12. Apart from emphasising the time-honoured truth that it is better to prevent the existence of disease than to cure it when it has emerged, we do not, however, think that the time is appropriate even for an adumbration of the practical conclusions to which these considerations might lead. The problem, which should not be impracticable of solution, is to devise a method whereby society, while guaranteeing to every individual the opportunity of a reasonably complete life, shall yet be able to protect itself against the infusion of elements calculated to be a source of weakness. So far from the conjoint attainment of these two ends being impracticable, it may be suggested that the first and more visionary is possible of achievement only on condition that the second and less popular is in some measure realised. We have ventured to submit these observations, not with the object of making concrete suggestions, but rather in order to discourage an easy and prevalent optimism which lightly overleaps the limits of the practical and attainable, and also in the hope that those who are impressed by the inadequacy of our national efforts on the health side may be led to seek for a deeper cause and so prepare the way for a more fruitful discussion of these matters.

(Signed) ANDREW R. DUNCAN.
ALEXANDER GRAY.

MINORITY REPORT.

MAY IT PLEASE YOUR MAJESTY,

1. We regret that we have not found ourselves able to accept those conclusions of the majority of Your Commissioners which, in our view, deal with the really essential problems of the Scheme of National Health Insurance, and we therefore crave leave to present separately our own views on these matters.

GENERAL.

2. The recommendations contained in the Majority Report may be considered in two parts, namely, those designed to improve details under whatever system National Health Insurance is administered, and those designed to secure improvements within the present system and within the present financial limits of the Scheme. With regard to the first part, we are in agreement with our colleagues except as to those matters to which we shall refer later, and with regard to the second part, we agree that in the main the recommendations will effect improvements upon the existing system and within the present financial limits. We shall, however, refer later to certain recommendations which we feel will be of doubtful value.

3. The main questions of principle on which we differ from our colleagues are as follows :—

(1) The evidence which we, in common with them, have heard, convinces us that it is undesirable to retain Approved Societies any longer as the agencies through which benefits paid in cash are distributed to insured persons : and

(2) we do not accept the view that it is either necessary or proper to assume that we are to recommend no development intended to provide, in the words of the Act of 1911, "for insurance against loss of health, and for the prevention and cure of sickness," which cannot be paid for out of the produce of the contributory scheme of Health Insurance as it stands; and we feel it our duty to make recommendations in favour of :—

(*a*) The provision of medical treatment and attendance for :—

(i) children of school-leaving age; and
(ii) dependants of insured persons;

(*b*) Extended provision for child-bearing women before, at, and after confinement;

(*c*) Increase of the rates of benefits paid in cash under the National Health Insurance Acts to the present rates under the Unemployment Insurance Acts.

Approved Societies.

4. We are in fullest agreement with those statements in the Majority Report which lay stress on the need for linking-up all medical services under Local Authorities, i.e., the County, Town or District Councils. We believe that the only way to deal effectively with the health of the community is by doing away with the overlapping of Authorities, and that efficiency and economy must result from changes which, in the words of a circular recently issued by the Minister of Health are " directed to securing as close as possible an approach to the position that a single Local Authority shall be wholly or mainly responsible for the local administration of its area and co-incidentally for viewing as a whole the finances of local government in the area." This principle has been so cogently argued in the Majority Report, that it is unnecessary for us to labour it, but we are unable to find any good reason for making an exception to it in favour of that part of the system of provision for health services which is at present administered by Approved Societies.

5. Until that part of the system is taken out of the hands of Approved Societies and placed in the hands of Local Authorities, we hold that the policy which received the general support of our colleagues, and is being urged by the Minister of Health in application to services at present administered by Boards of Guardians, cannot be applied to its full and proper extent.

6. We take this view because, first, we think that in essence the administration of benefits paid in cash under the National Health Insurance Acts is a health service. These payments are made either

(1) When a woman within the present scope of maternity benefit is confined of a child; or

(2) When an insured person becomes and remains incapable of work owing to illness; or

(3) When an insured person who happens to belong to a Society which can provide additional benefits, can show that a payment enabling him to get one of these benefits would be likely to improve his health.

7. If the function of the Approved Society in relation to these types of payment is examined, it will be seen to be as follows :—

(1) The interest of the Approved Society in the child-bearing woman begins and ends with handing over to her a lump sum of money. That Local Authorities could make this payment equally well is self-evident. It is scarcely less obvious that much more could be done for child-bearing women who need other services directed to safeguarding the health of mothers and infants by Local Authorities, who already administer such services, than by Approved Societies, who have nothing to do with them.

(2) The interest of the Approved Society in the normal and the additional benefits is less narrow. In relation to the normal benefits they are concerned (*a*) to see that insured persons who are entitled to benefit are promptly paid, and (*b*) to see that no insured person is paid unless he is entitled to payment.

Local Authorities, who deal with people living in their respective areas, could of course pay benefit in proper cases at least as quickly as Approved Societies, whose members may live in any one of the administrative areas of the country.

Whether a payment ought to be made to an insured person depends upon the answer to the question, " Is this person incapable of work owing to illness? " This question is answered, in practice, by a doctor, subject to the right of the body through whom payment is made to scrutinise the doctor's certificate, to obtain a further medical opinion, and to complain if they think that the doctor has not told the truth.

Now it seems to us that the whole of these proceedings are an integral part of the medical service rendered by insurance practitioners under their contracts.

The Commission are unanimous in recommending that Insurance Committees should be abolished and that their functions should be transferred to Local Authorities, and we cannot resist the further conclusion that Local Authorities could and should take the place of Approved Societies as the Authorities through whom sickness and disablement benefits should be administered.

(3) In relation to the payment of sums enabling an insured person to get an additional benefit :—

(*a*) so far as the additional benefits consist in increases of the normal benefits, the Approved Society is concerned with the points already dealt with;

(*b*) so far as the additional benefits are in the nature of medical benefit, the interest of the Approved Society is, or (as our colleagues agree) ought to be, no more extensive. They do not provide the benefits. They merely hand over to some of their members, who, if properly selected, are so selected on medical grounds, money enabling the benefits to be obtained. They are not qualified to assess the value of the services rendered for the money, and we gather that the business of securing a proper return for the sums spent on dental and ophthalmic treatment given by way of additional benefit is, in fact, receiving the attention of the Minister of Health.

We are convinced that the whole of this work, so far as it is a matter of local administration, could be far better done by the Local Authorities already responsible for other health services.

8. Secondly, we do not think that the administration of benefits paid in cash, being a health service, is a health service which it is desirable to administer through agencies specially constituted for the purposes of this service alone.

9. In support of this view we would submit four arguments, one based upon considerations of general policy, and three upon the practical consequences of these considerations.

10. The first is that the citizenship of insured persons is more important than their insurability. Just as Your Majesty's Government refuse to accept the argument of Boards of Guardians that separate authorities ought to deal with citizens who happen to be destitute, so we hold that any attachment which insured persons may have to their Approved Societies can and should be transferred, with the work of the Societies, to the Local Authorities of the areas in which they live.

11. The second argument is that the result of this transfer would be to remove the scandal, admitted by our colleagues, that Approved Societies comprising a very large part of the total insured population are administered with complete disregard of the direction of Parliament contained in Section 23 of the Act of 1911 that their affairs should be subject to the absolute control of their members.

12. The Majority Report seems to us to evade that issue in the statement that most people do not "maintain that degree of interest in public affairs which good citizenship postulates."

13. The fact is that the constitution of the Approved Societies to which we have referred, makes it impossible for the members to take any substantial part in the management.

14. The local government franchise at least makes it possible for all electors to develop and manifest a proper concern in local administration.

