Secretary of State on methods of effecting the closer liaison between the family doctor, the child welfare clinics and the hospital, as forecast by the Orr Report on Infantile Mortality. They will be there to advise all those authorities as needed, and will be able also to send representatives to sit with the larger Regional Hospitals Advisory Councils to assist—with their right of directly expressing their views to the Secretary of State at any time—in making the liaison complete.

In addition, as the new general practitioner service will no longer require the local Insurance Committees which have operated under the National Health Insurance scheme in the past, no doubt such of the functions of these bodies as do not need in future to be centrally undertaken might be usefully entrusted to the Local Medical Services Committee. But these are matters for later consideration.

VIII.

PAYMENT FOR THE SERVICE.

The cost of the comprehensive health service will mainly fall upon central and local public funds. The ways in which it might be shared between the exchequer and the local rates, and other financial aspects of the service generally, are considered in the Financial Memorandum appended (Appendix E).

So far as individual members of the public are concerned, they will be able to obtain medical advice and treatment of every kind entirely without charge except for the cost of certain appliances. They will be paying for medical care in a new way, not by private fee but partly by an insurance contribution under whatever social insurance scheme is in operation and partly by the ordinary process of central and local taxation. The position in regard to disability benefits, for those ill at home and for those in hospital, will be dealt with in the Government's later proposals on social insurance.

Hospitals in the scheme will, as explained, receive from central funds payments which will include their share of the money representing the social insurance contributions of the public, so far as this is attributable to hospital services. This share can be payable on a bed-unit basis, according to the number of beds put into the service by each hospital under each area plan—except that the share of the voluntary hospitals can, if they wish, be pooled and redistributed in the manner earlier mentioned.

The voluntary hospitals will receive in addition fixed service payments from the new joint authority in respect of all services which they render to the scheme. For the rest, they will meet the costs of their participation in the service out of their normal resources, including charitable subscriptions and donations, on which their voluntary status depends. The position of medical teaching will be specially considered.

The joint authorities will receive from central funds the bed-unit payments which include their share of the social insurance contributions attributable to hospital services. Otherwise their expenses in the service—including their service-payments to voluntary hospitals—will be met partly out of rate resources and partly out of central funds. For their rate revenues the joint authorities will depend upon precept upon the counties and county boroughs included in each joint area. The county and county borough councils will receive Exchequer aid towards the cost of meeting these precepts and their own expenses in the service.

IX.

GENERAL SUMMARY.

It may be convenient, at this point, to summarise the proposals of this Paper in outline:—

1. Objects in view.

(1) To ensure that everybody in the country—irrespective of means, age, sex, or occupation—shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.

(2) To provide, therefore, for all who want it, a comprehensive service covering every branch of medical and allied activity, from the care of minor ailments to major medicine and surgery; to include the care of mental as well as physical health, and all specialist services, e.g. for tuberculosis, cancer, infectious diseases, maternity, fracture and orthopaedic treatment, and others; to include all normal general services, e.g. the family doctor, midwife and nurse, the care of the teeth and of the eyes, the day-to-day care of the child; and to include all necessary drugs and medicines and a wide range of appliances

(3) To divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge (apart from certain possible charges in respect of appliances) and to encourage a new attitude to health—the easier obtaining of advice early, the promotion of good health rather than only the treatment of bad.

2. General principles to be observed.

(1) Freedom for people to use or not to use these facilities at their own wish; no compulsion into the new service, either for patient or for doctor; no interference with the making of private arrangements at private cost, if anyone still prefers to do so.

(2) Freedom for people to choose their own medical advisers under the new arrangements as much as they do now; and to continue with their present advisers, if they wish, when the latter take part in the new arrangements.

(3) Freedom for the doctor to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference.

(4) The personal doctor-patient relationship to be preserved, and the whole service founded on the "family doctor" idea.

(5) These principles to be combined with the degree and kind of public organisation needed to see that the service is properly provided—e.g. to ensure better distribution of resources and to give scope to new methods, such as group practice in Health Centres.

3. General method of organising the service.

(1) The maximum use of good existing facilities and experience; no unnecessary uprooting of established services, but the welding together of what is there already, adapting it and adding to it and incorporating it in the larger organisation.

(2) The basis to be the creation of a new public responsibility; to make it in future somebody's clear duty to see that all medical facilities are available to all people; the placing of this duty on an organisation answerable to the public in the democratic way, while enjoying the fullest expert and professional guidance.

(3) Some temporary limitations of the full service inevitable—e.g. in dentistry (owing to insufficient dentists), in ophthalmology and perhaps elsewhere; but the design to be comprehensive from the outset, and to be fulfilled as fast as resources and man-power allow.

(4) The first step to be the making of positive plans for each area of the country, determining what is needed for all people in that area; this to be followed by measures to ensure that what is needed is then secured.

(5) A combination, for all this, of central and local responsibility, to ensure that both general national requirements and varying local requirements are equally met.

4. **The administrative organisation; central and local.**

(1) **Central.**

(i) Central responsibility to Parliament and the people to lie with the Minister.

(ii) At the side of the Minister, to be a new central and statutory organisation for voicing professional views on technical aspects of the service generally; to be known as the Central Health Services Council; to represent general and specialist medical practice, medical teaching, hospital organisation and other professional interests; to be appointed by the Minister in consultation with those interests, and to choose its own chairman; to be consultative and not executive; to advise the Minister not only on questions referred to it by the Minister but also on its own initiative; the Minister to report annually to Parliament on the work of the Council.

(iii) A special executive body to be also set up, composed in the main of members of the medical profession; to be known as the Central Medical Board, and to act under the general direction of the Minister; to be the " employer " body with which the general practitioner enters into contract in the new service, and to concern itself with the distribution and welfare of practitioners and assistants.

(2) **Local.**

(i) Local organisation to be based on the county and county borough councils, operating in their normal local government areas where possible, but combining as joint authorities over larger areas where necessary.

(ii) Areas of suitable size and resources for the operation of a full hospital service of all kinds, to be designated by the Minister after consultation with local interests.

(iii) For each of these new hospital areas a joint authority to be constituted, being a combination of the existing county and county borough councils in the area; in the few cases where the area may coincide with an existing county area, the authority to be the county council of that area.

(iv) The new joint authority also to be charged with preparing an area plan for the health service as a whole, not only the hospital service, in manner described below.

(v) Existing county and county borough councils, while combining for these duties of the new joint authority, to be responsible severally for local clinic and domiciliary services not belonging to the hospital and consultant sphere, within the general area plan; the responsibility for child welfare to be assigned broadly on the same lines as responsibility for child education. General medical practice to be the subject of special organisation, partly local, partly central.

(vi) In each joint authority area, to be a local consultative body for voicing professional guidance on technical aspects of the service; to be known as the Local Health Services Council; to serve a similar purpose locally to the central professional body already described; to advise both the joint authority and the county and county borough councils, and to be free to express advice and views to the Minister.

5. **The planning of the local services.**

(1) Each joint authority, in consultation with the local professional body referred to and with others locally concerned, to prepare an " area plan " for securing the comprehensive health service for its area; the plan to be based on an assessment of the needs of the area in all branches of the service, to propose how each of those needs should be met, and to be submitted to the Minister.

(2) The Minister to consider each area plan, and any representations made to him by the local professional body or others affected, and to approve the plan with or without modification; the plan, as approved, to be the operative plan for that area; to be the duty of all concerned to provide and maintain their services within the general framework of the plan; the plan to be modified or replaced from time to time, according to requirements, by the same procedure.

6. **Provision of the various parts of the service under the plan.**

(1) **Hospital and Consultant Services.**

(i) To be the duty of the joint authorities themselves to secure a complete hospital and consultant service for their area—including sanatoria, isolation, mental health services, and ambulance and ancillary services—in accordance with the approved area plan.

(ii) The joint authorities to do this both by direct provision and by contractual arrangements with voluntary hospitals (or with other joint authorities) as the approved area plan may indicate.

(iii) Powers of present local authorities, in respect of these services, to pass to the joint authority, with all existing hospitals and similar institutions.

(iv) The voluntary hospital system to continue side by side with the publicly provided hospitals; voluntary hospitals to participate, if willing to do so, as autonomous and contracting agencies; if so, to observe the approved area plan and to perform the services for which they contract under that plan, and to receive various service payments.

(v) All hospitals, municipal or voluntary, taking part in the service to observe certain national conditions (e.g. as to remuneration of nurses, appointment of consultants); these conditions being centrally prescribed.

(vi) Special provision to be made for inspection of the hospital service, through selected expert personnel (some part-time) working in panels over different parts of the country.

(vii) Consultant services to be made available to all, at the hospitals, local centres or clinics, or in the home, as required; to be based on the hospital service, and arranged by the joint authority, either directly or by contract with voluntary hospitals under the approved area plan.

(viii) Measures for improving the distribution of consultants, dealing with methods of appointment and remuneration, and relating this to other branches of the new service generally, to be considered after the report of the Goodenough Committee, but general direction of changes to be:—

(*a*) Consultants taking part to be remunerated in future (usually by part-time or whole-time salary) by the particular hospital or hospitals with which they are associated under the area plan; standards

of remuneration to be centrally settled in consultation with the profession.

(*b*) New arrangements for securing proper standards for consultant appointments in the service, possibly through suitable machinery set up to advise all hospitals making appointments of senior staff.

(2) **General medical practice.**

(i) The Minister, with the new Central Medical Board, to undertake nationally the main arrangements for a general practitioner service for the country, through which anyone who wishes to do so can associate himself with a "family doctor" of his own choice and obtain the advice and treatment of that doctor at home or at his present consulting room or at a specially provided and equipped consulting room in a Health Centre, as the case may be.

(ii) These central and national arrangements to cover terms of service, remuneration of doctors from public funds, and other general aspects of organisation, and the individual doctor to be in contract with the Central Medical Board.

(iii) The joint authority in each area to have the duty of:—

(*a*) including in their area plan an assessment of the needs of their area in general medical practice;

(*b*) keeping these needs under review and bringing to the notice of the Minister and the Central Medical Board any general features or requirements of the general practitioner situation in the area which they consider to need attention;

(*c*) ensuring that general medical practitioners taking part in the service in the area are acquainted with hospital and consultant and other services available under the area plan, and that they are able (as, under their terms of service, they would be required) to use those services for their patients.

(iv) The county and county borough councils to be responsible for providing, equipping and maintaining such Health Centres for the conduct of general medical practice in the new service as may be approved from time to time by the Minister in respect of any part of their area, and in such cases to be joined in the doctor's contract with the Central Medical Board.

(v) Future development to include both new methods of "grouped" medical practice in Health Centres (and, where suitable, outside them) and familiar methods of "separate" practice; each being developed as experience proves best in each area. A high place in the scheme to be given to a full and careful trial of the Health Centre method.

(vi) Existing practitioners to be able to participate in the new service in their present areas of practice, and where they do so from their own consulting rooms to be normally remunerated on a capitation basis (though other methods to be considered in certain cases if desired by the practitioners themselves). Where they participate in group practice in Health Centres, remuneration to be by salary or similar alternative.

(vii) Practice in the public service not to debar a doctor from private practice for such patients as may still request this.

(viii) Appropriate limits to be fixed to the number of persons whose care a particular doctor can undertake, taking into due account the extent of private medical practice and the calls made upon a doctor's time by other public appointments; higher limits where assistants are engaged; more regulation of the conditions of the employment of assistants in the service;

a requirement that newly qualified doctors shall normally serve a period as assistants before practising on their own in the new service, and power for the Central Medical Board to require them to give full time to the public service in their early years if necessary.

(ix) New practitioners wishing to participate in the service, and existing practitioners wishing to do so in new areas or new practices, to be required to obtain the consent of the professional Central Medical Board—to check the need for additional public practice in the area, and to ensure a reasonable distribution of resources inside the public service.

(x) Compensation for loss of selling value of practices to be payable where a doctor transfers his public practice into a Health Centre, or where a public practice falling vacant is not allowed to be refilled by the Central Medical Board.

(xi) Superannuation to be provided for doctors practising at Health Centres and, if practicable, for doctors participating in the service in other forms of practice.

(xii) The question of the sale and purchase of public medical practices in future to be discussed more fully with the profession.

(3) **Clinic and other local services.**

(i) To be the duty of the joint authority to deal in its area plan with all necessary clinic and other local services (e.g. child welfare, ante-natal and post-natal clinics, home-nursing, health visiting, midwifery and others), and to provide for the co-ordination of these services with the other services in the plan.

(ii) Administration of these local clinic and non-hospital services, however, to be normally the responsibility of the individual county and county borough councils which collectively make up the joint authority: the administration to be in accord with the general provisions of the area plan.

(iii) The exact allocation of responsibility between the joint authority and the individual county and county borough councils to be settled in each case by the Minister in determining the area plan; but normally on the principle that services belonging to the hospital and consultant sphere fall to the joint authority, while other local and clinic services fall to the individual councils.

(iv) Child welfare duties always to fall to the authority responsible for child education under the new Education Bill, but to be as much the subject of the "area plan" as any other branch of the service.

(v) New forms of service, e.g. for general dentistry and for general care of the eyes, to be considered with the professional and other interests concerned as soon as circumstances allow. In the case of dentistry, the report of the Teviot Committee to be first awaited.

7. **The service in Scotland.**

(1) The scope and objects of the service to be the same in Scotland as in England and Wales, and the foregoing proposals to apply generally to both countries—but subject to the differences below.

(2) Certain differences in detailed application in Scotland, due to special circumstances and geography and existing local government structure there; differences mainly affecting the arrangement of responsibility, central and local, for planning and carrying out the service.

(3) Central responsibility to rest with the Secretary of State. A Central Health Services Council and a Central Medical Board to be set up, as in England and Wales.

(4) Local organisation to differ from that in England and Wales and to be on the following lines:—

(*a*) Regional Hospitals Advisory Councils to be set up for each of five big regions; to consist of equal representation of the new local authority Joint Hospitals Boards (below) and of voluntary hospitals; also representation of the Local Medical Services Committee (below) and of medical and medical-education interests; independent chairman to be appointed by Secretary of State.

Councils to be advisory to Secretary of State on the co-ordination of the hospital and consultant services in each region.

(*b*) Joint Hospitals Boards to be formed by combinations of neighbouring local authorities (county councils and town councils of large burghs), to ensure an adequate hospital and consultant service in their areas; these to take over all responsibility for the hospital services of the constituent authorities (including services like the tuberculosis dispensaries, which essentially belong to the hospital and consultant field) and also to arrange with voluntary hospitals.

