benefit. In Chapter V we have indicated the nature of the evidence directed to this question, evidence which leaves in our mind no doubt that this extension should come first in any order of priority of proposals and that such an expansion should be made if or as soon as the necessary financial resources are available. It is unnecessary to traverse the ground again, but we may refer to two answers of Mr. Brock's which sum up the official attitude: "It has always been recognised that medical benefit could not continue indefinitely to be limited only to a general practitioner service." (*Brock*, Q. 23,830.) "In 1914 provision was made in the Budget and the money was voted by Parliament for the provision of specialist services, but that fell through on account of the War." (*Brock*, Q. 23,835.) Medical benefit is at present a general practitioner service; but it cannot seriously be claimed that this is a satisfactory state of affairs. It means that the medical service

given in respect of the insurance contribution stops short just where the need is greatest. In the serious and expensive cases the insured person is thrown back on his own resources or on the limited provision made by the general hospitals.

262. We feel very strongly that the completion of one, and that a highly important, element ought to take precedence over the introduction of new elements, however desirable in themselves the latter may be.

We have indicated in Chapter IX a financial method by which a generous provision of expert out-patient services can be made available without entrenching on the margin in the present contribution disclosed in Chapter VII, which margin we propose (as will be seen in Chapter XI) should be applied in another important direction. This method of providing the necessary funds has, as we consider, the additional merit that it at the same time reduces that disparity of resources between the various Societies which has evoked adverse criticism in so many quarters. But whether the cost of an extended medical benefit is met in this or in some other way, such extension should, as we have said, receive first and immediate consideration. Without it, indeed, the limitations of medical benefit remain the most obvious weakness in the whole scheme of benefits under National Health Insurance.

The Content of an Extended Medical Benefit.

263. What, then, should be the content of this extended medical benefit which is to be available for all insured persons until such time, whether near or remote, as a more comprehensive system of health service is evolved? The following should, we think, be provided in addition to the general practitioner treatment of the present contract :—

(1) Expert medical advice and treatment for patients who can travel to meet the specialist.

(2) Expert advice for persons who are unable to travel.

(3) Laboratory services.

These elements may be briefly described as " expert out-patient services "—a definition which is intended to cover all the out-patient services which specialists give as a class, including, for example, ophthalmic diagnosis and prescription of glasses.

The Problem of In-Patient Treatment in Hospitals.

264. We have not included in-patient treatment in hospitals for a variety of reasons, though that also would form part of a really complete medical service. Under present conditions we must very largely be guided by considerations of cost, and that for in-patient treatment would be very heavy, involving not

only the cost of maintenance but probably also that of medical and surgical services now given gratuitously. The Ministry of Health representative informed us that " in the view of the Ministry it would not be desirable to attempt to include institutional treatment in the Acts as a statutory benefit. To provide the whole cost of in-patient treatment of insured persons would be extremely costly, and there is the difficulty that a statutory benefit implies some guarantee that the required accommodation will be available when it is needed. So far as regards voluntary hospitals no such guarantee could possibly be given. . . . Any scheme which resulted in preference being given to a particular class, however large that class might be, must in our view be prejudicial to the voluntary system." (*Brock*, Q. 23,852.) The Scottish Board of Health, who have urged strongly that this element should be included in any immediate extension, estimate that for Scotland alone an expenditure of about £160,000 a year would be required. For the whole of Great Britain the cost would be, on that basis, about £1,500,000, which, added to the cost of the three elements we have suggested above, would far exceed the amount available if, as we propose in Chapter XI, anything is to be done in the way of improving the cash allowances in sickness and disablement. Further, the Scottish estimate is only for part (about one-quarter) of the total cost, the assumption being that private subscriptions and donations would continue to meet the balance. This, we think, is an untenable assumption. Once the insurance funds were committed to meeting part of the cost of in-patient treatment, it would be highly probable that the part would change gradually into the whole so far as insured persons were concerned, and that a liability far beyond the present estimate would ultimately be incurred. In any case we must point out that so long as the hospitals treat the insured and the uninsured on the same basis and retain, as they desire to do, complete independence in the management of their funds, it would be very difficult to justify a systematic and substantial support from the insurance scheme for this purpose. We think that the present arrangements, under which Approved Societies may give financial assistance to the hospitals under their schemes of additional benefits or by way of donations under Section 26 of the Act (with a certain modification in the latter which we recommend in Chapter XIII), may be continued, but that no general provision of hospital treatment can be at present contemplated within the Insurance Scheme. We fully appreciate the great work the hospitals are doing alike for the insured and the uninsured, and we do not underrate their financial difficulties. But both on grounds of finance and policy we accept the view of the Ministry of Health (as set out in reply to Q. 23,852) that an extension of this nature must be left over for future consideration.