15. The lesson of events, as Your Majesty's Government recognise in relation to Boards of Guardians, is that the way to encourage citizens, including insured persons, to face their responsibilities and protect their pockets, is to reduce the number of bodies on whose proceedings they are called upon to pass judgment, and to concentrate in the hands of the Local Authorities already charged with most of the business which affects insured persons' lives, the residue of the powers which can and should be locally exercised.

16. The third argument is that the transfer to Local Authorities of the administration of benefits paid in cash would result in a greater equalisation of liabilities over the insured population as a whole than is secured under the present system. The present association of insured persons in Approved Societies is inimical to the interest of those persons as a whole, and to the interest of employers and taxpayers who contribute to the cost of the system, because in practice it encourages the process by which the members composing the healthy groups get most (by way of additional benefits) in return for their contributions, and the least healthy least. Under the Approved Society System it is, in our opinion, impossible to use the whole resources of National Health Insurance to the greatest advantage of the insured population as a whole.

17. The object of a "national" health insurance system must presumably be, not to supply cream to the fat and skim milk to the lean, but good milk to all insured persons.

18. It is already an accepted doctrine of local government that the inhabitants of a given town or county have such community of interest with each other that those who are able can properly be called upon to pay for services which others need. A system based upon the historic administrative areas of the country has, therefore, the indefinable but important advantage of enlisting the support of local sentiment and local patriotism.

19. Where the local community of interest in a public service stops, and the interest of the community as a whole in the efficiency of the service begins, that fact is recognised by the payment of a contribution by the taxpayer in aid of the cost of the service.

20. The fourth argument is that the transfer of the work of Approved Societies to Local Authorities must, if it had any effect of this kind at all, improve and not weaken the possibility of putting into operation the provisions of the Act of 1911 which were designed to enable the burden of cost resulting from excessive sickness (that is, sickness which could and should have been prevented) to be put upon the right shoulders.

21. It is clear from Sections 15 (7), 22 and 63 of the Act of 1911 (now Sections 85 and 107 of the 1924 Consolidating Act), and from the statements made in Parliament on the introduction of the Bill, that the framers of the measure intended their scheme to be intimately connected with the other health services, and enquiry and action were to be possible wherever bad environment induced ill-health. Thus action could be taken wherever the conditions or nature of employment, bad housing or sanitation, insufficient water supply, or, indeed, neglect on the part of any person or Authority to enforce the law relating to public health or housing was involved.

22. Yet Section 107 is a dead letter, and that this is so is largely due to the fact that membership of Approved Societies is scattered all over the kingdom instead of being localised, and that in one street, or indeed in one house, every inhabitant may belong to a different Society, each with its headquarters entirely out of reach of the ordinary insured member.

23. This brings us to another essential point laid down by the framers of the Act. The scheme was to be democratic, controlled by the insured for the insured. Here again the Act is almost a dead letter, and we feel that in this case also the constitution of the Societies renders it inoperative.

24. The statement of our colleagues that most people do not "maintain that degree of interest in public affairs which good citizenship postulates" is of general philosophic interest, but it appears to us to have no bearing on the question before us. In every class of life people are interested in matters which affect their pockets, and the fact that insured members are not interested in the management of a scheme which involves deductions from their wages and accruing benefits, suggests something very wrong with the machinery. We believe that different results might be achieved if these Societies came under the control of the Local Authority. This would limit their numbers to about 150 Societies as against 7,876 existing financial units. The best officers already trained in Approved Society work would be available and the varying occupational risks which at present aggravate inequalities would be modified by territorial grouping.

The Approved Society System.

25. We have reviewed the system of Approved Societies in order to ascertain on the one hand whether it has fulfilled the intentions of Parliament, and on the other hand, whether it is the most effective method of administering a scheme so closely related to public health in all its phases.

26. With regard to the first part we are definitely of the opinion that the wide disparity in valuation results was not contemplated by Parliament, and that the complete lack of any real opportunity for membership control, affecting over half the insured population, has rendered almost negligible a feature of the system to which Parliament attached very great importance.

27. The views adduced that in general the free choice of Society disposes of any suggestion of hardship upon the members of Societies with no surplus, does not in our judgment dispose of the matter. Nor do we agree that this segregation of the insured population into Societies is an essential part of a scheme which some witnesses consider embodies a "true insurance principle."

28. We are aware that the generous estimate of the liabilities of the Act which has hitherto formed the actuarial basis, has been

responsible for the immense surpluses which Societies are now distributing in the form of additional benefits, and that the disparity in valuation results would have been the same if either the expenditure had been heavier in the aggregate or the actuarial estimate had been less generous.

29. In either of the latter events, however, the statutory or normal rate of benefits of the Act would have been jeopardised to such an extent and for so large a proportion of the population as to have created a problem with which Parliament must have been compelled to deal.

30. So long as nearly every Society is able to maintain or increase the normal rates of benefit the disparities do not get the attention they otherwise would.

31. The Departmental Actuarial Committee state in para. 5 of their First Report "It is clear . . . that Parliament intended the scheme to be solvent, regarded as a whole, whatever might follow from the grouping of risks incidental to the voluntary segregation of insured persons in Approved Societies," and it is further reported that the new actuarial basis referred to in the Report, "will be that which, so far as we can estimate, would be required if the whole system were operated through a common fund."

32. We think that these two quotations point to an intention of greater uniformity in the scale of benefits than has been in fact realised and we feel sure that Parliament could not have foreseen that over the whole insured population there would be a surplus of 40 to 45 million pounds, nor that the segregation of insured persons would produce such wide disparities.

33. We agree that on the whole the administration by Approved Societies has been of a high standard and that many of the grounds for criticism are due to the weakness of the system and not to any incapacity upon the part of the officers of the Societies. At the same time we are compelled to say that there are no methods of judging the real standard of efficiency of Societies. A standard which passes the Treasury auditors is a criterion only as to accuracy in accounting and in a lesser degree as to the legal accuracy of the work done. There is no test, other than that made in individual cases in which complaint is made to the Minister, as to whether benefit is paid to every member who is properly entitled to it. An auditor may discover an irregular payment, but he cannot discover an irregular non-payment.

34. We are led to draw attention to this by the often-repeated statement that the Approved Society system provides an incentive to good management. If such an incentive exists we fear that its product must be stringent management against which no system

of audit or of inspection or of appeal in the case of disputes is a sufficient safeguard for the insured person.

35. We agree also with our colleagues that evidence from insured persons themselves would have been desirable and we recognise the difficulties mentioned. Our anxiety in this respect is not lessened by the observations accompanying the recommendations in the Majority Report that the Department needs further disciplinary powers to ensure higher efficiency, and more particularly with para. 242 of the Report. We also attach much importance to the observations in the Memorandum appended to the First Report of the Departmental Actuarial Committee, para. 13, "it . . . . seems to suggest that Societies are applying to the disablement claims of married women a degree of activity that might well be exerted, and at an earlier stage, on all claims of prolonged duration." Further significant passages on this subject appear in para. 18 of the same Memorandum.

36. In the absence of evidence from insured persons themselves we attach the greatest importance to the foregoing indications of features which must operate against the interests of insured persons as a whole and must give rise to grave injustice to individuals and classes who, so far as can be judged, most need the benefit of the Act.

37. The tables of expectation of sickness and disablement benefits are not sacrosant, and we see little virtue in them in relation to a standard of administration. The real standard of administration is not merely that insured persons should be restrained from receiving benefits improperly, but also, and perhaps of greater importance, that insured persons incapable of work should always get the cash benefits to which they are entitled. If "experience" belies "expectation," means other than drastic administration must be sought to right matters.

Control of Societies by their Members.