These Joint Boards to prepare a scheme for the hospital service of their areas, to submit this to the Secretary of State, who will consult the Regional Hospitals Advisory Council before deciding to approve or amend it.

(*c*) Education authorities (county councils and town councils of four cities) to retain responsibility for school health service and clinics; existing major authorities (county councils and town councils of large burghs) to retain responsibility for the ordinary local clinic and similar services; the necessary co-ordination to be secured (i) through their membership of the Joint Hospitals Boards and (ii) through the Local Medical Services Committees (below).

Powers of Secretary of State to be strengthened to require local authorities to combine for any purpose proved necessary, after public local enquiry, for the efficiency of the new service as a whole.

(*d*) Local Medical Services Committees to be set up over the same areas as the Joint Hospitals Boards; to be advisory bodies; to include representation of all the local health authorities and of local medical, dental, pharmaceutical and nursing professions and other interests; free to appoint smaller sub-committees and groups, as found desirable.

These Committees to advise the Secretary of State on local administration of the general practitioner service; also to provide liaison between the different branches of the service.

(5) Central provision of Health Centres more suitable in Scotland owing to the smaller size of the problem and the special circumstances of geography and distribution of population—with a power to the Secretary of State to delegate his functions in this respect to a local authority, where found desirable.

8. **Financial.**

(i) The service to be free to all, apart from possible charges for certain appliances. Questions of disability benefits, for those ill at home and for those in hospital, to be dealt with in later proposals on social insurance.

(ii) Cost of the service to be met from both central and local public funds. These arrangements, as affecting the various local authorities and the voluntary hospitals, are fully considered in a special financial memorandum appended.

APPENDIX A.

THE EXISTING HEALTH SERVICES.

GENERAL SURVEY OF THE PRESENT SITUATION AND ITS ORIGINS.

ENGLAND AND WALES.

Before the nineteenth century there was little regular intervention by public authority in the personal health of the people, which was left to rest in the main on private arrangements and on various forms of charity and voluntary organisation for relief. The early nineteenth century brought the beginning of full-scale attempts to protect and relieve the destitute (and as a corollary to tend the destitute sick) and also a quickening of interest in the welfare of the younger generation, particularly in the supervision of child labour in industry. As the century went on, more attention began to be given to the environmental conditions of health, to sanitary services, drainage, water supply, street cleaning and the whole make-up of public hygiene, and to the idea of local government responsibility in matters of public health—while measures for the prevention of the major infectious diseases, including notification and isolation, became more and more the subject of public regulation and concern. It was not, however, until the present century that the public provision of direct services for personal health began to get into its real stride, and began to evolve the wide variety of services which are now familiar—like the services for maternity and child welfare, midwifery, tuberculosis, the health of the school child, the National Health Insurance scheme, venereal diseases, and the provision of general hospitals by public authority for others than the destitute sick.

In general terms, the result is a complicated patch-work pattern of health resources, a mass of particular and individual services evolved at intervals over a century or more—but particularly during the last thirty or forty years—and for the most part coming into being one by one to meet particular problems, to provide for particular diseases or particular aspects of health or particular sections of the community. Each, as it emerged, was shaped by the conditions of its time, by the limited purposes for which it was designed, and perhaps by the fashions of administrative and political thought current when it was designed. Most of these services, though progressively expanded and adapted as the years have gone on, are still broadly running on the lines laid down for them at the start and are administered largely, or partly, as separate and independent entities. The patchwork, however, contains some very good pieces—well established and by now rich in experience.

It is worth looking at these principal pieces in more detail—to make a survey of how the ordinary man and woman and child can at present get the various medical services which they need.

General Medical Care.

To the individual the natural first-line resource in all matters of personal health is the general practitioner—the personal medical adviser, the " family doctor." With one important exception (and a few minor ones) the relationship of the ordinary member of the public to the general medical practitioner has been, and is now, a matter of private arrangement. He makes his own choice of doctor, from among those who happen to be accessible to him, seeks his advice and attention when he wishes to, and pays whatever private fees the doctor is accustomed to charge him. The relationship is a purely personal one between doctor and patient, and no form of public organisation is involved in it. The general medical practitioner, for his part, pursues his profession privately and individually. He decides for himself where he wishes to practise, he usually obtains the " good-will " of an existing practice by purchase from another practitioner, and he practises in the open competitive market. He may choose to combine with other practitioners in a voluntary partnership—and there is an increasing tendency to do so in recent years—but that is an individual decision and a matter of business agreement. The traditional basis of general medical practice, in fact, is one of free and private buying and selling in which the State does not intervene—apart from the provisions of the Medical Acts with regard to qualification and registration and professional conduct.

The earliest exception to this rule was the provision of a general practitioner service under the poor law. An organisation designed for the "destitute sick," and including a domiciliary service, was gradually built up throughout the nineteenth century and still gives valuable aid to those in difficulty. Although generally officered by part-time (or occasionally whole-time) District Medical Officers, it has in recent years been converted in some areas into a service of the "panel" type, in which all doctors practising in the locality can take a share. Apart from this limited service, arrangements for general practitioner treatment were, up to 1912, either of a purely private kind or were organised by Friendly Societies, medical clubs and similar organisations.

The National Health Insurance service, instituted in that year, formed part of the provision made by the National Health Insurance Act for the protection of the bulk of the working population against loss of health and for the prevention and cure of sickness. Broadly speaking, its "medical benefit" extends to the whole insured population (some 21,000,000 people) representing for the most part those employed under contracts of service whose income is less than £420 a year. These select from the local panel of doctors their personal medical attendant, who can be consulted as and when the need arises, without fee, and from whom they can obtain such advice and treatment (including visits at their homes) as are within the ordinary scope of the general practitioner. Similarly, they can obtain drugs which the doctor considers requisite and a limited class of surgical and medical appliances. Provision is also made for the issue of medical certificates free of charge. Any doctor who so wishes has the right to take part in the service. The range of medical benefit provided by the scheme does not normally cover consultants or hospital services, although certain facilities for obtaining specialist advice and diagnostic services in difficult cases are afforded. The scheme is designed in fact, for a limited object, which is to enable the great bulk of the employed population to get advice and treatment and necessary medical certificates from doctors of their own choice, without the deterrent of fees. This object has, on the whole, been fulfilled.

Apart from the National Health Insurance scheme and the poor law, there is no public provision for general medical attention on any considerable scale. There are various special services for children and other limited groups, as will be seen. Also some adult members of the public are entitled to general advice and treatment under schemes for particular vocational groups (such as Post Office employees or the Police) some carried on by Government departments, others by local authorities, and others by large industrial concerns. Some members of the public—particularly in parts of the London area—obtain advice and treatment from the out-patient departments of hospitals and from dispensaries of various types without going first to a general practitioner. Others do so through co-operative arrangements made in societies or clubs—an example of which can be seen in the "Public Medical Services" set up in some areas, largely for the dependants of insured persons, on the initiative of the medical profession itself. A war-time development of a somewhat similar kind has been the arrangement made by the Government, through the Local Medical War Committees of the profession, for the medical attendance of evacuated schoolchildren.

Hospital and Consultant Services.

For those who require hospital treatment, as in-patients or as out-patients, or who require specialist advice beyond the ordinary scope of the general medical practitioner, a wide range of hospital services is available. The individual may, of course, choose to enter a private nursing home and to engage the services of a specialist to attend him there—just as he may, for consultation, make purely private arrangements with the specialist at his home or at the specialist's consulting room. In such cases the whole matter is one of personal arrangement at private cost, in which no intervention of a publicly organised service arises—although the State intervenes to a limited extent to secure reasonable standards by the registration and inspection of nursing homes. Similarly, the individual may arrange to enter a private room or ward set aside in a voluntary hospital for those who want to make their own arrangements at their own expense. Apart from any such private arrangements as these, the public look to the ordinary hospital services both for hospital treatment and for specialist medical advice, usually arranging for either or both through their general medical practitioner in the first instance.

There are two distinct systems of hospital provision in this country, running side by side—the voluntary hospitals and the public or municipal hospitals. They have quite separate origins and histories, and are quite differently organised and financed. In earlier years the two systems had little working contact with each other and each went its own way with its own kind of service to the public. In recent years there has been an increasing tendency for the two systems to get closer together, to realise their common aims in the service of the public and the value of a greater degree of organised partnership in improving that service together. But in all questions of hospital provision and of future hospital reorganisation it has to be clearly kept in mind that there are these two quite distinct systems at the moment, and that both are strongly rooted and established, with their own traditions and experience. The way this has come about, and the extent to which each contributes in making up the present total service, are not always clearly kept in mind—and are worth summarising.

Until recent years the main burden of providing hospital treatment for acute medical and surgical conditions (though not so much for infectious diseases or mental ills) was carried by the voluntary hospitals, and rested in fact upon voluntary philanthropy rather than on publicly organised provision. The voluntary hospital is, in essence, an independent charitable organisation, deriving its money from the voluntary subscriptions or donations or endowments of benevolent individuals or associations; it is administered by its own governing body or trustees and provides its own service to the public in its own way, subject to the conditions laid down by its constitution. In origin, a few of them can trace their existence back to mediaeval ecclesiastical foundations, but the great majority have come into being during the last two hundred years. There are, at the present day, more than a thousand voluntary hospitals in England and Wales, and they vary enormously in type and size and function. Some of them are large and powerful general hospitals of the kind familiar in London and certain of the big cities, with distinguished specialists and consultants available, with first-class modern equipment and treatment facilities, sometimes associated with well-known medical schools, and drawing their patients from areas wide afield—as leading institutions in the medical world. Others are highly specialised hospitals, concentrating on particular kinds of diseases and conditions such as eye conditions, or ear, nose and throat complaints, or diseases of the nervous system. The rest cover a wide and varying range of size and function, with varying degrees of specialist and other facilities, including a large number of small "cottage" hospitals served in the main by the local general practitioners and really functioning as local nursing homes for the mutual convenience of doctor and patient. Something of the diversity of size and scope of the voluntary hospitals is evidenced by the fact that, of rather more than 900 hospitals in England and Wales of which particulars were available before the war and which provided about 77,000 beds, there were about 230 specialised hospitals dealing mainly with particular diseases, and the general all-purpose hospitals numbered about 700. Of these 700 only some 75 were hospitals of more than 200 beds (and about 25 of these were teaching hospitals); some 115 of the rest provided between 100 and 200 beds each; over 500 had less than 100 beds, and more than half of these had less than 30 beds.

The other arm of the present hospital services—the hospitals provided directly by public authority out of public funds—had its first roots partly in the early public measures for protecting the sick poor, in the first half of the last century, and partly (a little later in that century) in measures which were taken to combat the spread of epidemic infectious diseases. From these two strains there gradually emerged, in recent years, the wider conception of providing through local government machinery and out of public funds a general hospital service—no longer related only to the sick poor or to infectious diseases, but catering for the ordinary public and their ordinary hospital needs.

From the time of the earliest poor-houses it was usual to provide some sort of public accommodation for the destitute sick. Out of the first horrors of the mixed workhouse there began to emerge the notion of the separate and special sick ward, endorsed by the Poor Law Commissioners and adopted more and more by the early Boards of Guardians; from this the wholly separate infirmary or poor law hospital developed—catering still in the main for the chronic and incurable or senile cases. Standards improved, the poor law flavour diminished, and the interpretation of the " destitute " sick became elastic; the field of treatment grew and the poor law idea as a whole became outworn as the expanding public health services began to oust it. This long process of over a century culminated at last, in 1930, in the final acceptance of the principle that general hospital provision was a proper activity of the major local health authorities, rather than of the poor law machinery.

Since 1930 it has been the accepted function (though not the statutory duty) of the major local authorities—the county and county borough councils—to enter the field of general hospital provision for the ordinary hospital case, side by side with the voluntary hospitals already engaged in that field. Many of the earlier poor law hospitals have been taken right out of the poor law sphere and converted to this new and wider function, and new hospitals have been built. Some of the older poor law hospitals still form part of the poor law service (which has itself also passed into the hands of the county and county borough councils), but many even of these have lost their earlier poor law atmosphere. The result of all this new activity is that, just before the war, there were in England and Wales—quite apart from special hospitals for such conditions as maternity, tuberculosis, or infectious diseases—nearly 70,000 beds in 140 general hospitals maintained by the local health authorities under public health powers, and nearly 60,000 more in 400 hospitals and institutions still administered under the poor law. This great pool of 130,000 beds represents a varied service, at every stage of development from the sick wards of an institution for the aged or chronic sick to the most modern and up-to-date of hospitals with every kind of special department and equipment and highly skilled staff.

It has for some time been recognised that all these varying and independently provided hospital facilities, both in the voluntary system and in that of the public authorities, need a great deal more co-ordinating, and some supplementing, so as to ensure a right distribution of hospital accommodation according to local need—and so as to secure that all the types of specialised and general work which the different hospitals are best qualified to perform are arranged in some better related scheme; in a word, to make the hospitals complementary to each other in a combined and balanced service.

At present the hospital facilities to which any particular individual can get access, when in need, depend to a large extent on what kind of hospitals happen to be available in his area, on his ability—if the right hospital is not at hand—to go perhaps a long way afield and arrange for admission to one elsewhere, and on the extent to which his local doctor has been able by his own initiative to maintain personal contact with hospitals and consultants. It is not at present the duty of any public authority, central or local, to ensure that all the right kinds of hospital facilities are available and reasonably accessible to him or that every general practitioner is readily able to obtain every kind of hospital or consultant service which he is likely to need for his patients. The exercise by the major local authorities of their power to provide hospitals and the activities of voluntary hospitals do between them often have the result that the right hospital is where it is wanted and do usually have the result that hospital provision of some kind is available in every area. But these present powers and activities do not extend to any duty to review all branches of the local hospital service and to see that they are so adjusted to each other—and if necessary so supplemented—that the total service available corresponds, both in kind and in quality, with the likely demands upon it. The anomalies of large waiting lists in one hospital and suitable beds empty at another, and of two hospitals in the same area running duplicated specialist centres which could be better concentrated in one more highly equipped and staffed centre for the area, are largely the result of a situation in which hospital services are many people's business but nobody's full responsibility.