265. In illustration of the way in which the small contributions of the people—insured and non-insured alike—are applied towards securing hospital treatment, we may refer to the statement submitted by the Hospital Saving Association (App. CXXX). It is there explained that for a contribution of threepence a week a large number of hospitals have agreed to relieve from any enquiry as to means, the contributor or his dependants when admitted to the hospital; and this arrangement applies equally to in- and out-patients. If the patient is treated at a hospital not on the list of the Association the contributor is reimbursed, by the Association, any normal payments which he has been called upon to make towards his maintenance for a period not exceeding ten weeks. These arrangements, which we think are in themselves wholly commendable, make apparently no distinction between the insured and the uninsured, and accordingly we are reinforced in our view that the claim of the hospitals to assistance from Health Insurance funds is not valid under present conditions and can never be so until an appropriate preference is given to insured persons either financially or by way of priority in treatment or in some other manner that definitely recognises the dual position which in such matters they clearly occupy.

266. In this connexion one further point should be noted. We have referred in Chapter V to the difficult position that would arise if, for example, hospital in-patient treatment were provided for the insured while the classes of persons just above the insurable level, to whom the cost of a major operation is a severe and often crippling burden, were given no assistance from public funds. If we were recommending as part of the extended medical benefit, the inclusion of such services either in the home or in the hospital, we should feel seriously concerned about the position of non-insured persons of moderate means. Under these circumstances, indeed, we are sure that an attempt would have to be made to find some way of making a similar benefit available to this class. We are convinced that this problem must ultimately be faced and that no large and unified scheme of health services will be entirely satisfactory unless it provides a solution. Within the limits of our present proposal, however, the difficulty does not assume the grave form which it would indubitably present if it were suggested that hospital treatment and major operations should be included within the scope of medical benefit.

Maternity and Dental Services.

267. Nor have we included maternity services and dental treatment, though these also, we hope, would find their place in any full Public Health Service of the future. In Chapter XII we deal at some length with these problems in their immediate aspects, and in particular make an important recommendation for improving the dental service given under the additional benefit

schemes. Here we need only say that our exclusion of these elements from any immediate provision of a generally available medical benefit is dictated in the main by financial considerations —though, of course, we have carefully considered from every point of view the relative claims of the various possible extensions on the available funds.

268. We conclude, then, that the extended medical benefit to be recommended for immediate adoption should add to the general practitioner service only the three elements stated in paragraph 263 above. We now proceed to describe these in detail, to indicate methods of administration, and to give estimates of the cost involved. In this connexion we direct special attention to the statement which the Ministry of Health have submitted to us in Appendix CIII, dealing with the numerous discussions of these problems between the National Health Insurance Commissioners and the medical profession and also to the examination of Mr. Brock and Dr. Smith Whitaker in Questions 23,830 to 23,846. The problem is obviously no new one, and but for the War would probably have been solved many years ago.

Provision of Expert Treatment or Advice for Persons Able to Travel.

269. The services which specialists can render to supplement or assist the work of the general practitioner include (1) advice as to diagnosis, (2) advice as to treatment which the practitioner can himself properly undertake, and (3) treatment of a kind which only a specialist can give, or for which special resources of equipment and skilled assistance such as that of masseurs or electricians, are requisite.

270. A difficult question of principle emerges at the outset. Services of this kind are, to a certain extent, already available for insured persons, as for other members of the community, in the out-patient departments of hospitals. Do the services thus obtained fall short of the requirements of a satisfactory service for the whole insured population? If they do, is some scheme of supplementation of these services practicable and desirable? Or are we driven to the conclusion that the specialist out-patient service must be provided completely irrespective of what the hospitals are already doing?