38. We have definitely come to the conclusion that the vast majority of insured persons take no interest whatever in the affairs of the Societies and that probably two-thirds of the insured population cannot exercise any real control in their Societies. The constitution and government of the Friendly Societies and Trade Unions, and of certain of the smaller centralised or localised Societies provide the opportunity for members to exercise their will; but the volume of evidence shows that insured persons as such have not exercised, and are not exercising, any real control. In those Societies, where the development of the "fraternal spirit" was expected, it is admitted that the insured members "take no real interest in the work." (*Heather*, Q. 5523,5616). In the case of the large Industrial Companies it is not pretended that membership control is

possible (*Neill*, Q. 4442). " . . . . it is simply that the machinery is not there." (*Kinnear*, Q. 23,576.)

39. In general the evidence proves conclusively that membership control "is largely theoretical" (*Kinnear*, Q. 578) and that "as a general rule the great majority of insured persons take little or no interest in the government of their Society." (*Kinnear*, Q. 515; see also *Brock*, Q. 959). The number of members necessary to form a quorum at a General Meeting of a Society, given in Table 3, and the following paragraphs of the evidence of the Department (Section B of Appendix I) emphasises the absurdity of the so-called "membership control":—

> "23. It will be seen that at one end of the scale, eight members constitute a quorum in the case of the Mayfield Temperance Friendly Society (Approval No. 1274) a small local Society, consisting of 48 members. Yet even this restricted quorum could not be obtained in 1922. At the other end of the scale is the Liverpool Victoria Approved Society (Approval No. 119) which, with nearly half a million members, is required by its rules to have a quorum of 12, whether insured persons or not, including any officers and members of the committee present, who themselves number eight.
>
> 24. Similarly with the large industrial Approved Societies, such as the National Amalgamated (Approval No. 125) and the Prudential Societies (Approval Nos. 136 and 137). The former has over two million members, and the requisite quorum is 50 in England, and 20 in Scotland, including the officers and Committee men, who themselves number about 20.
>
> The rules of the two large Prudential Societies each with over one million members, also provide that 50 members, including any officers and members of the Committee present, shall form a quorum."

40. This, considered together with the evidence given on this subject by representatives of the Industrial Societies (Q. 4515-4529, 4568-4743), leads us to the conclusion that the intentions of Parliament in this respect have not been fulfilled.

The Incentive to Good Management.

41. We have shown that the members as such are not interested in the management of their Societies, but it is claimed that the officers are able so to develop their system of administration as to exercise a vital influence upon valuation results.

42. We agree with our colleagues that the effect of this incentive upon the valuation results is grossly exaggerated, and that other factors, occupational and otherwise, are the predominating causes of the great disparities in the surpluses declared.

43. We submit that in so far as the incentive does exist it is inimical to the improvement of the standard of national health. In the main it only manifests itself in two ways: (1) by a judicious selection of good lives, and (2) by a reduction of expenditure on benefits.

44. The absence of control by the insured persons is, in itself, to be deplored in a public scheme, but when it is remembered that the close interest of the members in the work of their Societies was designed to produce an incentive to efficient administration it will be realised that its absence assumes much greater importance.

45. It has been claimed by many Society witnesses—and in certain parts of the Majority Report our colleagues appear to support the claim—that this incentive is a necessary and desirable feature of National Health Insurance. We propose therefore to examine the contention further.

46. As we understand it, the theory is that the members of each Society would interest themselves in the management of the Society with a view to conserving the funds in order to produce a surplus at a valuation.

47. The practice of rejecting applicants for membership who are thought to bring an abnormal risk means segregation of all good lives from all bad lives, with the consequent breakdown of the preventive and curative objects of the Act for those sections of the community which need them most. "If by economical management is meant the exclusion by medical examination of those likely to be a charge upon Societies . . . . then the Union sees little virtue in it" (*Medical Practitioners' Union*, App. XLVIII, 18, i).

48. There is no doubt that witnesses have considered the main effect of the incentive to be the safeguarding of the funds against what they considered to be undue claims, and it is mostly in this respect that it has been effective. If the scheme were administered through a system which contained an element of uniformity the operation of such an incentive would be less undesirable, but when it is remembered that there is an almost complete absence of uniformity from the issue of a medical certificate to the payment of the benefit, the effect of an incentive with the purpose of economising on benefits is definitely vicious. Saving the funds by curtailing the benefits of the sick persons and forcing them back to work or otherwise leaving them to starve, is not a feature that is either economical in the long run, or moral in a State scheme, but that it is present there is no doubt whatever. "Some of the Societies are inclined to apply too rigid a test when the alarming question of disablement benefit comes to their notice." (*Kinnear*, Q.313.)

49. We consider it a fallacy to conclude that a high surplus at a valuation means good administration and that a deficiency provides a *primâ facie* case of bad administration. We think, on the contrary, that in general the Society with the heavier expenditure will be more likely to be actuated by the "incentive," as it is generally understood, than the Society in which the expenditure is low. As an illustration: a Society carrying the hazardous risks of the miners being in deficit at a valuation would require to prove that its standard of administration was of a high order before it could make a claim upon the Central Fund, whereas a Society composed of healthy lives could afford to, and would, undoubtedly, be less strict upon its members.

50. The only evidence of an incentive alleged to operate in a direction consistent with the objects of the Act was given by a representative of Employers' Provident Funds, who claimed that in order to reduce the expenditure on benefits the employers sought to improve working conditions. (*Lesser*, Q. 13,375.)

Valuation Results.

51. The large surpluses and the disparities in those surpluses have been referred to at length in the Majority Report, and certain developments and modifications designed to reduce the surpluses and to some extent the disparities are there recommended.

52. We are of the opinion that the effect of extending the statutory benefits to absorb the moneys released by the new actuarial basis recommended by the Actuarial Committee will create a serious position for those Societies which, on the present financial basis, have little or no surplus. The operation of the Central Fund and the partial pooling of surpluses will probably enable all Societies to continue to provide the normal rates of benefits, but unless the equalising operations precede the valuation reports the position of certain Societies will still appear quite hopeless. We agree that "no Society and no type of Society can claim a prescriptive right to a guaranteed existence," but we think it proper to say that the gradual decrease in the membership of Societies below the average financial standard will ultimately compel their decease and that the only Societies which could afford to accept a transfer of engagements of such a Society are the largest, which are just those where membership control can be least effective.

53. The emergence of surpluses and the consequent provision of additional benefits have emphasised the weakness of the system when viewed from the standpoint of the prevention and cure of sickness. It will be obvious that a Society is only able to provide additional benefits in proportion to the standard of

health of its membership. If it is composed of extremely healthy members it can, by providing a wide range of additional benefits, many of a medical character, enable them to become still more healthy. If, on the other hand, it is composed of members whose standard of health is below the average, or who may be engaged in hazardous occupations, or occupations which call for a higher degree of physical strength than others, the current expenditure on cash benefits leaves no margin for surplus, and, as a consequence, that section of the community who need all possible services of a preventive and curative character are limited strictly to the bare statutory benefits of the Act. As we have been told, the position of such a member is as follows:—" . . . . the Act goes on providing him with medical treatment necessary for dealing with the consequences of his defective teeth, but unless he happens to be in a Society which has some sort of dental benefit . . . . nothing whatever is done for his teeth." (*Brock*, Q. 1,080.)

Hindrance to Development.