When admitted to hospital in the ordinary way, the patient is usually expected to pay what he can reasonably afford towards the cost of his treatment and accommodation there. Local authorities are required to make these charges (except in the case of infectious disease, where they have a discretion) and voluntary hospitals usually follow the same practice. Very often the patient compounds for this liability by joining one of the many contributory schemes, associated with voluntary hospitals, in which he pays a small sum weekly and in return is paid for by the scheme's fund when he is in hospital. Those schemes may apply only to a particular hospital or group of hospitals—on which he must then depend entirely or go elsewhere and pay what he can afford—or they may (and this is the growing tendency in the more up-to-date schemes) entitle him to be relieved of payment in any hospital, whether voluntary or belonging to a public authority, in a wide variety of hospitals.

On many of the existing hospitals the war-time Emergency Hospital Scheme of the Government has had a considerable effect. Seeking to use (and where necessary to improve) the services of the hospitals for various war-time purposes, this emergency service has temporarily entered the field, adding new buildings and extensions to the number of about 50,000 beds; up-grading surgical and X-ray and other medical facilities; relating the hospitals one to another for the interchange of patients according to their special needs; developing specialised treatment centres for fractures and rehabilitation, brain surgery, chest disorders, neurosis and other purposes; and providing inter-hospital transport, country branches and recovery and convalescent homes. It is a war-time organisation which would not suit the requirements of peace; but it will, in its passing, have left improved resources—even entirely new hospitals where none existed before—and above all experience of what it means to translate a collection of individual hospitals into something of a related hospital system.

Rehabilitation.

What has come to be known as " rehabilitation " is more a process or a method than a separate organisation or service. But its requirements, in modern technique, have caused it to be so often specially and separately considered in recent years that it justifies special mention in this review.

So far as it belongs to the sphere of the health services (it is partly a health problem, partly an industrial and vocational one) it rests on the principle that the actual mending or curing of an injury or disease is often not sufficient unless it is accompanied by a process of completely restoring the whole of the patient's previous capacities—or doing so as completely as possible; i.e. restoring the whole of muscle tone, of full function, of general health and strength, as well as cure of what was wrong. It involves various processes supplementary to ordinary treatment, such as massage, exercise, electro-therapy and occupational therapy, and therefore it may often involve special accommodation and apparatus and staff. Thus, while in principle it has been accepted in good surgery and medicine for a long time, it has still not become as much part and parcel of hospital and medical practice as many think it ought to be, and it is legitimate criticism of the existing services that they are not yet organised on the whole (although there are brilliant exceptions in particular areas and institutions) to give the scope that ought in future to be given to the rehabilitation aspect of hospital and medical treatment.

Considerable experiment has been conducted—and considerable result achieved—in this direction by developments in particular hospitals and centres under the Emergency Hospital Scheme. An important review of the whole subject was published recently in a report of an Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons, and this report recommended greatly increased attention to the rehabilitation principle in any future arrangements of the hospital and health services. The subject is not one for any detailed review here, but it has to be mentioned if only to note what has hitherto been a deficiency in existing services and to keep in mind the necessity for developing it in any reorganisation.

Infectious Diseases and Isolation Hospitals.

Apart from sanitary and other improvements, public action in relation to infectious diseases was first taken in the Vaccination Act of 1840, providing public

facilities for vaccination against smallpox. In 1853 provision was made for penalties against parents for failure to have their children vaccinated, and a series of enactments on the vaccination question followed right up to the present century. Since 1898 it has been possible for a parent or guardian who believes that vaccination would prejudice a child's health to withdraw the child from the application of the Acts. At the present time only one-third of the children born each year are vaccinated. It is probable that the time has come to amend the law, and to substitute for compulsory vaccination a system of free vaccination for all through the family doctor, the clinic services, or otherwise. This is the method adopted during the present war in organising the immunisation of children against diphtheria. Supplies of the necessary toxoid have been provided free, and immunisation has been performed normally without charge to parents, while every method of publicity has been used to encourage them to take advantage of the facilities provided. By the end of 1942 about half the child population under 15 had been immunised.

Infectious diseases are the subject of a special service of treatment in isolation hospitals, which is provided by the councils of the boroughs and urban and rural districts, but not usually the county councils. This separately organised service was one of the earliest of the local government medical services to take shape—as far back as 1866. Before that, some of the charitable institutions had provided specially for fever or smallpox patients, and the invasions of Asiatic cholera which began in 1831 had reinforced the arguments of the Poor Law Commissioners that there should be more regular provision made for infectious diseases; but only temporary measures had been taken during epidemics under orders made by the Privy Council. The first real powers to provide public isolation hospitals began with the Sanitary Act of 1866, and from then on the local authorities of the sanitary districts—which became in time the county borough, borough and urban and rural district councils—began to develop, severally or in combination, the system of the separate treatment of infectious diseases in isolation hospitals which exists to-day. In London a special Metropolitan Asylums Board was created in 1867 for the central provision of asylums for certain of the sick poor, and it became in time the general provider of infectious diseases hospitals for the metropolis, until its services were finally transferred to the London County Council in 1930. In spite of the general tendency to attach public hospital provision to county councils and county borough councils, the county councils were not, prior to 1929, brought very directly into the infectious diseases service, though they were given certain powers by the Isolation Hospitals Acts, 1893 and 1901, which have since been repealed. In 1929, by the Local Government Act, they were given the function of drawing up a local scheme for adequate isolation accommodation in each county, in consultation with the county district authorities. The carrying out of the schemes has normally remained a function of the latter authorities, though occasionally a county council has undertaken the provision for the whole or part of a county.

In 1889 the sanitary authorities were authorised to make certain infectious diseases notifiable in their respective districts, if they so desired; before that notification applied only in a few areas where special powers had been conferred. Ten years later the notification principle was made universal throughout England and Wales for these diseases. Other diseases, such as tuberculosis, have since been made notifiable by general regulation of the Minister. Local authorities can also, with the Minister's approval, make local additions to the list.

The present situation is that there are some 1,500 local authorities with powers to provide for the hospital treatment of infectious diseases (including smallpox) in their areas. They do not all make separate and independent provision, and the obvious good sense of pooling resources so as to plan a more useful and economical service for larger areas has resulted in many of them combining into formal Joint Boards or less formal joint committees for the purpose. About 800 of them have so combined, into about 160 Joint Boards—apart from the other less formal combinations referred to—so that the principle of planning over more suitably sized areas already exists to a considerable extent in this service.

Altogether there were, just before the war, something like 38,000 beds in isolation hospitals provided under the infectious diseases and smallpox service, and they were to be found in some 810 separate hospitals, about 630 of which contained less than 50 beds. The hospitals thus tend to be small (although there are well-known exceptions) and they vary considerably in quality. Some of the provision is very good of its kind, much of it reasonably satisfactory; but in general the small and separate hospital for infectious diseases is uneconomical, viewed as a medical and nursing organisation; and for most infectious diseases it is to be regarded as less satisfactory—in future planning from the medical point of view—than either the provision of larger units or of separate blocks inside the bigger organisation of the general hospitals.

Admission to infectious diseases hospitals is in many areas quite free of charge for any of the inhabitants of the area—as distinct from the ordinary practice of recovery of costs according to ability to pay, which applies in the general hospital services.

Tuberculosis.

Public measures for the care of the tuberculous are organised under a separate machinery, and in many cases by different authorities from those concerned with general infectious diseases. Before 1912 there existed some 5,000 or 6,000 tuberculosis beds in sanatoria or hospitals, mostly administered by voluntary organisations or private individuals, and mostly quite small. The greater part of them had been established within the previous ten years or so. A few local authorities had provided sanatoria themselves, and some were treating tuberculosis cases in smallpox hospitals or infectious diseases hospitals when accommodation was available. There were also about 50 tuberculosis dispensaries in existence. From 1912 onwards public intervention in the treatment of tuberculosis began to quicken and in that year all forms of the disease were made for the first time notifiable. Local authorities were encouraged by exchequer grants to make better provision for the treatment of tuberculous persons in their areas, and sanatorium benefit under the National Health Insurance scheme was designed to secure that insured persons, if they were found to be suffering from the disease, should get the advantages of sanatorium and other treatment whether or not they could afford to pay for it.

The strain of the 1914-18 war was reflected in an increased incidence in the disease and there was a heavy demand for accommodation, in particular for men discharged from the Forces. This led to increased exchequer assistance which resulted in further provision of sanatoria and other accommodation. In 1921, Parliament imposed a general duty on the county and county borough councils to make arrangements for the treatment of tuberculosis, this legislation being later incorporated in the Public Health Act of 1936. From these beginnings there has emerged a strong and still developing special service dealing with all aspects of the diagnosis and treatment of the disease and providing a considerable amount of supplementary help and after-care to those suffering from it. The county and county borough councils fulfil their duties partly by their own direct provision of dispensaries, sanatoria and other institutions, partly by arrangements which they make with voluntary and other agencies. At the outbreak of the present war there were some 28,000 regular beds in tuberculosis institutions, with many more available in approved institutions for use when required. About 400 sanatoria were provided by the local authorities directly, and some 270 by other agencies. These sanatoria are not usually very large, only about 30 having more than 200 beds.

Apart from actual diagnosis and treatment, the service provides—in a degree varying from area to area, and partly through voluntary Care Committees or similar organisations—a variety of supplementary services dealing with additional comforts, extra nourishment and clothes, training for employment, help in obtaining suitable housing, dental care, and other matters. Valuable pioneer work in rehabilitation and resettlement of the tuberculous has been done by a small number of voluntary organisations, eminently in two well-known village settlements and tuberculosis colonies. Local authorities have made full use of these facilities, just as for suitable types of case they have linked up with the training and settlement resources of the Ministry of Labour and National Service. Increasing interest has recently been taken in the rehabilitation of the tuberculous patient

(although hampered at the moment by the restricted conditions of war), and also in new aids to early detection and diagnosis afforded by mass miniature radiography. Another recent advance has been the scheme for the payment of allowances to patients under observation or treatment, in order to encourage early recourse to treatment where financial responsibilities might otherwise be an obstacle tending to delay it.

For the exercise of their duties a few local authorities have combined with each other in seven Joint Boards. Some of these Boards have taken over all the tuberculosis services of their constituent authorities; some only undertake the joint management of particular institutions. A unique experiment in large-scale combination has been in operation in Wales for the last 30 years, in the King Edward VII Welsh National Memorial Association. This was established in 1910, as part of a national campaign against tuberculosis in Wales, and its special constitution (under a Charter of Incorporation) provides for the representation of all the county and county borough councils in Wales, and also includes co-opted members, members nominated by the Minister of Health and others. It provides dispensaries and visiting stations and some 2,000 beds in its own sanatoria and hospitals, and also arranges for accommodation through other agencies.

The tuberculosis service—even after allowing for the indirect effects of improved housing and food and environmental conditions generally—has very tangible results to its credit over the last twenty years, reflected in improvements in the rate of mortality from the disease. It tends to be administered as a separate entity, perhaps not enough related to the diagnosis and treatment of other chest and respiratory conditions or to the work of the general hospitals, because it has come into being as a separately organised service with one particular objective.

Venereal Diseases.

A special service for the early diagnosis and treatment of venereal diseases has, since 1916, been the responsibility of the county and county borough councils. It provides some 200 out-patient clinics and centres (usually by arrangement with local hospitals, sometimes independently) for free and confidential diagnosis and treatment for all, irrespective of place of residence or circumstances. Hospital beds and hostels are usually available for in-patient treatment if required. During the war the service has been supplemented by arrangements made, particularly in rural areas, under which suitably qualified general practitioners give free treatment in their own consulting rooms. Doctors in general practice are always at liberty—and are encouraged—to use the laboratory and other resources of the service free of charge and to consult the expert medical officers of the service on any case under treatment.

Cancer.

Just before the present war the Cancer Act of 1939 put upon the county and county borough councils a new special duty, to see that facilities for the diagnosis and treatment of cancer were available to meet the needs of their areas. The Act contemplated a new and comprehensive service for detecting and treating the disease, based on a local scheme which would utilise existing resources (in voluntary hospitals and elsewhere) and would supplement them, as necessary, with new diagnostic centres and with additional treatment facilities. It was expected that, in many cases, it would be necessary for county and county borough councils to combine in order to operate an effective scheme over a wider area, and provision for such combination was included in the Act. The whole service would be backed by arrangements for access to a centralised supply of radium organised by the National Radium Trust and Radium Commission.

The outbreak of war immediately after the Act was passed, however, prevented the new service from materialising—except for a few interim schemes which have been started in some areas. Some special war-time arrangements, designed to relieve some of the cancer centres in certain large towns, have been made through the Emergency Hospital Scheme, but these do not properly form part of the present review.

Mental Health Services.

Provision for the care and treatment of persons suffering from mental disorder is made by local authorities under the Lunacy and Mental Treatment Acts, 1890 to 1930. The local authorities concerned are the councils of counties and county boroughs, and of 15 non-county boroughs. Many of the functions are obligatory, particularly as regards provision for certified patients. The powers conferred on local authorities in regard to provision for voluntary patients and out-patient diagnosis and treatment are permissive; but this part of the service has in fact developed rapidly since the passing of the Mental Treatment Act of 1930. In 1941, 35 per cent. of the admissions to public mental hospitals were voluntary patients. Local authorities are required by these Acts to exercise all their powers and duties through Visiting Committees which have powers in regard to staff and finance that give them a certain measure of independence. This arrangement is a survival of an Act of 1845. Three county councils—London, Middlesex and Surrey—have by local Act modified this arrangement so as to bring the committee dealing with this service into line with the position normally occupied by statutory committees of local authorities.

In this service combination between authorities is a common feature. There are three Joint Boards established under local Acts. These provide for the combination of the county council with the county boroughs in the county in Lancashire, the West Riding of Yorkshire and Staffordshire. Joint action has been taken under the provision of the Lunacy Act by a large number of counties and county boroughs for the provision and maintenance of a mental hospital to serve the combined area. Of 101 public mental hospitals (accommodating some 130,000 patients) 42 are managed by a Joint Board or by a combination of two or more local authorities. The provision of a public mental hospital must clearly be entrusted to an authority covering a considerable area. The average number of beds required per 10,000 of population is about 32. The optimum size of a public mental hospital is between 1,000 and 1,200 beds, and it has been found that when the number of beds in such an institution is below 500 it tends to become uneconomical in management.

Under the Lunacy and Mental Treatment Acts a considerable number of patients are treated in private institutions. Some 2,500 are in registered hospitals (i.e. private institutions supported partly by voluntary contributions or charitable bequests) and rather more in licensed houses, i.e., private profit-making establishments, licensed under the Lunacy Act. There are about 12,500 persons of unsound mind in the public assistance institutions and public health hospitals.

