Moreover, we have been told that the fluctuations do not always reflect the standards of the service provided.

422. The generally high level of pay bed charges and their wide variations between comparable hospitals have led many of our witnesses to suggest that the present method of calculating the charge should be abandoned altogether and one of a number of alternatives substituted in its stead, e.g.:—

(*a*) An arbitrary charge, considerably lower than the existing charge, should be fixed nationally, to enable a greater proportion of the population to use hospital pay beds. The continual increase in the enrolment of new members by Provident Associations, etc. proves that many people are anxious to use pay beds and to have the consultant of their choice, and are willing to make the necessary financial provision for this purpose by insurance. Their numbers would be increased still further if the pay bed charges could be reduced; and the occupancy rate would thereby be raised.

(*b*) Standard charges should be laid down each year either nationally or regionally for all hospitals or groups of hospitals and should be based on the average cost of a pay bed during the preceding year, according to certain categories of hospital, e.g. London teaching hospitals, provincial teaching hospitals, non-teaching general hospitals, etc. etc.

423. We do not ourselves believe, however, that it would be advisable to depart from the principle that the user of a pay bed, having contracted out of the free hospital service, should pay the full cost of the accommodation and services provided, while making his own arrangements for paying the consultant of his choice. Hence we do not recommend the adoption of an arbitrary charge which would be demonstrably lower than the actual cost of the facilities provided. No doubt pay beds would be used more widely by paying patients if the charges were reduced, but we believe that the charges would have to be reduced very substantially indeed to effect any large increase in demand—so much so that the net effect would most probably be a loss to the Exchequer as compared with the present position.

424. We have carefully considered whether the adoption of regional or national average charges for particular categories of hospital would be preferable to the present system, but on balance, we see no real advantage in their adoption. An average charge, calculated nationally or regionally, might remove some of the objections to the present range of charges, but it would cause many users of pay beds to pay more than the cost of the services provided, and it would be little compensation to them to know that other users were paying less. After considering the effect of introducing regional averages for certain categories of beds in three Hospital Regions, we have concluded that there was no reason to believe that average charges would produce any better relationship between the charge and the value or quality of the services provided than that produced under the existing charging provisions. We therefore offer no recommendation on this matter.

HOSPITAL SUPPLIES

425. Supplies purchasing is clearly an extremely important aspect of hospital management and one which will repay a close investigation; we therefore welcome the appointment in 1955 of a special Committee of the Central Health Services Council "to investigate and report on the organisation of all forms of hospital supplies, including their purchase, storage and issue, throughout the National Health Service". We understand that the

Committee (under the Chairmanship of Sir Frederick Messer, C.B.E., J.P., M.P.), will be taking evidence from a wide range of bodies and organisations both inside and outside the National Health Service. We do not propose therefore to offer any recommendations on this subject in advance of the Committee's report.

426. From the limited evidence we have heard on this matter, we are left with the impression that hospital authorities generally have not yet taken full advantage of the enormous volume of knowledge and well tried practices in supplies purchasing which are already common to all large undertakings in this country. In our view, it is desirable that these practices should be ascertained and applied wherever practicable to the hospital service to ensure that the best value is obtained for the money spent. It is true that this process has been under way in the hospital service since 1948, both centrally and in certain of the Hospital Regions, but progress appears to us to have been slower than might have been expected.

PART IV

THE FAMILY PRACTITIONER SERVICES

Administrative Organisation

The Insurance Committees before 1948

427. Immediately before the inception of the National Health Service, the general practitioner service under the National Health Insurance scheme was administered by Insurance Committees of which there were 129 in England, 17 in Wales, and 54 in Scotland. In England and Wales there was one Committee for each county and county borough (and one for the Isles of Scilly), and in Scotland one Committee for each county and large burgh (with one exception).

There were 20–40 members in each of the Insurance Committees in England and Wales and 30–40 in Scotland. The membership of the Committees in England and Wales was made up as follows[1]:—

Three-fifths of the members represented insured persons;

One-fifth appointed by the local authority concerned;

1 doctor appointed by the Minister (except on Committees with less than 30 members);

1 doctor appointed by the local authority;

2 doctors appointed by the Local Medical Committee.

The remaining members (from 1–4) consisted of chemists or women members appointed by the Minister.

Briefly, the duties of the Committees were:—

(*a*) to make arrangements for the medical treatment of insured persons,

(*b*) to make arrangements for the supply of drugs, medicines and certain appliances to insured persons,

(*c*) to keep lists of doctors and chemists providing the services, and registers of the persons on the panel of each doctor,

[1] The membership of the Committees in Scotland was made up in much the same way.

31519 F 2

(*d*) to pay the cash benefits due to persons who were not members of Approved Societies,

(*e*) to investigate complaints and to deal with questions by insured persons relating to the provision of medical benefit and drugs, etc.,

(*f*) to make the appropriate payments to doctors and chemists.

The Insurance Committees were therefore responsible for the maintenance of an adequate medical service (which included both treatment and drugs) for the insured persons in their area.

Administrative Organisation under the National Health Service

Executive Council Machinery

England and Wales

428. The family practitioner services provided under the National Health Service consist of general medical, general dental, pharmaceutical and supplementary ophthalmic services. These services are administered by 138 Executive Councils; there is one Executive Council for each county and county borough, except for eight[1] each of which covers the areas of two counties or county boroughs. As the councils of counties and county boroughs are the local health authorities for the purposes of the National Health Service Act, it follows that the areas of Executive Councils are generally co-terminous with those of the local health authorities.

429. Each Executive Council consists of 25 members of whom 8 are appointed by the local health authority for the area of the Council, 5 by the Minister, 7 by the Local Medical Committee, 3 by the Local Dental Committee and 2 by the Local Pharmaceutical Committee. The 5 members appointed by the Minister originally included the Chairman, but under the provisions of the National Health Service (Amendment) Act, 1949, the Councils were empowered to elect their own Chairmen.

The members of Executive Councils serve in a voluntary capacity but provision is made for loss of earnings and additional expenses incurred in attending meetings and for travelling and subsistence expenses.

430. Committees known as the Local Medical Committees, Local Dental Committees, Local Pharmaceutical Committees and Local Optical Committees set up by and representing the medical practitioners, the dental practitioners, the pharmacists and the opticians in the area of each Executive Council have been recognised by the Minister, and the Council is required to consult with them in exercising its functions.

431. The functions of an Executive Council in relation to the supplementary ophthalmic service are exercised by Ophthalmic Services Committees which include members appointed by the Council, ophthalmic medical practitioners, ophthalmic opticians and dispensing opticians.

432. The Councils appoint their own staffs, who are not civil servants and whose remuneration and terms and conditions of service are determined by the National Health Service Whitley machinery. The numbers of senior officers are determined in relation to the population of the area served by the Council. Table 43 shows the numbers of administrative and clerical staff employed by Executive Councils at the end of each financial year, from 1949 to 1954.

