CHAPTER XII.

CONSIDERATION OF CERTAIN MAJOR PROBLEMS.

327. Our proposals up to this point have absorbed the financial resources which we consider to be available for extensions of any magnitude, viz., the margin in the contribution not actuarially required to support the statutory benefits and the proceeds of the scheme for partial pooling of surpluses which we have proposed in Chapter IX. We now pass on to consider six questions of substantial importance. Some of these do not involve large financial considerations, others do; and where such large financial considerations are in question, we are for that very reason compelled to advise delay in making fundamental changes.

328. The six problems dealt with in sections of this Chapter, are as follows :—

SECTION A.—The extension and consolidation of the maternity services;

,, B.—The promotion of dental benefit to the status of a complete and generally available benefit;

,, C.—The provision of medical benefit to the dependants of insured persons;

,, D.—The transfer of the powers and duties of Insurance Committees to the Local Authorities;

,, E.—The improvement of the position of deposit contributors who cannot secure admission to Approved Societies; and

,, F.—The remuneration of the insurance practitioners and the machinery for dealing with complaints against them.

We take these problems in that order.

SECTION A—MATERNITY SERVICES.

329. In Chapter V we have considered at some length the general problems of a maternity service, especially on its medical side, and have reviewed the evidence which has been placed before us. We have indicated the direction in which we think such a service should develop so that on the one hand all the medical provision will become an integral part of a co-ordinated medical service; and on the other the money benefit will take its place among the cash provisions under whatever system of insurance is then in being.

330. At this point therefore we need only discuss what immediate modification might be made in the existing arrangements for maternity benefit were the necessary funds available. We have been much impressed by the need for something beyond the present relatively small cash payment in view of the great importance to the future generation of adequate supervision and maintenance at the time of childbirth.

331. A large volume of evidence has been directed to show that the sum payable as maternity benefit is almost entirely absorbed in the fees of the doctor or midwife and that very little, if any, money is left over for the other needs of the mother and child. We are inclined to think that the original conception of the benefit was something wider than this. At any rate we do not feel that the payment merely of the fee is an adequate content for a maternity benefit in a developed scheme of health services. And obviously if any expansion were contemplated regard would have to be given, even in any immediate changes, to the medical side of the Insurance Scheme and to the parallel activities under the Maternity and Child Welfare Schemes of the Local Authorities which we have described in Chapter IV.

THE WASHINGTON CONVENTION.

332. Our attention was directed by certain witnesses, including the National Association of Trade Union Approved Societies (App. XCII, 127-131; Q. 22,058 and 22,087 to 22,096) and Dr. Marion Phillips, on behalf of the Standing Joint Committee of Industrial Women's Organisations (App. C, 17-27; Q. 23,034 to 23,041), to the terms of the Maternity Convention adopted by the International Labour Conference held at Washington in 1919 under the provisions of the Covenant of the League of Nations. These were as follows :—

> "In any public or private industrial or commercial undertaking, or in any branch thereof, other than an undertaking in which only members of the same family are employed, a woman :—
>
> "(*a*) Shall not be permitted to work during the six weeks following her confinement.
>
> "(*b*) Shall have the right to leave her work if she produces a medical certificate stating that her confinement will probably take place within six weeks.
>
> "(*c*) Shall, while she is absent from her work in pursuance of paragraphs (*a*) and (*b*) be paid benefits sufficient for the full and healthy maintenance of herself and her child, provided either out of public funds or by means of a system of insurance, the exact amount of which shall be determined by the competent authority in each country, and as an additional benefit shall be

entitled to free attendance by a doctor or certified midwife. No mistake of the medical adviser in estimating the date of confinement shall preclude a woman from receiving these benefits from the date of the medical certificate up to the date on which the confinement actually takes place.

"(*d*) Shall in any case, if she is nursing her child, be allowed half an hour twice a day during her working hours for this purpose."

333. The witnesses urged that this Convention should serve as a model in considering the provision to be made for maternity in this country. We would point out, however, that the Convention is confined to women who are themselves engaged in industrial or commercial employment, while under the Health Insurance Scheme we have to consider not only these women but also those in domestic employment, and the vastly greater number of women who are not themselves employed but are the wives of insured men. As we shall show, our problem is an essentially different one from that which was before the framers of the Washington Convention.

Character of Maternity Benefit.

334. Both the Washington Convention and the Maternity and Child Welfare Schemes suggest to us that maternity benefit must in the present state of thought be considered in close connexion with the wider question of the provision to be made for women immediately before, during, and immediately after childbirth. It is not so much the money payment that is of importance as the question of taking steps to secure that every woman receives proper attention from doctor or midwife in suitable surroundings during a reasonable period centred on the confinement. In other words the character of the benefit should change from "cash" to "health" and it should be linked up with the other related health services. This is not to say that there should be no cash payment at the time of confinement. Such a payment is undoubtedly of value and will be utilised wisely by most mothers; but other elements must, we think, eventually be introduced.

335. The existence side by side of the maternity benefit under the Insurance Scheme, the arrangements made under the Maternity and Child Welfare Schemes, and the provision under the Poor Law illustrates the variety which characterises the existing National Health arrangements to which we have adverted elsewhere. In this instance we have three independent authorties administering in the same area schemes governed by different social and financial principles, but all attempting to solve the same problem—the assistance of the

mothers who in varying degrees do not or cannot meet their difficulties by purely individual effort.

The Medical and the Maintenance Elements.

336. It may at this point be of interest to submit some details of the cost of an extended maternity service which have been provided for our use. There are two main groups of elements which have to be considered. In the first place there are the medical services, with a cash payment to the woman to enable her to buy any necessaries and comforts incidental to the occasion. In the second place there is the provision of maintenance for the working mother and her child during a specified period before and after the confinement on the condition that remunerative work is given up during these periods.

Cost of the Medical Provision.

337. The average number of confinements in respect of which maternity benefit is payable is estimated to be 717,500 per annum, of which 517,500 are cases of uninsured women. The first of the new requirements would seem to be provision for medical examination, ante-natal and post-natal. An outside fee for these examinations would be 5*s*. each (10*s*. in all). It is open to argument whether, as regards insured women, these particular services are not to a great extent included within the scope of the medical benefit to which the women concerned are entitled, and are therefore covered by the obligation which at present rests on the insurance practitioner. For the purpose of our estimate we have treated them as new services, but this must not be taken as an expression of opinion on the content of the present medical benefit in relation to the class in question.

338. The second requirement is the provision of ordinary medical care during the period of pregnancy. Apart from attendances which would be necessary in all cases as part of the ante-natal treatment, the risk of ordinary attendances being required during pregnancy is clearly higher than it would be at other times. Even if the doctors were prepared to undertake this new service on a contract basis it cannot be assumed that they would be willing to accept payment on the basis of the ordinary capitation rate applicable to insured persons generally. The offer of free medical attention in the ante-natal period might be expected to result in consultation with the doctor regarding pregnancy at an earlier date than is otherwise usual. Assuming that on the average the doctor would be informed at the end of the second month, the payment on the basis of a capitation fee of 9*s*. a year would be 7/12ths of this amount, or 5*s*. 3*d*. But the present

capitation rate is based on an experience which shows that roughly half the persons entitled to medical benefit do in fact receive some attendance during the year. It would probably be contended that practically all pregnant women would require attendance at some period during their pregnancy (apart from any attendance for the purpose of examination) and that the doctor's obligation would be regarded as double the risk in ordinary cases. On this basis the fee for a general seven months' liability would become 10*s*. 6*d*. This charge would not arise in the case of insured women, since the service is covered by the present medical benefit.

339. The other medical service for which provision would have to be made would be the risk of the doctor being called in to attend at confinement in cases beyond the skill of the midwife. An estimate of a fair payment to cover the risk of having to attend at the confinement has been arrived at from information, obtained from Local Authorities, as to (1) the total number of cases in the areas of those authorities attended by midwives; (2) the number of these in which doctors were called in by the midwives, under the Rules of the Central Midwives Board, and a fee claimed from the authority; and (3) the total amounts paid in fees to those doctors. This, for various reasons, does not give the exact average cost, spread over all confinements, of the aggregate fees paid where doctors were called in. The data for a precise adjustment do not exist. But the margins of possible error are not great, and it may fairly be inferred that a charge of 2*s*. 6d. per confinement attended by a midwife would yield a fund sufficient to defray all the doctors' fees payable under existing conditions. Under a scheme of the kind under consideration, there would, however, be a large increase in the number of cases in which the doctors were called in, and to cover this increased risk of attendance a higher fee would have to be paid per case accepted. Probably 4*s*. would suffice, but to avoid an under-estimate it has been taken at 5*s*.

340. There remains to be considered the amount to be allowed by way of cash benefit. Though much general evidence on the question of the absorption of the present maternity benefit by the doctor's or midwife's fee has been received the figures supplied to us have varied within wide limits. The average fee now charged by midwives would seem to be about 30*s*. and the amount available for other purposes in the case of women entitled to only one maternity benefit would thus be about 10*s*. We feel, however, that this sum would be too small to be of much practical value and we could not recommend a lower cash payment than 20*s*.

341. On this basis the cost per case would work out as follows :—

	£	*s*.	*d*.
(1) Fee to midwife	1	10	0
(2) Fees to doctor for ante-natal and post-natal examinations (5*s*. each)		10	0
(3) Fee to the doctor to cover risk of personal attendance at confinement		5	0
(4) Cash benefit	1	0	0
	£3	5	0

And in the case of uninsured women only :

(5) Payment to doctor to cover other medical attendance during the ante-natal period, already provided for insured women as part of medical benefit ...		10	6

The total charge on this basis would be £3 15*s*. 6*d*. in the most common case in which the husband was working but the wife was not. Where, however, the mother was herself an insured person a portion of the liability would be covered by the existing medical benefit and the corresponding charge would be £3 5*s*. If both husband and wife were insured persons one set only of medical charges would arise, but a further 20*s*. would be appropriate as a cash payment in respect of the wife's own insurance and the total charge would thus be £4 5*s*. In this case also questions arise as to the apportionment of the charge between the husband's Society and the wife's Society. The adoption of this scheme would involve the abolition of the present incongruous arrangement under which in the case where the husband of an insured married woman is not himself an insured person her Society is required to pay to her a double maternity benefit.

342. We referred to the Actuarial Committee the question of the cost which would be involved in replacing the present maternity benefit by a provision on the lines indicated above and the matter is dealt with in the Third Report of the Committee which is printed in Appendix A to our Report. It will be seen that on the assumptions set out in the Report, the additional cost would be such as to impose a charge of ·44*d*. per week on the contribution payable in respect of men, while reducing the charge on women's contributions by ·11*d*. per week. If, therefore, the provision were limited in accordance with the proposals outlined above and further explained in the Report of the Actuarial Committee, and if this provision were made, the next charge on the margin in the present weekly contribution after meeting the balance of the cost of the present medical benefit, it would be possible to defray it out of the present resources of National Health Insurance.

343. We have given long and careful consideration as to whether we should recommend that this improved provision for maternity should receive second place in the extensions to be recommended by us, the first place having been allotted to the provision of a specialist and consultant medical service. We fully recognise the importance, in the interests of the health of the nation, of doing everything possible to insure that women should have skilled attention during pregnancy and childbirth, and we were impressed by the evidence submitted to us as to the failure of the present maternity benefit to effect any reduction in the rate of maternal mortality. Finally, however, we came to the conclusion that the second place in our recommended extensions should be given to the provision of allowances to the dependants of insured persons in receipt of sickness or disablement benefit, and that extended provision for maternity should be given the third place, with the result that it cannot be included in the extensions which will become immediately practicable under the financial re-adjustments which we recommend in Chapters VII and IX of our Report. It was with considerable reluctance that we arrived at this decision. Apart from the claims, on its own merits, of the proposal for giving allowances in respect of dependants, we were influenced by the consideration that it was of the utmost importance that any scheme for making better provision for maternity should be linked up in the closest possible way with the maternity and child welfare work of the Local Authorities. There might, therefore, be some advantage in refraining from change until the Local Authority has become (as we propose) responsible for the insurance medical service as well as the other public health services, and has had time to take stock of the position on both sides of its work and to familiarise itself with the new problems which will arise.