Provision for the care of mental defectives is made under the Mental Deficiency Acts, 1913 to 1938. The local authorities concerned are the county and county borough councils. For the execution of the Acts these councils are required to appoint a committee for the care of defectives, some members of which may be co-opted. Certain of the functions are obligatory while others are permissive. The local authorities are required to make arrangements to ascertain what persons within their areas are defective and subject to be dealt with under the Mental Deficiency Acts. The service covers provision for institutional care for patients who need it and community care for defectives who are placed under guardianship or supervision. There are some 37,000 mental defectives in certified institutions, and about 5,000 under guardianship and 37,000 under statutory supervision. Some 9,500 are in public assistance institutions approved for the reception of mental defectives.

Institutional provision under the Act generally is considered to be inadequate. The operation of the principal Act of 1913 was checked at its inception by the outbreak of the last war, and further developments are essential if an adequate service is to be provided. Here again joint action is fairly common, 13 out of a total of 61 certified institutions being carried on by Joint Boards or Joint Committees. Some of the largest certified institutions have been provided by organisations other than local authorities; and there are a number of small certified houses and approved homes which are privately owned.

The central supervision of the mental health services is exercised by the Board of Control, which was reorganised under the provisions of the Mental Treatment Act, 1930. The members of the Board are appointed by the Crown, on the recommendation of the Minister of Health, with the exception of the legal

member, who is appointed on the recommendation of the Lord Chancellor. The Minister appoints the Chairman, and the appointment of the staff of the Board is also subject to his approval. He is responsible for the presentation of the Board's estimate in Parliament, and anwers questions in the House of Commons relating to the mental health services. He is consulted, and his directions are taken by the Board, on all questions of major policy. The Board exercises independently of the Minister certain quasi-judicial functions conferred on them by statute in relation to the discharge of individual patients.

Maternity and Child Welfare.

The health of the expectant or nursing mother and of the child under five who is not attending school is the subject of a specially organised maternity and child welfare service. This service is mainly a development of the present century, and particularly of the years between the two great wars. There were beginnings in the latter part of the nineteenth century, when concern about the high infant death rate led to the start of a health visiting service of women workers (volunteers at first, then professional and qualified visitors) who advised mothers on infant welfare in their homes; it led also to the establishment of special depots or centres, where the mothers could attend for advice, and for milk and other special necessities. This work was made easier, and the way for a more organised service was paved, by making the notification of births compulsory—a process which began in 1907 and was extended in 1915. The real foundation of the present service was, however, the Maternity and Child Welfare Act of 1918.

The service is provided by local welfare authorities, which may be county councils or county borough councils or minor authorities according to circumstances which need not be elaborated here. The actual result is that outside London there are nearly 400 separate local welfare authorities, of which 60 are county councils, 83 county borough councils, 162 borough councils, 63 urban district councils, and 10 rural district councils. In London the Common Council of the City and the 28 metropolitan borough councils are the welfare authorities. The service is not a duty of these authorities, but a power—although in practice all of them provide it, in varying degree. It is concerned to provide medical and general advice and attention (but not treatment, except for a few minor ailments) to the young child and its mother, before the child's birth and afterwards until it is five years old or until it attends school. The service includes the provision of ante-natal and post-natal clinics and welfare centres, where attendance is for the most part free and advice and minor treatment are given, the supply of milk and special foods, and the visiting and advice of health visitors at the home.

The close connection between this service and the school medical service, which is referred to below, has always been recognised and under the Local Government Act, 1929, the Minister has power, on representations made by a council which is the education authority, to transfer the welfare functions to that council. When the two services are in the hands of the same body they are usually linked closely with each other.

For her actual confinement the expectant mother may be helped by the welfare authority—through their own provision or through arrangements made by them with other agencies—to get admission to a bed in a maternity home or hospital. She may, alternatively, be confined in accommodation provided as part of the general hospital services. Or again she may, and commonly does, have her confinement at home, and in this case there is a separately established midwifery service which has grown up under the Midwives Acts 1902-1936 in the hands of local supervising authorities. These—for historical reasons—may or may not be the same as the welfare authorities; there are in fact 188 of them and they include 62 county councils, 83 county borough councils, 39 borough councils and 4 urban district councils. Their original duties (which explain their title) were to supervise the practice of independent midwives in accordance with the professional rules of the Central Midwives Board; but since 1936 they have been charged to see that an adequate service of domiciliary midwives is available in their area for those who need it, and they do this either by arrangement with voluntary organisations or by themselves directly engaging and employing midwives. Of some 16,000 midwives in practice, nearly 2,700 are directly employed by the local authorities as domiciliary midwives and over 5,200 are in the employment of voluntary

bodies, usually county or district nursing associations. Many midwives, particularly in country areas, combine midwifery work with home nursing and health visiting.

Nothwithstanding the complication of the system, the quality of the maternity and child welfare and midwifery services is in general high, although they vary in scope considerably from area to area. Results, reflected in lower maternal and infant mortality, have been striking and well reward the growing efforts of the service in its relatively short development between the two wars. The commonest ground of criticism is that it is divided up among too many separate agencies and kept too much apart from the related fields of the family doctor and the hospital and specialist services.

Home Nursing.

Home nursing forms a most important branch of the health services, and one which is almost entirely the concern of voluntary organisations. Local authorities have limited powers to employ nurses for nursing at home patients suffering from infectious diseases, or expectant or nursing mothers or children under five suffering from various conditions, but they have no general power to provide a home nursing service and the number of nurses employed directly by them is very small. Within the limits of their responsibilities local authorities have, however, used extensively the services of the voluntary organisations providing home nurses, and they have also assisted them financially under powers, originally derived from the poor law, enabling them to make subscriptions and donations to these bodies.

The home nursing service is for the most part provided through district nursing associations, the majority of which are affiliated directly or through the appropriate County Nursing Association to the Queen's Institute of District Nursing and are under the supervision of the Institute. The district nurse is a familiar and welcome figure, particularly in country areas. In co-operation with the doctor she visits the patient's homes, tends the sick and the injured, and acts as adviser and educator in health matters. In many districts she acts also as midwife and health visitor by arrangement with the local authority. In all some 8,000 district nurses are at work over the whole of England and Wales.

The income of the associations is derived from subscriptions and donations, payments made by patients directly or through a contributory scheme, and grants from local authorities. The proportion received from public funds has increased in recent years, and especially since the Midwives Act 1936 placed on supervising authorities the duty of providing a domiciliary midwifery service. This duty is frequently discharged by the district nursing associations in return for a grant from the authority.

There is little doubt that, with some development, and with closer co-ordination with other branches of the health services, home nursing could play an even greater and more useful part. The need here is for extending and strengthening a service which has fully proved its value, and for linking it intimately with general medical practice and with hospital treatment.

The health of the school child.

For the school child, over the age of five, or from the time of his first attending school, there has gradually developed during the present century a special school medical service. Towards the end of the nineteenth century certain special provision was made for the care of blind, deaf, defective and epileptic children; but the origin of the school medical service may be traced directly to the Report of the Interdepartmental Committee on Physical Deterioration which was issued a few years after the South African War. As a result of this Report the Education (Administrative Provisions) Act was passed in 1907 setting up a regular system of medical inspection and empowering authorities to provide certain types of treatment. From then onwards, a system of increasing medical inspection and care of the health of the school child has been steadily built up. It is now based mainly on the provisions of the Education Act of 1921 and is one of the subjects falling within the scope of the Education Bill now before Parliament.

The operations of the present school medical service are broadly of three kinds. First, it provides for the regular medical inspection of all children in public elementary schools, in secondary schools, and in certain other schools. Second, it provides for the medical treatment, as well as inspection, of children in public elementary schools—but in regard to other schools there is no obligation (only a power) to provide treatment. Third, it enables the educational system, with its regular contact with parent and child, to influence both in principles of healthy child life, and to assist and guide them in securing that the child resorts to the kinds of medical treatment or care that it may need. The first and last of these functions are essentially aspects of the educational system, as such, and it is the second—personal medical treatment—that is of most interest for the purpose of the present review.

Responsibility for arranging this medical treatment rests with the local education authorities. There are at the moment, for elementary education, 315 of these, and they include counties and county boroughs and certain non-county boroughs and urban districts; for higher education, there are 146 of these, all counties and county boroughs. The present provision made by local education authorities for medical treatment varies considerably—in some areas dealing only with the treatment of teeth, eyes, ears, nose and throat, and minor ailments; in others extending to such matters as orthopaedic treatment and certain provision for rheumatic cases and for maladjusted children. The authorities are required to recover the cost of treatment from the parents, unless they are satisfied that this would not be reasonable. Some of the treatment activities are conducted in the schools themselves, some at clinics, provided for the purpose by the local education authorities, some by arrangements made between these authorities and hospitals or other independent agencies.

The local education authorities' organisation for these purposes includes school medical officers, whole time or part time, the chief of whom is in nearly all cases also the medical officer of health of the local authority concerned and combines his school functions with his general public health duties; it also includes school nurses, who are able to do much of the follow-up work in direct contact with the home and the parents (and who may combine their duties with those of a health visitor) and school dentists and other technical officers. A valuable activity of the education authorities, side by side with this medical work, is the provision of good school meals and extra nourishment. This has been greatly expanded since the beginning of the present war, is no longer limited (as it was in earlier days) to children whose parents are necessitous or who cannot readily get to their homes at mid-day, and will remain an important feature in the proposed educational reorganisation.

The central supervision of the school medical service rests with the Board of Education, under powers delegated by the Ministry of Health, and a close association of its work with general public health policy is assured by the two Departments enjoying the services of a single Chief Medical Officer, and by regular arrangements made through him for the co-ordination of the medical work at the centre in both fields.

Dental Services.

The existing publicly organised dental services are of several kinds, and apply to various classes or groups of the population.

Through the National Health Insurance scheme many—but not all—of the 21,000,000 persons insured under the scheme can get what is known as "dental benefit". In fact, nearly two-thirds of them, or some 30 per cent. of the population, are probably eligible for this benefit, which first began to be provided in 1921. It does not take the form of direct public provision of dental treatment, but of a money payment of the whole or a part of the approved cost of treatment. The individual obtains treatment for himself from any dentist who is willing to treat him, under certain conditions and at certain scales of fees which are centrally regulated by the scheme. Most dentists in private practice are willing to accept the "dental benefit" patient in this way, although there is no obligation to do so and no "panel" system comparable to that on the medical side of the Insurance Scheme. Whether

"dental benefit" is obtainable by any insured person, depends upon the ability of the Approved Society (or branch) to which he belongs to make payments for this benefit out of its surplus funds. Although probably about 13,000,000 people are eligible for this benefit, it is noteworthy that only some six or seven per cent. of them actually claim it in any given year.

Under the maternity and child welfare service most local welfare authorities arrange—in varying degree—for dental treatment for expectant and nursing mothers and, where necessary, for children under five. The majority do this by providing a service directly, at their welfare clinics (or at school clinics dealing with older children), others by arranging through private dentists or hospitals. The service includes the provision of dentures in the majority of cases. No charge is usually made for fillings or extractions, but for dentures most authorities recover what the mother can reasonably afford. This service dates back to the Maternity and Child Welfare Act of 1918, though its main development is more recent.

Dental treatment is also provided as part of the arrangements for the treatment of tuberculosis, by the county and county borough councils. Here the main object is to deal with cases where the state of the teeth prevents the full benefit of tuberculosis treatment (e.g. by interfering with nourishment) and, although this limitation is not too strictly observed, the arrangements are only an ancillary activity of the main tuberculosis service. The arrangements vary locally, being sometimes provided at the sanatoria themselves, sometimes at other centres by the dentists employed for the maternity and other services described, sometimes by private dentists.

In the schools the school medical services of the local education authorities provide dental inspection and treatment, in varying degree. School dental officers and dental attendants and other staff are appointed directly by the authorities. The work is done mainly in clinics or in certain country districts in the schools themselves. There is no statutory restriction on the scope or nature of the treatment which can be given—although it will be remembered that the school medical treatment service is at present a duty of the authorities only in the case of elementary schools, and a discretionary power in other cases. In actual fact, the dental service provided (every education authority has a dental scheme) varies within wide limits, dependent largely on the number of children who accept the offer of treatment, and although it does not (in the view of the Board of Education) represent anything like a fully adequate service for the school child it was before the war one of the most rapidly expanding branches of school medical work.

Apart from these publicly organised services the individual citizen must depend on his own private arrangements. He may have access to special dental hospitals (where these exist), or to some of the general hospitals where he will normally be asked to pay what he can reasonably afford, or he may use facilities which some business houses or industrial organisations provide for their employees, or some charitable or voluntary organisation in his neighbourhood. Otherwise he seeks treatment privately from a dental practitioner in the ordinary way; or if he is in serious financial need and requires urgent treatment he may seek the assistance of the poor law, which in most areas will arrange for essential treatment in the last resort.

Ophthalmic Services.

The position in regard to the public provision of ophthalmic services is very like that in regard to dental services. "Ophthalmic benefit" under the National Health Insurance scheme is the principal method of obtaining ophthalmic advice and treatment and spectacles, and about half the insured groups, or some 25 per cent. of the population, are eligible for benefit. There are two ways in which spectacles are obtained—either through a medical practitioner with special experience of ophthalmic work who normally gives a prescription for any necessary spectacles to be made by a dispensing optician, or through a sight-testing optician. The Approved Society (or branch) which provides ophthalmic benefit is required to pay the cost of ophthalmic treatment up to a maximum amount, the cost of an authorised ophthalmic examination, and the whole or part of the cost of spectacles if they are needed.

Ophthalmic treatment is open to schoolchildren through the school medical service. Arrangements for this form of treatment, usually by specialists, are made by all education authorities. It is one of the most comprehensive of all branches of school medical work and provides a more comprehensive ophthalmic service than is available for any other section of the community. Apart from this service, only partial and irregular public facilities are available, for example through the out-patient departments of some special and general hospitals or through the poor law. Otherwise the citizen must rely on private arrangements.

Industrial Medical Services.

In addition to the services described there are various medical activities associated specially with industry and employment, which need to be mentioned although they are not primarily concerned with the personal medical advice and treatment of the individual but more with general welfare and the environmental conditions of his work. Although they can all be referred to loosely as "industrial medical services", they vary considerably in kind.