54. We consider that the Approved Society system in itself militates against a variety of developments which might be found desirable. Evidence was given to show (1) that the extension of cash benefits to dependants would accentuate the present deviation from the general average which results from the system of insurance through Approved Societies (Second Report of the Actuarial Committee and *Kinnear*, Q. 23,460) and (2) that "it would not be practicable for Approved Societies organised on their present lines to administer Workmen's Compensation" (*Kinnear*, Q. 23,461). The Friendly Society Movement was unanimous in desiring the limitation of cash benefits, notwithstanding that the present rates were admittedly insufficient (*National Conference of Friendly Societies*, Q. 10,649-10,679; *Heather*, Q. 5590.) "It may be thought that that answer is prompted by selfish motives, or by a desire to protect an existing vested interest. If that is so I plead guilty to that quite frankly (*Duff*, Q. 4,070); and again, "We are advocating that nothing shall be done which will injure the Friendly Societies." (*Shaw*, Q. 10,725.)

55. The Friendly Societies submit that they give an opportunity to the insured population to insure themselves privately, and urge that it is desirable that personal thrift should be encouraged. We express no opinion on this latter point, but it is important to note that the representative of one of the largest Orders agreed that "as regards a very large proportion of seven million people, State Insurance is the only form of insurance they can hope to get." (*Heather*, Q. 5,608.) The system is a hindrance to the development of a complete Public Health policy, inasmuch as it is primarily concerned with the distribution of cash benefits without the slightest relationship to public activities affecting the need for these benefits.

56. We accept the principle laid down by the Majority Report as to "the desirability of bringing into closer relationship the various services directed towards the prevention of sickness and the improvement of health." We submit that this is impossible while one essential health service is left unattached; and we recommend the substitution of Societies under appropriate Local Authorities, which would apparently be the County Councils and County Borough Councils, for the present system of Approved Societies.

57. It seems to us that substantially each of these groups would be fairly representative of the industrial population of the country, but in so far as they were not equally representative the operation of a Central Fund might be the means of equalisation.

58. At the outset, for the purpose of securing essential statistics and in order to determine the standards of health in different parts of the country, it may be necessary to consider each group as an area Society, the Society operating financially very similarly to an Approved Society under the present system; but as time and experience allowed, it is not unreasonable to suppose that the actuarial basis as we know it, and the valuations as they are now conducted, could be very materially modified. We should, then, for the purpose of establishing this new system, proceed along existing actuarial lines.

The Finances of the Present Scheme.

59. We are unable to agree that we should make no recommendation which takes us outside the financial limits of the present scheme. We submit that there is financial loss due to the overlapping of the various services at present in operation and that the money available will be increased when these services are unified and controlled under the Local Authority.

60. We are also clear that a Commission dealing with National Health Insurance must take into account national loss resulting from neglect to provide sufficiently for the health of all those who are or will be employable.

61. The whole question of national health is bound up with that of efficiency and output, and it is impossible to rank as a "burden" on industry or on the community an outlay which safeguards industrial well-being and (to put it no higher) conduces to the efficiency of the machine. These charges produce a definite return. "There is five per cent. in good conditions," said a great employer of labour.

62. We agree with our colleagues that it is desirable "that a balance between the expenditure on these schemes

and the productive capacity of the country should from time to time be struck, even though this can probably be done only in a very general way and without reduction to any precise formula." But since everything which impairs efficiency reduces that productive capacity, the final balance will not be realised till we have carried all our social services to perfection. Our recommendations at this moment are, however, confined to those which appear to us urgently necessary, and immediately practicable.

63. Social services, as has been well shown in the Majority Report, are financed from various sources. The State, the Local Authority, and various systems of insurance supply the funds, and it is impossible to draw a hard-and-fast line between the services to which we should contribute as taxpayers or ratepayers, or as employers and employed persons. We do not subscribe to the distinction drawn between social services conducted in the interest of the individual, and similar services conducted for the general well-being of the community, since the "well-being of the community" is involved in all. In this connexion we feel that there is cogency in the representations made to us, that the contributions of employer and employed to National Health Insurance should alike be reduced and the State's contribution proportionately increased (*National Confederation of Employers' Organisations*, App. CVII, 28). The salient fact is that for every deficiency in our social services, someone pays. We can alter the incidence of payment, and treat our obligations as matters to be supplemented by the Poor Law, or by voluntary aid, but the only case in which we pay without return is in support of the disabled, who could by larger preventive outlay have given us the return of efficient healthy labour. While we feel that our present methods of conducting our social services are expensive and over-lapping, and that real economies are to be effected from their unification, we also feel that any further moneys needed for the services indicated below will go far to relieve us of the "burdens" (properly so-called) described by Sir George Newman and the accredited officers of the Ministry of Health.

Medical Benefit.

64. We support the recommendations of the Majority Report to extend the scope of medical benefit, but it should be noted that Parliamentary grants were voted in 1914 for services, the development of some of which has not been undertaken owing to War conditions. Such services included:—

(1) Medical referees.
(2) Medical experts from whom second opinions could be obtained by medical referees.

(3) General practitioner clinics.
(4) Laboratory services.
(5) Nursing for insured persons.
(6) Health lectures. (App. CIII.)

65. In our view the extension proposed will still leave out of medical benefit services which the evidence has shown would tend both to prevent sickness and to effect a speedier and more complete cure of the insured person.

66. As both these results are not only desirable in themselves, but would be accompanied by economy of expenditure on cash benefits, we submit that the provision of a complete medical and treatment service should not depend for its financing entirely upon current contributions. We agree with our colleagues that "considering the beneficial results on the health of the insured community which ought to follow from the medical service provided by the Act . . . . it is not unreasonable to look for improved conditions so far as the claims are concerned." (para. 177.)

67. The experience of administering the insurance medical service gained since 1912, which has made practicable many desirable developments impossible at the inception of the Scheme, should enable an estimate to be made of the future effect of a considerable extension of that service upon expenditure on cash benefits. In other words, the loading for actuarial safety of the cost of cash benefits should be affected by the kind and extent of preventive and curative services available for the insured population. The following extract from the evidence affords an example in relation to dental benefit merely. "I think the experience of those Societies that have provided dental treatment . . . . does give ground for hoping that systematic dental treatment would lead ultimately to a reduction of sickness benefit claims . . . ." (*Brock*, Q. 23,914.)

68. The National Conference of Friendly Societies (App. XXVI), the National Association of Trade Union Approved Societies (App. XCII), the British Medical Association (App. XLVII, 20) and other organisations are unanimous in advocating great extensions of medical benefit.

69. As to the desirability of including dental advice and treatment within the range of medical benefit, it was stated by a Departmental witness that "something like three-quarters of the industrial population probably are suffering from dental defects of one sort of another." (*Brock*, Q. 23,914.)

70. We therefore recommend that medical benefit, extended as recommended in the Majority Report, should be further

extended to include attendance at confinement and dental and ophthalmic advice and treatment.

Medical Benefit for Dependants.

71. The great weight of evidence from Approved Societies and from medical and other professional organisations was in favour of the extension of medical benefit to dependants.

72. Witnesses representing many diverse interests expressed the view that if the provision of medical services to the dependants of insured persons is desirable then the absence of those services is a cost to the nation in one form or another. But even considered from the narrower standpoint of National Insurance, we submit that the future value of present expenditure upon medical and treatment services to children and mothers of children may be taken into account in estimating the future liabilities of the Scheme. We, therefore, submit that medical benefit should be provided for the dependants of insured persons.

Cost of Medical Benefit.

73. The expense of a national system of medical services is difficult to estimate, but we submit that it is a fallacy to count all expenditure as cost. The state of the health of the people, young and old, is such as to be of incalculable loss to the nation, and a well-organised, comprehensive scheme must diminish the loss with increasing force.

74. The linking-up of the contemplated medical services with other public medical services would in itself effect direct economies in administration, and as experience dictated, further economies would follow.