The Problem of Maintenance.

344. Turning now to the other aspect of the question as represented to us by witnesses, viz. : the provision of maintenance for mother and child, we have found some difficulty in arriving at a reliable estimate of the cost which would be involved and we foresee many difficulties in the administration of such allowances as are proposed. On this matter also we sought the guidance of the Actuarial Committee. In reply it was pointed out to us that the problem of intention to resume work must necessarily arise, and that calculations could not be made authoritatively until the method of dealing with that problem had been settled. The aim of the advocates of this part of a maternity scheme is to provide for the wage-earning woman so as to recompense her for the definite pecuniary loss incurred by her withdrawal temporarily from employment by reason of her pregnancy and confinement. The difficulty of determining whether or not a particular woman, who leaves her work some time before her confinement, has definitely given up her status as a wage earner lies at the root of the matter. Some test would have to be applied if the right to benefit depended on the settlement of the point. The choice of a test which is equitable and at the same time easy to apply has in similar circumstances in the past, e.g., in the original provisions of the 1911 Act relative to insured women giving up their work on marriage, proved to be so serious a difficulty as to have led to the abrogation of the system under which it arose, the right to benefit being now based on entirely different considerations

345. We have considered, as a possible way of meeting the difficulty of ascertaining "intention," a suggestion that the benefits should be paid at the confinement of every insured married woman, whether she was an ordinary employed contributor or in the special class (Class K), or in the ordinary free year's insurance following cessation of employment. Under this plan the benefit would be paid yearly to about 91,000 women in Class K and to about 94,000 women who were either employed or in the free year. The number in the free year is probably relatively small. The suggestion then comes to this, that in order to pay about 90,000 women, who are normally working so as to induce them to stay away from work before and after confinement, payment would also have to be made to at least 90,000 other women who have recently married and in whose case the presumption is that they have entirely given up work. We do not think that such a result can be contemplated. In the circumstances we have not felt justified in asking the Actuarial Committee to proceed further with the subject.

346. To one general point we may in conclusion refer. It would appear open to question whether in practice the benefits of this type could be, for long, limited to employed women. It seems not unreasonable to assume that following the adoption of such a scheme for the wage-earning mothers there would spring up an immediate and insistent demand for the extension of the benefits—or at any rate a part of them—to all mothers irrespective of any question of employment. Such a demand would be peculiarly difficult to resist. It would be urged—and with good reason—that the home-keeping mother was as deserving of the assistance of the State as the woman who had continued in industrial employment. The contrast between the position of the home receiving two sets of wages and the maintenance benefit with that receiving only one set of wages would be too marked to escape criticism. And if such criticism led to the extension of the provision to all mothers, the cost would at once be enormously increased and an expenditure of £6 to £8 millions a year, for maintenance alone, might have to be contemplated.

347. This consideration is in our opinion sufficient in itself to render impracticable for the present the suggested modification of the existing provision for maternity in the direction of providing for the maintenance of the mother and child; and, taken in conjunction with what we have said above as to the provision of medical services during pregnancy and confinement forces us to the conclusion that for the present the existing arrangements for Maternity Benefit should in their general outline remain unchanged.

SECTION B.—DENTAL BENEFIT.

348. Dental benefit is, as we have pointed out in Chapter V, one of the most popular, if not the most popular, of the additional benefits, and as such it is available in some form or another to large numbers of insured persons. The membership of all the Societies and Branches in England which provide this additional benefit reaches a total of about 10,700,000. The desirability of making it a normal benefit under the Act, available under uniform conditions to the whole insured population, has been urged upon us from many quarters, and much evidence, a summary of which has already been given in Chapter V, has been submitted to us by responsible professional and lay witnesses. The advantages to general health and the consequent beneficial reactions upon the benefit funds have been specially pressed upon our notice. Nevertheless we do not propose to recommend that any substantial change in the present arrangements should be made in the near future. It is therefore desirable that we should examine this problem at some length to justify the conclusion we have arrived at in the face of so much evidence.

349. It is mainly the question of cost which has caused us difficulty in this matter and to that we will now turn. The evidence received from such Societies as have given Dental Benefit and from the professional bodies suggests that the cost of this benefit on a complete basis would be—in the initial period and before the accumulation of dental defects has been overtaken—in the neighbourhood of 5*s.* or 6*s.* per annum per insured person. (See, e.g., *Hearts of Oak Benefit Society*, Q. 3553-3558; *Gordon*, Q. 7727; *Joint Committee of Approved Societies*, Q. 8725; *National Insurance Beneficent Society*, Q. 8828; *British Dental Association*, Q. 9246-9247; *British Society of Dental Surgeons*, Q. 9487, 9519-9521, 9566-9578; *United Women's Insurance Society*, App. XXIV, 38-39, 51; Q. 10,284, 10,287-10,291; *Brock*, Q. 23,939; *Leishman*, Q. 24,381-24,386.) In fact the Scottish Board of Health put the cost as high as 7*s.* 6*d.* per insured person per annum. In view of the heavy annual cost thus foreshadowed we have thought it well to invite the Ministry of Health to give us more precise indications not only of the cost, but of the scope and administrative arrangements of such a service.

Cost of a Statutory Dental Benefit.

350. The cost of providing a dental service for all insured persons cannot we are told be determined with any precision because of the impossibility of estimating accurately the number of persons who might apply for treatment. It is generally agreed that the dental condition of the industrial classes is deplorable. The proportion of insured persons needing some form of dental treatment is put at from 60 per cent. to 80 per cent. of the total. The precise figure, however, is not material, even if it were exactly ascertainable, since the important point in framing any estimate is not the number of persons who need treatment, but the number who would be likely to seek it. This must be a matter of conjecture, but it is material to note that the demands on Approved Societies which have provided dental treatment as an additional benefit have shown a marked and continuous increase. With an unrestricted dental service, open to all insured persons without any contribution being required from patients, it would, we are told, not be safe to calculate on less than 5 per cent. of the total insured population applying for treatment in a year. We understand that the percentage of members eligible for the existing Dental Benefit who apply for treatment is about 4 per cent., but allowance must be made for those who are deterred from applying by the knowledge that they will have to bear part of the cost. In the case of the United Women's Insurance Society the proportion of applicants has been as high as 9 per cent., a figure which is significant in view of the long experience of this Society in the provision of dental treatment. (App. XXIV, 22-51.)

351. The other item in estimating the cost of a dental service is the cost per case treated. It is clear that the majority of persons now applying for treatment need dentures, and until the present arrears have been worked off, which would take some years, the proportion of denture cases is bound to be very large. The inevitable result is that the cost per case treated is high. In the initial period it would not be safe to estimate the average cost per case at less than £4, and it might prove to be nearer £5, on the basis of the present scale of the Public Dental Service Association. It is possible, though by no means certain, that some saving might be effected by the adoption of a system of remuneration based upon the time given to the work in preference to one based on a scale of fees for services rendered.

352. Accepting for the moment the estimate of 5 per cent. of insured persons applying for treatment in each year at an average cost of £4 per case, estimates which are probably on the low

side, it follows that an unrestricted non-contributory dental benefit would cost at least 4*s*. per insured person per annum, which is the equivalent of a penny contribution. If the percentage of applicants exceeded 5, as in course of time it probably would, or the average cost per case exceeded £4, as in many areas it does at present, the total cost of a "100 per cent." service would exceed the equivalent of a penny contribution.

353. The establishment of a complete dental service for the insured might, as we have said, be followed sooner or later by a reduction in the expenditure on sickness and disablement benefits, which would to some extent be a set off against the new expenditure. But this is a wholly conjectural factor, and no effect can be given to it for the purpose of framing actual estimates.

Methods of Restricting Liability.

354. If an unrestricted service is too costly under present conditions, the question arises whether the liability could be limited. In examining possible methods of limitation we have to weigh the ultimate gain in the improved dental condition of the insured people against the claim to immediate relief of those actually suffering in health owing to neglect of the teeth. From the medical point of view there are obvious advantages in concentrating on the treatment of young persons and in spending the money on conservative work. But such a policy is not likely to be acceptable, since it does nothing for those older persons whose mouths are in such a condition as to produce digestive and other disorders resulting in present suffering and, what is important as an insurance consideration, consequent demands on the benefit funds. The two conflicting points of view might possibly be reconciled by making no charge for conservative and operative treatment, but requiring the insured person to contribute a substantial proportion (say 50 per cent.) of the cost of dentures. Such a proposal is open to the obvious objection that it would tend to exclude the most necessitous of the insured population who need dentures and who could not afford £2 or £3 towards their provision. (See *Brock*, Q. 23,943.) This difficulty might, to some extent, be met by allowing Societies some discretionary power in cases of proved need to contribute the balance as an additional benefit. We recognise that such discretionary benefits are difficult to administer and are liable to abuse. But it does not seem to us impossible to devise tests which would afford at least a partial safeguard against administrative abuses. No restricted service can ever be quite satisfactory, but the restriction we have suggested seems to us least open to objection.

355. An alternative method of limitation would be to make the benefit recommendatory and to leave the selection of cases to the Insurance Committees or their successors, on the basis

of some general rules which would determine the order of priority. A recommendatory benefit is open to the administrative objection that it creates expectations which can only be partially fulfilled and is, therefore, likely to give rise to a continuous agitation for increased financial provision.

356. But, apart from the administrative or social objections, the proposal seems to us open to criticism on medical grounds. The fundamental difficulty is that the selection has to be made by lay administrators on the basis of reports by doctors who are each reporting on their own patients and necessarily can have no opportunity of considering the cases in relation to one another. It must in practice be extremely difficult for any committee, even with expert guidance, to arrive at any true estimate of the relative needs of a number of cases on the basis of reports which in the nature of things cannot be relative. Further any system of priority must tend to give a preference to the cases in which the need for treatment is most obvious because they have been so long neglected. In practice it would mean that most of the money would be spent on the treatment of "end-results," and however long such a scheme remained in operation the dental state of the younger insured people at the end of the time would be nearly as bad as at the beginning.

357. So long as Approved Societies are administering an additional benefit with only a limited amount of money available, the selection of cases on the basis of urgency is justifiable, and Societies could not be blamed for adopting the method of selection which promises most immediate reduction of their sickness benefit claims. But the establishment, as a permanent part of the insurance system, of a dental benefit which made no provision for conservative treatment would be open to grave criticism. Theoretically this difficulty could be avoided by a suitably devised table of priority, but in practice this would be very difficult to frame, and the tendency of any system of selection must be, as already explained, to concentrate the expenditure on the cases least hopeful from a medical point of view. It has to be remembered also that a statutory benefit is judged by a standard very different from that applied to additional benefits. An additional benefit is in the nature of a windfall; it is better than nothing, and the insured person thinks himself lucky to get it. But a statutory benefit is on a different footing, and is subject to far more critical scrutiny. A selective benefit which makes no adequate provision for the treatment of early cases would be in our opinion a most unfortunate policy to adopt.

Cost of a Restricted Service.