First, the Factory Acts provide for arrangements for factory inspection which include medical as well as other Inspectors. The history of the direct intervention by the State in industrial welfare and working conditions is a long one, and most of it is not relevant for the present purpose. Sufficient to say that it has its origin, well over a century ago, in the appointment after 1802 of factory "Visitors" by the Justices of the Peace (mainly to enforce the legal requirements affecting the employment of juvenile labour) and that this arrangement was superseded by the first Government inspectorate of factories after the Factory Act of 1833, from which the line of succession of the present system can be more or less directly traced. The first appointment of a medical inspector was not made until about the end of the 19th century; but the medical side of the factory inspectorate has since developed into an important and well-known arm of the service, and now occupies the whole-time services of more than a dozen medical inspectors. In addition, however, the Inspectorate has, for over 100 years, been assisted by part-time doctors (formerly called Certifying Surgeons, now Examining Surgeons, and now numbering about 1,700) whose duties included the investigation of cases of accident and industrial disease as well as investigating the physical suitability of juveniles for factory employment and periodically examining workers employed in various unhealthy processes—in connection with preventive measures (including, where found necessary, the suspension of individuals from the particular kind of work). Their investigation of accidents (but not of cases of disease, poisoning, gassing, and other special cases) was dropped in 1916, but the other sides of their work have been developing. This organisation is not designed to provide personal medical treatment and advice to the individual worker; it is designed as an integral part of the highly technical machinery for promoting, fundamentally through the employer, safety, health and welfare in factories and other premises within the scope of the Inspectorate.

Next, industrial concerns often appoint works medical officers, full-time or part-time, who are in a rather different position. An intermediate kind of case is where the firm arrange for the Examining Surgeon to carry out additional functions at the works, beyond those for which they are legally required to employ him, so that he is substantially a part-time works doctor. These "works doctors" are engaged mainly to keep an expert eye on the medical aspects of the factory's work and hygiene, on the effects of environment upon the health of the workers, on the wise adjustment of types of work to the workers' capacity, on arrangements for dealing with accidents and emergencies, and generally for the giving of proper medical advice to the factory management. Before the war, arrangements of this kind were often encouraged by the Factory Inspectorate, and the Factories Act of 1937 gave wider powers to the Home Secretary to order employers to make arrangements for medical supervision in their factories. Further, in 1940, the Minister of Labour and National Service made an Order, under Emergency Powers, requiring munitions and other firms to appoint works doctors if directed to do so. Formal directions under the

Order have not been found necessary; but, since it was made, many more firms have in fact appointed whole-time or part-time works doctors, so that there are now some 175 whole-time doctors of this kind and about 700 exercising substantial medical supervision in the factories on a regular part-time basis. The "works doctors" do not, any more than the Factory Inspectorate, exist primarily as a personal medical service; but in connection with their functions of advising the management and dealing with preventive and first-aid measures in the factory they often provide, incidentally and as a matter of common-sense utility, a certain amount of useful personal medical advice to the factory employees on the spot—perhaps particularly in war-time with its reduced opportunities for ordinary medical consultation outside working hours and its greater need for uninterrupted attendance at a place of work.

The Ministry of Supply, in its capacity of factory employer, has on similar principles developed a medical service in connection with its Royal Ordnance Factories. This service, as might be expected in a large industrial undertaking, includes a central organisation concerned with the general problems of the particular classes of factory under consideration, in which medical and other technical experts play their part, combined with a service of works doctors who look after conditions at the individual works in conjunction with other experts there, and who incidentally, as in other cases, give a certain amount of personal medical advice. Similarly, but on a smaller scale, the Air Ministry and Admiralty make arrangements for medical services at their civilian industrial establishments.

For the mining industry, the Ministry of Fuel and Power has found it increasingly desirable to enlist the medical expert in its national organisation dealing with working conditions and welfare in the industry, and it also encourages greater use in the mines themselves of medical advice on the "works doctor" principle. These activities also involve some entry into the field of personal medical care, but they do not set out to provide any full separate medical service. The miner, like other industrial workers, is within the scope of the National Health Insurance scheme and has recourse to hospital and other services on the basis already described. The Miners Welfare Commission has also been active in mining areas, in assisting in the provision of additional facilities (such as X-ray installations or physio-therapy centres at hospitals).

Generally, in these and other industrial medical services, the picture is not one of personal doctoring and individual health advice organised in vocational groups. It is not a question of separately organised medical treatment services for classes of industrial workers as distinct from the rest of the population. With few exceptions (like the arrangements for the police and for certain Post Office workers, referred to under the paragraphs on general medical attention above) the main health and treatment services, already summarised in this paper (National Health Insurance, the local authority services, the hospitals, and so on) apply in the main to the people or to sections of the people irrespective of their particular form of vocation or employment—for the most part equally to the worker in the field or in the mine or in the factory or elsewhere. The "industrial" medical services are primarily concerned with enlisting the medical expert in the supervision of general industrial welfare and organisation. They are not a direct personal treatment service, though to the extent indicated they are sometimes concerned incidentally with personal advice or limited treatment.

General.

This, then, is a broad outline of the picture of the health and medical services—the main picture, but not by any means the whole picture. A full review would have to detail the multitude of voluntary and private and semi-public efforts of a host of associations, trusts, societies, clinics, institutions and other organisations and groups, which have sprung from private initiative or from public charity over a long period of years. It would have to analyse the many local variations of both statutory and non-statutory services, the many different kinds of experiment in grouping and combination of services locally, the attempts made both recently and earlier, in different quarters, to relate separate services more closely to each other and to "rationalise" the pattern here and there. There is no room to deal with all this. The general picture given is perhaps enough to reveal the essential features of the present situation.

THE PRESENT HEALTH SERVICES IN SCOTLAND.

General.

The health services in Scotland had the same origin and their development has followed much the same course as the health services in England and Wales. There has been the same evolution from the measures taken by public authorities at the beginning of last century to relieve the destitute sick, followed later in the century by the development of the environmental public health services and the treatment of infectious diseases, to the expansion of the personal health services in the present century. There has been the same haphazard growth of these services through the years, leaving much the same gaps to be filled and the same kind of problems to be solved. This being so, a description of the history and the present state of the health services in Scotland would inevitably repeat much of what has already been said in this Appendix. But the development of the services in the two countries has not been uniform. Some of the Scottish services differ in their scope and organisation from the corresponding services in England and Wales; others, such as the Highlands and Islands Medical Service, have no English counterpart at all. The following paragraphs draw attention to the most important of these differences.

Local Authorities.

The Local Government (Scotland) Act, 1929, substantially reduced the number of local authorities concerned with the health of the people. The health services of local authorities (excluding for this purpose the environmental services—general sanitation, water supply, drainage and housing) are now administered by the 55 "major health authorities," namely, the county councils, of which there are 31, and the town councils of large burghs, of which there are 24. A large burgh is one nominally with a population of over 20,000. The school health service, however, is administered only by the county councils and the town councils of the four Cities (Edinburgh, Glasgow, Aberdeen and Dundee), which are education authorities.

Hospital and Consultant Services.

In broad outline, the development of the hospital services in Scotland has been similar to that in England and Wales. The two hospital systems—voluntary and local authority—have grown up side by side in much the same way in both countries. But the voluntary hospitals in Scotland still provide much the bigger part of the institutional service for the treatment of acute medical and surgical conditions. Before the war there were some 220 voluntary hospitals with a total of over 14,000 beds. On the other hand, local authorities have entered the "general" hospital field only in recent years and so far have provided only some 5,500 beds in nine local authority general hospitals. With one small exception, these hospitals are found in the four Cities. There are still about 1,700 beds in public assistance institutions accommodating the "chronic sick" coming within the scope of the poor law.

The tradition of the Scottish voluntary hospitals is to afford free treatment. There has been very little development of the pay-bed system; and it is not customary to ask the patient in ordinary wards to make a payment towards the cost of his treatment. While there are organised schemes in offices, factories and work places, for collecting subscriptions for hospitals, little has been done to organise voluntary contributory schemes of the type found in England and Wales. Local authorities which have provided hospitals for the general sick apart from the poor law are obliged by statute to charge a reasonable sum towards the cost of the patient's treatment. But there is no power to charge for the hospital treatment of infectious disease. (Further reference is made below to infectious diseases hospitals and sanatoria.)

Between the wars, the re-organisation of the Scottish hospital services was widely discussed and a number of important committees reported on the subject. Considerable support has been given to the view that Scotland both requires and lends itself to a regional co-ordinated hospital service comprehending both the voluntary and local authority hospitals. This view takes account mainly of the fact that the country's key hospitals as well as the medical schools are all to be found in the four Cities of Edinburgh, Glasgow, Aberdeen and Dundee, and that

these centres are natural focal points for a regional organisation. The conception of four hospital regions based on these Cities, with a fifth based for geographical reasons on Inverness, has thus become the common currency of all discussions on Scottish hospital policy. The recently published report of the Hetherington Committee not only re-affirms this conception but makes definite proposals for setting up Regional Hospital Councils with primarily advisory functions.

Scotland has for long suffered from an acute shortage of hospital accommodation and the waiting list problem has been serious. This gives special importance to the fact that the Emergency Hospital Service, organised originally for the treatment of air-raid casualties, has added some 15,000 new beds to the country's total hospital provision. Of these, 8,000 are in annexes at existing hospitals, and 7,000 are in seven completely new hospitals. While these beds are in buildings of emergency construction and while their number will be materially reduced to conform to peace-time standards of bed-spacing and the like, they will form a welcome addition to the post-war hospital service. The annexes are administered by the hospital authorities responsible for the parent hospitals to which they are attached: the seven new hospitals are directly administered by the Department of Health for Scotland.

Fortunately, little call has had to be made so far on the emergency hospital organisation for the treatment of air-raid casualties and beds have therefore been free, within the limits of the available nursing staff, for other purposes. For example, emergency beds have been used to great public advantage in relieving the waiting lists of the voluntary hospitals: up to the end of 1943, some 24,000 patients had been admitted for treatment from these lists.

The existence of staffed beds in the emergency hospitals under the Department's direct control with full consultant and diagnostic facilities available has also facilitated an interesting and successful experiment in preventive medicine, involving the close co-operation of the family doctor, consultant and hospital services. This was originally known as the Clyde Basin Experiment which had its origin in reports received from various sources towards the end of 1941 suggesting that war strain, long hours, and the black-out were affecting the health of the working population in Scotland, including that of young women who had entered industry for the first time. At the same time it was becoming clear that the man-power needs of the nation required the organisation of the civilian medical services on lines which would secure that early and correct diagnosis and treatment were available for any condition which threatened to impair the working capacity of war workers or to leave a war aftermath of chronic invalidism. Accordingly, early in 1942, the Secretary of State launched the experiment for the benefit of young industrial workers between 18 and 25 years of age, in the West of Scotland. Family doctors in the area were asked to refer to the Department's Regional Medical Officer patients in a debilitated state or showing symptoms suggesting the need for expert diagnosis. The experiment was successful from the start and by the end of the year it was extended to cover war workers of all ages in the whole of the industrial belt. It is now known as the Supplementary Medical Service Scheme. Under the scheme, the Regional Medical Officer, either himself or with the aid of consultants, makes a thorough examination of every case referred to him; a full range of consultants is available for the purpose. Where necessary, the Regional Medical Officer arranges for the patient's admission to hospital for observation and full clinical investigation or to a convalescent hospital if rest or "building up" is needed. Where on medical grounds a change of work seems desirable the Regional Medical Officer consults the Ministry of Labour and National Service. A full report is furnished to the family doctor in every case for his future guidance and, in selected cases, follow-up work is undertaken.

Up to the end of 1943, some 6,300 patients had been referred to the Regional Medical Officers for examination. The scheme has shown what can be done in bringing the family doctor into close and effective contact with the consultants and the hospitals—contacts which have evoked the warmest appreciation from doctors and patients alike.

Infectious Diseases Hospitals.

As in England and Wales, it was not until the middle of the nineteenth century that organised steps were first taken to deal with infectious diseases.

Glasgow's first municipal fever hospital was opened in 1865. Two years later the Public Health (Scotland) Act, 1867, empowered local authorities for the first time to make provision for the prevention and mitigation of epidemic, endemic or contagious diseases. These powers included one to provide hospitals for the sick generally but by the Public Health (Scotland) Act, 1897, this power was limited to the provision of hospitals for those suffering from infectious diseases.

This Act of 1897, which is still the principal Public Health statute applicable to Scotland, is the basis of the present system of public health administration. It made compulsorily notifiable throughout Scotland the diseases which previously had been notifiable only in the areas of local authorities which had adopted the Infectious Disease (Notification) Act, 1889, and it gave powers to the Central Department to require the notification of other diseases. Through the years the list of notifiable diseases has been considerably extended.

Many local authorities combined to discharge their duties under the Act of 1897 with regard to the treatment of infectious diseases. The Local Government (Scotland) Act, 1929, in reducing the number of local authorities responsible for this service to 55, consequentially reduced the number of hospital combinations. There are now 12 joint boards providing infectious diseases hospitals on behalf of 23 of the authorities. In all, there are 109 infectious diseases hospitals with about 7,600 beds, excluding beds for the treatment of tuberculosis. Sixty-six of the hospitals have less than 50 beds. The institutional treatment of infectious diseases in Scotland is entirely free.

Tuberculosis.

Responsibility for the treatment of tuberculosis in Scotland is included in the general responsibility for treating infectious diseases laid by the public health statutes on the 55 major health authorities. There is no separate statutory provision dealing with tuberculosis as in England and Wales and in particular there is no specific power to provide for the after-care of persons who have suffered from tuberculosis.

The main features of the tuberculosis schemes derive from the efforts of the late Sir Robert Philip who in 1887 laid in Edinburgh the foundation of an anti-tuberculosis organisation based on the association of the dispensary, the sanatorium and the farm colony. The higher techniques in the treatment of tuberculosis have been greatly developed since these early days, but the basic principles of this pioneering effort still hold good.

Local authorities were at first slow to follow Sir Robert Philip's lead. One or two of them in 1904 experimented with the isolation of pulmonary tuberculosis in spare wards of infectious diseases hospitals, but it was not until 1906 that substantial progress began to be made. In that year the Local Government Board for Scotland (at that time the central Department) made pulmonary tuberculosis compulsorily notifiable and extended to this disease the statutory obligation which already rested on local authorities to deal with certain other infectious diseases.

Before the war, there were about 5,300 tuberculosis beds in Scotland, of which about 4,700 were in local authority institutions. Although some of these beds were converted to other uses when war broke out, alternative arrangements, including the provision of beds in the Department's emergency hospitals, have resulted in a net increase in the available bed accommodation.

The incidence of tuberculosis is relatively higher in Scotland than in England and Wales, and it has tended to increase in war-time. There are empty beds available for tuberculosis patients which cannot be used for lack of nurses. This has produced a lengthening waiting list of sufferers requiring institutional treatment, one of the distressing features of the present state of the public health.