75. We therefore look upon the expenditure on this service, not as a cost, but largely as a new channel through which existing expenditure is to be diverted, with the difference that the new channel is ordered and directed to the prevention of sickness, whereas the old method is wasteful, fortuitous, and frequently comes into operation too late to be effective.

76. At this point it will be convenient to refer to the recommendation in the Majority Report that the first call on the margin in the contributions resulting from the proposals of the Departmental Actuarial Committee must be the balance of the cost of the present medical benefit (para. 182).

77. Paras. 130 to 142 of Section C of Appendix I to the Minutes of Evidence review the various modifications in the rates of payment for medical treatment from 1912 to the present time. In that review it is seen that the original estimate of the cost of medical benefit was 6*s*. per head per year and that this amount was supplemented by an Exchequer grant of 2*s*. 6*d*. per head

which, with 6*d*. added in respect of the domiciliary treatment of Tuberculosis, made available a sum of 9*s*. per head per annum for medical benefit. An Exchequer grant in respect of medical benefit continued until the 31st March, 1922, since when the cost of medical benefit has been met from insurance funds, including the statutory State grant of two-ninths of the cost. This change was made in pursuance of a recommendation of the Committee on National Economy under the Chairmanship of Sir Eric Geddes.

78. At the commencement of the Act, when the estimated cost of medical benefit was 6*s*. per head, each Insurance Committee was to enter into agreement with each Approved Society as to the sum to be paid by the Society to the Committee in respect of the cost of medical benefit for its members resident in the area (Section 15 (6) of the Act, 1911). This arrangement being impracticable, the organisation of medical benefit was undertaken by the Central Department.

79. While we agree that the modifications in the method of administration were necessary we suggest that the removal of the duties from the Local to the Central Authority has obscured the intentions of Parliament expressed in Section 15 (7) of the Act of 1911, now Section 85 of the Act of 1924. That Section, which has never been repealed, provides that the Treasury and the Local Authorities may bear some part of the cost of medical benefit beyond the statutory grant.

80. There is moreover a further reason why the provisions of the Act in this respect should be considered. We have already indicated our complete agreement with our colleagues in their recommendations to transfer the administration of medical benefit to Local Authorities. We feel, however, that to bestow powers and duties of such importance and magnitude upon the Local Authorities without any direct financial responsibility, is a departure from the principles of local government hitherto considered essential in this country. We take the view also that the Central Authority exercises its powers of enforcing economy on and of encouraging desirable developments by Local Authorities by reason of the financial arrangements between the two Authorities and we should be more confident of securing efficient development and of enlisting local interest if the usual financial principles operated in respect of medical benefit.

81. We therefore disagree with our colleagues that the first charge on the margin should be the balance of the cost of the present medical benefit and we recommend that the cost of the present medical benefit in excess of the sum of 9*s*. 6*d*. per insured person per annum provided in the Act of 1920 should be borne by the Treasury and the Local Authorities as provided by Section 85 of the Act of 1924. The aggregate cost of this balance is estimated at £2¼ millions.

82. Again, we agree with the recommendations to extend the content of medical benefit by the inclusion of specialist and consultant services, but we cannot agree to the cost being met solely from insurance funds. The need for extension along these lines was realised in 1914, and Parliament voted moneys for the purpose. We submit that these services should also be met under the provisions of Section 85 of the Act of 1924. The estimated cost of the proposed extension is £1½ million a year.

83. We have recommended that medical benefit should include attendance at confinement. We shall refer to the maternity service later and it will suffice at this point to say that we see no season why the cost of this service should not be met from insurance funds.

84. We agree with our colleagues as to the need for dental services and as to the ultimate beneficial effect upon benefit expenditure, but we view with alarm the decision of our colleagues not to include dental benefit as a part of the medical benefit, especially when it is predicted that the aggregate surplus at the second valuation will amount to 40 to 45 million pounds, and that 3,485 Societies and branches in England with a membership of 10,700,000 insured persons " provided some form of dental treatment and this number will certainly be increased when all the schemes under the second valuation become effective."

85. In our opinion there are several grave objections against allowing the present method to continue. We have already submitted that it could not have been foreseen by Parliament that there would be a surplus over the whole insured population sufficient to provide benefits " in the nature of medical benefit " for nearly the whole insured population, otherwise such benefits would have been provided as normal benefits and not as additional benefits. In any case we submit that Parliament should consider the position in the light of experience gained since 1911.

86. A further, and we feel, a fundamental objection to leaving the matter where it is, to be found in para. 81 of the Majority Report. " There is neither uniformity in the selection of benefits nor in the content of the same benefit as given by different Societies, with the result that there is widespread confusion in the minds of the members as to what precisely their rights are," and again, a witness from the Department considers " that the administration of additional benefits in the nature of treatment by Approved Societies can never be very satisfactory." (*Brock*, Q. 23,996.)

87. Another objection is that in some of the smaller Approved Societies " the sum available each year (for additional treatment benefits) . . . would not exceed a few pounds, the whole of which might be exhausted in the first two or three claims for benefit which had to be dealt with." (para. 213.)

88. We cannot pass from this subject without referring to the increased difficulties with which the transfer of the administration of these benefits from Approved Societies will be faced if the administration has been allowed to develop through these bodies to the extent foreshadowed by the valuation figures.

89. The dental benefit which we recommend should form part of medical benefit might at the outset be of such " partial service " as may be organised within the estimate of £2¼ millions a year and we recommend that existing surpluses should be brought into the scheme for the provision of such service.

90. We now come to our recommendation that medical benefit as extended should be available for the dependants of insured persons. It is estimated that the cost of providing for dependants a service equivalent to the present medical benefit would be £9,500,000 a year. We submit, however, that the net cost would be a very much smaller amount. From the statement of evidence submitted by the Ministry of Health as to the scope and inter-relations of the various health services in England and Wales supported by public funds (Appendix CIV) it was shown that the expenditure on medical services other than those associated with mental infirmity amounted to £16,700,000 and the expenditure on medical benefit amounts to about £9¼ millions a year. We have thus an expenditure of £26 millions a year, if to which is added the eight millions spent on mental infirmity, brings us to the sum of £34,000,000 a year for public medical services of one kind or another, of which only a small proportion is borne by the Exchequer. Having regard to the expenditure by the hospitals and payments to medical practitioners in private practice, we see no reason to doubt the statement made by the National Association of Trade Union Approved Societies (Q. 22,046) that apart from the indirect cost to the nation resulting from the limited character of the medical benefit to insured persons and the absence of such services to their dependants, the nation is spending £40,000,000, possibly even £60,000,000 a year on medical services.

91. The case for the co-ordination of all forms of Public Medical Services is to be found in the Majority Report signed by our colleagues. We therefore need not do more at this point than emphasise the conclusion that such co-ordination " should tend to diminish disease and sickness " (*Maclachlan*, Q. 24,226), that " an effective scheme for the treatment of tuberculosis cannot be confined to one section of the community " (*Maclachlan*, Q. 24,092), that the present scheme "has almost certainly reduced national sickness " (*British Medical Association*, Q. 14,613) and that " medically the Insurance Acts have educated the population." (*Brock*, Q. 23,852). We believe it to be unquestionable that a general improvement in the standard of national health has been

effected and that further improvement would follow the extension of medical benefit to the whole nation. " Illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case," is the considered view of the British Medical Association, a development which, however desirable among the insured population, must be even more desirable for young children and mothers. " The public health is the primary asset of the nation's welfare, whether measured by capacity, employability and production or by length of days or by personal well-being." (Annual Report of the Chief Medical Officer, Ministry of Health, 1924, Para. 586) and " Wise progress is not to be looked for in the curtailment of public medical services . . . . but for their prudent establishment and where necessary their extension on sound lines . . . , Public assistance, insurance and education are the three great principles which seem to lie at the foundation of a public health service." (Para. 587).