358. As already indicated, an unrestricted dental service could not be provided for less than 4*s*. a head per annum. Indeed, it

would probably not be safe to attempt to provide such a service if the amount available was less than 6*s*. While we do not anticipate that the cost would be as high as 6*s*. at first, it might easily approximate to this as insured persons become better acquainted with their rights and realise the advantages of dental treatment. But we think that the restricted service we have suggested could be provided at the outset for about 3*s*. a head if the insured persons were required to contribute half the cost of dentures. A contributory scheme would reduce the number of applications, and the saving on denture cases would be considerably more than the amount contributed by the insured persons. But if the sum which it will ultimately be found possible to set aside for this purpose proves to be less than 2*s*. 6*d*., it would not in our opinion be desirable to attempt to provide a general dental benefit. A dental service costing less than 2*s*. 6*d*. a head would not be worth offering. The restrictions necessary to keep the cost within any lower limit would make the benefit irritating and to a large extent illusory. Treatment would tend to become a matter of chance rather than of right.

359. An alternative suggestion, which has much to commend it on medical grounds, would be to provide all conservative and operative treatment free but to leave dentures to be paid for by the patient or to be provided by the Approved Societies as an additional benefit. Such a dental service would be of great value to the younger insured persons and would not be costly to provide; but a benefit which fails to provide the one form of treatment which the older insured people desire is not likely to be welcomed and we have not made any attempt to estimate the cost on this basis.

Method of Payment of Dentists.

360. If dental benefit were to become a normal benefit the question of the method of payment of the dentists might arise as a more important issue than it does at present. With the precedent of the success of the capitation method in medical benefit before us, we thought it desirable to examine witnesses on this point. Mr. Brock, in reply to Q. 23,952, stated that "dental benefit does not lend itself to payment on a capitation basis at all. To begin with, there are no sufficient data available on which you could calculate a capitation rate, and if the adoption of a capitation system were proposed to the dentists they would be tempted naturally to insure themselves by demanding an excessive rate." He goes on in the same reply to cite other objections of a fundamental nature, and adds that there are really only two practicable methods of payment, one the attendance basis with an agreed scale specifying the fee for each separate kind of service, and the other, payment

by time at so much per session. The latter method is difficult of application, except where a clinic is established. The former is difficult to administer economically unless estimates are submitted in advance and some system of inspection and supervision is provided.

General Conclusions.

361. Reviewing all these considerations, we come to the conclusion that no change should be recommended at present in the main provisions for dental treatment. A complete dental service would be eminently desirable. But it would cost about £4½ millions a year, or 1½*d*. on the contribution. A partial service has, as we have indicated, many defects and difficulties, medical as well as administrative. Any reasonable partial service would cost about £2¼ millions a year. Even this smaller sum is not available within the present financial limits after provision has been made for those two extensions of benefit already described, which we think should rank higher in order of priority. Quite apart from financial considerations, there are indeed grounds on which it might be suggested that delay in this matter may not be wholly disadvantageous. The benefit, administered as an additional benefit, is still in an experimental stage, and much may yet be learned from further experience of its operation in its present form. On such questions as those of the cost involved, the reaction of dental treatment on health, possible methods of organisation and control, there is room for greater and more accurate knowledge than we possess at present; and it might reasonably be held that, in a matter of such great moment, we shall have a better prospect of building securely in the future, if meanwhile we are content to wait until a somewhat fuller experience has been gained. In the varied system of provision of dental services as an additional benefit by numerous Approved Societies a useful arena for such experiment is given. Under these schemes 3,485 Societies and Branches in England, with a membership of about 10,700,000 insured persons, provide some form of dental treatment, and this number will certainly be increased when all the schemes under the second valuation become operative. In refraining from recommending dental treatment as a normal benefit, we are by no means leaving the insured persons without any provision at the cost of the insurance funds for the care of their teeth. Moreover, we consider that it is not irrelevant to the question before us to observe that the Dental Profession, consequent on the passing of the Dentists Act, 1921, is at present in a state of transition, and it might accordingly be suggested on various grounds that the present is an inopportune moment to inaugurate a comprehensive scheme of dental benefit administered universally as a normal benefit under arrangements made by the Central Department on lines similar to those which govern medical benefit.

A Regional Dental Staff.

362. But we should be sorry to leave this question without making any practical proposals at all. And we do make one now which we consider will have beneficial effects on the somewhat varied collection of additional benefit schemes for dental treatment. We refer to the institution of a Regional Dental Staff. No insurance dental service can, we are told, be satisfactory without effective supervision, especially over the quality of materials and standard of workmanship used in dentures. (See *Brock*, Q. 23,952.) In the experience of the Ministry of Pensions we understand that in one pension area 35 per cent. of the cases examined were stated to be unsatisfactory. This did not mean that 35 per cent. of all the work done was unsatisfactory, since the cases examined included all those in which any complaint had been made by the patient.

363. A Regional Dental staff would be responsible for the examination of all estimates, and would actually see a proportion of the cases after treatment was complete. The proportion of cases seen need not, apart from complaint cases, be large. The value of such a system of inspection is to a great extent psychological, and the effect is due to the knowledge that any particular case may come under scrutiny.

364. It is clear to us that if dental benefit is eventually made universal, a system of regional officers would be essential for its successful operation. If, realising the larger alternative, dental treatment were to become one element in a general health service for the whole population, some such arrangements would be equally necessary. But even at the present stage of additional benefits there would be a real value in establishing a partial system of control which could naturally develop into the fuller scheme. In fact, just because the present system is so varied in its methods and provision, it may be held that some such control is specially needed.

365. As to cost, we have received from the Ministry of Health an estimate for a Regional Dental Service, on the assumption of dental benefit being universally available on uniform terms. Twenty-one Regional Dental Officers are suggested, each with a clerk, and all under the control of a chief inspector at headquarters. With due allowance for travelling expenses, office accommodation, &c., the cost is estimated at £31,000 a year. For the service under present conditions the cost would be substantially less. We have not received an estimate for such a limited provision, but even if it approached the above-mentioned figure we would recommend the expenditure as a very desirable means of improving the present service. As the activities of the Regional Dental Service would in very considerable measure tend to protect the expenditure of the Approved Societies on additional

benefits, and as the greater efficiency of the treatment would in the long run tend to conserve the Benefit Funds, we think it only fair that a substantial proportion of the cost of the Regional Dental staff, if it is established, should, as in the case of the Regional Medical staff, be borne by the Approved Societies concerned.

SECTION C.—EXTENSION OF MEDICAL BENEFIT TO THE DEPENDANTS OF INSURED PERSONS.

The Question of Cost.

366. Two important and independent considerations arise when we approach this problem. In the first place there is the question of cost, which on any reasonably safe assumptions must be very considerable and must necessarily at this stage be dependent upon a number of factors difficult to estimate with any accuracy.

367. The terms upon which the medical profession would be prepared to undertake the service would necessarily have to be a matter of negotiation, and it might happen that if an initial rate were agreed actual experience might lead to a demand for its revision. Such an extension of medical benefit would bring in two classes of persons who require to be considered separately, (1) the uninsured wives of insured men, and (2) children up to the age of entry into insurance. Broadly speaking, married women may be expected to require more attendances than the average of insured men. Children up to the age of about three would also require more attendances than men; but children from three to sixteen would probably require considerably less, partly because many of the ailments of most frequent occurrence during school ages are those for which provision is made through other Health Services, e.g., infectious diseases and the minor ailments dealt with by the School Medical Service. In any event, the doctors would not have to undertake any certification duties in the case of dependants.

368. From investigations made by the Ministry of Labour it would appear that for every insured man the number of dependants is on the average 1·5, and for every insured woman ·15, making the total number of dependants 15¾ millions, or slightly more than the total number of insured persons. We may divide these dependants into the two groups indicated by the conclusions in the preceding paragraph (1) children above the age of three, and (2) children under the age of three and uninsured married women. In the former group the amount of medical attendance which would be required would be less than the average for insured persons generally, while in the latter it would be more. On the whole, it would not be unfair to assume that the doctors could afford to take the risk of all the dependants at the present

capitation rate, the extra attendances required for the latter group being set off against the fewer attendances required by the former. The present cost of medical benefit in Great Britain is about £9,000,000 a year, and on the assumptions indicated above the extra cost of extending benefit to dependants would be about £9,500,000 a year.

369. This is a very large sum, and one which far outruns any margin in the present contribution. Even if on other grounds it were felt that this extension merited the first place in the order of priority, the cost appears to us to be prohibitive having regard to our general views on the financial position. An addition of £9,500,000 to the charges on the Benefit Funds would mean an addition of between 2*d*. and 3*d*. to the weekly contribution even supposing that a corresponding addition to the State grant would be forthcoming. Such large expenditure cannot, we think, be contemplated in present circumstances.

370. But quite apart from cost, there are certain general considerations of policy which lead us to the conclusion that this extension is undesirable if it were proposed within the ambit of the present Insurance Scheme. Before we proceed to examine this matter we may give a short summary of the evidence we have received on the question.

Points raised in Evidence.

371. The Loyal Order of Ancient Shepherds (App. XLIV, 35) urge the provision of medical benefit to the dependants of insured persons and are of the opinion that this could be made a first step towards the establishment of a Public Medical Service. They express the view that insured persons would be willing to pay an increased contribution to meet the cost of this benefit. The Independent Order of Rechabites (App. VIII, 30; Q. 6310) think that the provision of medical benefit to dependants would be a distinct advantage to public health and would tend to remove the overlapping which at present exists between the Public Health Services. The Coventry Insurance Committee (Q. 12,299-12,300, 12441-12,442) state that the effect of the non-provision of the benefit to the dependants of insured persons is to set up different standards of health in the community. The Cheshire Insurance Committee (App. XXXIV, B, 21-24; Q. 12,626-12,630) suggest an increase of the contribution for the purpose of providing medical benefit to dependants. The British Medical Association (App. XLVII, 13-15; Q. 14,843-14,876, 14911-14,913) suggest that medical benefit should be available only to persons with less than a certain income, and that if this income limit is fixed sufficiently low the dependants of such persons should be included. Mr. Cohen (App. LXXVI, 6-7) urges the provision of the benefit, and points out that "the burden of the illness of a wife or child, borne as it is by the workmen's wage, has in effect the same influence in reducing his standard of living as similar expenditure resulting from his own illness." The National Association of Trade Union Approved Societies (App. XCII, 100; Q. 22,052) suggest the inclusion of dependants in the extended medical benefit which they propose, and submit that "in the average home medical attention and treatment is more often required by the mother and children than by the man. If, therefore, it is considered necessary to protect the worker against the cost of medical services for himself, it is more necessary to protect him against the heavier risk."

Considerations of Policy.

372. Our conclusion on this problem (irrespective of the financial considerations) may, we think, be inferred from certain parts of Chapter V, and here we need not go into any great detail. Briefly, we consider that medical provision for dependants should form an integral part of any scheme of general health services, administered by the Local Authorities. Whether a contribution to such provision is to be made from insurance funds or not, the fact remains that medical service for dependants is too large a problem to be considered apart from medical service for the whole working-class and, perhaps, middle-class population. If the dependants of the present insured population are brought into the system of medical benefit, the residue of the working-class population is relatively small, and that residue may be still further reduced by the proposals for dealing with the destitute poor which are now under the consideration of the Government. Further, one effect of including the dependants in the medical service of the present Insurance Scheme might be to impede or postpone any ultimate unification of health services. If this were so, we should all the more be inclined to pronounce against medical benefit for dependants at the present time. We may quote Mr. Brock's reply to Q. 23,847 in this connexion: "If a complete medical service, short of institutional treatment, is going to be provided for insured people, of course, it must emphasise the anomaly that at present their wives and dependants can only obtain such medical treatment as they are able to pay for. But it does seem to be open to question whether the better way of providing for dependants is through a system of insurance which must necessarily exclude a certain number of people . . . If it was proposed to provide either a general practitioner service or a complete medical service for the whole industrial population, there are strong arguments in favour of providing this service out of local funds and making it available to all sections of the population . . ." Later he states: "Extension of medical benefit to dependants would be less logical and probably less satisfactory than the establishment of a public medical service at the expense

of local funds." (Q. 23,992.) We also note that Mr. Alban Gordon, who is, at any rate, no reactionary in these matters, has very definitely recommended to us this point of view. He says (App. XIII, 56) :

> " I should, indeed, consider the mere extension of medical benefit to dependants of insured persons as a retrograde step, since it would stereotype the present system so deeply as to render it far more difficult to bring into existence at any future date the co-ordinated medical service which the health of the country so urgently needs."