[1] Devon and Exeter
Gloucestershire and Gloucester
Kent and Canterbury
Leicester and Rutland
Nottinghamshire and Nottingham
Oxfordshire and Oxford
Denbigh and Flint
Monmouth and Newport

TABLE 43

Administrative and Clerical Staff employed by Executive Councils in the years 1948–9 to 1953–4

England and Wales

Date	Total Employed
31.3.49	4,056
31.3.50	3,872
31.3.51	3,816
31.3.52	3,829
31.3.53	3,413
31.3.54	3,341

A review has been carried out of the numbers of staff employed by each Executive Council and establishments have been laid down which may not be exceeded without the Minister's approval. These reviews have helped to secure the reductions in recent years revealed by the table.

433. Executive Councils inherited from their predecessors, the Insurance Committees which operated under the National Health Insurance Act, staff, offices and office equipment, etc., but considerable expansion has been necessary in order to cope not only with the wider functions of the new bodies but also with the additional volume of work flowing from the provision of services for the whole of the civilian population instead of the limited number previously entitled to medical benefit under the National Health Insurance Act.

434. The policy followed in relation to each of the services administered by Executive Councils is largely determined by the Minister in discussion with the professional bodies concerned, and is embodied in regulations or memoranda issued by the Ministry. The scope for local initiative is therefore more limited than in the hospital service. Within the framework of that policy the expenditure of the Executive Councils on the services is determined by the rates of remuneration of the practitioners and contractors providing the services (which are settled through the National Health Service Whitley machine or by the Ministry in direct negotiation with the professions) and by the use made by the public of those services.

435. Funds are advanced by the Minister each month to enable Executive Councils to meet the costs of administration and to make the necessary payments to the practitioners and other professional men providing services under this part of the Act. These advances are based on estimates supported by cash statements showing payments to the end of the previous month.

The accounts of Executive Councils are audited by auditors appointed by the Minister and a summary is incorporated in the Summary Accounts which are presented to Parliament each year.

Scotland

436. In Scotland, the general practitioner services are organised through 25 Executive Councils which have the same functions as the Councils in England and Wales. The 25 Executive Councils cover the areas of one or more local health authorities—one for each of the four cities, 13 for single county areas, and 8 for combinations of two or more county areas (the large burghs, which are also local health authorities, being included within their respective counties). The membership of the Executive Councils follows the English pattern, except in the case of two Councils covering the areas of six and four local health authorities respectively, which have memberships of 37

31519 F 3

and 27 respectively. There are Local Medical, Dental and Pharmaceutical Committees as in England, but in the case of the Ophthalmic Services Committees, five regional committees, known as Joint Ophthalmic Services Committees, have been established instead of one committee for each Executive Council's area.

437. The numbers of administrative and clerical staff employed by the Executive Councils in Scotland at 1st April, 1949, and at 15th September in each year since 1949 are shown in table 44

TABLE 44

Administrative and Clerical Staff employed by Executive Councils 1949 to 1954

Scotland

Date	Total number of staff employed
1st April, 1949	537
15th September, 1949	471
15th September, 1950	456
15th September, 1951	617*
15th September, 1952	454
15th September, 1953	425
15th September, 1954	408

* Includes temporary staff employed on the elimination of " inflation " from doctors' lists.

A Working Party appointed by the Department of Health in 1952 to review the staffing and organisation of Executive Councils issued their report in January, 1953, and action has been taken by the Executive Councils on their recommendations to effect any possible economies.

POINTS MADE IN EVIDENCE(1)

Amalgamation of Areas

438. There has been general agreement among our witnesses that the Executive Councils have functioned well since the Appointed Day and that no radical changes are required either in their membership or their organisation.

439. The suggestion has often been made, however, that the family practitioner services could be administered more economically and perhaps more efficiently if some of the existing areas were amalgamated under one Executive Council, particularly in the case of the county and its associated county borough where the offices of the two Executive Councils are often situated in the same town (e.g. Worcester and Worcestershire). Admittedly, the savings achieved by this means would not be substantial, because the bulk of the work of an Executive Council consists of registration, maintenance of lists and records, etc., and so long as doctors continue to be paid on a capitation fee basis, this work will have to be continued whatever the form of administrative organisation adopted. There would be some saving in the number of senior posts and in general overhead expenses, however, and little inconvenience would be caused to the public, so long as the amalgamations were not carried too far. There is the further point that some of the smaller Executive Councils, having only a few disciplinary cases to deal with each year, may find these cases more difficult to handle than their larger neighbours who are more accustomed to the regulations and procedures involved. To this extent, it might be argued that the amalgamation of the smaller Executive Council with a larger neighbour would actually increase the efficiency of administration.

(1) The proposal to transfer the work of Executive Councils either to the local health authorities or to Regional Hospital Boards has already been dealt with in Part II of our Report.

The Case against Amalgamation

440. The witnesses who have opposed any further amalgamation of Executive Council areas have referred to the paramount importance of linking closely the services administered by Executive Councils with those administered by the local health authorities. They have argued therefore that the boundaries of Executive Council areas should generally be co-terminous with those of the local health authorities, so that the general practitioner in particular may work closely in conjunction with the domiciliary health services and serve as the clinical leader of the local domiciliary health team.

441. We heard from the Ministry of Health that although the Department had favoured amalgamation of Executive Council areas before the Appointed Day, they had since come round to the view, as a result of the experience gained since the inception of the Service, that it was desirable that Executive Council areas should generally follow the local health authority pattern for the reasons stated in the preceding paragraph.

442. If amalgamations were carried too far, witnesses have generally agreed that the wider areas served by one Executive Council would be less convenient to the public and to the profession, and would give rise to considerable objection. The feeling of "communal interest" which had been built up in the local authority areas would also be lost.

Our own view

443. We have considered this matter carefully and have reached the conclusion that the existing pattern of Executive Council areas is broadly right, for the reasons stated in para. 440 above—i.e. that the boundaries of Executive Council areas should generally be co-terminous with those of the local health authorities, so as to strengthen the link between the general practitioner and domiciliary health services. There may be a few areas in England and Wales where amalgamation might be effected without detriment to the service, and we suggest that the possibility of marginal adjustments of this nature might be borne in mind by the Departments when reviewing the structure of the Executive Councils; but we do not believe that the savings achieved by such amalgamations would be substantial.

Membership of Executive Councils

444. The suggestion has been made to us that the Executive Council machinery may be popular with the professions because it allows them in effect to run the service in their own way without responsibility to the State or the taxpayer. As the record of attendance of lay members at Council meetings is not up to the standard of the professional members, there may be occasions when the lay members are actually in a minority. We have heard that representatives of the local authorities are often at fault in this matter, chiefly because local authorities continue to appoint people from among their own members who are already heavily burdened with attendance at Council and Committee meetings. We consider that it would be an advantage if local authorities would look outside their own membership for at least a proportion of the members nominated to serve on Executive Councils.

445. The majority of our witnesses, however, have maintained that there are enough checks and balances in the constitution of Executive Councils to ensure that the public interest is protected. They have pointed out that rates of remuneration and the terms of contracts etc., are settled nationally and are not within the discretion of each Executive Council to decide, with the result that there is little scope for the exercise of self-interest; and they have contended that the experience of the last seven years shows that the professions have acted in the main in the interests of the Service and of the public. We have formed the opinion that in general the Executive Councils have carried out their duties well and efficiently, and that no case has been made out for altering the balance of their membership.