271. Dr. Smith Whitaker, in answer to questions on these points, replied:—"The local authorities, whatever they were, who had to carry out the organisation would probably adopt a variety of methods, some in one place and some in another, but generally we doubt whether a system which was based on contracts with the hospitals for providing the services would work satisfactorily. The insurance authority,

whatever it might be, would be responsible for the efficiency of the service provided, and probably they would feel it was necessary that the service should be under their direct control" (Q. 23,834). "Whenever this question has been discussed, particularly when it was discussed with representatives of the Medical Profession in 1919, the greatest possible importance was attached to communication between the practitioner and the consultant with regard to the case . . . That, I think, is one of the weaknesses of the present system that you cannot secure that kind of close co-operation, and it is doubtful whether you could ever get the co-operation carried out satisfactorily unless the consultant and the practitioner were both responsible directly to the same body" (Q. 23,835). "While it would be very desirable to utilise hospital premises by renting them wherever possible, the system could not be so satisfactorily worked by entering into contracts with the hospitals to provide the service" (Q. 23,833).

Availability of Out-patient Treatment at Hospitals.

272. It appears that the extent to which specialist treatment and advice are obtained at the hospitals varies greatly in different parts of the country, and even as between different medical men practising in the same area. These variations result from :—

(1) differences in the accessibility of patients to hospitals;
(2) the different customs of different hospitals, as a whole;
(3) personal characteristics of particular members of the medical staffs of hospitals;
(4) differences in the attitude of practitioners and in their relationships to particular consultants;
(5) differences of attitude of insured persons.

273. In the large centres of population, in the neighbourhood of the great hospitals attached to medical schools, there is little difficulty in obtaining specialist treatment. Second opinions are also readily obtained in the majority of cases by those practitioners who take a not unreasonable amount of trouble to obtain them. At some of these hospitals, great pains are taken to convey to the practitioner information as to treatment which has been given, or advice as to diagnosis or treatment, even though he should have himself failed to send particulars of the case to the hospital. The position is on the whole less satisfactory in places in the immediate neighbourhood of large hospitals not attached to medical schools. In such cases the general practitioners have probably less confidence in the opinion of the staff of the hospital, which includes a considerable proportion of men who are themselves general practitioners and the former, therefore, are not so ready to seek the advice of the latter.

274. Distance from the hospital plays, obviously, a very important part in determining the extent to which insured persons

avail themselves of such facilities. Beyond this, there is a certain amount of evidence that many insured persons are reluctant to go to the out-patient departments, as a charity, while they would not hesitate to avail themselves of the same specialist services if included in medical benefit, as they would then feel that they had a full legal and moral right to receive these services when needed. Some are deterred by the crowded state of the out-patient departments and the long time they may have to wait for attention. Others are deterred by the charges made. Again, some of the insured persons whose income brings them near the limit of insurability, prefer, when specialist advice is necessary, to employ the specialist privately, thinking that in this way they will receive more careful attention than if they obtained gratuitous advice.

275. It is clear that under existing conditions many insured persons do not obtain from the out-patient departments the specialist treatment that is needed, and, in respect of those who do, the attending practitioner frequently does not obtain the second opinion on diagnosis or treatment which is desirable in the interest of his patient.

General Conditions for the New Scheme.

276. If expert out-patient services are to be provided as part of medical benefit, it is necessary, in the first place, that these services should be sufficiently accessible in all parts of the country, specialists being employed to attend at frequent intervals in central places in those districts in which there are at present no physicians or surgeons who possess the necessary qualifications. Further, travelling expenses of insured persons referred to specialists under the scheme should be defrayed as part of the service. These two provisions would not add a relatively large amount to the cost of the scheme, and would remove the present deterrent effects of distance.

277. Taking all these matters into consideration, we come to the conclusion that the new system should be built up, not by way of supplementation of the existing out-patient work of the hospitals, but as an independent scheme organised effectively throughout the whole country, providing for the closest consultation and reciprocal communication between the general practitioner and the specialist, and giving the title to the service to all insured persons as part of the consideration for which they are paying their compulsory contributions.