And the National Conference of Friendly Societies, representing those who have for generations carried on the movement for help through insurance, are equally definite. They say (App. XXVI, 35-37) :

> " 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 shopkeepers, &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."

373. When a body representing about 4 million insured persons urges these views upon us, we can hardly be accused of disregarding the interests of the insured population if we exclude, as we do deliberately, the provision of medical benefit to dependants from our immediate recommendations on the Insurance Scheme, and suggest that the matter should be left over to be considered in connexion with any wider proposals for reorganising the health services of the community which may commend themselves to later students of the problem.

SECTION D.—INSURANCE COMMITTEES.

Successful Work of the Committees.

374. We have already mentioned in Chapter V our conclusion as to the disappearance of Insurance Committees not only as part of any future arrangement for the co-ordination of the Insurance Medical Service with other health services, but also as an element of the present Insurance Scheme. As these bodies have played a very important and successful part in the provision of medical benefit during the last 13 years, we must necessarily devote some space to the justification of their proposed demise. We desire to state at the outset that we have had no evidence of failure on the part of these Committees or their officers to perform adequately the task which they had to undertake. On the contrary, their work has been done with a notable degree of success and we have received many tributes to the zeal and thoroughness which have characterised it. For example, Mr. Brock, giving evidence on behalf of the Ministry of Health, states (Q. 23,974) : " But I should like to add that, whatever may be the shortcomings of Insurance Committees as part of the machinery of local government, that is in no way traceable to any failure on the part of their staffs, and I should like to put it on record, if I may, that the clerks to Insurance Committees, with very few exceptions, have carried out their duties, without any precedents to guide them, extraordinarily well, and I think we owe to their work a great deal of such measure of success as has been achieved in the very difficult task of accustoming 12,000 or more doctors to that degree of supervision that participation in the public service implies. The Insurance Committees' staffs have done their work exceedingly well, and I want to make it quite clear that, while I cannot dissent from the general criticism of Insurance Committees, I do want to pay my tribute to the efficiency of the work of their staffs." Sir William Glyn Jones, to whose vigorous recommendations that Insurance Committees should be abolished we shall refer later, in reply to the question (Q. 24,420) whether the officials of the Committees had carried out in an efficient manner the duties falling upon them, replied " Undoubtedly, I think the officials have done extraordinarily well." Again the same witness did not consider that the present position was " due to any slackness on the part of the Insurance Committees themselves or their officials " (Q. 24,402). We would also refer to

the account of the Administration of Medical Benefit given in Section C of Appendix I submitted by the Ministry of Health. There will be found a full official account of the successful administration during 13 years of a very complicated system—and part at least of that success must be attributed to the local administrative bodies. The British Medical Association, representing the bulk of the doctors who are in contract with the Committees and in daily touch with their officials through the administration of medical benefit, make no adverse criticism of their performance and many Societies express themselves as thoroughly satisfied with this part of the machinery.

Two Reasons for Abolition.

375. If, then, medical benefit has been a success, and if the Insurance Committees have been responsible for its local administration, the question may well be asked, Why abolish these bodies? To this we shall attempt to give a two-fold answer. In the first place unification of local effort on health services is, as we have indicated in Chapter V, a consideration that should, in our view, be paramount whatever the success of the isolated pieces of machinery which now exist. In the second place the evidence we have heard convinces us that whatever may have been the position at the outset and whatever the aims of the framers of the Act, in real fact these Committees have not now sufficiently extensive or sufficiently important duties to justify their existence as independent administrative bodies. In 1912, when the Scheme was launched, much may have been gained from the impetus and interest which might be expected from specially constituted bodies. But that stage is long past. The duties are now of a routine character and could equally well be performed by the same officials working under the control of the Local Authority.

376. To the first of these considerations—the need for unification—we need not here devote any space as the principle has been fully discussed in Chapter V, and does indeed, we believe, command general acceptance. We therefore immediately turn to the second consideration and inquire what, in fact, is the present work of an Insurance Committee and what are the views as to the future of these bodies placed before us by critical witnesses. For a full description of the powers and duties of Insurance Committees we may refer to the Ministry of Health statement (Section C of Appendix I), to the evidence of the Federation of Insurance Committees (App. XXXVI) and of the Scottish and Welsh Associations of Insurance Committees (Apps. XXXVII and XXXVIII respectively). These are descriptions of the general system. For a picture in closer perspective of the routine work of, on the one hand, an urban Committee, on the other of a county Committee, we would refer to the statements supplied by the London Insurance Committee (App. XCVIII) and the Cheshire Insurance Committee (App. XXXIV). We will here attempt to give in broad outline an account of that work.

The Work of Insurance Committees.

377. Insurance Committees, of which there are 128 in England and 17 in Wales, were constituted for every County and County Borough. Three-fifths of the total membership of each Committee are appointed so as to secure representation of the insured persons resident in the area of the Committee. One-fifth are appointed by the County or County Borough Council. Of the remaining fifth two are medical practitioners appointed to represent the medical practitioners in the area, one is a medical practitioner appointed by the County or County Borough Council, and the others are appointed by the Minister. In Scotland there are 54 Committees constituted for the Counties and for the Burghs of 20,000 population and over, and the membership is allocated in very much the same way as is described above.

378. It will be seen that the object of the somewhat complicated arrangements for the membership is to secure majority representation for the insured persons; and at the same time affiliation to the Local Authority in its general aspects, to the Local Authority in its medical aspects, and to the body of practitioners in the area; and to include a small element deriving authority from the Central Departments.

379. Originally the Committees in England consisted of from 40 to 80 members, but in the interests of economy these numbers were reduced to one half by the Act of 1921. In Scotland, however, the original numbers were retained. Normally, members of Committees hold office for three years, but the Committees themselves are corporate bodies with perpetual succession. The number of insured persons for whom the Committees severally are responsible varies very widely. In England, at one end of the scale is the Scilly Isles with 375, and Rutlandshire with 6,000; at the other, London with 1,700,000.

380. The work of Insurance Committees may be broadly classified under the following five heads:—

(1) the arrangements for medical benefit;

(2) inquiries into complaints arising from the provision of medical benefit, including the supply of drugs;

(3) inquiries into the causes of excessive sickness in the area of the Committee and the consequential affixing of liability;

(4) propaganda as to health by means of lectures, leaflets, &c.;

(5) administration of the cash benefits of certain special classes, viz., deposit contributors and members of the Navy, Army and Air Force Insurance Fund.

381. Sanatorium benefit was, until 1921, administered by the Insurance Committees, but in that year was discontinued, the responsibility for the institutional treatment of tuberculous insured persons being transferred to the Local Authority, which already dealt with the uninsured, and the responsibility for domiciliary treatment remaining part of the content of medical benefit.

Medical Benefit.

382. Taking the above five points in order, we have first to consider medical benefit. The normal arrangement by which medical benefit is made available to insured persons is that the Insurance Committee form a list of the doctors and a similar list of the chemists in the area who are willing to treat or to provide medicines for insured persons at a scale of remuneration and under conditions agreed upon by the Committee subject to the approval of the Minister. It was originally intended that these contracts should be framed locally, and that they might vary considerably in nature according to the particular conditions of the several areas. It was found, however, that in practice the whole of the arrangements leading up to the contracts had to be made centrally by discussion between the Departments and representative bodies of practitioners and chemists. The terms so agreed form the basis of the local contracts throughout the country. Local modifications are of a comparatively unimportant character (App. I, C, 35-36).

383. Thus what might have been a very responsible and difficult piece of work has in fact so far as the Insurance Committees are concerned, been reduced to a routine capable of being performed by the local officials under a minimum of supervision by the Committees. The really responsible part of the duty is performed by the Central Departments. And once the lists are drawn up and the contracts signed, what remains for local action is merely the keeping of the index register up to date, keeping similarly the list of insured persons for whom each doctor is responsible, calculation and issue of the periodical payments to doctors and chemists and issue of the medical cards—all of which are essentially matters of machinery.

384. Another matter under this head in which the work of Insurance Committees has been substantially curtailed by the force of circumstances is the pricing of chemists' prescriptions. Originally it was intended that each Committee should do this work for its own area. But in consequence of the uniform tariff agreed upon centrally, it was found much more convenient and much more economical to set up " Pricing Bureaux " to do this work on a uniform method for large areas of the country. In England and Wales there are 15 of these bureaux; in Scotland one for the whole of that country. The duty of the Insurance Committees in this matter is thus reduced to the routine operation of sending the prescriptions to the bureaux and, on their return, making out the cheques.

Complaints.

385. The procedure for dealing with complaints does raise matters of some moment. A judicial function has to be performed and members of the Committees are called upon to take their part in this. As a complaint may lead to the institution of a Court of Inquiry by the Minister and the finding of that Court may involve the removal of a doctor or chemist from the panel it is obvious that important issues are involved. Indeed it is in this part of the work that we find the only really substantial element in the Insurance Committee's work. We refer to paragraphs 40-49 of Appendix I, Section C, for a description of the procedure for dealing with complaints, and to paragraphs 55-56 of the same Appendix for an account of the procedure for removing practitioners or chemists from the lists.

386. The problem of complaints is, as we have said, important in character. If it were large in volume there might be some justification for continuing the Insurance Committees on this score. But it is not large in volume. In the evidence of Mr. Brock we find (Q. 1070) that the total number of complaints against insurance practitioners which have been investigated by the Medical Service Sub-Committees of the Insurance Committees between 1st April, 1920, and 31st October, 1924, was 1,819 for England and Wales. Of the 1,819, 735 resulted in the doctor being acquitted or the case not substantiated. But taking the total, the number of complaints against doctors per Committee per year is rather less than 3. Even when the complaints against chemists are added (and they are, we understand, equally insignificant in number) it cannot be said that there is here justification for a specially constituted body. We have to bear in mind that the inquiry is not made in the first instance by the Insurance Committee itself but by a specially set up Sub-Committee which reports to the Insurance Committee. Such an investigating committee could, we think, equally well be set up by the Local Authority.

387. Of course, the number of cases of complaints dealt with by an Insurance Committee, though small on the average, may be substantial in the larger urban areas. In London, for example, the number of cases against practitioners dealt with in 1923 was 104 and about 40 cases against chemists arose in the four years 1920-1924. (*London Insurance Committee* App. XCVIII, 31, 48.) The Medical Service Sub-Committee is in this case, no doubt, kept fairly busy. But such a Committee could equally well be appointed by and report to the general Local Authority.

Inquiries into Excessive Sickness.

388. Very high hopes were founded on Section 63 of the Act of 1911 (Section 107 of the 1924 Act) which deals with excessive sickness; but in fact the section has remained a dead letter.

389. We deal in Chapter XIII with the reasons for this, and offer certain suggestions intended to make more practicable the aims of the section, even if on a less ambitious scale. So far as Insurance Committees are concerned, the section would only have had application in respect of deposit contributors, and the problem would therefore have been of small magnitude. But in any case nothing has been done, so that no argument for the continuance of Insurance Committees can be inferred from the existence of this provision.

Health Propaganda Work.

390. Section 50 (1) (*b*) of the 1924 Act empowers Insurance Committees to make such provision for the giving of lectures and the publication of information on questions relating to health as they may consider desirable. It has, however, appeared in evidence given before us that only a very restricted use has been made of this power, owing mainly to lack of funds. (*Brock*, Q. 23,976.)