446. Some witnesses have drawn our attention to the fact that, in the larger Executive Council areas in England and Wales (particularly in London), it is difficult to find lay members who can spare the time to attend all the meetings of the disciplinary committees, which consist of three laymen, three professional members and one independent chairman. The professional members are allowed to send deputies to meetings when unable to attend personally, but the lay members have no such option. This difficulty might be met either by increasing the number of lay members of Executive Councils in the larger areas, or by appointing additional deputy lay members to attend the meetings of disciplinary committees. As an increase in the number of lay members would upset the balance between lay and professional membership, we were advised that the authorisation of deputies was probably preferable.

447. We agree that there is a problem here, and accordingly we recommend that the existing disciplinary regulations in England and Wales be amended so that, in the case of the largest Executive Councils, provision might be made for additional deputy lay members to be appointed with the Minister's approval.

The Services Administered by Executive Councils

448. We now go on to examine in turn the general medical and pharmaceutical services, the general dental service, and the supplementary ophthalmic services.

GENERAL MEDICAL AND PHARMACEUTICAL SERVICES

The position before 1948

449. Under the National Health Insurance scheme, medical benefit was provided for the whole of the insured population, i.e., some 21 million people in England and Wales and some 2,300,000 in Scotland representing for the most part persons employed under contracts of service with incomes of less than £420 per year. The insured person was entitled to select his own general practitioner from the local "panel" of doctors, and was able to obtain such advice and treatment as he needed (including visits to the home where necessary) without the payment of fees. The doctor was able to prescribe any drugs which he considered necessary for the treatment of his patients, and a limited list of surgical and medical appliances. Medical certificates were also provided by the doctor without charge. This medical benefit which was an insurance benefit in the full sense of the term did not extend to the wives, children and dependents of insured persons. It follows that more than half the population of the country drew upon the services of general practitioners as paying patients.

A general practitioner service was also provided before the Appointed Day under the provisions of the Poor Law. The organisation of this service—which included domiciliary visiting when necessary—had been built up throughout the nineteenth century for the "destitute sick" and was generally officered by part-time, though occasionally by full-time, district medical officers. In some areas shortly before the inception of the National Health Service, the Poor Law medical service was reorganised on the "panel" basis, and all doctors practising in the area were able to take part in its provision.

Various special services were provided for children and other groups and there were in addition special schemes for adult members of the public, organised by Government Departments, local authorities, industrial concerns, societies and clubs.

Highlands and Islands Medical Service

450. From 1913 to 1948, to deal with the difficulties arising from the nature of the country and the sparseness of the population, special arrangements for the provision of medical services were in force in the Highlands and Islands area of Scotland. This Highlands and Islands Medical Service, established following the Highlands and Islands (Medical Service) Grant Act, 1913, covered an area of more than half the land surface of Scotland but containing less than one-fifteenth of the total population. The basis of the service was the provision of medical attendance to patients at uniform fees irrespective of the distance which the doctor might have to travel. This was secured by paying grants to the doctor to compensate him for his travel and his time, in return for which he undertook to attend patients at modified fees. These arrangements applied to the families and dependents 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. The service was provided in consultation with the county councils, but the contracts with doctors were entered into directly by the Department of Health for Scotland. Radical improvements in the medical and nursing services were secured under these arrangements; grants were also paid for the provision of consultant services and for the development of certain hospitals in the area.

General Medical Services under the National Health Service in England and Wales

451. Under the National Health Service, general medical services are given by doctors who are under contract with Executive Councils to provide such services for patients whom they have accepted on their lists. A doctor who has contracted to provide these services is required to render to his patients "all proper and necessary treatment . . . which does not involve the application of special skill or experience of a degree or kind which general medical practitioners as a class cannot reasonably be expected to possess". The range of treatment provided includes the prescribing of medicines, the giving of certain medical certificates, and arranging for consultant and hospital services where necessary. General practitioners practising in rural areas may dispense drugs and medicines and supply certain appliances for their patients. The general medical services are available free of charge to all persons in this country, British or foreign, who may require and claim treatment. Persons can freely choose or change their doctors, while the doctor is free to accept a person or not as he chooses.

Patients normally visit the doctor's surgery, but when necessary are visited by him at home. Special arrangements are made for the treatment of persons who are temporarily living away from home and for emergency cases.

452. In England and Wales, there are now more than 19,000 doctors (i.e. principals providing general medical services) in the National Health Service, and over 42,000,000 patients on their lists, representing 97 per cent. of the population(1). The average number of patients per list is therefore a little over 2,200.

453. A doctor who wishes to start in practice in any area may apply to "put up his plate" or to succeed to a place in a partnership or some other vacancy created by the death or retirement of a doctor. Such applications are considered by the central Medical Practices Committee, which has a medical Chairman, 6 other medical members and 2 lay members. If the doctor wishes to start a new practice, the permission of the Medical Practices Committee must be granted unless they are satisfied that there are sufficient doctors in the district. (The Committee publish lists of areas showing where permission will be forthcoming immediately.) They also grant approval automatically in the case of a succession to a partnership. In other cases where a number of doctors have applied to fill a vacancy created by a death or retirement, the selection is made by the Medical Practices Committee, acting normally on the advice of the local Executive Council and Local Medical Committee. There is a right of appeal to the Minister. The effect of these arrangements has been to improve the distribution of doctors throughout the country since the Service began.

454. At present, a doctor may not normally accept more than a maximum of 3,500 persons on his list, if he is single-handed, and another 2,000 if he has an assistant. Before 1st April, 1953, the normal maxima were 4,000 and 2,400; these were reduced when the arrangements for remuneration were revised following on the Danckwerts award (see para. 456 below).

455. General practitioners whose qualifications entitle them to be on a local obstetric list may as part of their contracts with the Executive Councils provide maternity medical services (consisting of care and supervision during pregnancy, attendance at the confinement if necessary, and post-natal care) both to women on their lists of patients and to other women. They are paid fees, up to a maximum of 7 guineas, for the services provided. Doctors not on the local obstetric list may give these services only to patients on their own lists, and are paid lower fees (maximum 5 guineas).

456. General medical practitioners are paid by the Executive Councils with whom they are in contract. The main part of their remuneration derives from the share of England and Wales and Scotland in a Central Pool for Great Britain. A dispute between Ministers and the profession about whether the size of the Central Pool gave effect to the recommendations of the Spens Committee which had reported in 1946, was resolved in 1952 by an award (with retrospective effect) given by Mr. Justice Danckwerts who had been asked to adjudicate. Under the revised method of distribution worked out following the award, doctors receive from the Central Pool an annual payment for each person whom they have accepted, with a special "loading" for every person from the 501st to the 1,500th. Special allowances may be paid for a period of up to three years to new entrants in under-doctored areas. Doctors in rural areas receive mileage payments. Other payments include those for treating temporary residents, and fees for maternity medical services, for drugs and appliances supplied, and for the training of assistants.