278. Under such a scheme, there would be laid upon the insurance practitioner an obligation to refer a case for specialist advice and treatment when the circumstances rendered such a course appropriate. He would also have to furnish a statement of the history and the present condition of the patient, as known

to him, and a statement of the points on which specialist opinion is desired. Such an arrangement is already in force where cases are referred to the Regional Medical Officer or to the Tuberculosis Officer. This system has received the cordial approval of the medical profession. The obligation thus placed on the insurance practitioner would be accompanied by a similar definite obligation on the specialist. The practitioner should receive a report on any person treated by the specialist, with advice as to further treatment, and also in cases not needing specialist treatment, advice as to diagnosis or as to the treatment which the practitioner himself should carry out.

279. The provision of specialist services in this way as part of medical benefit would result in :—

(1) A substantial increase in the availability of such services.

(2) A substantial increase in the proportion of cases in which general practitioners would avail themselves of such services.

(3) A greater disposition on the part of insured persons to obtain benefit.

(4) An exchange, not as now in a proportion of cases only, but in all cases, between the practitioner and the specialist, of the information which each should have, and definite guidance for the practitioner as to both diagnosis and treatment.

Reactions on Efficiency of General Practitioners.

280. These in themselves would be great advantages, but of equal importance, in their ultimate bearing on the health of insured persons and of the community generally, are the prospective indirect effects of such a system in improving the efficiency of the general practitioner. It has been long recognised that he suffers great disadvantages in the maintenance of his professional efficiency, through the isolation experienced under present conditions of practice. A large proportion of practitioners have few opportunities for coming into contact with those who are devoting themselves to the study and practice of particular branches of medicine and surgery. Unless they have mixed practices with a fair proportion of persons of means there are few opportunities of comparing the expert's view on a case with their own. Of the real deficiencies in their methods which would be observed by a competent colleague, they are thus necessarily unaware.

281. In a system under which specialist services and general practitioner services were welded into one scheme, the conditions of general practice in this respect would be completely changed.

The mere obligation to furnish the expert with a statement of the case would have a valuable and educational influence in constraining the practitioner to give definiteness to his ideas. When he had to prepare a statement to come under the critical eye of the expert he would, by that mere fact, become alive to defects in his conduct of the case, which he had not previously realised. The indirect benefit resulting from such a requirement has, we are informed, already been seen in the work of the Regional Medical Staff. Again, the specialist's report will often reveal to the practitioner points in diagnosis or treatment which he might have overlooked. It will thus add to his knowledge by enabling him to assimilate the expert view of his cases as they come along. In all these ways the provision of a specialist service would operate as a most valuable form of post-graduate instruction and would probably be gratefully welcomed by the isolated general practitioner. The educational benefits so resulting would not be confined to the insured persons, but would be extended to the whole range of general practice.

Administrative Arrangements.

282. The administrative arrangements for this particular provision would be relatively simple and inexpensive in proportion to the total cost. They would naturally follow the present lines of administration of medical benefit, i.e., the responsibility of making local arrangements would lie with the body that takes over the work of the Insurance Committee, or possibly with a group of such bodies. Their duty would be to frame a scheme in accordance with principles laid down by the Ministry, after consultation with representatives of the medical profession, and the adoption of the scheme would be subject to the approval of the Ministry. The chief points requiring attention in each local scheme would relate to the provision for the selection of the specialists to be employed, the arrangements as to places and times at which patients should be examined and treated, the employment of ancillary staff, and the rates and methods of remuneration.

283. It should be open to any doctor possessing the requisite qualifications to take part in the work, and the decision as to whether particular doctors possess the requisite qualifications might lie in the hands of a mixed lay and medical committee, some at least of the medical members being drawn from outside the area.