Venereal Disease.

There are about 50 out-patient clinics and centres in Scotland for the treatment of venereal disease. Some are in voluntary hospitals but many have been specially provided.

Mental Health Services.

Provision for the care and treatment of persons suffering from mental disorder is made by local authorities under the Lunacy (Scotland) Acts, 1857 to 1919.

While these Acts make some provision for voluntary patients, no specific powers have been conferred on local authorities with regard either to voluntary patients or to out-patient diagnosis and treatment. There is indeed no counterpart in Scotland to the English Mental Treatment Act of 1930. Nevertheless, this part of the service has developed steadily in recent years. In 1942, 14.2 per cent. of the admissions to mental hospitals provided by local authorities were voluntary patients.

There are 23 local authority mental hospitals in Scotland, of which 13 serve combinations of two or more authorities. The 23 hospitals had 12,800 patients on 1st January, 1943. Four single authorities and two combinations have no mental hospitals of their own but depend on contracts made with the Royal Mental Hospitals (or Asylums).

There are seven Royal (or Chartered) Mental Asylums which originated under endowment schemes and are the oldest of the existing institutions for the insane in Scotland. On 1st January, 1943, they had 5,300 patients.

Provision for the care of mental defectives is made under the Mental Deficiency (Scotland) Acts, 1913 and 1940. As in England, the war of 1914-18 checked developments under the 1913 Act, and institutional provision is still very inadequate. On 1st January, 1943, there were 3,900 mental defectives in certified institutions and 1,750 under guardianship. Five of the 13 institutions are managed by joint boards or joint committees. One of the largest of the institutions and two small ones have been provided by organisations other than local authorities.

Central supervision of the lunacy and mental deficiency services is the responsibility of the General Board of Control for Scotland, the members of which are appointed by the Crown on the recommendation of the Secretary of State.

The Committee on Scottish Health Services pointed out the need for the revision and consolidation of the Scottish lunacy and mental deficiency laws, and this problem is now being considered by a Committee appointed for the purpose under the chairmanship of Lord Russell. The former Committee also emphasised that the outstanding need of the mental health service was for a co-ordinated movement to deal with early mental and nervous disorders. It is in this field that the service has been chiefly lacking.

Maternity and Child Welfare.

The local organisation of the maternity and child welfare service is the responsibility of the 55 major health authorities. There is no counterpart in Scotland to the minor authorities of England and Wales.

Local authorities had no statutory powers to undertake child welfare work till 1915, when they were empowered by the Notification of Births (Extension) Act to attend to the health of expectant and nursing mothers and of children under five years of age. At the end of 1919 schemes for this purpose were in operation in areas comprising 55 per cent. of the population: ten years later the percentage had risen to 94: and since the passing of the Local Government (Scotland) Act, 1929, the remaining 6 per cent. of the population has been covered.

The scope of the service is broadly similar in the two countries, resting as it does on the employment of doctors, midwives, health visitors and specialists, and on the apparatus of clinics, centres, nurseries, maternity hospitals and homes. But there is one noteworthy difference. The Maternity Services (Scotland) Act, 1937, created a domiciliary maternity service which differs from that in England and Wales in that, while the English service is based on the midwife alone, the Scottish service is based on the doctor-midwife combination. That is to say, under the Act of 1937 it is now a duty on every local authority in Scotland to make available to all women, who are to be confined at home and who apply for the service, the joint care throughout pregnancy, labour and the puerperium of a doctor and of a certified midwife, with the advice and help, so far as it is practicable to provide it, of an expert obstetrician at any time if the doctor thinks this necessary.

There are some 1,400 practising midwives in Scotland, including 90 whole-time employees of local authorities.

While the maternal and infant mortality rates have shown a big improvement over the years, the position in Scotland is still much less favourable than that in England and Wales. The recently published Report of the Orr Committee examines the problem of infant mortality in Scotland and, among other things, calls attention to the poor liaison between the hospitals, the family doctor and the child welfare service.

Home Nursing.

The Queen's Institute of District Nursing have 1,050 nurses operating in Scotland. The District Nurse plays an important part in many areas as health visitor and tuberculosis nurse under the local authority schemes. She has a special importance in the sparsely populated rural areas where clinic services are remote or non-existent. Under the Maternity Services (Scotland) Act, 1937, many of the authorities are dependent on the District Nurses for their midwife services. In respect of these various statutory services, the District Nursing Associations are subsidised by the local authorities concerned.

The Health of the School Child.

The first step taken in this field was the appointment in 1902 of the Royal Commission on Physical Training (Scotland) to inquire into the physical condition of school children. The Commission found that data on the subject hardly existed, but that army recruiting returns showed a disquieting proportion of unfit applicants for military service. After a medical examination of 1,200 children in Aberdeen and Edinburgh, the Commission recommended that school boards should undertake the medical inspection of school children and record the results. This finding was emphasised by the Interdepartmental Committee on Physical Deterioration in 1904. Four years later the Education (Scotland) Act, 1908, provided for the medical examination and supervision of all school children, and authorised school boards to employ doctors and nurses for the purpose.

This was followed by the passing of the Education (Scotland) Act, 1913, which empowered school boards to provide for the medical treatment of children of necessitous parents. More recently, the Education (Scotland) Act, 1942, in effect places a duty on education authorities to arrange for the medical treatment of any school child who is unable, for the lack of treatment, to take full advantage of the education provided.

As already indicated, the local authorities for school health administration are the 31 county councils and the town councils of the four cities of Glasgow, Edinburgh, Dundee and Aberdeen, which constitute the 35 education authorities of Scotland. Central responsibility rests with the Secretary of State who exercises his functions through the Department of Health for Scotland.

The Highlands and Islands (Medical Service) Scheme.

The Highlands and Islands area is the only part of Scotland—and for that matter the only part of the United Kingdom—in which an attempt has been made to organise a complete medical service available to all classes. The keystone of this structure is the Highlands and Islands Medical Service, a unique effort in co-operation between the State and doctors in private general practice, which has revolutionised medical provision in the area. A Sub-Committee of the Scottish Health Services Committee, reporting in 1936 on the suitability of the Service to the peculiar conditions of the Highlands and Islands, suggested that it might even provide a model on which to build the future medical service in Scotland as a whole. Now that the time is come to consider this larger issue the Highlands and Islands Medical Service is of special interest and worth examining.

The Medical Service was set up following the investigation of the Dewar Committee who reported in 1912 that on account of the sparseness of the population in some districts, its irregular distribution in others, the configuration of the country and the climatic conditions, medical attendance was uncertain for the people, exceptionally onerous or even hazardous for the doctor and generally inadequate. The Committee also reported that the straitened circumstances of the people precluded the adequate payment of doctors by fees alone. The result was the passing of the Highlands and Islands (Medical Service) Grant Act, 1913, which constituted the Highlands and Islands Medical Service Fund, annually replenished

by Parliament, for the purpose of providing and improving means for the prevention, treatment and alleviation of illness and suffering in the area. The Fund is administered by the Department of Health for Scotland.

The area covered by the operations of the Medical Service comprises the seven counties of Argyll, Caithness, Inverness (excluding the burgh of Inverness), Ross and Cromarty, Sutherland, Orkney and Zetland, and the Highland District of Perthshire. This area covers more than half the land surface of Scotland but contains less than one-fifteenth of the total population.

A single visit in the Highlands and Islands may involve a doctor in a journey of many miles lasting some hours. Fees which would adequately recompense the doctor in these circumstances would be beyond the means of all but a few of the population. The basis of the Medical Service, therefore, is that it should provide medical attendance to beneficiaries at uniform fees irrespective of the distance which the doctor may have to travel. This is secured by paying grants to the doctor to compensate him for his travelling and his time, in return for which he undertakes to attend to his patients at modified fees. This modified fee system applies to the families and dependants of insured persons, uninsured persons of the crofter and cottar classes, and others in like circumstances who could not otherwise pay for their medical attendance. These arrangements have led to an enormous increase in the number of visits paid to beneficiaries. Where the grant payable on the basis of mileage travelled would not provide the doctor with an adequate income, the payments out of the Fund are calculated with reference to the net income of the practice so as to provide the doctor with a reasonable living. This applies in 23 out of a total of 153 subsidised practices. The doctor's income is, of course, not derived wholly from the Fund. But what is received from this source is usually a substantial supplement to his other sources of income —National Health Insurance capitation fees, payments from the County Council for public appointments, and fees from private patients.

The Medical Service is provided in consultation with the County Councils in the area, but the contract takes the form of an agreement entered into directly between the doctor and the Department. On a vacancy arising in a single-doctor area the County Council advertises for a local medical officer to undertake public assistance, school inspection and tuberculosis work. The Department then consider whether they are prepared to enter into an agreement for Medical Service work with the doctor whom the County Council propose to appoint. In areas with more than one doctor, the new doctor may receive no public appointment and the Department conclude their agreement with him independently of the County Council. It is a condition of each agreement that the doctor uses a car for the purposes of his practice.

The Department do not exercise any detailed control over the doctor's services: there is no interference whatever with his professional practice. Medical officers on the Department's staff visit doctors in the area periodically to smooth out difficulties and to keep the Department generally in contact with the administration and development of the Service. This method of central administration, free from restrictive conditions and anything resembling vexatious control, has proved an outstanding success: it has satisfied the Department's reasonable requirements and is acceptable to the doctors.

Special arrangements are made to provide the doctors with holiday reliefs and with opportunities for post-graduate study. The Fund also assists in the building of doctor's houses and in the improvement of existing houses.

But the test of the Medical Service is primarily not what it does for the doctor —and it does much for him—but what it does for the patient. The answer here is clear. The " quite inadequate " general medical service, described by the Dewar Committee in 1912, is a thing of the past and in every district in the Highlands and Islands the services of a doctor are available on reasonable terms. And the doctors which the Medical Service attracts are generally of a better type than some that were to be found in the area before.

A similar improvement has been effected in the nursing service. This was lamentably deficient before 1912, partly because of the difficulties of travel in the area, and partly because voluntary effort did not suffice to maintain an adequate

service. Liberal grants are therefore made out of the Fund to district nursing associations towards the cost of employing district nurses, and providing them with houses and motor cars and cycles. There are now over 200 nurses at work throughout the area, nearly double the number working in 1914. Almost all are fully trained nurses, and all are certified midwives.

There have been developments beyond the primary essentials, medical and nursing. The Royal Infirmary, Inverness, has been largely rebuilt (the work being assisted by substantial grants from the Fund); and it now occupies a pre-eminent place in the hospital resources of the area. The Lewis Hospital at Stornoway has likewise benefited and, with its latest extensions, is able to provide a comprehensive service which obviates the transfer of many patients to mainland hospitals. Arrangements have been made with other hospitals for the employment of full-time qualified surgeons. Thus grants are paid towards the salaries of surgeons attached to hospitals at Lerwick, Kirkwall, Golspie, Fort William, Wick and Thurso. Additional subsidised services include a medical consultant at Inverness, a dental service for the people of Skye and part of the Outer Isles, a massage service for Caithness and Sutherland, a special service for the treatment of tuberculosis in Zetland, Lewis and South Uist, where the incidence of this disease is high, and an ambulance service. The air ambulance has now become a familiar feature of the service: patients, in urgent need of treatment, are flown to the Glasgow Infirmaries from islands lying off the west coast.

The amount of grants paid out of the Highlands and Islands (Medical Service) Fund for the various services during the year ended 31st March, 1943, was just under £100,000.

APPENDIX B.

EARLIER DISCUSSIONS OF IMPROVED HEALTH SERVICES AND AN OUTLINE OF EVENTS LEADING UP TO THE PREPARATION OF THIS PAPER.

It was recognised very shortly after the inception of medical benefit under the National Health Insurance Scheme in 1913 that there was a strong case for supplementing the general practitioner service with a consultant service. Preparations for this were advanced at the outbreak of the 1914-18 war. The war put an end to further progress in the matter, but towards its end a series of discussions took place between the National Health Insurance Commissioners and leading members of the medical profession on the general subject of the extension of health services.

Shortly after the establishment of the Ministry of Health in 1919, a Consultative Council on Medical and Allied Services was appointed by the Minister under the chairmanship of Lord Dawson of Penn. This body was invited to consider and report on schemes " requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area ".

Space does not permit describing in detail the recommendations made in the valuable report of this body which was published in 1920, but the general conception which its authors had in mind was that of a comprehensive scheme under which all forms of medical service would be made available, under suitable conditions, to the population at large. The report recommended the establishment of Health Authorities for local administration and it contemplated, as does the present Paper, the co-ordination of municipal and voluntary agencies as the basis of the scheme. It is worth noting that the Council justified their recommendations " because the organisation of medicine has become insufficient and because it fails to bring the advantages of medical knowledge adequately within reach of the people ".

In the same year (1920) a Consultative Council on Medical and Allied Services appointed by the Scottish Board of Health under the chairmanship of Sir Donald MacAlister reported on a somewhat similar remit. Their report urged that " a complete and adequate medical service should be brought within the reach of every member of the community." They made a number of recommendations designed to ensure that the family doctor (on whom the organisation of the nation's health service should be based) would be provided with all supplementary

professional advice and assistance, and they proposed that the State insurance medical service should be extended to cover persons of the same economic level as insured persons and dependants of insured persons. These and their other proposals provided a basis for much of the later discussion on the requirements of a national health service.

In 1921 there was issued the report of the Voluntary Hospitals Committee under the Chairmanship of Lord Cave, which had been set up by the Minister of Health to consider the financial position of the voluntary hospitals. In addition to recommending an exchequer grant to meet the immediate needs of the hospitals, the Committee proposed the establishment of permanent machinery to co-ordinate the work and the finances of voluntary hospitals throughout the country. This machinery was to consist of a central Voluntary Hospitals Commission and of local Voluntary Hospitals Committees for county and county borough areas. The report of the Committee touched on many of the problems with which this Paper is concerned, though its scope was limited to recommendations affecting voluntary hospitals. The Government accepted the findings of the Committee to the extent of providing an exchequer grant for the voluntary hospitals of £500,000 (not £1,000,000 as the Committee had suggested), but the long-term proposals of the Committee for the establishment of co-ordinating machinery were not carried into effect.

Sixteen years later the position of the voluntary hospitals was again reviewed by a body established under the chairmanship of Lord Sankey by the British Hospitals Association, and known as the Voluntary Hospitals Commission. The report of this body, like that of its predecessor, proposed the establishment of central and local bodies with co-ordinating functions and recommended a system of exchequer grants in aid of the voluntary hospitals.