457. Doctors taking part in the Health Service are debarred from selling the whole or any part of the goodwill of their practices. Every medical practitioner whose name was entered on the Medical List at the Appointed Day was therefore deemed to have suffered a loss and to be entitled to compensation. £66 million was in fact set aside in Great Britain to compensate doctors for the loss of the right they had previously enjoyed to sell their practices. This compensation is normally payable on the death or retirement of a doctor and interest at the rate of 2¾ per cent is payable on the outstanding amount. Payments of compensation and of interest are made by the Minister direct. In certain cases of proved hardship, advance payments can be made at the Minister's discretion.

(1) See paras. 495–503 below, however, for the effect of inflation on doctors' lists.

General Medical Services under the National Health Service in Scotland

458. Arrangements for general medical services in Scotland are very similar to those operating in England, and the only major administrative differences relate to the filling of practices left vacant by death or retirement. In Scotland the Medical Practices Committee can direct an Executive Council to advertise a vacant practice; and the selection of a doctor for a vacancy is entrusted to the Executive Council, in consultation with the Local Medical Committee, with a right of appeal from their decision to the Medical Practices Committee. The latter Committee consists of a medical Chairman, 3 other medical members and 2 lay members. The Committee publish from time to time lists of areas where they consider that additional doctors are necessary or desirable.

459. In Scotland any doctor, when obtaining admission to the Medical List, may arrange to provide maternity services also; and any doctor may provide them to a person on his ordinary list of patients. A doctor may also be admitted to a medical list to provide maternity services only. Broadly speaking the arrangements for the provision of maternity services follow out the principle of the Maternity Services (Scotland) Act, 1937, which provided for a doctor-midwife service backed where necessary by a consultant obstetrician service.

460. The arrangements for the payment of doctors out of the Central Pool are in all essential respects the same in Scotland as in England. Capitation fees and "loadings" are at the same rates in both countries; but there are minor differences in relation to inducement payments and payments for temporary residents, and the geographical circumstances of Scotland are recognised to justify a relatively large share of the money set apart for mileage payments.

461. The number of principals in general practice in Scotland is about 2,500, with over 4,900,000 patients on their lists. The average number of patients per list is just under 2,000.

Pharmaceutical Services in England and Wales

Present arrangements

462. Doctors are entitled to prescribe any necessary medicines and certain specified appliances for their Health Service patients. Dentists may also prescribe a limited range of medicines for their Health Service patients. These prescriptions (except in some rural areas) are made up by pharmacists and other persons (subsequently referred to as chemists) in contract with the Executive Councils. Regulations made in accordance with the National Health Service Act enable a person to contract for the supply of such drugs, medicines and appliances as he is entitled by law to sell.

463. Chemists are paid for these services on the basis of each prescription dispensed. The payment includes the net (or wholesale) cost of the ingredient or appliance (calculated according to the Drug Tariff), an on-cost allowance of 25 per cent. for overhead expenses and profits, a dispensing fee in respect

of the professional skill involved in dispensing, (the average in June, 1954 was 12·38 pence per prescription) and a flat rate allowance of 1¼d. for providing bottles and other containers. (Variations in the allowances for on-cost, dispensing, and containers have been made since the Appointed Day in the light of experience.)

464. In some rural areas doctors themselves supply certain patients ("dispensing patients") with drugs and specified appliances. At 1st January, 1953, there were about 2,800,000 such patients in England and Wales. These doctors may elect to be paid on the same basis as chemists or by means of a capitation payment for each of these patients. Additional payments are made to doctors paid on a capitation basis, to cover the cost of certain expensive drugs and appliances.

Pricing of prescriptions

465. Prescriptions are priced under the direction of the Joint Pricing Committees for England and Wales which work through 17 Pricing Offices. These Pricing Offices price prescriptions surrendered monthly by chemists, and certify to Executive Councils the amounts due. They also price prescriptions surrendered by doctors where payment is according to the Drug Tariff. Most of the Pricing Offices were set up by Insurance Committees or groups of Committees under the old National Health Insurance scheme. Under the National Health Service they were brought under the central control of the Joint Pricing Committee for England and Wales, which are elected mainly by Executive Councils with additional pharmacists and doctors nominated by the Department.

Methods of pricing

466. The pre-war practice under the National Health Insurance scheme was to price each and every prescription dispensed under the scheme. The numbers of prescriptions (71·5 million in 1947 compared with 219·7 million in 1953) and their comparative simplicity (the average cost per prescription was approximately 1s. 8d. in 1947 but 4s. 1d. in 1953) made full pricing practicable at that time. Because of loss of staff after the war, however, many Pricing Offices fell into arrears with their pricing and had already adopted some form of partial pricing when the National Health Service commenced. The volume of prescriptions dispensed[1] under the National Health Service added to their difficulties, and further methods of partial pricing (which have become known as "averaging") had to be used from the outset.

467. Under the system which was operative from June, 1949 to August, 1954, arrangements for pricing prescriptions were as follows:—

Prescriptions were sorted into bundles according to price. Payment was made in full for prescriptions of ingredient cost over 5s., and for some special prescriptions. Of the remainder at least 20 per cent. (in bundles selected at random) were priced, and the remainder paid for at the average cost of the prescriptions priced.

Owing to the very large number of prescriptions dispensed and to difficulties in obtaining the skilled staff required for the work, pricing was until June, 1954, some months in arrears. Chemists were, therefore, given payments on account each month for each of the prescriptions dispensed in the previous month, based on the chemist's own average cost per prescription for an earlier month. A final settlement was made when pricing for the month in question was completed. The payments on account were supplemented from time to time to ensure that as far as possible chemists, in general, were no worse off than if pricing were up-to-date and payment in full were made in the month after surrender of the prescriptions to the Pricing Office.

[1] Over 200 million instead of the estimated 140 million.

468. Through the application of this averaging system, Pricing Offices were able to effect a steady reduction in the arrears of pricing; and, when these arrears were finally overtaken, the Ministry of Health introduced some modifications in the pricing arrangements which are described in detail in para. 471 (*f*). It should be noted that the steady rise in the average cost of prescriptions up to 1954 meant that the proportion of prescriptions priced was itself increasing; in June, 1954, it was running at the rate of approximately 44 per cent. of all prescriptions representing approximately 60 per cent. of the total cost. By 1955, 55 per cent. of all prescriptions were being fully priced.

The Rising Cost of the Pharmaceutical Services

469. Since the beginning of the Health Service, the gross cost of the pharmaceutical services has increased substantially and the annual rate of expenditure is now more than double what it was in the first few months of the Service. As will be seen from Part I of our Report (para. 45), these rising costs are due mainly to the increased use of new and expensive drugs, (particularly antibiotics), whether in the form of proprietary preparations or otherwise; and also, to a lesser extent, to the increased quantity of drugs prescribed.

470. Table 45 shows the number of prescriptions dispensed, their total cost, and the average cost per prescription from July, 1948 to December, 1954.