391. We feel that work of this nature may be made of the greatest possible value in the public efforts to promote health. But in our view it is open to question whether such work, undertaken in the interests of the health of the whole community, should be financed only from insurance funds. We think that duties under this head would more appropriately fall within the province of the local health authority. And our view is reinforced by the opinion of the official witness of the Ministry of Health, Mr. Maclachlan, who said: "Until quite recently the powers of local authorities in regard to Public Health propaganda have been very limited. That defect has been remedied by the Public Health Act of 1925 which has just passed through Parliament, and which gives pretty wide powers to all local authorities to undertake education and progaganda in relation to the prevention and treatment of any disease." (Q. 24,143.) If our conclusion is accepted, it is obvious that still another branch of the work of the Committees would disappear.

Deposit Contributors and Navy, Army and Air Force Fund Members.

392. Lastly, we have to consider the work done by the Committees in connexion with the cash benefits of deposit contributors and members of the Navy, Army and Air Force Insurance Fund. This is the merest routine (*Kinnear* and *Brock*, Q. 23,981-90). A list of the deposit contributors of the area has

to be maintained, but the accounts are all kept by the Central Department and the calculations of the benefit due are also made there.

393. Similarly, in connexion with the administration of the benefits of the members of the Navy, Army and Air Force Insurance Fund, there is nothing that in fact calls for control by a large body of the type of an Insurance Committee.

Points from the Evidence.

394. With this review of the work of Insurance Committees before us we may now turn to what witnesses have to say on the matter.

395. Taking first the evidence which we received from certain of the Insurance Committees themselves, we were informed by the Coventry Insurance Committee (App. XXXIII, 30; Q. 12,240, 12,226-12,273, 12,305-12,316) that they had no wish to perpetuate these bodies as they are at present constituted and with their present limited functions, but suggest that "the Insurance Committees' current organisation is such that it can immediately and with considerable economy be utilised for extended administrative work, or brought into organic relationship with the local authority." The Cheshire Insurance Committee (App. XXXIV B, 40-50; Q. 12,454, 12, 457-12,458, 12,513) state that the Insurance Committee is truly representative of local interests, and feel that "to scrap the machinery of Insurance Committees or to make it a subsidiary part of a greater machine would be disastrous to insured persons," and they call for the continuance and enlargement of their duties. The Leicestershire Insurance Committee (Q. 12,663-12,665) maintain that the Committees are in close touch with insured persons and are familiar with local conditions, and they express the opinion that the District Councils and County Councils would not be prepared to take over the work as they are already overburdened. The view expressed by the British Medical Association (App. XLVII, 46-47) is that "the local administration of all health services should be in the hands of a local authority established *ad hoc*," and the Association suggest that a unification of medical services such as they contemplate would involve the disappearance, as such, of Insurance Committees. The Retail Pharmacists' Union (App. LXV, 82; Q. 18,091) recommend the retention of the present method of administering medical benefit through Insurance Committees. Mr. Alban Gordon, who speaks from some practical experience, as he was Clerk to the Coventry Insurance Committee in 1912, a member of the London Insurance Committee from 1913 to 1921, and a member of the Brighton Insurance Committee during 1924 and 1925, states: "The continued existence of Insurance Committees with their present

limitations is, except for one single function, a pure farce. That exception is the Medical Service Sub-Committee, which performs useful work. Apart from this, however, it is impossible to see anything whatever for the Insurance Committees to do that could not be equally well accomplished by a subordinate official in the local Public Health Office" (App. XIII, 21-22). He contends that the insured persons' representatives on the Committees are, in fact, nominated by the larger Approved Societies, and that there is thus no real representation of insured persons. (*See also* Q. 7452, 7725, 7766-7768, 7775-7785.) Dr. Harry Roberts gave evidence on similar lines. He says (Q. 16,120) that he "would like to see Insurance Committees either abolished or, at least, their constitution entirely altered, because they are now but another name for Approved Societies. For all practical purposes they are the chairmen and secretaries of the Approved Societies, which was not the original purpose of the Act. The insured person is not represented on them in any way whatever." The Society of Medical Officers of Health (App. LVI, 7; Q. 16,941, 17,100-17,101), while admitting that Insurance Committees "have done well according to their abilities and opportunities," state that the Committees have certain general public duties, but have failed to be efficient instruments in the promotion of better health conditions. The Society think that "Insurance Committees are, as separate bodies corporate, no longer required. Their duties would be more efficiently carried out by the local health authority . . ." Mr. Torrance giving evidence on behalf of the Ancient Order of Foresters (Q. 4308-4309) states that Insurance Committees do not, under present conditions, justify their existence. The Hearts of Oak Benefit Society (App. IV, 285-293) suggest the retention of the Insurance Committees and would regret the loss of the experience gained in matters relating to medical benefit during the last 13 years. The National Conference of Industrial Assurance Approved Societies (App. VI, 26; Q. 5448-5449), the Manchester Unity of Oddfellows (Q. 6053-6056) and the Rational Association Friendly Society (App. IX, 34; Q. 6651-6653) also support the retention of Insurance Committees. The National Association of Trade Union Approved Societies (App. XCII, 151-156; Q. 22,077-22,078) favour the formation of a committee of each local authority with certain representative persons co-opted to undertake the local administration of medical benefit. The evidence of Sir Wm. Glyn Jones (App. CVI; Q. 24,398-24,532) indicates the difficulties which hamper the work of Insurance Committees in their administration of medical benefit, and which, in his view, make it impossible to expand the scope of that benefit whilst its administration is in their hands. In conclusion, we may refer to the evidence given on behalf of the Ministry of Health by Mr. Brock (Q. 23,974-23,990), who states that "the duties devolving upon Insurance Committees (as distinguished from their staffs) have become so limited in range that they do not offer sufficient attraction to public-spirited people, who could find much better scope for their energies on other local bodies. . . In some committees the members appointed by the County or County Borough Councils really form the only section with much experience of public administration." He adds: "They really have so little to do except disciplinary work, which is mostly done by the Medical Service Sub-Committee. On the other hand, if you give them more work to do, say, an extension of their general health duties, you bring them into competition with the other local health authorities" (Q. 23,975). We may quote also the following question and answers: "Do you consider that the Insurance Committees perform an essential service in regard to the benefits of deposit contributors that could not be otherwise arranged for?"—(*Sir Walter Kinnear*): "No." (*Mr. Brock*): "I agree with Sir Walter" (Q. 23,982). "The position is very much the same with regard to the Navy and Army Insurance Fund." (*Kinnear*; Q. 23,985). "We think a transfer of the powers and duties of Insurance Committees to the appropriate committees of the County and County Borough Councils would have the great advantage of being a step towards the co-ordination of all local health functions which is generally recognised as the logical corollary of the co-ordination of central health functions in the Ministry of Health. It would certainly facilitate co-ordination between Insurance and other Public Health services, and it would secure the independent expert advice of the medical officer of health and other medical officers of the Councils . . . . Whatever Committee" (i.e., of the County and County Borough Councils) "is charged with these duties, it is desirable that it should contain a strong co-opted element including adequate representation of the doctors." (*Brock*, Q. 23,991.)

Transfer of Powers and Duties to Local Authorities.

396. The conclusion we come to, then, is that Insurance Committees should be abolished, and that their work, very much in its present form, pending any radical remodelling and unification of the Health Services, should be handed over to committees of the appropriate Local Authorities with possibly a co-opted element. We do not enter into any details as to what is the appropriate local authority, as this question is dependent on the results of the deliberations of the Royal Commission on Local Government now sitting. Until the lines on which the general framework of the local government of the country is to be remodelled are known, any specific recommendations would be useless. If our recommendation in this matter is adopted, we think it may safely be assumed that

provision would be made for the absorption of the staffs of the present Insurance Committees.

SECTION E.—DEPOSIT CONTRIBUTORS.

397. We now come to a problem which has exercised the minds of the administrators of the Insurance Scheme ever since its inception—that of the deposit contributors. This class was established at the institution of National Health Insurance as a temporary arrangement for the accommodation of those insured persons who would not, or could not, join Approved Societies. The arrangements were to be reviewed in three years. The difficulties of finding a solution of this problem have been so great and the arrangements in their present form have worked with such a considerable degree of success, that the Deposit Contributors Fund still remains an integral part of the Scheme. The present membership of the deposit contributor class is about 240,000 persons, i.e., about 1½ per cent. of the total number of insured persons.

398. The following table shows the number of deposit contributors in England in November, 1924, classified in accordance with the years in which they became deposit contributors :—

Year of becoming a Deposit Contributor.	Men.		Women.		Men and Women (combined).	
	Number.	Per-centage.	Number.	Per-centage.	Number.	Per-centage.
1912	13,663	9·01	6,007	7·03	19,670	8·30
1913	1,999	1·32	1,191	1·39	3,190	1·35
1914	2,127	1·40	1,099	1·29	3,226	1·36
1915	3,959	2·61	2,320	2·71	6,279	2·65
1916	3,478	2·29	3,450	4·04	6,928	2·92
1917	4,117	2·72	4,549	5·32	8,666	3·65
1918	4,206	2·77	4,203	4·92	8,409	3·55
1919	19,495	12·85	4,018	4·70	23,513	9·92
1920	11,938	7·89	6,694	7·83	18,632	7·86
1921	11,958	7·89	8,131	9·51	20,089	8·47
1922	20,358	13·42	12,117	14·18	32,475	13·70
1923	31,204	20·58	18,337	21·46	49,541	20·89
1924 (to Nov.)	23,128	15·25	13,344	15·61	36,472	15·38
Totals ...	151,630	100·00	85,460	100·00	237,090	100·00

The table shows :—

(1) That only 8·3 per cent. of the present total membership became deposit contributors in 1912.

(2) That for the succeeeding six years the corresponding figure is extremely low, and even for 1918 it is under 4 per cent.

(3) That approximately half the present total of 237,090 joined the class within the last three years.

The following table shows the number of deposit contributors at various points since the beginning, and the exits from this class in the periods stated :—

EXITS FROM DEPOSIT CONTRIBUTORS FUND.

Year	Transfers to Approved Societies.	Exits for other reasons.	Total Exits.	No. of Deposit Contributors at end of year.
1912–16	265,736	229,512	495,248	300,470
1917	61,418	15,715	77,133	337,048
1918	55,181	71,623	126,804	349,394
1919	43,601	75,487	119,088	416,926
1920	74,432	135,184	209,616	305,785
1921	63,603	109,810	173,413	247,122
1922	44,870	83,731	128,601	245,019
1923	43,428	77,374	120,802	238,547
1924 (to 1.11.24) ...	43,288	60,396	103,684	237,090

It will be seen :—

(1) That apart from the inflation in the War years due to many persons coming into insurance temporarily for various reasons, the numbers appear to be falling.

(2) That the exits during each of the last three years are somewhat under half the total number in the class at the end of the year.

(3) That a large proportion of the total exits represent transfers to Approved Societies.

399. These tables appear to show that the Deposit Contributors class is, in large part, in a fluid state and that the permanent residue is not considerable. We understand that from the results of an inquiry on a restricted scale which was made in 1913, supplemented by the experience of the last 13 years of administration, deposit contributors may be fairly accurately classified as follows :—

(1) persons suitable for Society membership who have not yet chosen a Society, but will eventually do so ;

(2) persons who through ignorance or indifference, or personal objections, neglect or refuse to apply for Society membership ;

(3) persons temporarily, or intermittently employed, or not expecting to remain permanently in this country ;

(4) persons expelled from Societies and unable to obtain admission to another Society ;

(5) persons in ill-health who are unable to obtain admission to a Society.