In 1936 the report of the Committee on Scottish Health Services—(the Cathcart Report)—was published. The Committee reviewed the whole of Scotland's health services, personal and environmental, and made many important recommendations within a national health policy for promoting the " fitness " of the people. The recommendations of the report assume throughout that the separate medical services must be integrated and that a co-ordinated medical service should be based, as far as possible, on the family doctor. The report is too comprehensive in scope to lend itself to brief quotation, but it is one of the most complete official surveys of the country's health services and health problems yet attempted. The recommendations of the Committee have already formed the basis of legislation in particular fields.

The latest official report on hospital problems is that recently issued by the Committee which, under the chairmanship of Sir Hector Hetherington, was appointed by the Secretary of State to advise on various post-war hospital problems in Scotland. This report contains detailed recommendations for the setting up of five Regional Hospital Advisory Councils in Scotland. It also makes various suggestions for improved co-operation between hospitals and deals at length with financial arrangements as affecting the future voluntary hospital system.

Other helpful contributions to the study of hospital problems have been made from time to time by many other bodies, including the British Hospitals Association, the King Edward's Hospital Fund for London, the Contributory Schemes Association and most recently the Nuffield Provincial Hospitals Trust which has combined theory with practice in its well-known enterprises in paving the way for greater local co-ordination in the hospital services.

Throughout the period between the two wars, the British Medical Association have been active in focussing the mind of the medical profession upon constructive proposals for the extension and development of the existing health services. In 1930, and again in 1938, they published comprehensive proposals for " A General Medical Service for the Nation ", and in 1942 the Medical Planning Commission organised by the Association issued a draft Interim Report which offered for the consideration of the profession far-reaching suggestions for the improvement of the medical services of the community. Salient passages from this important document are quoted in the body of this Paper. Other publications in this field of

which mention should be made are a report issued by a professional group known as Medical Planning Research and representing for the most part the younger elements in the profession, a proposal for a National Health Service by the Society of Medical Officers of Health and a valuable and mainly factual report published by Political and Economic Planning (P.E.P.) in 1937. These publications, and many others too numerous to be mentioned, have been supplemented by copious discussion in the columns of the professional and the lay press.

It is not possible, within the limits of this document, to review all this field of political and professional literature, but it may be said in very general terms that the principles most frequently recurring in the presentation of plans for future developments are the following:—

(1) that there should be made available to every individual in the community whatever type of medical care and treatment he may need;

(2) that the scheme of services should be a fully integrated scheme and that in particular a much closer linking up between general practitioner services on the one hand and consultant and hospital services on the other ought to be achieved; and

(3) that for certain services, particularly the hospital service, larger areas of local administration are needed than those of any existing kind of local authorities.

It is against this background of constructive thinking and discussion during the last quarter of a century that the proposals in the present Paper have been prepared and are put forward.

The Government announced—in October, 1941—their intention to ensure, by means of a comprehensive hospital service, that appropriate hospital treatment should in future be readily available to everyone in need of it. The declared basis for this was to be a new duty upon major local authorities, in close co-operation with voluntary agencies working in the same field, to see that a full hospital service, of every necessary kind, was made universally available; it was expressly recognised that this would mean designing the service over areas larger than those of most of the existing local authorities and that the full use of the powerful resources of the voluntary hospitals, while putting their relations with the local authorities on a more regular footing, would be of the essence of the scheme. To pave the way a detailed and expert survey was started on the Minister of Health's behalf—partly conducted directly by the Ministry and partly organised for the Minister by the Nuffield Provincial Hospitals Trust—of the hospital services already available in each area in England and Wales. This survey is now nearing its completion. So also is a similar survey in Scotland, instituted by the Secretary of State.

Then, more recently, the report of Sir William Beveridge having taken as one of the bases of its proposals the assumption that a comprehensive national health service, for all purposes and for all people, would be established, the Government announced in February, 1943, that they also accepted this assumption.

The Health Ministers thereupon approached the medical profession, the voluntary hospitals and the major local government authorities, from each of whom they wanted—on a proposal of this magnitude—to obtain all possible help and expert guidance from the outset. It was arranged with them that, for the first stage, they should appoint small groups of representatives of their own choice and that these groups should take part in general preliminary discussions.

The programme was that there would need to be three stages in the evolution of the Government's proposals.

There would be a first stage, in which a preliminary exchange of ideas would be conducted informally and confidentially and without commitment on either side—to enable the Ministers to get a general impression of the feeling of these representatives on some of the main issues involved and to help them to clear the ground.

This second stage would be one of public discussion in Parliament and elsewhere. It would be the stage at which everybody—the public generally, for whom the service would be designed, the doctors and the hospitals and the local authorities and other organisations which would be concerned in it or affected by it, and those men and women (including doctors) who are now engaged in the Armed Forces—would be able to discuss what was proposed and to voice their opinions about it. To assist in this the Government would issue a White Paper which would serve as a focus for detailed discussion.

The third stage would then be one in which the Government would settle what exact proposals they would submit in legislative form for the decision of Parliament.

For the first stage the representative groups were duly formed. In England and Wales, for the medical profession the British Medical Association, in collaboration with the Royal Colleges, brought together a representative group of medical men and women. For the voluntary hospitals representatives of the British Hospitals Association and the King Edward's Hospital Fund for London, with representatives of the Nuffield Provincial Hospitals Trust joining as observers, together formed a group. For the major local government authorities the County Councils Association, the Association of Municipal Corporations and the London County Council combined to form the third group.

Separate arrangements were made by the Secretary of State for Scotland for discussions with representatives of the medical profession in Scotland, the Scottish local authority associations and the Scottish Branch of the British Hospitals Association. These separate discussions took account of Scottish experience and of geographical, administrative and other differences.

Discussions took place with each group on those aspects of a comprehensive service which most affected them. For the purpose of discussion the Ministers offered to each group—in memoranda and orally—a series of suggestions and ideas for them to consider. They made it clear throughout that they welcomed criticism and alternative suggestions and were not at any stage confronting any of the groups with a predetermined scheme. They received suggestions from the groups on many of the subjects involved, and discussion from the outset was on the frankest basis. Inevitably there was divergence of opinion on some of the issues involved, which each group approached from a different background of experience and opinion, but the discussions were useful as a preliminary sounding of the expert view.

The present White Paper does not purport to sum up the discussions which have taken place, or to reflect any agreement or represent any views reached in these discussions. That would be inconsistent with the terms on which the discussion were undertaken.

APPENDIX C.

POSSIBLE METHODS OF SECURING LOCAL ADMINISTRATION OVER LARGER AREAS THAN THOSE OF PRESENT LOCAL GOVERNMENT.

On the assumption that for certain aspects of the health service, particularly the hospital service, there is need for larger areas of local administration than exist for these purposes now, and that the body responsible for the administration must be representative of and answerable to the electors of the area, there are, broadly speaking, three possible courses:—

(1) to establish a directly elected body for the sole purpose of administering these parts of the health service;

(2) to establish a directly elected body for the purpose of administering a group of services including these parts of the health service;

(3) to secure joint action by the councils of the existing counties and county boroughs which make up the proposed area of administration.

The creation of a directly elected local authority for some particular purpose would run counter to modern developments in local government, which have been towards replacing the system of special authorities for the administration of particular services (such as Boards of Guardians and School Boards) by the system of authorities covering a wide range of functions. But, apart from that

the process of electing a one-purpose authority operating over a fairly large area is not likely to arouse sufficient public interest to attract an adequate proportion of local voters to the poll. Moreover, the system—if generalised over all the social services locally administered—would create an impossible complexity of separate authorities for separate local administrative functions, each requiring separate local election, each operating over a different area, and each requiring separate arrangements for rating or precepting in order to obtain its local revenue.

An alternative suggestion, of establishing new local authorities over wider areas for a substantial group of local services, has been canvassed in recent years. For instance, a proposal for comprising in a single local administrative area the county of Northumberland, part of the county of Durham, and four county boroughs lying on either side of the Tyne, was made in the Majority Report of the Royal Commission on Local Government in the Tyneside Area (1937) and it was recommended that six of the major local government services —Public Health (Medical and Allied Services), Education, Public Assistance, Police, Fire Brigades, and Highways—should be administered by a body with jurisdiction over the whole of this area. Proposals of a similar kind have been made in various quarters since the outbreak of the present war.

An authority performing so many important functions would need to be directly elected. But its establishment would involve a major alteration of the structure of local government. It would deprive county councils of practically all their chief functions—if, indeed, the few minor functions left could be held to justify their continued existence at all, and it would so denude county borough councils of their powers as to leave them with functions in some respects less than those of the "minor authorities" of to-day. Recent publications of the various local government associations and other bodies have shown that there is a wide divergence of view as to the future pattern of local government. It is clear that this must be the subject of a comprehensive inquiry, which could not be instituted under present conditions or completed in a short time. Settlement of the machinery of the new health service cannot await the conclusions of such an inquiry and the passing of any consequent legislation.

The only practical course—pending a general review of local government—is to use the present machinery and the existing facilities for securing such combinations of authorities as may be necessary. This means the application (and possibly some adaptation) of the well-established practice of securing larger administrative units by joint action.

The advantages and disadvantages of administering particular services by combinations of local authorities organised as joint boards have often been argued. The members of the Tyneside Commission, referred to above, differed on the point, the majority regarding the joint board system as "undemocratic", the signatory of the minority report taking the opposite view and recommending the extension of the system as going a considerable way to meet the problems with which that area was faced. The general convenience of arrangements which make it possible to have an area of administration exactly appropriate to any particular service, and to set up an authority for that area, chosen by persons who are themselves direct representatives of the local electorate, cannot be denied. But it is true that the system, if completely generalised, would leave the constituent local authorities who choose the members of the boards with little to do beyond nominating those members, instead of administering services themselves.

Other objections are often advanced. It is said that joint boards tend to attract the more elderly and less effective members of the constituent councils, and that their efficiency is thereby diminished. This is a matter of impression. It may be that, even if it is true, it is due not to the nature of joint boards but to the subject matters with which they happen to deal. A joint board administering (say) an infectious diseases hospital or a sewage disposal system—although its activities may be not less essential to the public welfare—may well attract less interest than would be taken in housing or education, two subjects which excite the keenest interest among local administrators. In any case, this particular weakness of the joint board system, if it exists, is one for which the remedy lies in the hands of local authorities themselves.

Another common criticism is that the powerful weapon of precepting on constituent authorities for funds weakens a joint board's sense of financial responsibility; or—to put it another way—that the members of a joint board, being indirectly elected and therefore at two removes from the ratepayers, have not the same need to justify policy to their supporters as the members of a directly elected authority. There may be something in this, but it is a point which could be met; *e.g.*, by requiring the joint authority to submit to its constituent councils (at intervals of, say, one or two or three years) estimates of their proposed expenditure, for the approval of all—or of a specific majority—of those councils. Some means of removing deadlocks (probably by way of arbitral powers vested in the appropriate Minister) would be needed, unless a majority decision were to be binding. This device, coupled with a more regular habit among the constituent councils of examining, and if necessary debating, the annual and other reports of the joint board, would go a long way to preserve a proper relation of the board to its constituent councils and the electors.

It is also said that the joint board system is bad in that it separates the services entrusted to it from the rest of the main machinery of local government. So far as the health service is concerned, the answer is the practical one—that the need to settle areas of proper size and resources for certain aspects of the service is urgent, and that (temporarily at least) the joint board seems to be the only practicable means of doing this. There need be no question of ruling out any wider development of local government which may later emerge, as the need for new services and extensions of existing services reveals itself. But that is a matter of long-term policy, for which the establishment of a comprehensive health service cannot be delayed.

APPENDIX D.

REMUNERATION OF GENERAL PRACTITIONERS.

The National Insurance Act of 1911 did not itself lay down any method by which the doctors taking part in the service were to be remunerated, nor did it fix the amount of the remuneration. The former has from the outset been prescribed by regulation, the latter negotiated between the Government and the profession or on some occasions determined by arbitration. For the former, the Medical Benefit Regulations have from the start envisaged two systems—one by way of a capitation fee for each person for whom the doctor had accepted responsibility, and the other by way of fees for services actually rendered. Provision is made for combinations and variants of these two systems, but with certain minor exceptions the capitation fee quickly became universal, chiefly owing to the difficulty of checking over-attendance under the other system.

So long as payments for insurance work remained a part only—and in many cases not the major part—of a doctor's professional income, it was difficult to find any rational criterion on which to arrive at an appropriate capitation fee other than by reference to previous fees—*i.e.*, by the limited method of deciding whether any events occurring since the previous fee was fixed were such as to justify its further alteration. It is well known that the original sum fixed in 1912 had regard to the practice of Friendly Societies and Medical Clubs, and that all subsequent sums have been built up from that basis. But it must be expected that in future the bulk of general practitioners will look to the new service for the whole, or substantially the whole, of their professional earnings. Hence, whatever methods of payment are adopted—whether by capitation fees, by salary, or in some other way—the substantial question at issue must be seen in a new light. It must be seen as the question of what is on ordinary professional standards a reasonable and proper remuneration for the whole-time services of a general practitioner working in a public service. Whether this should be worked out in terms of gross or net earnings, whether superannuation rights are to be assumed and taken into account, what adjustments are to be made for part-time work, are matters of comparative detail. When once the main figures have been satisfactorily settled, not only remuneration by capitation fee but remuneration under the salaried or part-salaried systems could be easily determined.

As the White Paper makes clear, the Government do not contemplate the introduction of a universal salaried system, but they propose that doctors taking part in the public service should be remunerated on a basis of salaries or the equivalent in any part of the service in which this form of payment is necessary to efficiency. They contemplate also that it may be possible in certain other cases to offer remuneration by salary where the individual doctors concerned would prefer such an arrangement. In any event, whether payment is on a salaried or part-salaried system or on a basis of capitation fees, two principles will have to be observed in the arrangements made. First, the doctors taking part in the scheme must be assured of an adequate and appropriate income. Second, the aim must be to achieve a system flexible enough to allow for proper variations attributable to extra qualifications and extra energy and interest, as well as representing the reasonable and normal expectations of general practice at all its stages.

The Government fully recognise the importance, and the urgency from a professional point of view, of reaching an understanding on these crucial matters, and they will be ready to discuss them in detail with the profession's representatives.

APPENDIX E.

FINANCE OF THE NEW SERVICE.

ENGLAND AND WALES.