TABLE 45

Cost and Volume of Prescribing 1948–54

England and Wales

Year	Number of prescriptions	Total cost of prescriptions	Average cost per prescription
		£	d.
1948 July–December...	83,725,810	11,309,300	32·42
1949	202,011,412	30,331,303	36·04
1950	217,144,505	34,804,535	38·47
1951 (*a*)	227,693,920	41,662,354	43·91
1952 (*b*) (*c*)	215,999,629	43,768,599	48·63
1953 (*b*)	219,756,904	44,700,965	48·82
1954	218,712,815	45,969,621	50·44

Notes

(*a*) Influenza epidemic in January, 1951.

(*b*) Fog and influenza in December, 1952 and January, 1953.

(*c*) A charge of 1s. per prescription form was imposed in June, 1952.

We understand that proprietaries now account for nearly one-third of the prescriptions dispensed and in total account for over one-half of the total ingredient cost of all prescriptions.

Special measures to check the growing cost of the Pharmaceutical Service

471. In an effort to check the growing cost of the pharmaceutical service several special measures have been introduced at various times by the Ministry of Health.

(*a*) Since March, 1950, a prescribing investigation unit has been working at the Ministry. This unit examines the prescriptions given by doctors who are believed to be prescribing excessively or extravagantly. The Department's medical officers discuss these cases with the doctors, usually to good effect. If there is no improvement, the cases are referred for local investigation by the Local Medical Committee and if the Committee finds that there was excessive prescribing cost, money can, under power given by regulations, be withheld from the doctor's remuneration (and sums varying from £25 to £400 have been withheld in a number of cases).

(*b*) Doctors are encouraged to prescribe standard rather than proprietary preparations wherever appropriate. This is prompted by the acceptance and distribution by the Ministry of a National Formulary published jointly by the British Medical Association and the Pharmaceutical Society of Great Britain (which helps doctors by providing standard formulae which they can prescribe by short titles), and also by the publication of periodical Prescribers' Notes compiled by an editorial committee on which the medical and pharmaceutical professions are represented. In addition, a prices list of National Formulary preparations and of frequently prescribed proprietary preparations, with standard preparation prices where appropriate, has been sent to doctors.

(*c*) A Committee on Prescribing(1) set up jointly by the Central and Scottish Health Services Councils, under the Chairmanship of Sir Henry Cohen, has strongly advised doctors not to prescribe publicly advertised proprietary preparations, and has classified other proprietary preparations into six categories:—

(i) one relating to new drugs of proved therapeutic value which are not yet standard and which they advise should be prescribable under the Health Service;

(ii) three relating to preparations which they regard as not therapeutically superior to standard preparations but which they think should be prescribable subject to satisfactory price arrangements with the manufacturers; and

(iii) two relating to drugs which, in the opinion of the Committee, are not of proved therapeutic value and which they advise ought not to be prescribed.

Following on this Committee's discussions, letters were sent to general practitioners asking for their co-operation in securing economy and enclosing a list of publicly advertised proprietary preparations (which the Committee felt ought not to be prescribed). When the initial work of classifying the other preparations was completed, lists of those preparations falling into the categories named in paras. (i) and (iii) above were also circulated to doctors. Negotiations with the manufacturers of preparations in the categories listed in (ii) above are being conducted by a Drug Costs Investigation

(1) Central and Scottish Health Services Councils—Report of the Joint Committee on Prescribing on Form E.C.10.—(H.M.S.O., 1954.)

Unit which has been set up by the Ministry. We shall examine the working of this Unit in a later section of our Report.

(*d*) Doctors have also been given guidance as to border-line substances which should not be regarded as drugs or medicines. They are liable under power given by regulations to be called upon to repay the cost if they prescribe such substances.

(*e*) From June, 1952, as part of the arrangements for seeking to keep the cost of the Health Service for Great Britain for 1952–53 below £400 million, a power given by the 1949 Act to make patients pay part of the cost of the pharmaceutical service was used to impose a charge of 1s. 0d. for each National Health Service prescription form dispensed for a patient (irrespective of the number of prescriptions on the form). The object, we were told, was not only to reduce the cost to the Exchequer directly through the charges paid by patients, but also indirectly by reducing calls on doctors for prescriptions, e.g. for household remedies which patients might reasonably be expected to buy themselves. In the first six months after the introduction of the charge there was in fact a significant drop in the number of prescriptions, but this was largely offset by an increase subsequently ascribable to the effects of fogs and influenza, and as the figures in table 45 show, the total number of prescriptions in 1952 and 1953 was not in fact much less than the total for the preceding year. In addition, to some extent the yield of the charges has been reduced by a tendency to write an increasing number of prescriptions, on average, on each form. There is reason also to suppose that some doctors have tended, since the charge was introduced, to prescribe rather larger quantities of medicine. (See Part I: para. 45.)

Charges were also imposed for elastic hosiery at the same rates as those introduced for the supply of elastic hosiery at hospitals. The other appliances for which charges were made at hospitals are not supplied under the pharmaceutical service.

(*f*) Under the National Health Insurance scheme it was the normal practice for Pricing Offices to calculate periodically the average cost of each doctor's prescribing and to compare it with the area average. This kept doctors aware of their costs and showed up cases which needed further investigation.

When the arrears of pricing prescriptions under the National Health Service were overtaken in the summer of 1954, the Ministry of Health was able to adopt a partial return to this system and a new scheme was launched experimentally in October, 1954, by agreement with the Central National Health Service (Chemist-Contractors) Committee and the Joint Pricing Committees. The aim of the new scheme was to price in full for one month the prescriptions of doctors in selected areas in turn, thereby enabling doctors to compare their prescribing costs with those of their colleagues in the same area, and increasing the proportion of total prescriptions to be fully priced. This was achieved by inviting all the chemists in a selected area to sort their prescriptions for a period of three or four months into doctor order. Pricing Offices price these prescriptions in full during the period for each individual chemist and certify them for payment on this basis. It was felt that this would go some way to meet criticisms by chemist con-

tractors that the averaging system of prescribing worked to their disadvantage.(1)

To make the story complete, we should add that, since August, 1954, chemists with small accounts have had all their prescriptions priced in full by the Pricing Offices.

Pharmaceutical Services in Scotland

472. The arrangements for the provision of pharmaceutical services are generally the same in Scotland as in England. There are however some differences in prescribing and dispensing habits in the two countries, and the methods of payment, though broadly similar, are negotiated separately. The costs of ingredients and appliances are based on a separate Scottish Drug Tariff, and while the on-cost allowance is the same as in England the average dispensing fee and container allowance are higher.

473. Two Pricing Bureaux run by the Drug Accounts Committee on behalf of Executive Councils carry out the pricing of prescriptions. Since January, 1952, final payment has been made regularly to chemists for prescriptions in the second month following that in which they were dispensed. Under the existing pricing arrangements over 50 per cent. of prescriptions are priced in detail, comprising all the more expensive ones, and at least 20 per cent. of the less expensive ones. About 200,000 patients in rural areas have their drugs and appliances supplied by doctors.

474. The special measures taken in Scotland in an effort to check the growing cost of the pharmaceutical service are similar to those described above. In Scotland the initial responsibility for dealing with excessive prescribing is laid by the regulations on Local Medical Committees, and not, as in England, on the Minister. Prescribing costs are taken out for all doctors for one month (the same month) in every four, and the figures are sent to the Executive Councils for examination by the Local Medical Committees.