400. It is not, we understand, possible to say in what proportions deposit contributors fall into these classes but the first class is the most numerous. The Ministry of Health informed us (App. I, A. 100) that " a majority of deposit contributors are in good health and would have no difficulty in joining a Society." We were also informed by the Scottish Board of Health (App. II, A. 28) that " an investigation of a sample of deposit contributors in Scotland disclosed that only 8 per cent. had been refused admission by Societies and that more than two-thirds had failed to join Societies by reason of neglect or ignorance." Contrary to original expectations, it is clear, therefore, that the class is not made up almost entirely of " bad lives," and that so far as health is concerned the majority are eligible for Society membership. The fact that certain Societies have offered to take over the whole of the deposit contributors and that other Societies have pressed for allocation of the whole of the deposit contributor class among Societies, confirms this view.

401. We are informed (Ministry of Health, App. I, A, 97, *Kinnear*, Q. 384) that though not engaging in direct propaganda among deposit contributors, the Department make use of every reasonable opportunity of impressing on them the desirability in their own interests of seeking admission to a Society. Thus, a reasoned explanation and exhortation is given first place in the leaflet of instructions sent to every deposit contributor; all contribution cards issued at Post Offices have a note on the subject; and advice to join a Society is printed on every Record Card issued to a deposit contributor.

402. It has to be borne in mind that, while the payment of contributions is compulsory, the further steps to be taken, e.g., the choice of an Approved Society and the making of an application for membership, call for voluntary action on the part of the insured person. Not all insured persons are able or willing to take the necessary steps within any time which may be officially prescribed, though they may have no objection to the underlying principle. They become deposit contributors for a time, but afterwards choose and join Societies.

Points from the Evidence.

403. The evidence which has been placed before us indicates the difficulty of the problem, and suggests varying solutions. For example, the Hearts of Oak Benefit Society suggest (App. IV, 89-107; Q. 2926-3025) the abolition of the class and compulsory allocation among Societies. The National Conference of Industrial Assurance Approved Societies (App. VI, 14; Q. 4874-4892, 4908-4909) would abolish the class and allocate members to Societies with increased reserve values for impaired lives. They would, however, offer no objection to the institution of a State Society. The Ancient Order of Foresters

(Q. 4383) object to the formation of a State Society, and hold that the retention of the class for the residuum is desirable. The Manchester Unity Order of Oddfellows (App. VII, 64-66; Q. 5847-5848, 5851-5855, 5882-5888) suggest the formation of a special Deposit Contributors Society. The Independent Order of Rechabites (Q. 6116) and the Joint Committee of Approved Societies (Q. 8243) would abolish the class and would accept compulsory allocation to Societies, but would not give up the right of expulsion. The Prudential Approved Societies (Q. 9686) would have no objection to the formation of a State Society.

404. The National Federation of Rural Approved Societies (App. XXIX, 16; Q. 11,716-11,732) suggest that those deposit contributors who are unable to join an Approved Society by reason of the state of their health should be entitled to benefits at such rates as may be found actuarially possible, but not exceeding the normal rates, and that for this purpose the accrued interest on the Deposit Contributors Fund and the balances in the accounts of those members who cease insurance should be available after any member of the type referred to has exhausted the amount standing to his individual credit.

Question of Compulsory Allocation.

405. We have considered the proposal for compulsory allocation of the deposit contributors among Approved Societies, but are convinced that such a scheme, however attractive in theory, would fail on the practical side. It would be expensive and contentious; it would provide a difficult and continuing problem. It might involve renunciation by all Societies of their right to reject an applicant or expel a member. Some Societies would be willing to make this sacrifice, but others, particularly those identified with special interests (such as temperance), are unwilling, and it would be difficult to require such Societies to renounce the essential basis of their association. Moreover, compulsory allocation would tend to destroy the fundamental conception of Approved Societies as voluntary associations of insured persons, and the Department ought not to be a party to forcing unwilling members on unwilling Societies, especially as, in the case of small units (which could not be ignored), the allocation of one bad life might adversely affect the interests of all the members. Even if the difficulties as regards Approved Societies were surmounted, the still greater difficulties of the allocation authorities would remain, whether these were central or local bodies. At the cost of much labour and expense the Department could supply classified lists of existing deposit contributors, but while the allocation authorities deliberated, new cases would be arising at a rate not far short of 50,000 every six months, and these also would require to be sorted and listed; while provision would have to be made for the payment of benefits becoming due before completion of allocation, and

a list of allocations maintained lest a contributor should be allocated more than once—for some persons would refuse to recognise the allocation and would continue, for a time, at least, to send their cards to the Department. It will be understood that preliminary correspondence is often necessary before the position in insurance of persons surrendering cards, presumably as deposit contributors, can be determined. This is referred to in paragraph 99 of Section A of Appendix I to the Minutes of Evidence. Some form of official " Clearing House " would be inevitable.

406. No Society or other body has at any time put forward a practical scheme for allocating deposit contributors, and we are informed that, despite prolonged and careful examination, the Department has been unable, so far, to devise one which would give satisfaction to insured persons, to Approved Societies, or to those who would be required to administer it. Further, having regard to the consideration of the shortness of the average insurance life of deposit contributors, as such, it is doubtful whether, weighing the cost against the probable results, the adoption of an allocation system could be justified, even if a satisfactory practical scheme were forthcoming. In substance, there would be elaborate machinery for allocating insured persons, many of whom would, in any event, without the intervention of the Department, allocate themselves within a short space of time.

407. We have dealt above with the difficulties of allocation chiefly from the point of view of the Department. There is, however, another aspect which must be examined. Approved Societies are bodies formed by voluntary effort and, as a rule, have close relations in each case with some particular form of social activity. Some, for instance, are Friendly Societies, several of which require special qualifications, e.g., total abstinence, for membership. Others are, or exist in connexion with, trade unions; yet others are connected with organisations engaged in industrial assurance; while a considerable number have been established for the employees of particular firms or commercial companies. The insured person who cannot find one Society to suit him among the diverse organisations which open their doors to him is doubtless hypercritical, but his susceptibilities are nevertheless so far to be respected that he ought not to be forced, by Departmental allocation, into any particular Society, regardless of his views upon the subject. The fact is that, if every insured person is to be compelled to be a member of some Society, a Society must be established by the State to receive those persons who object to taking up membership in any of the voluntary bodies, and who, if they were allotted against their will, could render the whole scheme of insurance inoperative, so far as they were concerned, by declining to surrender the cards containing the evidence of the contributions which had been exacted from them. There are,

however, strong objections to the establishment of a special State Society for those insured persons who do not choose to join one of the existing Approved Societies. Such a Society would be in competition with Approved Societies and would offer benefits which, even if restricted, would almost inevitably have to be guaranteed by the Government. It would be a departure on a large scale from the principle of self-governing Societies self-contained financially, which is the essence of the National Health Insurance Scheme.

General Considerations.

408. The fact that the present scheme is working smoothly and meeting the real problem of insured persons on their way to Approved Societies or of those who only expect to be in insurance for a short time, goes far, in our view, to dispose of the criticisms directed against its retention. This is specially so since the additional benefit schemes of Approved Societies have come into operation, for they have offered a marked and increased inducement to transfer from the Fund to Societies. So far, indeed, as the types of person referred to in (1), (2), (3) and (4) of paragraph 399 above are concerned, we see no reason whatever to alter the system. Insured persons of these types will always be with us. The Deposit Contributors Fund provides for them as convenient an arrangement as can be made. They can have no grievance against the system since it is open to them at any time to apply for admission to one or other of the numerous Approved Societies of all types. The persons in class (4) might, indeed, have difficulty in getting into a Society, but their number is so small and their position is so much due to their own default that we do not think they merit any special consideration.

409. When, however, we come to class (5)—those persons in ill health who are unable to obtain admission to a Society—we feel that something more than the meagre cash benefits of the Deposit Contributors Fund should be provided. We feel that in a scheme of National Health Insurance under which compulsory contributions are exacted, the continued existence of this class, under its present conditions, invites serious criticism. We direct attention to the evidence submitted by Sir Walter Kinnear on behalf of the Ministry of Health in Q. 23,616-23,646; and also to the suggestions, already referred to, made by the National Federation of Rural Approved Societies in paragraph 16 of Appendix XXIX. The recommendations which we make are generally on the same lines as are suggested in the evidence in question.

Proposed Insurance Section.

410. We propose that two sections of the Deposit Contributors Fund should be formed—an " Individual Account Section " on

the present basis, and an "Insurance Section" on a mutual basis. The latter section would provide for the persons in ill health who prove to the satisfaction of the Department that they are unable to obtain admission to an Approved Society, the former for all the rest. In respect of the former class, the only change we recommend is that the right of a deposit contributor on death or emigration to half the balance to his credit should be abolished, and that those half-balances be dealt with as described below.

411. In the Insurance Section we think that the normal benefits of the Act (but no additional benefits) should be paid for a certain period of years, and that if, at the end of that period a valuation reveals a deficiency, the position should be met out of the resources available under the Act in the manner explained in paragraph 413 below. The funds for the Insurance Section should, we think, be derived from four sources—the contributions of the members of the Section; the appropriate State grants; the balances of the deposit contributors in the Individual Account Section released on death or emigration; and the accruing interest on the whole Fund, which, we understand, runs to about £40,000 a year. It is difficult to say whether the total of these resources would sustain the Fund in view of the uncertainty as to the number in the Insurance Section. We believe, however, that that number would be so small that the experiment is worth trying.

412. Some form of test for admission to the Insurance Section would be necessary. A test of the kind we contemplate already exists in the case of the Navy, Army and Air Force Insurance Fund, namely, rejection by one Society on the grounds of health. It might be desirable to require rejection by two or even three Societies of different types before admission to the Section was allowed and also to provide for a periodical review by requiring the members to submit further evidence of the same kind at intervals.

413. As the Insurance Section would have the character of an Approved Society we think that the usual deductions for the purposes of reserve values, the Contingencies Fund, and the Central Fund should be made from the contributions of its members and that if there is a deficiency on valuation of the Section, the normal provisions for recourse to the Contingencies Fund and Central Fund should have effect. In this connexion we refer to the evidence of Sir Walter Kinnear. (Q. 23,643-23,646.)

414. We have recommended above that the balances released on death or emigration and the accruing interest on the whole Deposit Contributors Fund should be credited to the Insurance Section. In respect of these special sources of revenue, therefore, the Section would differ from the ordinary Approved Society. It is impossible to forecast what the position of the

Section is likely to be on valuation, but it is possible that by reason of these exceptional revenues a surplus might be shown. In that event we consider that in so far as such surplus is attributable to the additional sources of revenue to which we have just referred, it should be paid into the Central Fund.

415. So far as the members of the Individual Account Section are concerned, it would be desirable that the Department should continue the efforts to induce these members to transfer to Societies.

416. It may be suggested that some Societies would object to this system as instituting competition by a State Society. We do not, however, think that such objections could be seriously sustained if the arrangements took the restricted form we have outlined. Further, we may recall that the witnesses representing the Prudential Approved Societies which contain about 3,200,000 members stated in evidence that they had no objection to a State Society. In any case the reply to Societies is clear. If they are willing to admit any particular deposit contributor the problem is solved. The member would be so admitted or would be transferred from the Insurance Section to the Individual Account Section of the Fund.

417. We understand that there is interest accumulated by the Fund since 1912 amounting to about £400,000 and that there is no statutory authority for the disposal of this sum. We think that in any amendment of the Act authority should be given for passing the accumulation up to the date of the institution of the new system which we propose, to the Reserve Suspense Fund, where it would be available for the redemption of reserve values.

SECTION F.—THE INSURANCE PRACTITIONERS' CONTRACT.