92. So far from agreeing with the argument that the provision of medical benefit to dependants would postpone or impede the establishment of a fully developed public medical service as foreshadowed in the Majority Report, we feel confident that it would, on the contrary, further the realisation of that scheme. We therefore recommend that Medical Benefit should be provided for the dependants of insured persons and that the immediate expenditure should be met by the Exchequer and the local rates in equal proportions.

Rates of Sickness and Disablement Benefits.

93. The inadequacy of the rates of these benefits would, in our judgment, be sufficient reason for recommending an increase, but attention was drawn to the disparity between the rates of benefit under the National Health Insurance Act and the Unemployment Insurance Act by witnesses representing the Department, Friendly Societies and Trade Union Approved Societies. Sir Walter Kinnear referred to the difference as " rather anomalous " and " as difficult to defend," and expressed an opinion (Q. 473) which supports the view of the Hearts of Oak Benefit Society, that " formerly people on the border line of incapacity would tend to go on the sick fund. They will not do so now, because it pays them to receive unemployment benefit " (Q. 3368). Our colleagues repeatedly express their opinion " that it is difficult to justify a less generous provision for the invalid than for the man who is in good health, whose circumstances certainly involve smaller expenditure."

94. The necessity for uniformity in the rates of benefit does not dispose of the whole matter. We think it not unreasonable to suppose that unemployed persons will delay in obtaining medical advice and treatment under the Health Insurance Act, lest they should be disentitled to the higher rates of the Unemployment Act and so a force is created directly opposed to the public interest and to public health. The evidence of the British Medical Association rather indicates that this undesirable effect of the disparity has been noticed by the officials of Employment Exchanges and goes on to state that medical certificates to the effect that a claimant is fit for work are demanded " whenever the clerk in charge of the Exchange thinks they could not work if they were offered it " (Q. 14,788-14,793).

95. The effect upon health of inadequate maintenance allowance during sickness and unemployment is vividly illustrated in the Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1924, paras. 94 and 95. In his Annual Report for 1923, Dr. Dickinson Leigh, the Tuberculosis Officer for Sunderland, in drawing attention to the check in the decline of tuberculosis, points out that, " The unparalleled poverty and distress due to want of employment is the chief explanation. The want of essential foodstuffs, especially of fats, such as butter and milk, and the lack of suitable clothing and footwear, has markedly lowered the resisting power of the population."

96. In the Report of the Tuberculosis Officer for Newcastle-on-Tyne the increased mortality among women and children from tuberculosis was ascribed to undernourishment and general distress through unemployment; and Dr. James Watt, in the Annual Report of the Metropolitan Asylums Board, suggests the same evil effect of an inadequate standard of maintenance. The obvious effect of insufficient provision for the wage-earner against contingencies of life such as sickness and unemployment, would be a fitting subject to consider in relation to Chapter VI of the Majority Report on the Financial Burden of Existing Social Services. We think, however, it will be agreed that to increase the rates of sickness benefit to the same level as the existing rates of unemployment benefit would be as much in the interest of the prevention of future sickness as in the interest of the sick person at the time of incapacity. We therefore recommend that the normal rates of sickness benefit under the Health Insurance Act should be raised to 18*s*. per week for men and 15*s*. per week for women.

Disablement Benefit.

97. We are not satisfied that Societies generally have administered this benefit as a continuation of sickness benefit at a reduced rate. On the contrary, we feel as has been suggested in evidence by Sir Walter Kinnear (Q. 313), that the test of incapacity has been too rigid. The effect of a rigid or drastic administration of this benefit, which in the main applies to cases of chronic incapacitation, is to throw insured persons out of insurance who from recurring incapacity and ignorance of their legal position allow their " free year " to lapse without enforcing their claim.

98. We know of no way under the Approved Society system, with the " incentive " in operation, of overcoming this feature. We do suggest, however, that the department, when undertaking the enquiries into the administration of this benefit, as recommended in the Majority Report, should direct their attention to the possible effect of a drastic administration of disablement benefit upon the position of an insured person, especially of advanced years, in relation to the Widows', Orphans' and Old Age Pensions Act. We refer to this here in order to call attention to the fact that title to Old Age Pensions will depend to some extent upon the attitude of Approved Societies, and grave injustice might easily ensue from the absence of uniformity which characterises the Approved Society system of administration.

99. What has been said as to the adequacy of the rates of sickness benefit applies with equal, if not greater, force, to disablement benefit and we feel that under the system of administration through local authorities the dangers associated with a comparatively high rate of disablement benefit would be considerably diminished and that the observation of our colleagues on this subject in paras. 312 and 313 would be less applicable.

100. We suggest that the term " disablement benefit " does not properly describe the reduced rate of sickness benefit and is in part responsible for the application of drastic methods of administration. We therefore recommend that even if the benefit is continued at a reduced rate the use of the term " disablement benefit " should be discontinued.

101. In our view, however, the normal rates of sickness benefit should be payable to an insured person so long as he is certified to be incapable of work.

Allowances to Dependants.

102. We further recommend that allowances to dependants shall be provided at the same rates as are provided under the Unemployment Insurance Act.

Maternity Benefit.

103. We regret that the Majority Report does not propose to alter in any way the present provisions under the Act in respect of Maternity Benefit. We have already indicated our view that medical benefit should include medical attention at confinements, not only for insured women, but for all women who would under our proposals be entitled to medical benefit amongst whom would, of course, be included the uninsured wives of insured men.

104. The extension of medical benefit to include all women would remove a difficulty in the way of organising a complete maternity service. The insured woman receives medical attention before and after confinement and a cash benefit. " These two considerations would greatly facilitate the institution

for insured women of a scheme of comprehensive provision of all services required from the time that the woman is first known to be pregnant to the time when she has recovered from the effects of confinement and such schemes have . . . . been considered by . . . . the Department, and discussed with representatives of the medical profession. As regards the uninsured wives of insured men, the difficulty of including this class . . . . arises from the fact that in their case there is at present no provision of general practitioner services such as are afforded by medical benefit." (*Maclachlan* Q. 24,159.)

105. The high maternal death rate and the great amount of sickness amongst mothers clearly prove the need of reorganisation and extension of maternity work. Witnesses directed our attention to the Annual Report of the Chief Medical Officer to the Ministry of Health, in which it is shown that 2,847 women died in childbirth in 1924, and that there has been no diminution of the maternal mortality rate for the whole of the period since the Act came into operation.

106. In no fewer than three recent publications of the Ministry of Health, viz., the Annual Report of the Chief Medical Officer for 1924, " Public Education in Health," and " Maternal Mortality," it is made abundantly clear that " much of this maternal mortality and sickness could be prevented by proper supervision of the expectant mother; " that " avoidable maternal deaths are a matter of everyday occurrence," and that " if a woman can rely upon securing the services of a careful, up-to-date practitioner, or upon the attendance of a well-trained midwife, who is able to obtain prompt and competent medical assistance in case of need, nearly all other conditions become of minor importance."

107. The close connexion between the absence of adequate services during pregnancy and at confinement, and the heavy incidence of sickness among married women was referred to by witnesses (*National Association of Trade Union Approved Societies*, Q. 22,057; *Standing Joint Committee of Industrial Women's Organisations*, Q 23,027; *Maclachlan*, Q 24,226) and may be best illustrated by the following quotation from Sir George Newman's preface to " Maternal Mortality:"—
" Returns reveal only part of the damage done. An incalculable amount of unreported and often untreated injury and ill-health results from pregnancy and labour," and " 3,000 mothers a year die and tens of thousands of young mothers are unnecessarily damaged or invalided every year. (Public Education in Health.) There is also a close connexion between the absence of adequate services for expectant mothers and the infant mortality rate. While the death rate of infants under the age of one year is about one-half that of 25 years ago, the death rate of infants up to 4 weeks old is 33 per 1,000 births in 1924 against 38 per 1,000 births in 1912 (the commencement of the Act).