475. Table 46 gives details of the cost and volume of prescribing in Scotland in the period to December, 1954:—

TABLE 46

Cost and volume of prescribing 1948–54

Scotland

Year	Number of prescriptions	Total cost of prescriptions	Average cost per prescription
		£	d.
1948 July—December ...	6,577,000	1,153,000	42
1949	17,177,000	3,507,000	49
1950	19,505,000	4,267,000	52·5
1951	20,787,000	5,024,000	58
1952	20,389,000	5,330,000	62·75
1953	20,495,000	5,462,000	64
1954	20,949,000	5,677,000	65

[*Notes*

1. Influenza epidemics—January, 1951, and last two months of 1954.
2. Stock orders (which are peculiar to Scotland) are not included in the above figures. Their annual value is fairly steady at around £100,000.]

(1) It may be noted that the results of payment on the averaging system were checked in consultation with the Government Actuary by pricing in full the prescriptions of a representative 1 per cent. sample of chemists, and comparing the results with those obtained from averaging. For the year 1953 it was found that 81·76 per cent. of chemists were paid within 1 per cent. above or below the priced cost; that 98·74 per cent. of chemists were paid within 2 per cent. above or below the priced cost; and that all chemists were paid within 3 per cent. of the priced cost.

POINTS RAISED IN EVIDENCE

THE GENERAL PRACTITIONER AND THE PATIENT

476. We wish to say at the outset that we have received no evidence of substance which would lead us to make any recommendation within our terms of reference with regard to the relationship of the general practitioner and the patient.

One or two witnesses have expressed the view that the relationship between doctor and patient has been seriously disturbed by the introduction of the National Health Service and that the quality of the service itself has been lowered; but this view was not borne out by the great volume of our evidence, which is in agreement with the conclusion of the Cohen Committee on General Practice:—

> "The Committee does not think that in general the advent of the National Health Service has disturbed the relationship between doctors and their patients. The evidence of the British Medical Association, of an enquiry made by the Social Survey for the Committee and of an enquiry made independently but submitted to the Committee, bear out the general impression made by the evidence of individual doctors, that the relationship is good; in some respects indeed, it was found to be better than before, and this was attributed to the absence of the money bar and to increased co-operation between doctors."(1)

477. We understand that while general practitioners as a whole are now seeing more patients than before the inception of the National Health Service, they are generally doing more work for each patient. As payment is no longer a factor to be considered, there is no reluctance on the part of patients to seek the advice of a doctor on all matters connected with the family's health, and doctors generally welcome this freedom of approach, even if it may occasionally be misused. There was some abuse of the service in the early days, but it is now considerably less than it was.

478. We have noted too, how the distribution of doctors over the country as a whole has improved since the Appointed Day, and a more reasonable balance struck between over-doctored and under-doctored areas. There is still room for further improvement in this matter, but the developments so far have clearly been in the right direction and they bear witness to the effective work of the Medical Practices Committees and to the influence of the inducement awards for doctors practising in under-doctored and unattractive areas. The reports of the Medical Practices Committees have shown that:—the numbers of doctors in contract with Executive Councils have increased since the Appointed Day; that the new entrants to the service have generally taken up practice in areas where their services are most needed; and that the relative sizes of doctors' lists have been adjusted through an increase in the number of doctors in the under-doctored areas and a decrease in the over-doctored areas.

THE GENERAL PRACTITIONER AND THE DRUG BILL

Limited list of prescribable drugs

479. The most drastic proposal we have heard for reducing the cost of the drug bill is that general practitioners should be authorised to prescribe free of charge (or subject to the shilling prescription charge) only the drugs contained in a restricted list. Patients would then be required to pay the whole

(1) Central Health Services Council: Report of the Committee on General Practice within the National Health Service. (H.M.S.O., 1954)—See para. 38.

or part of the cost of the drugs prescribed outside the list, except in cases of hardship where help would be provided by the National Assistance Board.

480. This proposal has received a good deal of support in a number of quarters and we have given it careful consideration. As against its apparently obvious advantages, there must be set a number of objections. In the first place, it would be exceedingly difficult for the Health Departments, or some other responsible body, e.g. an expert committee, to draw up an acceptable and workable list of drugs for this purpose and to provide for its revision so that it would continuously be kept up to date. Secondly, in the light of the experience gained from a similar scheme in Australia, there is reason to believe that the introduction of a limited list might increase the demand for the drugs on the free list. Thirdly, if one purpose of a limited list was to check the prescribing of proprietary products, it must be remembered, inter alia, that certain of these are cheaper to buy than their standard equivalents when dispensed by a chemist. Fourthly, a limited list would impose a very appreciable additional burden on doctors in their work of prescribing and would be disliked by the majority of them as well as by their patients. Taking all things into consideration, we are not in favour at the present time of the introduction of a limited list of prescribable drugs in the National Health Service.

481. The recommendations of the Cohen Committee on Prescribing, the action taken by the Health Departments on those recommendations, and the publication of Prescribers' Notes and the prices list (mentioned in para. 471 above) have contributed to make doctors more cost conscious in their prescribing of drugs, and to cause them to review their prescribing habits. Every effort should continue to be made to keep doctors informed about the cost of prescribing generally, and in particular to stimulate them to review carefully their prescribing of expensive drugs and the quantities prescribed; while patients in their turn should, as far as possible, be educated out of the "bottle of medicine habit". We are of opinion that these and similar measures, reinforced by the methods of controlling prescribing which are already being employed by the Health Departments and which have been set out in detail in para. 471 above, represent the most practicable line of approach to this problem.

Pricing of prescriptions

482. We appreciate that there would be some advantage in introducing a system of full pricing of all prescriptions in the pharmaceutical service. The pharmacists would welcome its introduction, since it would ensure that their payments were calculated with 100 per cent. accuracy and not, as now, partially on a system of averaging. Some of the medical profession also might welcome its introduction, as it would give certainty to the figures showing the level of doctors' prescribing, and would prevent doctors' prescribing habits being judged on a relatively brief period.

483. On the other hand, experiments have shown that the introduction of full pricing would substantially increase both the cost and the staff required. About 1,200 staff are already employed on pricing prescriptions in England and Wales, and the cost is running at about £½ million per year. Moreover, the Health Departments are satisfied that the existing pricing arrangements will produce all the essential information about doctors' prescribing costs and will enable the Departments to exercise the degree of control required for this important section of the National Health Service.

484. It would seem, too, that full pricing is not essential to ensure that pharmacists are paid on a reasonably fair basis. We understand that, in the last four years, over 98·5 per cent. of the pharmacists in the Service have

been paid within a margin of error not exceeding plus or minus 1·99 per cent. (i.e. in any one year since 1951). Among the whole of the pharmacists employed in the Service a margin of error of plus or minus 2·99 per cent. has not been exceeded in any year since 1950. It is worthy of note too that under the present arrangements about 55 per cent. of all prescriptions are already being fully priced.