418. Among the important problems of the Insurance Scheme is the administrative relationship of the medical profession to the Central Department and to the Insurance Committees. Two important elements in this appear to call for discussion here—the method and scale of remuneration of the insurance practitioners and the procedure under which complaints against them are determined. As to the first, there has not been much evidence in criticism of the present rate of remuneration though alternatives to the capitation method of payment have been suggested. As to the second, we have received representations from the medical bodies to the effect that the Regulations press rather harshly on the defendants in such cases.

419. No one is likely to under-estimate the importance of these two questions when it is remembered that 15,000 doctors and 15 million insured persons are involved. The success or failure

of medical benefit must depend to a very great extent upon the cordial acceptance of the financial terms of the contract by the medical profession and upon their approval of the Regulations under which their daily duty towards the insured persons is carried on. We will accordingly devote some space to a review of these matters.

The Method and Scale of Remuneration.

420. A full account of the course of the arrangements for remunerating the insurance practitioners since the inception of the Scheme up to the present date will be found in paras. 105 to 142 of Section C of Appendix I to the Minutes of Evidence. The earlier parts of this are now mainly of historical interest but we may describe briefly the arrangements since the beginning of 1920, when the so-called " floating sixpence " was abolished, with the consequence that the discussion of the capitation fee became simplified by the elimination of the drug factor. On that footing the Insurance Acts Committee of the British Medical Association, acting on behalf of the general body of insurance practitioners, claimed that the fee should be 13*s*. 6*d*. The Minister, acting for the Insurance Committees, who, in fact, make the individual contracts, did not accept this figure but offered 11*s*. The difference was referred to arbitrators who determined the latter figure and this remained in force from 1st January, 1920, to the end of 1921. During 1922 and 1923, a reduction to 9*s*. 6*d*. was accepted by the Profession on the ground of the urgent necessity for national economy. On a further proposal by the Minister for the reduction of the fee to 8*s*. 6*d*. for three years, or 8*s*. for five years, there was again resort to arbitration with the result that 9*s*. was determined for the three years ending 31st December, 1926.

421. New terms must be settled before the end of 1926 and, obviously, must take account of any change (whether resulting from our recommendations or otherwise) in the nature and volume of the services to be rendered by the practitioners under their contract.

422. Although the Minister's offer was for less, and the doctor's claim for more than was, in fact, awarded at the last arbitration, and although the Approved Societies made at the time very strong representations for a more substantial reduction of the fee, the award appears to have given, on the whole, as much satisfaction as is possible in such circumstances. In assessing the effect of the award upon the actual remuneration of practitioners with lists of various sizes, the existence of the large mileage grants must be kept in mind. These provide substantial additions to the capitation income of many rural practitioners. An account of the scale and methods of allocation of these grants is given in paragraphs 163 to 169 of Appendix I, Section C.

Points from the Evidence.

423. We may now conveniently give some extracts from the evidence submitted to us on these matters.

424. Dr. Smith Whitaker, in reply to a suggestion that the figure should be based very largely on the amount of the remuneration the doctor received in pre-war days, with a reasonable loading for the rise in the cost of living, remarked, " Is the question not really this, what does the general practitioner, as a class, consider the value of his time and skill? Our service has to compete with other sources of income that are open to him, and in the result it is a kind of balance of the inducements to different doctors throughout the country." (Q. 1447.) He added, that it was difficult to say whether effective comparisons could be made with other professions in this matter. (Q. 1448.)

425. Mr. Alban Gordon, in referring to the financing of the extensions of medical benefit, refers to " the present method of remuneration of panel practitioners, which is not only, in my opinion, generous in itself but is unduly generous in the case of the urban practitioner possessing a large panel " (App. XIII, 56). In answer to Q. 7834, he states, " I think the present system . . . is bound to be either unjust to those who have too little work or unduly generous to those who have a great deal."

426. The British Medical Association state that they are " convinced that the capitation fee is still too low . . . " and that " the extra amount allowed for rural conditions requires reconsideration." (App. XLVII, 59.) We may refer also to App. XLVIII, 60-62, where the views of the Medical Practitioners' Union are set forth.

Considerations as to Future Negotiations.

427. The immediate problem arising from the above considerations and from the course of the evidence falls into two parts: (1) Assuming the same services are given, has any change in the economic or other circumstances arisen since 1923 to justify a variation of the capitation fee? (2) If extended services are given, what is the fair reward for them?

428. We do not think that it falls within our province to make a recommendation under either head. This is a subject which clearly must be discussed between the Minister and the Medical Profession in settling the terms of service to take effect at January next. The point to which we direct attention is the frequency of the review of the rate of remuneration. On this

we would emphasise the need for the desirability of fixing the figure over a reasonable period of years, so as to give to all parties a settled financial basis for their relations. We cannot think that periodical disputes over remuneration are good, either for the Profession or for the professional work. Further, new entrants to the Profession, and persons contemplating the long course of studies now required, ought to be in a position to assess the rewards of the Profession for a period of years ahead. We cannot but think that if some such stability were assured, the advantages would be very great. And as prices now seem to have reached a fairly stable level, there is clearly the opportunity for some settlement, valid over a period of years.

429. If the question of the capitation fee is to be re-opened, it appears to us that there are two distinct principles which may be considered. The Ministry may proceed on past history and adjust the fee according to the cost of living and the rates in force in the contract practices of pre-insurance days. We need only refer in passing to the difficulties attendant upon this method—the limited scope of contract practice, its peculiar nature, the equipoise of the large volume of private practice, which has now in considerable measure disappeared, and so on. The other method—and it is one on which the British Medical Association has laid stress in its evidence before us—is to assess the present market value of the services under the contract, as measured by the rewards secured for similar services in private practice, and the inducements necessary to secure a sufficient flow of properly qualified entrants into insurance practice. We feel that it is a little difficult to apply this criterion, as private practice among the wage-earning population has been so drastically curtailed by the Insurance Scheme. Still the dependants remain, and probably there are sufficient data available in this way to give a measure of market value.

430. As we have indicated, we do not feel that it is for us to recommend a definite figure. We have had little evidence on the point, and, indeed, one of the two parties principally concerned, namely, the British Medical Association, deliberately refrained from submitting arguments, on the ground that the problem must be dealt with later by the Department when our general recommendations had been received and considered. (App. XLVII, 58-59.)

Alternatives to the Capitation Method.

431. We may direct attention, however, to the method of calculating the remuneration for the general practitioner service. We come unhesitatingly to the conclusion that the capitation basis should remain. We have heard arguments in favour of the attendance system, the case value system, and even the full-time salaried system. But the overwhelming weight of evidence,

especially that of the British Medical Association, has been for the capitation method; and we cannot believe that a system that has been in successful operation in practically all parts of the country for 13 years can be open to serious criticism. It embodies the salutary principle that it is to the interest of the doctor that his patients should remain in good health, or be restored to good health as quickly as possible. It directs attention to the preventive side of the work at an early stage. We have had no evidence to show that the system has induced members of the profession to scamp their duty to their patients or to treat them with want of sympathy or attention. We have received evidence from those in favour of the attendance system which is operative only in Manchester and Salford; but we have come to the conclusion that that system has in practice become so hedged about with restrictions to prevent over-attendance and with adjustments to meet the general interests of the whole body of doctors working it, that —apart from the complicated nature of the machinery which it necessitates and the inexactness of the results attained—it really differs in essence very little from the capitation system. As to the case value system, we refer to Appendix XCI for a description of this; but we do not feel that at this stage in the development of insurance practice it could or should be introduced as a universally obligatory system. We need not go into the arguments for or against a salaried service. The fact that the profession is almost unanimously against this method is sufficient to make it impracticable. Mr. Brock's reply to a question on a somewhat larger issue is equally applicable here. "No public medical service embracing four-fifths of the population and requiring the co-operation of the great majority of general practitioners could be effectively worked unless the remuneration and conditions of service were such as to be acceptable to the majority of the profession." (Q. 24,178.)

432. To one other suggested modification in the method of remunerating insurance practitioners it is perhaps desirable to refer at somewhat greater length as it involves a point of some novelty. The National Federation of Rural Approved Societies recommend that doctors be remunerated for their services according to a graduated scale, instead of by a uniform capitation payment as at present (App. XXIX, 11-13). Under such an arrangement it is suggested that the highest rate should be paid in respect of the first 500 insured persons accepted, a lower rate or rates being paid in respect of the remainder. In examination it was made clear that this proposal was put forward primarily on the alleged ground that a list of 1,000 does not involve twice as much time and expense as a list of 500. A system of remuneration, in which the capitation fee decreased at successive stages with an increase in the number of insured persons accepted, would obviously operate to discourage the existence of unduly large lists, and it might be advocated on these

grounds. We were assured, however, that while this obvious consequence was present in the minds of those who advocated the scheme, this consideration did not furnish the justification for the proposal, which was defended on the ground of its own inherent equity (Q. 11,612-11,617). We consider that if the existence of large lists is still productive of evils (as it indubitably was in the earlier days of the Health Insurance Scheme) such an indirect method of discouragement is not to be commended, and that preference should be given to the method (which has in fact been adopted) of definitely limiting the number of insured persons whom a doctor may accept. It is only right to add that we have had no evidence to show that under present conditions any evils result from the existence of lists which can be regarded as unduly large.

433. Turning to the merits of the proposal, it can hardly be contended, and it was not in fact contended by Mr. Wood, who appeared for the National Federation of Rural Approved Societies, that the work involved increases otherwise than proportionately with the number of insured persons accepted. The only ground then on which the scheme can be advocated is the assumed saving in time and overhead charges which comes with an enlarged practice. In neither case do we consider that, so far as Health Insurance practice is concerned, there is a law of diminishing cost so markedly operative as to make it expedient to grade the remuneration of practitioners in the manner suggested. The fact that the attendance given under the Health Insurance Act is only a part of most doctors' practices renders the reasoning of the Federation on this point inadmissible. A doctor with a small insurance practice may yet have a large practice otherwise, and may enjoy all the economies of time and of overhead expenses inherent in large scale practices. The doctor should receive remuneration primarily for work done, and only secondarily for time taken; and when in exceptional circumstances the time involved becomes a factor demanding consideration, the appropriate method of meeting the circumstances is by the grant of a mileage allowance. Apart from these fundamental difficulties the scheme would, we are satisfied, tend to many anomalous results; it is unlikely that it would commend itself to the Medical Profession as a body, and we are therefore unable to recommend its adoption.

The Complaints Machinery.

434. We now turn to the more difficult question of the machinery for determining complaints against Insurance practitioners.

435. We have given very careful attention to the criticisms advanced by representatives of the medical profession on certain aspects of the present Regulations affecting the obligations of

insurance practitioners and on the present procedure for the investigation of complaints against practitioners.

436. The procedure for dealing with complaints is described in Appendix I, C, 40-56. The criticisms will be found in Appendix XLVII, 35-43, Q. 15,213-15,220 and Appendix XLVIII, 43 and 47, Q. 15,504-15,511, 15,519-15,627, 15,682-15,712, 15,715-15,728.

437. We refer particularly to the lengthy evidence which the Medical Practitioners' Union App. XLVIII, 43 and 47; Q. 15,504-15,511 and 15,519-15,627) submitted on the subject of the complaints procedure. Much of this evidence is directed to similar points to those put forward by the British Medical Association, though in a more emphatic form. We deal with the whole subject on its general bearings below. We would, however, remark here that the privileged position, which the Medical Practitioners' Union urge should be granted to practitioners under the complaints procedure, is one which we do not think could be conceded on any grounds of public policy; nor do we think that the witnesses of the Union were able in oral examination to sustain effectively the demands which they put forward.