Financial questions were included in the discussions held with the interested bodies before the present White Paper was issued, and are referred to in various places in the Paper. This Appendix sets out the general lines on which the Government think that a reasonable financial basis could be found for the scheme outlined in the Paper, and covers the suggested financial responsibility of the main agencies involved. This basis is suggested as being appropriate to the early years of the scheme. When once the service is well established some simpler basis unrelated to the expenditure of individual authorities may be considered. Further it will be appreciated that any estimates of cost made at the moment can only be conjectural, and it will not be possible to make better estimates until the new scheme is nearing its final shape, and the necessary discussions and negotiations with the interested parties have made progress.

Responsibilities of Local Authorities.

The scheme outlined in the White Paper contemplates that a new joint authority will be responsible for the hospital and consultant services. The new authority will also have the duty of preparing and submitting to the Minister a plan for the whole health service of its area and it is proposed that this plan, taking all the local circumstances into account, should determine precisely how responsibility for the remaining services should be allocated. It is proposed, however, that child welfare responsibilities should always be entrusted to the authority which is also the local education authority, the precise arrangements to be made being governed by the provisions of the current Education Bill as finally approved by Parliament. The intention as regards other local services is that those which are essentially consultant services and thus closely linked with hospital administration should be the responsibility of the new joint authorities, and those which belong more to the sphere of general health care should be the responsibility of county and county borough councils.

The principal new health services which will have to be set up if the White Paper scheme is adopted are home nursing, the provision of Health Centres and new dental and ophthalmic services. In the case of these new services, as in the case of existing services, there will be need for flexibility and it is contemplated that the final allocation of responsibility will be a matter for the area plan. It is assumed, however, that ordinarily responsibility for the provision of Health Centres and for the home nursing service will be assigned to county and county borough councils. But no assumption can be made regarding the other two services. The shape of the new dental and ophthalmic services cannot be foreseen until the report of the Teviot Committee on the former has been received and

discussions on both have taken place with the interests concerned. It is consequently impossible to say at this stage whether the whole or a part of these two services will be administered by local authorities or, if so, which authorities should be made responsible for them.

For the purpose of framing an estimate of the cost of the new health service as a whole however, it is immaterial to know precisely how responsibility for different parts of the service will be allocated among the various local authorities or to a central organisation. The hypothesis on which the figures given below are based must not therefore be read to imply that decisions have been taken on any questions of allocation of responsibility which are left open in the White Paper. The hypothesis selected as convenient for presenting the figures is that the new joint authorities will be responsible for the hospital and consultant service, tuberculosis dispensaries and mental clinics, and the county and county borough councils will be responsible for the provision of Health Centres and for the other existing local services, for the new home nursing service and, if the new dental and ophthalmic services are, in fact, entrusted wholly to local authorities, for these two services as well.

The New Joint Authority.

The scheme outlined in the White Paper contemplates that the new joint authority will take over all hospitals at present provided by rate-payers, including infectious diseases hospitals and mental hospitals* and will make arrangements with voluntary hospitals for the treatment of patients. They will also take over any tuberculosis dispensaries and mental clinics. Suitable financial adjustments will be made between the joint authority and the local authorities in respect of capital assets and liabilities taken over. A new service for which the joint authorities will be responsible is the provision of consultants (based on hospitals). In addition, they will need administrative and technical staff in the exercise of their duty of co-ordinating all the health activities of their area.

The total annual expenditure of all the new joint authorities will be very considerable. For example, in 1938-39 the cost to the existing local authorities of the services to be transferred was:—

	£ millions.
Mental Hospitals	12.3
Infectious Diseases Hospitals	4.2
Other Hospitals and Institutions	14.6
Tuberculosis Services	4.6
	35.7

There was no direct exchequer grant in aid of this expenditure, but there was indirect assistance to the rate-payers through the operation of the block grant to local authorities under the Local Government Act, 1929.

After the war the 1938-39 cost will be considerably increased. There will be some expansion of accommodation and services provided (e.g. for cancer), prices in general will be higher, and nurses' salaries have been increased substantially. In addition the joint authorities will be put to expense in connection with the arrangements to be made with voluntary hospitals, and in providing for the consultant service based on their own and on the voluntary hospitals. In these circumstances the cost to the joint authorities of these services in the years immediately after the war and of their general administrative expenses may approach £70 millions.

As regards the existing services, although there is no direct exchequer grant at present (except for cancer treatment, on which only a small amount was spent before or during the war by local authorities), the Government think that there should be a grant based on the number of hospital beds provided under the scheme. This grant would be substantial and would help to meet the cost of

* The term mental hospital is used in this appendix to include also mental deficiency institutions.

providing the consultant service based on hospitals. The grant for cancer treatment would be discontinued, as would the temporary war-time grant in respect of increases in the salaries of nurses, midwives, etc. In the case of the other new services a 50 per cent. grant is proposed.

For the purposes of this appendix the grant per bed has been taken as £100 per annum in the case of all hospitals other than mental hospitals and infectious disease hospitals and £35 per annum in the case of mental and infectious disease hospitals. A lower grant in the case of beds in these latter hospitals is justified not only on the ground of comparative cost of treatment and maintenance, but because the new scheme broadly does not impose any additional duties on local authorities in respect of treatment. The number of mental hospital beds has been taken as 170,000, of infectious disease hospitals as 40,000 and of other municipal hospital beds as 210,000.

On the above assumptions, the new joint authorities would spend about £70 millions a year. They would receive direct exchequer grants of £6 millions in respect of mental hospitals, £1.4 millions in respect of infectious disease hospitals and £21 millions in respect of other hospitals, a total of £28.4 millions.

The balance of cost—on these assumptions £41.6 millions—would be raised by means of precept on the constituent counties and county boroughs in the area of the joint authority, who would levy a rate for it. The rate-payers would accordingly have to find this £41.6 millions as against the £35.7 millions they had to find in 1938-39. The Government propose that this increased rate demand should be mitigated by an exchequer grant, as explained in the paragraphs which follow dealing with counties and county boroughs.

Counties and County Boroughs.

As already indicated, this financial appendix is based on the hypothesis that county and county borough councils will remain responsible for clinic services other than tuberculosis dispensaries and mental clinics, the major ones being maternity and child welfare and venereal disease, and will continue to be the responsible authority under the Midwives Act. In addition, it is assumed that they will provide and maintain Health Centres and will administer the home nursing service.

Taking figures of cost for 1938-39, the total expenditure on the services proposed to be transferred to the new joint authorities was £35.7 millions and that on the remaining services was £4.6 millions. Included in this latter figure was the balance of expenditure under the Midwives Act, after taking account of a grant of £.6 million.

The cost of these services will be greater after the war, owing to increased prices generally, to the cessation of fees charged for the attendance of midwives and the increased salaries of midwives and to any necessary expansions. It is proposed that there should continue to be a 50 per cent. grant towards the cost of the midwives service, and with the increased cost the grant may well amount to £1.5 million a year.

In the early years after the war £1 million per annum may be spent on home nursing, though it is difficult to forecast the cost of this service. The Government contemplate a 50 per cent. grant.

The cost of the provision and maintenance of Health Centres is difficult to forecast at the moment. Excluding the remuneration of doctors in the Centres the running costs (loan charges, heating, staff, etc.) of the Centres established during the first year or two would probably not exceed £1 million a year. The Government propose a 50 per cent. grant for this new service.

It will take some time to establish the new dental and ophthalmic services, and it will probably be several years before the net expenditure on the services reaches £10 millions on the former and £1 million on the latter. The Government propose a 50 per cent. grant towards these new services if responsibility for them is placed on counties and county borough councils.

Taking these figures, the total direct expenditure of counties and county boroughs on health services might amount to about £22 millions, towards which

there would be a direct exchequer grant of £8 millions. (Indirect assistance is, of course, also given by the block grant under the Local Government Act, 1929.)

The total amounts falling on the rate-payers would be £41.6 millions under precept from the joint authorities and £14 millions direct expenditure, a total of £55.6 millions. This compares with the figure for these services in 1938-39 of £40.3 millions. The Government would propose that any increased rate demand of this sort should be mitigated by an exchequer grant amounting in total to about 50 per cent. of the increase in any year over the demand in some fixed year taken as standard. If 1938-39 were the standard year, then on the figures given the grant in aid of rates would be about £7.6 millions. The grant would be paid to each county or county borough as a proportion of its increased rate-burden, the proportion being higher for poor areas than for rich, on general block grant principles.

Voluntary Hospitals.

Before the war there were no exchequer grants to voluntary hospitals in respect of their expenditure on the treatment and maintenance of patients. Their income was derived as to about half from payments by patients, either direct or through contributory schemes, and as to the rest mainly from voluntary gifts and legacies and income from investments. During the war they have received payments from the exchequer for work done in connection with the Emergency Hospital Scheme and are at present receiving an exchequer grant towards the cost of increased nurses' salaries based on 50 per cent. of the additional cost they incur under that head.

The White Paper explains the part which it is suggested that the voluntary hospitals should play in the new health scheme. Each voluntary hospital which makes arrangements with the new joint authority for the maintenance and treatment of patients under the general conditions of the scheme will have part of the cost paid to them by the authority. This may take the form of a standard sum per occupied bed per week, varying only with the type of hospital concerned.

In addition, in connection with the arrangements of the joint authority for the provision of consultants agreed sums may be contributed in aid of salaries, etc.

The war-time grant in respect of increases in salaries of nurses, midwives, etc., will cease, but the Government propose a new grant in respect of each bed in a voluntary hospital which, under arrangements made with the joint authority, is used or kept available for patients in the scheme. Outside the arrangements of the scheme, a voluntary hospital will, of course, be free to provide such "private pay-beds" as it thinks fit. Assuming that this grant will be the same as was taken for beds in municipal hospitals, i.e., £100 per annum, and that the total number of beds included in arrangements with joint authorities may possibly amount to 100,000, the exchequer grant would amount to £10 millions. This sum, together with the payments by joint authorities towards the cost of maintenance and treatment of patients, would not cover the whole cost to the voluntary hospitals, which would still be dependent on voluntary resources for a substantial part of the income necessary to balance their expenditure.

The General Practitioner Service.

It is clearly not possible at present to give any but the roughest estimates of the probable cost of the general practitioner service under the new scheme. In 1938, in respect of 17,800,000 insured persons under the National Health Insurance scheme, 17,164 general practitioners as a whole received £8.4 millions, while in the same year £2.4 millions was paid to chemists for fees and drugs in dispensing prescriptions.

For the purposes of this Appendix it is assumed that the cost of the extended service would amount to £30 millions a year for doctors and chemists together.

No account is taken of the cost of any superannuation scheme which may be introduced or of the cost of compensation in those cases where it is applicable.

Total Annual Cost of the Scheme.

On the basis of the rough estimates given in the preceding paragraphs the following table shows the total annual cost of the scheme to public funds and the proportions in which that cost might be borne by the ratepayers and by central funds.

Service.	Cost met from central funds.			Cost falling on rate-payers.	Total cost to public funds.
	(a) by direct grants or payments.	(b) by grants in aid of rates or precepts.	Total cost from central funds.		
	£m.	£m.	£m.	£m.	£m.
Expenditure of new joint authorities	28·4	—	28·4	41·6	70
Exchequer grant to voluntary hospitals	10	—	10	—	10
Expenditure of county and county borough councils ...	8	7·6	15·6	6·4	22
Fees to general practitioners and payments to chemists...	30	—	30	—	30
All services	76·4	7·6	84·0	48·0	132·0

How far the central funds will consist of, or be assisted by, sums of money set aside out of contributions under a social insurance scheme will fall to be considered later. The Beveridge Report proposed that a sum of £40 millions per annum should be available for the new health services. Of this £35·7 millions would be the share appropriate to England and Wales, and if this assistance is assumed the proportions in which the total cost of the new service would fall on the social insurance scheme, the taxpayer and the ratepayer would be, on the foregoing estimates and ignoring the effect of the block grant under the Local Government Act, 1929:—

Social Insurance Scheme	£35·7 millions, or about	27 per cent.
Taxpayer	48·3 ,, ,,	36·6 ,,
Ratepayer	48 ,, ,,	36·4 ,,
	£132·0 ,,	

Again ignoring the effect of the block grant, the corresponding table for the incomplete services in 1938-39 would be approximately:—

	£m.	
Contributions under N.H.I. Acts	11·2	or about 20 per cent.
Taxpayer	3·0	,, ,, 6 ,,
Ratepayer	40·3	,, ,, 74 ,,
	54·5	

FINANCE IN SCOTLAND.

As explained in the White Paper, certain differences are necessary in the administrative arrangements and reorganisation of the new health service in Scotland, as compared with England and Wales. With one material exception, however, the financial arrangements will be on broadly similar lines in the two countries. That exception concerns the provision, equipment and maintenance of Health Centres, which in England and Wales are likely to be a local responsibility and in Scotland the responsibility of the central authority. This being so, the whole cost of establishing these Centres in Scotland will be met from the exchequer, and the precise adjustments to be made in the grants payable to local authorities under the new scheme to take account of this difference will be a matter for discussion with these authorities.

On the basis of the best information available to the Department of Health for Scotland, the following table gives a rough estimate of the total annual cost of the scheme in Scotland and its approximate allocation between the ratepayers and central funds.

Service.	Cost met from central funds.			Cost falling on rate-payers.	Total cost to public funds.
	(a) by direct grants or payments.	(b) by grants in aid of rates or precepts.	Total cost from central funds.		
	£m.	£m.	£m.	£m.	£m.
Expenditure of new Joint Hospitals Boards	3·4	—	3·4	4·6	8·0
Exchequer grant to voluntary hospitals	1·6	—	1·6	—	1·6
Expenditure of county and large burgh councils ...	1·0	1·0	2·0	·8	2·8
Fees to general practitioners and payments to chemists...	3·2	—	3·2	—	3·2
Health Centres	·2	—	·2	—	·2
All services	9·4	1·0	10·4	5·4	15·8

If it is assumed that Scotland's share of any sum set aside out of contributions under a social insurance scheme be £4·3 millions (corresponding to the figure of £35·7 millions for England and Wales) the total cost of the new service would fall on the social insurance scheme, the taxpayer and the ratepayer in the following proportions:—

Social Insurance Scheme	£4·3 millions or about	27 per cent.
Taxpayer	£6·1 ,, ,,	39 ,,
Ratepayer	£5·4 ,, ,,	34 ,,
	£15·8 ,,	

As the expenditure borne on the rates in 1938-39 was roughly £4·4 millions, the net additional contribution from the rates would be £1 million.

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