485. With some reluctance we have come to the conclusion that, on balance, the advantages likely to be gained from full pricing would not be worth the cost involved both in money and manpower. In reaching this conclusion, we have assumed that steps will be taken to follow up cases of excessive prescribing where this is found to be necessary.

486. We have further considered whether there would be an advantage in pricing prescriptions fully in selected areas for periods of 12 months (instead of for one month at intervals as now), on the grounds that the longer period might give a truer picture of doctors' prescribing costs. If the longer period were adopted, however, it would mean that doctors' prescribing costs could be provided only once in three or four years instead of once per year; and we have no doubt that the more frequent check is to be preferred. Moreover, it is doubtful whether such an arrangement would be welcomed by chemists, as it would leave an individual chemist whose prescriptions were not being priced in full with no check on his payments for a long time. For these reasons we do not recommend any change in the existing arrangements.

Container deposit

487. Under the National Health Insurance scheme, patients were required to pay a returnable cash deposit for medicine bottles provided under the scheme. Under the National Health Service, however, no such deposit is paid by patients using the pharmaceutical service. The suggestion has frequently been made since 1948, and was repeated in evidence to this Committee, that the cost of the pharmaceutical service could be reduced by reintroducing the returnable cash deposit for containers, so that patients would have an incentive for returning their medicine bottles, etc., which would then be available for re-use in the pharmaceutical service.

488. Other considerations apart, however, it seems unlikely that any material savings would in fact accrue to the Exchequer if this suggestion were adopted. The cost of labour and materials required for the recovery of bottles, etc., and for their cleaning and re-issue would probably be little less than the cost of providing new containers; and the Exchequer would still have to pay for the containers which are non-returnable.

Moreover, we have been told that before 1948 many of the poorer patients in the National Health Insurance scheme refused to pay the container deposit and developed the habit of taking their own containers (sauce bottles, beer bottles, etc.), to the chemist for their prescriptions. It is very probable there would be a return to this undesirable practice, if patients were required to pay a container deposit in addition to the shilling prescription charge.

489. From all the evidence we have heard on this subject, we are satisfied that no convincing case has been made out for the reintroduction of the returnable cash deposit for containers, and we do not recommend any change in the existing arrangements in this matter.

STOCK ORDERS SCHEME

490. The suggestion has been made from time to time that general practitioners should be permitted to obtain on a modified Form E.C.10, stocks of drugs within certain limited categories, for use in their own surgeries and in patients' homes. We have been told that there are a number of occasions when it would be more convenient and more economical for a general practitioner to hand over to his patient a few tablets, e.g., instead of making out a prescription which, in some cases, would be for a larger quantity than the patient would ultimately use. Such an arrangement already exists in the Scottish service and is said to be working well.

The scheme has not yet been adopted in England and Wales, mainly because of the opposition of the pharmacists themselves since the introduction of the shilling prescription charge. Representatives of the pharmacists maintain that the scheme would be open to abuse and that no adequate safeguards could be devised to prevent the abuse. There are other difficulties, too, in addition to the opposition of the pharmacists, some of which are mentioned in the Cohen Committee's report on General Practice(1)—e.g. the general practitioners might fall into error by unwittingly using these drugs for private patients or might be tempted to indulge in a concealed form of lavish prescribing aimed at attracting new patients. As the Cohen Committee has pointed out(1), however, these difficulties have not proved insurmountable in Scotland and we fully endorse their hope that the scheme may yet be given a trial in England and Wales. It seems to us that the introduction of the scheme should contribute to economy in prescribing. If in due course it were found that the scheme was being abused, it could be withdrawn.

INVESTIGATION INTO THE COST OF PHARMACEUTICAL PRODUCTS

491. We have heard evidence both from the Health Departments and from representatives of the pharmaceutical industry about the investigations which have been made, and are still proceeding, into the prices charged for pharmaceutical products purchased for use in the National Health Service. The investigations fall into three broad categories—first, those dealing with the general level of profit earned in the manufacture and distribution of unbranded standard drugs; secondly, those dealing with the prices of selected proprietary preparations; and thirdly, those dealing with the costs of manufacture of selected basic drugs.

We understand that the cost investigation into standard drugs and preparations has now been completed. After investigating the margin of profit, the turnover and capital employed of a sample of nineteen companies with an annual turnover of about £24 million, the Health Departments were able to satisfy themselves that the general level of prices received by manufacturers in this field had not been excessive, and that there was no occasion for the Departments to seek to influence the level of these prices so long as the circumstances remained unchanged.

In the second field of enquiry, the Health Departments and the industry are now discussing the general principles which might form a reasonable basis for fixing the prices of proprietary preparations, or for setting a limit to such prices. In the meantime, selected manufacturers were asked to make price reductions for particular products where this appeared to be justified. We understand also that there has been a general tendency for prices of

(1) Report of the Committee on General Practice within the National Health Service: para. 133.

proprietary preparations which have established themselves and are widely used in the Health Service to fall, though on the other hand new preparations tend to be expensive when first introduced.

When further progress has been made in the discussions concerned with the second field of enquiry, discussions will follow between the Departments and the industry about the prices of the selected basic drugs covered by the third field of enquiry; and this will complete the present series of investigations into the cost of pharmaceutical products.

Our comment on the Investigations

492. On the basis of our evidence we have no means of forming a judgment on the level of profits now being earned as a result of sales to the National Health Service by the two branches of the pharmaceutical industry which are still in process of investigation.

We understand that roughly one-third of the output of the British pharmaceutical industry is absorbed in one way or another by the National Health Service; about one-third is exported; and the remainder is sold to private purchasers in this country. But the proportions vary greatly between different products and are rarely, for any particular product, ascertainable with any degree of accuracy. Manufacturers are unable to identify or ascertain how much of their sales will eventually reach the Health Service. The prices which are ultimately agreed for Health Service supplies (other than those purchased under contract) must, therefore, apply to supplies which reach other home purchasers, and in practice react also on the prices charged for exports.

493. The whole problem is obviously one of great complexity and difficulty. On the one side, the Departments must be able to feel satisfied that reasonable, and not excessive, prices are being paid out of the public purse for the pharmaceutical products which are being consumed by the National Health Service. The Service is a very large buyer of these products (in some instances virtually the sole buyer) and it is clearly right that the taxpayer should have a voice, through the Departments administering the Service, in the prices which are to be paid. On the other side, account has to be taken of the present position and future development of the pharmaceutical industry of this country. Its representatives, when giving evidence before us, pointed out that the industry must be enabled to carry on with its essential work in supplying the Service with its pharmaceutical requirements; to finance research; to attract the necessary capital for further development; and to maintain and expand its valuable export trade. From the production aspect it must be borne in mind that if the National Health Service were unable to purchase at home the pharmaceutical products it requires, the country would have to import these products from overseas, at higher prices in many cases than those ruling in the home market, and with adverse effects on the balance of payments. So far as research is concerned we understand that by far the larger part of pharmaceutical research now being carried out in this country is promoted and financed by the pharmaceutical industry itself; although here there is the important complicating factor that the great bulk of the research carried out in this way is undertaken by a small minority of the firms—chiefly the larger firms in the industry.