438. The witnesses appearing on behalf of the British Medical Association classified the conditions of service of insurance practitioners in two categories—and we appreciate the importance of the distinction—namely, conditions affecting the professional relation between doctor and patient and conditions relating to the fulfilment of the doctor's contractual obligation to keep records and to perform other similar duties specified in his agreement and the Terms of Service. (App. XLVII, 40.) As to the latter category, it is admitted that in cases where the non-fulfilment of the obligation is established, disciplinary action is justifiable and, indeed, inevitable, though certain changes are advocated in the machinery of investigation. But it is suggested that questions affecting the relations of doctor and patient should not be made the subject of disciplinary procedure, on the ground that, with the present unrestricted choice of doctor, the patient has an effective remedy in his own hands. This contention we find ourselves wholly unable to accept, first, because we are not satisfied that the freedom of choice of insured persons can be relied upon as sufficient to produce the requisite result, and secondly, because the entire abrogation of the Minister's responsibility for the efficiency of the service rendered by insurance practitioners to their insured patients is, in our view, inconsistent with the fulfilment of the duties placed on the Minister by the Health Insurance Act, and with sound principles of administration of a publicly provided service.

439. The theory that competition for patients is sufficient by itself to secure a satisfactory service, clearly does not apply in those areas in which there is, in fact, no freedom of choice, and where, therefore, no competition exists. In many rural and semi-rural areas the geographical distribution of doctors is such that insured people have no real choice, while at the other end of the scale there are congested urban areas in which the number of available doctors is so limited that they want no more patients than they have already. But even in the areas in which there is a real freedom of choice, we see no sufficient grounds for assuming that the right of transfer would be by itself a sufficient protection to the patient. Before the Act came into operation there was unlimited freedom of choice in urban areas, but it can hardly be contended that the resulting competition produced a satisfactory level of service in the poorer areas, which had become accustomed to a low standard of professional work.

440. Apart from the special difficulty of the rural areas and the more congested and less attractive urban areas, we are not convinced that it is fair to assume, as a general proposition, that patients who feel dissatisfied with their treatment will seek another doctor. We agree that a wise doctor will not seek to retain a patient who has lost faith in him, but it does not follow that a transfer is always made either pleasant or easy. In any case, the inertia of a large proportion of the insured population will operate to prevent persons from making a change, though they may have legitimate grounds for dissatisfaction. Even with free choice, the percentage of changes at any time is, relatively, small, and it would be too large an assumption to suppose that among the vast majority who do not change there are none who have good reason for wishing to do so.

441. Even were the insured person in a better position than we believe him to be for securing the efficient discharge of his insurance practitioner's duties towards him, we consider that to place upon him, in effect, the entire responsibility in this matter, would be fundamentally inconsistent with the whole scheme of medical benefit, under which the Insurance Committee is primarily responsible for securing efficiency of the medical service within its area, subject to the general responsibility of the Minister. We find nothing in the Act to justify excluding from the questions of efficiency of the service for which the Insurance Committee and the Minister are responsible questions of the kind which the British Medical Association desire to have excluded. If, therefore, such proposals were to be brought into operation, this could only be done, as it appears to us, through amending legislation which would be so inconsistent with accepted principles of public administration and Parliamentary responsibility that we cannot recommend imitation.

442. On questions of procedure for dealing with complaints against practitioners, the British Medical Association made certain suggestions for the alteration of the Regulations, and also formulated certain principles which they considered ought to be observed in the exercise of the powers possessed by the Minister under the present Regulations. The alterations of Regulations suggested were: (1) that all complaints against a practitioner should, in the first instance, be sent to the Chairman of the Local Medical Committee and the chief administrative medical officer of the Local Authority; (2) that only such cases as could not be settled by them with the acquiescence of both parties should proceed further; (3) that questions of general conduct, detrimental to the service, or of giving false certificates should be reported upon in the first instance by the Local Medical Committee; (4) that an appeal to the Courts should be possible not only on the ground of improper procedure as at present, but on the ground that the penalty inflicted was out of proportion to the offence; (5) that in the case of proposed removal from the service the practitioner should have the right of appeal to a duly constituted central professional committee, and that the Minister of Health, in cases where this right was exercised, should not be able to remove the practitioner from the service unless the central professional committee advised this course. (App. XLVII, 41.)

443. The first two of these proposals involve entrusting to a purely medical body the duty of considering whether the complaint against a practitioner should, or should not, be proceeded with. Such an arrangement appears to us highly undesirable, and we gather that it was not pressed by the witnesses who appeared on behalf of the Association (Q. 15,226). We are also not satisfied that there is any good reason for the exclusion of the lay element from the primary investigation of the class of cases referred to in (3).

444. The fourth proposal involves placing upon the Courts of Law the responsibility for deciding questions of a kind which, in our opinion, can be more appropriately decided by a Minister who is answerable to Parliament for the manner in which he exercises his discretion. The fifth proposal we are also unable to accept. We appreciate that removal from the medical list may be, and usually is, a very severe penalty, but it has to be remembered that the ground of removal is that the retention of the practitioner would be prejudicial to the efficiency of the medical service of the insured persons, and it would, in our judgment, be contrary to sound constitutional practice that the Minister's responsibility to Parliament for the maintenance of an efficient service should be delegated to an outside body, whether professional or otherwise.

445. The four principles which the Association submitted for our consideration, not as requiring alterations in the Regulations,

but as affecting the Minister's exercise of his powers under the existing Regulations were as follows: (1) that when a complaint has been dealt with by the bodies set up by the Regulations for this purpose there should not be a liability to have the whole matter re-opened by separate Departmental action either by the Ministry itself or by those bodies at the instigation of the Ministry; (2) that when the complaint has been made in one prescribed form penalties should not be inflicted in respect of offences not formally alleged or of offences which, if alleged, should have been formulated in a different prescribed way, and might have required a different line of defence; (3) that full consideration should be paid to the findings or recommendations of a committee (whether Medical Service Sub-Committee, or Inquiry Committee) which has itself investigated the details of the case, in mitigation of the heinousness of the misconduct even when proved; (4) that it is essential to draw a strict distinction between professional conduct in the attention given to a patient and the nature of the exact professional treatment given to the patient, and that the propriety of any particular method or line of treatment should not be made the subject of investigation in connexion with the insurance service. (App. XLVII, 42.)

446. The Association submitted these principles, we gather, as a result of their consideration of particular cases recently dealt with by the Ministry. Details of those cases were not placed before us, and we are not, therefore, in a position to express any opinion as to how far the action of the Ministry may be open to criticism in the directions indicated. Moreover, it is difficult to express an opinion on the validity of some of these propositions without reference to particular cases, since they are stated in a form which is capable of various interpretations, and a general assent or dissent might be misleading. As regards the first point, we understand that the question arose in connexion with a particular case which came before the Lord Chief Justice, when this precise point was one of those on which the action of the Minister was challenged, and the Lord Chief Justice held that the Minister's action was perfectly proper. As to the expediency, as distinct from the legality, of such action, it appears to us that much may depend on the circumstances of particular cases, and the matter was not placed before us by the Association in sufficient detail to enable us to express an opinion as to the cases in which such an exercise of the Minister's powers might, or might not, be entirely desirable.

447. The fourth point is the one which the witnesses of the Association stated that they regarded as gravest and most vital. (Q. 15,220.) This proposition also appears to be one to which an unqualified assent might be open to misinterpretation. We agree that where it appears that a practitioner has exercised his

judgment to the best of his ability, his professional skill having been, in the words of one of the witnesses, "carefully and properly given to the patient," the Minister should not go into the question whether the line of treatment which was adopted is in accordance with any particular professional doctrine as to what is or is not the best line of treatment in such cases. From inquiries that we have thought it necessary to make we gather that the Minister accepts this view and would not regard it as part of his duty, when considering, as the Regulations require, whether a proper standard of treatment has been given, to enter into questions on which professional opinion might differ as to the efficacy of particular methods of diagnosis or treatment. This, however, is subject to the qualification stated, that the practitioner has, in fact, exercised his professional skill with reasonable care, and this appears to be a matter of which cognisance must be taken in the exercise of the Minister's disciplinary powers.

448. Evidence which we have heard in connexion with some of the foregoing points has brought to our notice one matter in respect of which the present practice appears to us to be open to criticism. We find that in cases in which representations have been heard by an Inquiry Committee, and the Minister, after considering their findings, has decided not to remove the practitioner from the Medical List, it is not unusual for grant to be withheld without any further hearing being allowed to the practitioner. (Q. 24,000.) It has been pointed out to us that this procedure is contemplated by the present Regulations, which were settled after consultation with the Insurance Acts Committee of the British Medical Association. But on the merits we are clearly of opinion that no grant should be withheld until the practitioner has been given an opportunity, if he wishes, of making oral representations and so of bringing to the Minister's notice any mitigating circumstances which in equity should be taken into consideration before any penalty is imposed. The task of the Inquiry Committee is to investigate definite allegations, and for the purpose of ascertaining the facts it is not relevant to consider whether there are extenuating circumstances. It follows, therefore, that if the Minister decides that the facts established by the Inquiry Committee do not warrant removal, but do appear to call for some lesser penalty, a new issue arises, and considerations may properly be taken into account which were not relevant to the major issue of removal from the List. For this reason we think that before any penalty other than removal is imposed, the doctor should be given an opportunity of a further hearing. If such an arrangement necessitates any alteration of the existing Regulations, a point which appears doubtful (Q. 24,000), we recommend that the necessary amendment should be made at the first convenient opportunity; but if the present Regulations

permit of it, we see no reason why this change in the practice of the Ministry should not be introduced at once.

449. It has been suggested to us by some witnesses, including those representing the Association of Insurance Committees, that an Insurance Committee should be able to make representations to the Minister against the inclusion of a doctor in the list of insurance practitioners where they consider that there are good reasons against such inclusion. (App. XXXVI, 37 and 39.) This proposal was strongly opposed by the witnesses from the British Medical Association. (Q. 15,214-15,215 and App. XLVII, 36.) The witnesses who gave evidence on behalf of the Ministry of Health regarded the suggestion as administratively inexpedient, if not impracticable, on the ground of the difficulty of establishing before a practitioner came on the List that his inclusion would be prejudicial to the efficiency of the Service. (Q. 23,999.) We are satisfied that it is inadvisable that the suggested change should be made.

CHAPTER XIII.

MISCELLANEOUS QUESTIONS.

450. In this Chapter we propose to bring together and discuss a large number of suggestions which we have received in the course of our inquiry, directed towards various modifications in the existing scheme of National Health Insurance. In dealing with a measure so complex as the subject of our investigation has proved to be, bearing so intimately on the daily life of almost every member of the community in one way or another, and so closely related to every aspect of social legislation, it was only to be expected that there should be a vast number of proposals for amendment of one or other of the many sections of the Act or of the regulations made thereunder. Some of these proposals are in their way directed to fundamental points of principle; a few may appear to relate rather to matters of administrative detail. In bringing them together for discussion in this Chapter we desire to guard ourselves against any suggested implication that these matters, being of a miscellaneous are therefore of an unimportant character. We have adopted this arrangement because the questions which we now propose to discuss do not fall naturally within the scope of any of the main sections into which we have divided our Report.

451. The subjects dealt with are classified under the following ten main headings:—

SECTION A.—Persons to be included in the Scheme.
" B.—Payment of Contributions.
" C.—Administration of the Cash Benefits.
" D.—Special Classes of Insured Persons.
" E.—Valuation of Societies and Provision of Additional Benefits.
" F.—Extension and Alteration of the List of Additional Benefits.
" G.—Limitation on Increases in Cash Benefits.
" H.—Miscellaneous Questions affecting Approved Societies.
" K.—Other Miscellaneous Questions.
" L.—Audit of Accounts.

SECTION A.—PERSONS TO BE INCLUDED IN THE SCHEME.

EMPLOYED CONTRIBUTORS.

452. The classes of persons who, under the existing Scheme, are subject to compulsory insurance are set out in Part I of the First Schedule to the Act and include briefly persons between