284. The arrangements as to the places and times at which patients should be seen might take a variety of forms. The doctors might see the patients at their own consulting rooms; arrangements might be made with the hospitals for the work to be done in the out-patient departments, or thirdly, the local authority administering the benefit might establish the requisite

number of clinics, using hospital premises for the purpose, whenever these could be obtained. We are aware of the objections of the medical profession to a general system of clinics, even clinics under professional control, and we have always before us the importance of securing the willing co-operation of the profession at each advance in the public arrangements. We therefore think it would be undesirable at this stage to attempt a uniform system and that full opportunity should be given for composite local schemes.

285. If arrangements were made for the work to be done at the physician's or surgeon's consulting room, no question of employment of additional nurses or other ancillary staff need arise. So far as arrangements were made with hospitals, they would usually be able to provide the requisite staff, as part of the contract for the use of their premises. In so far as it might be found necessary to establish new clinical centres, nurses, masseurs and electricians would have to be employed.

Method of Remuneration of Consultants and Specialists.

286. If the work were done at the doctors' consulting rooms they would probably prefer to be paid a fee per case. It would, however, be possible, even under that arrangement, to pay on a time basis, the arrangement being that a fixed number of cases would be summoned to attend at the consulting room at a specified time, this being the number which would normally occupy about 2½ hours. A fixed fee would be paid for the session. Where treatment was given at centres at which various specialists attended, the proper method of remuneration would be on a time basis.

Estimate of Cost of Provision for Persons able to Travel.

287. The Ministry of Health have submitted to us an estimate of the cost of providing this part of the service on the basis of sessions at fixed centres at which the specialist and the insured persons would attend. The costs to be provided for include (1) the fees for physicians and surgeons, (2) payment of ancillary staff, including nurses, masseurs and electricians, (3) rent of premises, (4) travelling expenses for insured persons, (5) cost of administration.

288. The estimate has been based upon inquiries made by the Regional Medical Officers and on statistics published by certain hospitals. The conclusion of the Ministry is that for the insured population of 13½ millions in England and Wales the cost would not, on the lowest assumptions as to number of persons referred and other factors of cost, fall below £487,000, and would be unlikely to exceed £940,000 per annum. This is, of course, a wide difference. It is mainly due to different assumptions as to the proportion of the insured population that would be referred to the specialist.

Provision of Consultant Services at Patient's Home.

289. As a result of recent inquiries by the Regional Medical Officers, the Ministry have found that a large number of practitioners thought it very desirable that the services of a specialist should be available for consultation at the patient's home in the case of persons who are unfit to travel. Some of these mentioned cases of acute illnesses, such as pneumonia or "acute abdomen," as cases in which such help was specially needed.

290. Of the value of second opinions in such cases, there can be no doubt, not only on account of the assistance given to the doctor in cases in which he needs expert advice as to diagnosis, or as to the best course of treatment to adopt, but also on account of the relief thus given to the mind of the patient, or of his relatives, in cases of dangerous illness, even although the general practitioner in attendance may have no doubt as to the diagnosis or the proper course of treatment. In the cases of the latter group, however, what is wanted is not necessarily the opinion of an expert. The second opinion of any general practitioner of wide experience and good standing will usually serve the purpose equally well. Moreover, in acute illnesses of patients residing at some distance from the nearest centre at which experts are available, considerations of time may make it more advisable to get the opinion of a general practitioner, who is more quickly available. These latter considerations obviously must affect materially the estimate of cost.

291. The appropriate method of administering such a provision would be to draw up lists of approved experts and approved general practitioners in different parts of the country who might be called in when required, and to supply such lists to the practitioners concerned. In the large cities and towns, it might be possible to allow an expert to be called in wherever a second opinion was desired by the practitioner in attendance. In other places, the practitioner might be allowed to call in an expert in a case in which he thought expert advice really necessary and otherwise to call in an approved general practitioner from the neighbourhood. It would, however, probably be desirable that the proposal to call in an expert should first be submitted for approval by a medical officer appointed for the purpose (who might be one of the Regional Medical Officers of the Ministry) except where the practitioner certified that the case was one of urgency. That, however, is a matter of detail which we think should be left over for negotiation between the Ministry and the profession when the general outlines of this part of the scheme have been settled.

Estimate of Cost of Home Service.