108. So far as vital statistics can reveal to the nation directions for extensions of national services, there is a conclusive case for a complete revision of maternity and child welfare services, with a view to the provision of more adequate ante-natal and maternity services.—" This . . . . is a matter that has been discussed . . . . with the medical profession in 1919 and since, and I think the general feeling is that if the requisite financial arrangements could be made it would be very desirable to end the present system under which you have the general practitioner responsible for treatment before labour, but having no responsibility during labour; the midwife under an entirely independent authority, giving attendance in labour and calling in a practitioner to attend in labour if necessary, who would be paid by the local authority; then you have the maternity and ante-natal centre giving assistance in the early stages. There is a great deal of overlapping and probably a good deal of waste, and it would be most desirable if it could be arranged to have a scheme that brought the family doctor, the midwife, the specialist if necessary, and all the services that are available at the maternity centre, under a common scheme and a common control, so that they each played their proper part and were brought into proper relation with one another, helping one another instead of acting at a distance as they do now. I do not think there is any doubt as to the desirability of it . . . . If the insured people were willing or if it were thought desirable to apply part of the present cash maternity benefit so as to make such a scheme practicable, the medical advantages would be very great . . . " (*Smith Whitaker*, Q. 23,896.)

The evidence seemed to show that the medical profession "would welcome an amendment of the Insurance Act whereby attendance at confinement would be brought within the scope of the provision made," provided that certain conditions were fulfilled, and " desire that the same provision should be extended to non-insured women of similar economic position." (Appendix CIII, 46.)

109. We recommend that the medical services during pregnancy and at confinements should be co-ordinated with the maternity and child welfare services under the Local Authorities.

Maternity Cash Benefit.

110. We are not satisfied that there is anything like uniformity in the methods adopted by Societies in administering sickness benefit during pregnancy, nor do we feel that the position is materially better in this respect than in the period reviewed by the Sickness Benefit Claims Committee, and later by the Departmental Committee on Approved Society Administration. We further consider that this important phase of public health cannot be dealt with solely through the Approved Society system. It is significant that the Departmental Committee on Sickness Benefit Claims in its findings (para. 34) recommended " that a new benefit should be created payable to a pregnant woman in respect of the last four weeks of pregnancy whether she is incapacitated or not, and that payment should be made to a pregnant woman who is incapacitated from following her occupation in the month previous to the last month, whether she is incapacitated by pregnancy alone, or by pregnancy accompanied by some other condition."

111. It was suggested by the National Association of Trade Union Approved Societies (Q. 22,084) that " there are great numbers in Class K, indeed in all classes, who cannot appreciate their rights under the Act, otherwise the number of claims would be much greater than they are," and Sir Walter Kinnear expressed surprise at the low percentage of women who claimed sickness benefit in Class K, and was of opinion that they were " not aware in the early stages that they are entitled to sicknesss benefit " (Q. 24,228.)

112. We submit that the evidence on the subject of the varying practice in the payment of sickness claims during pregnancy amongst Approved Societies, submitted by the Standing Joint Committee of Industrial Women's Organisations is of particular value inasmuch as it may be considered to be the evidence of insured persons themselves.

> " They have got more knowledge of it than they used to have, but there is real chaos on the subject. It is not only the insured women but it is the Societies and the doctors who are also doubtful about it. We have, for instance, information from a doctor that he may not give sickness benefit until the last four weeks of pregnancy. That is a statement of a doctor made to the secretary of one of our women's organisations. We have another statement, in fact we have the same statement, made about two Societies, that they do not give it at all, and about another that they do not give it until the last weeks. Further, there is the fact that some women think they have a right to it at a certain time . . . . On the whole, far fewer women apply for it than need it because of all these doubts . . . . Many insured women cannot afford to have a doctor for their confinement . . . . and they do not like to go and ask him for a certificate during pregnancy when they are not engaging him for confinement " (Q. 23,036.)

113. We submit that maternity benefit should be, in the case of the uninsured wife of an insured man, a cash payment of 20*s*. and in the case of an insured woman, maintenance for the mother and child at a rate not less than that of sickness benefit, for a period of twelve weeks, being not more than six weeks before and six weeks after confinement.

114. The conditions attaching to the payment of this benefit could be designed to encourage such ante-natal treatment as may

be considered desirable. The effect of the combined service and cash benefit would be beneficial in terms of health of mother and child, and later in terms of sickness expenditure saved. " It would do away with the temptation to work too long and to return to work too soon, if something which we should consider full and healthy maintenance for the mother and child was payable " (*Hearts of Oak Benefit Society*, Q. 3496.)

Age at Entry into Insurance.

115. We are not in agreement with the observations of our colleagues with reference to the age of entry into insurance, either in regard to the demand for a lower age of entry, or to the weight of the evidence produced in favour of it. The National Association of Trade Union Approved Societies in their evidence drew attention to the gap of two years between the present statutory school-leaving age and the age of entry into insurance and submitted that " employment within the meaning of the Act should commence at any time after a person has left school, having reached the statutory school-leaving age " (App. XCII, 54).

116. This evidence was submitted to, and endorsed by, the General Council of the Trades Union Congress, which is representative of six and a half million workers, the great majority of whom are insured persons. Further evidence was given by Mr. Gold of the Scottish Miners' Federation Approved Society: " It is a period that we have felt ought to be bridged over . . . . As a matter of fact they are left out of it entirely until they attain 16 years of age although we find that in some instances employers stamp cards immediately the lads commence work " (Q. 6949).

117. In Appendix XI, 4, the Lancashire and Cheshire miners say: " We suggest that the present age of 16 on entry into National Health Insurance shall be reduced to 14 years of age; or whatever may be the school-leaving age either now or in the future." " The principal reason is not to secure cash benefits but to get the advantage of medical treatment " (*Hibbert*, Q. 7063).

118. The evidence leads us to say that there is a widespread and important demand that there should be available for young persons between 14 and 16 years of age medical services and treatment, not less effective than those available during their school life.

119. We are not impressed by the suggestion that to lower the age of entry will militate against raising the statutory school-leaving age, more especially as we consider that the title to non-cash benefits might partly take the place of cash benefits for

young persons under the age of 16 years. We feel, on the contrary, that as the combined Health, Pensions, and Unemployment Insurance contributions represent a material proportion of the cost of cheap labour, there is a danger of a discrimination in favour of the employment of children under 16 years of age in certain industries. It is not easy to obtain direct evidence that insurance contributions are a factor in this connexion, but the following very guarded statement from the London Advisory Council for Juvenile Employment Report, 1924-25, is illuminating: " Those interested in the industrial welfare of juveniles have thought that the operation of Trade Board rates and the Unemployment Insurance Acts has caused certain employers to discharge their juveniles as soon as they reach 16 years in order to replace them by younger and cheaper workers. The information available has been carefully scrutinised in this connexion; only one per cent of the cases taken in July, 1924, and 0·3 per cent. of the cases taken in December, 1924, appear to have been discharged from this reason, but care should be exercised not to place undue weight on these figures as it is possible that of those whose discharge is attributed to ' slackness of trade,' &c., and amounting to 60 per cent. of the register there may be many who should be included in the category under consideration. In this same connexion it is interesting to note that the largest percentage of unemployed girls was to be found both in July and in December in the 16-17 age group."

120. It might be denied that insurability is a factor but it is not unreasonable to suggest that everything else being accounted for, employers will give preference to uninsured persons.

121. We think that the advantages to the nation of an uninterrupted medical service throughout life completely outweigh any hypothetical disadvantages in relation to a public policy which will in due course be decided from motives not related to National Health Insurance.

122. We recommend therefore (1) that the Act be amended to bring into insurance all persons employed after having reached the statutory school-leaving age; (2) that young persons shall be entitled from the date of their entry into insurance to medical benefit, possibly also a modified cash benefit, and to such treatment benefits as may be prescribed, with such administrative safeguards as may be considered necessary.

Sources of Revenue.

123. We have recommended that the cost of the extension of medical benefit as recommended in the Majority Report and the balance of the cost of the existing medical benefit should be met by the Exchequer and the local rates. We have also recommended

that the cash benefits should be raised to those of the Unemployment Act, which implies similar rates of allowances for dependants.

124. The margin in the present contribution was determined by the Departmental Actuarial Committee to be 1·55*d*. men, and ·82*d*. women. As we observe that the Majority estimate that it will be possible to provide the cost of the proposed extension of medical benefit, taken over the whole country, from the present financial resources of the system, we consider it proper to deduct the contribution value of that cost, namely ·44*d*. per week, from the actuarial calculation of the cost of existing benefits. There is therefore a margin available for our recommendations of 1·99*d*. men and 1·26*d*. women.

125. The Committee estimated that (1) to increase the rate of sickness benefit to that of unemployment benefit with one-half the rate for disablement benefit would add to the contribution of men ·9*d*. and women ·75*d*. (2) the cost of providing dependants' allowances at uniform rates with, and on substantially the same conditions as, the Unemployment Act would represent an increase in contributions of 1·6*d*. for men and ·16*d*. for women, and (3) the provision of maternity services for the wives of insured men and for insured women, would involve an increase of ·44*d*. in the case of men but would allow a reduction of ·11*d*. in the case of women.

126. The net cost of providing the benefits mentioned in the preceding paragraph, excluding the statutory State grant of two-ninths, is 2·94*d*. per week in the case of men and ·80*d*. per week in the case of women. This would leave nearly a penny (·95*d*.) a week to be found from other sources to supplement the contributions of men, but in the case of women, there is a margin of ·46*d*. towards the cost of our further proposals respecting sickness benefit after 26 weeks and maintenance allowance at confinement.

127. Our observations on the administration of sickness benefit to women during pregnancy might here be supplemented to suggest that part of the cost of the proposed maternity allowance would be a growing expenditure under any scheme. In so far as the extra moneys needed for our recommendations could not be provided on the present financial basis we submit that the general opinion, expressed so well in the Majority Report, that such services as we here recommend, will result in a higher standard of health and consequent reduction of expenditure on benefits would justify a further examination of the finances of the scheme, and that still further changes would be possible on the adoption of our recommendation to substitute the Local Authority for the Approved Society as the medium for administering all the benefits under the Act.

Summary of Conclusions and Recommendations.

We append a summary of our main conclusions and recommendations :—

(1) That it is neither necessary nor proper to confine the developments of the National Health Insurance Scheme to such as can be paid for within the present financial resources of the Scheme (para. 3).

(2) That the local administration of additional benefits could be more satisfactorily carried out by the local authorities responsible for other health services than by Approved Societies (para. 7).

(3) That the failure hitherto to give effect to the provisions of Section 107 of the Act as to inquiries into excessive sickness has been largely due to the fact that the Approved Society system is not adapted to the purpose (para. 22).

(4) That the test of good administration is not merely a low expenditure on benefits but the securing also that all insured persons receive the benefits to which they are entitled (para. 37).

(5) That the intentions of Parliament as to the control of Approved Societies by their members have not been realised (para. 40).

(6) That the Approved Society system is a hindrance to the development of a complete public health policy (para. 55).

(7) That it is undesirable to retain Approved Societies any longer as the agencies for the distribution of cash benefits to insured persons (para. 3).

(8) That Local Authorities could and should take the place of Approved Societies as the bodies through whom sickness and disablement benefits should be administered (para. 7).

(9) That there is financial loss due to the overlapping of the various health services at present in operation, and that the money available will be increased when these services are unified and controlled under the Local Authority (para. 59).

(10) That in considering the cost of proposed developments of health services there should be taken into account the loss to the nation resulting from neglect to provide sufficiently for the health of all persons who are or will be employable (para. 60).

(11) That an outlay which safeguards industrial well-being and conduces to efficiency should not be regarded as a burden on industry or on the community (para. 61).

(12) That as the provision of a complete medical and treatment service would tend to prevent sickness and to effect a speedier and more complete cure of illness, it would result in economy of expenditure on cash benefits, and that the provision

of such a service should not, therefore, depend for its finance entirely upon current contributions (para. 66).

(13) That medical benefit should be extended to include attendance at confinement, and dental and ophthalmic advice and treatment (para. 70).

(14) That medical benefit should be provided for the dependants of insured persons (para. 72).

(15) That the transfer to Local Authorities of the responsibility for the administration of medical benefit should be accompanied by some direct financial responsibility on the part of those authorities (para. 80).

(16) That the cost of the present medical benefit in excess of the sum of 9*s*. 6*d*. per insured person per annum, for which permanent provision is made, should be borne by the Treasury and Local Authorities as provided by Section 85 of the Act (para. 81).

(17) That the cost of the extension of medical benefit by the inclusion of a specialist and consultant service should also be met under the provisions of Section 85 of the Act (para. 82).

(18) That the dental treatment to be included in medical benefit might at the outset be restricted to such a partial service as could be provided at a cost of £2¼ millions a year, and that existing surpluses should be made available for the provision of the service (para. 89).

(19) That the normal rates of sickness benefit should be raised to 18*s*. a week for men and 15*s*. a week for women (para. 96).

(20) That benefit at the normal rate of sickness benefit should be payable to an insured person so long as he remains incapable of work (para. 101).

(21) That when an insured person is incapable of work allowances in respect of his dependants should be provided at the same rates as those under the Unemployment Insurance Act (para. 102).

(22) That the high maternal death rate and the great amount of sickness amongst mothers clearly prove the need of re-organisation and extension of the provision for maternity (para. 105).

(23) That the medical services during pregnancy and at confinement should be co-ordinated with the Maternity and Child Welfare service under the Local Authorities (para. 109).

(24) That in addition to medical services during pregnancy and at confinement there should be in the case of an uninsured wife of an insured man a maternity benefit in the form of a cash payment of 20*s*., and in the case of an insured woman maintenance for the mother and child at a rate not less than that

of sickness benefit for a period of 12 weeks, being not more than six weeks before and six weeks after confinement (para. 113).

(25) That the Act should be amended so as to bring into insurance all persons employed after having reached the statutory school leaving age (para. 122).

(26) That any persons up to the age of 16 should be entitled from the date of their entry into insurance to medical benefit and, in lieu of cash benefits, to such treatment benefits as may be prescribed (para. 122).

(27) That we concur in the recommendations contained in the Majority Report for the improvement of the present Scheme of National Health Insurance in so far as those recommendations are not inconsistent with those set out above.

We desire to associate ourselves most cordially with our colleagues in acknowledging the great services which have been rendered to us by our Secretary, Mr. E. Hackforth, and our Assistant Secretary, Mr. J. W. Peck.

All which, with our humble duty, we submit for Your Majesty's gracious consideration.

(Signed) JAMES COOK.
JOHN EVANS.
F. N. HARRISON BELL.
GERTRUDE M. TUCKWELL.

22nd February, 1926.