292. On the basis of such information as is at present available the Ministry have estimated that the cost of domiciliary consultant services would probably not exceed £250,000; but

the estimate is admitted to be highly conjectural, resting mainly on the personal impression of members of the Regional Medical Staff of the Ministry who have had extensive experience of general practice.

The great difficulty of forming even an approximate estimate of the cost of these particular services arises, first, from the lack of data of the extent of the real need of them, and, secondly, from the difficulty of devising adequate safeguards against unnecessary calls for second opinions. It is obvious that without such safeguards a large cost might be incurred without corresponding advantage. For these reasons, we recommend that the working of the arrangements for the provision of a domiciliary consultant service should be closely watched by the Central Department, particularly in the early stages, to ensure that the system is not resorted to by lax or negligent practitioners in cases where no real doubt arises in regard either to diagnosis or treatment.

Laboratory Aids to Diagnosis.

293. There appears to be a unanimous and strong desire for the provision of laboratory aids to diagnosis. Under this head are included :—

(1) Microscopic, bacteriological, or chemical examination of blood, fluids aspirated or otherwise obtained from the patient, such as cerebro-spinal, pleuritic and ascitic, urine, fæces, sputum, vomit, pus, tumours and other tissues.

(2) Tests of function, i.e., urea elimination, test meal.

This list is exclusive of the examinations made for the preparation of autogenous vaccines, and of the examinations now undertaken by local authorities, i.e., examinations of diphtheria swabs, sputum for the tubercle bacillus, Widal reactions, and Wassermann reactions and other tests in connection with venereal disease.

294. If a scheme were being prepared for the provision of services for the whole population, it might be worth while to go into questions of possible organisation of a scheme of laboratories that would be newly provided where not already available. But when considering provision for insured persons only, we understand that there is no reason to suppose that contracts could not be made with existing laboratories for doing all the work.

Estimate of Cost of Laboratory Aids.

295. As to cost, we understand that the estimates obtained from general practitioners of the prospective demand for such services have varied somewhat widely, and in some of them, sufficient account does not appear to have been taken of the considerable increase in the volume of work which would probably have to be undertaken, particularly if the service were associated with the provision of specialist clinical services. The figures given converge towards about £5 per 1,000 insured persons per annum. The highest figure suggested was about £10 per 1,000. The estimated cost for England and Wales may therefore be taken at about £100,000. (*Smith Whitaker*, Q. 24,013.)

General Summary of Cost.

296. Bringing together the estimates above stated under the three main heads it will be seen that the maximum annual cost of a scheme of expert out-patient services such as we have outlined, including all the work for a population of 13,500,000, is as follows :—

	£
Specialist services	940,000
Bedside consultations	250,000
Laboratory aids	100,000
Total	£1,290,000

297. These, we are informed, are outside figures in each case, and it is not probable that, even if reached eventually they are likely to be attained for some years after the commencement of the scheme. The financial aspect of the problem is summed up in Mr. Brock's answer to Q. 23,830 : " Such a service, we think, could be organised at a cost—I am putting it very roughly—of 2*s*. per head if you include provision for domiciliary attendance."

298. It should be noted that these estimates are for the insured population of England and Wales, viz., 13,500,000. We have received estimates for the corresponding Scottish problem which are in fair agreement, though somewhat lower for the same types of service. For a provision of specialist and consultant services, including institutional treatment but not including convalescent and dental treatment, the estimate of the Scottish Board of Health is from 2*s*. 9*d*. to 3*s*. per insured person per annum. (*Leishman*, Q. 24,334.)

299. In conclusion, then, we consider that an extension of medical benefit on the particular lines we have described could be provided for the whole of Great Britain, with its insured population of about 15 millions, at a cost (taking the maximum figures suggested to us) of about £1½ million a year. This is not a large sum in insurance finance. We are convinced that the results in the way of extending the scope of the medical diagnosis and treatment which the insured persons at present receive, and of spreading expert knowledge and modern methods among the general practitioners themselves, would fully justify the expenditure. As we have said, the money can be obtained by such a scheme of pooling as we have proposed. Accordingly we recommend that this addition be made available to all insured persons as an integral part of medical benefit under the Insurance Scheme.