494. Negotiations between the Departments and representatives of the industry have been under way for some considerable period; and there has been public criticism of the delay in reaching agreement. The issues on both sides are, however, large and of great importance; while the Departments have had to feel their way in a new and, for them, largely unexplored field.

We trust that these negotiations will speedily be brought to a definite and mutually acceptable conclusion.

THE CENTRAL REGISTER OF NATIONAL HEALTH SERVICE PATIENTS

Inflation of Doctors' Lists

495. Our attention has been drawn to the deficiencies of the existing Central Register of National Health Service patients, and the problems which are being created thereby. A primary function of the Central Register is to prevent inflation in doctors' lists of patients and thereby to enable the basis on which payments to doctors are made (i.e. by way of capitation fees) to be as accurate and as equitable as possible. The Central Register is also an important part of the machinery for checking claims in the dental and ophthalmic services. Our evidence suggests, however, that the machinery for central registration as it now stands is insufficient to serve adequately the purposes for which it was originally designed. The position can perhaps best be illustrated by a brief account of the national registration system itself and of the past events which led to its adoption in 1948 and its subsequent modification in 1952.

496. The existing Central Register consists of an index in numerical order which shows against the name of the person concerned the cypher of the Executive Council in the area of which he is registered with a doctor and the date of the first registration in that area. All notifications of change of doctor which involve a transfer from one Executive Council's area to another and all notifications of exit from the National Health Service (e.g. deaths, embarkation or enlistment) pass through the index.

This numerical index is the former central index of the National Register on to which have been grafted particulars of registrations with doctors from the records of Executive Councils and to which have been added the names and numbers of all persons who were born since National Registration ended in 1952, or who were previously unregistered but joined the National Health Service since that date; so that it will be obvious that it can only operate satisfactorily if the material referred to it bears the former national registration number of the person concerned.

Each Executive Council has its own local index of persons registered in its area, but for the purposes of the National Health Service a clearing house is required to deal with inter-area movement, exits from the Service, etc.

497. The national registration numbering system was adopted for this purpose under the National Health Service because it embraced everyone. So long as the National Register existed and identity cards and ration books (on which the national registration number was entered) were available, an effective machinery was at the disposal of the National Health Service. Practitioners were able to obtain the national registration number without difficulty in the vast majority of cases. Where it was not available at the Central Register, arrangements were made for the number to be obtained by the Executive Council from the alphabetical records of the Local National Registration Officer. The full national registration machinery, which included local alphabetical indexes and the surrender (by regulation) of the identity card at death, embarkation or enlistment, did not require a national alphabetical index because so very rarely was a person's national registration number unobtainable.

498. When national registration was discontinued in 1952, although part of the national registration machinery remained, the identity card (the

mainstay of the National Health Service registration system) ceased to be available; and reference could no longer be made to the local alphabetical indexes kept by the Local National Registration Officer.

When the discontinuance of national registration was announced in Parliament it was stated that the national registration numbers henceforward to be known as National Health Service numbers would continue to be used in connection with the National Health Service and that arrangements had been made to provide numbers for babies and other persons who did not possess former national registration numbers. Everyone was asked to verify that his number was on his medical card or to keep his identity card as a record of the number, and if he had no number or could not trace it, to write to the local Executive Council. Publicity was also given in the Press and by posters, to the need to continue the use of this number, but unfortunately many people failed to take the required action. For this and other reasons about half of the notifications of acceptance on a doctor's list are now received without the number being quoted; while a similar proportion of notifications of exits also bear no number. The number of cases where no number is quoted is steadily increasing. When a previous number cannot be traced, a new number has to be allotted, with the consequent possibility of inflation of doctors' lists.

499. In the absence of a national alphabetical index many expedients have been introduced to try and trace the National Health Service number where it is not quoted and so enable the numerical index to perform the function for which it was intended. All these expedients are, however, costly in staff, time, postage and stationery; moreover, they cause delay and, in any event, are not satisfactory. As a result, the failure to trace and cancel the previous registration in unnumbered cases is now causing inflation at the rate of some 300,000 to 350,000 cases per annum.

Inflation does not occur uniformly, but affects some doctors' lists more than others'. Since doctors are paid mainly on the basis of the size of their lists, the distribution of the Central Pool is distorted, and this distortion increases as time goes by. This has caused concern to the British Medical Association, who have made representations on this matter both to the Ministry of Health and to this Committee.

500. As in the case of the general medical services, the operation of the general dental and supplementary ophthalmic services is based on the use of the former national registration numbers for identification purposes. The Dental Estimates Board in particular is vitally interested in the establishment of a supporting alphabetical index at the Central Register, as over 10 per cent. of the claims now submitted by dentists do not bear the National Health Service number of the patient, and where no number is available the Board is unable to refer to the record of previous treatment in order to carry out a proper check. In the absence of an alphabetical index various expedients have been introduced (e.g. by sending enquiry letters to patients and/or Executive Councils) in an attempt to obtain a number, but again all these are expensive, time-consuming and by no means satisfactory.

501. The view has been expressed to us by the British Medical Association that a great many of the problems arising out of this situation could be solved by the establishment of a central alphabetical index to supplement the numerical index, and that the following advantages might be expected to accrue from its adoption:—

(i) the inflation of doctors' lists would be reduced and the distortion in doctors' payments decreased;

(ii) there would be a reduction in the amount of work now involved in dealing with cases under the general medical services, and claims under the supplementary ophthalmic services and general dental service, where the National Health Service number is not quoted or is incorrect. This, in its turn, would produce some savings in the cost now incurred by the local Executive Council services.

The Ministry of Health informed us that the desirability of reinforcing the present system by an alphabetical index has been discussed by them, in the light of these advantages, with the Treasury, but it has not been possible so far to reach agreement.

Our own view

502. We endorse the view that the existing Central Register is inadequate and that, in the absence of any suitable alternative, the establishment of a central alphabetical index would appear to be desirable on the grounds of efficiency, economy and equity. The initial cost of setting up a central alphabetical index was originally estimated at £50,000, and the extra annual cost of operating the index at £16,000; but recently revised estimates now put the figures respectively at £36,000 and £8,500. Against this additional cost must be offset the reductions in the expense now incurred by Executive Councils in dealing with enquiries under the general medical, dental and supplementary ophthalmic services where the National Health Service number is not quoted or where it is incorrect. We understand that the annual cost of maintaining the existing register is about £150,000 which represents approximately 0·3 per cent. of the total annual cost of the general medical service.

We are aware that the Committee of Public Accounts have in past years expressed some concern about the registration arrangements and their cost; but even under existing conditions and with all its imperfections, the Central Register fulfils an essential function and could not be dispensed with. The additional expenditure involved in providing a central alphabetical index, thereby greatly improving the effective working of the Central Register, would not appear to be excessive when it is borne in mind that in 1952 a single large-scale operation to remove the substantial degree of inflation which then existed in doctors' lists cost something in the region of £500,000.

503. We understand that an attempt has been made to assess statistically the degree of distortion in the distribution of doctors' remuneration resulting from the inflation of the registers under the present arrangements. This assessment has shown that eventually the degree of error resulting from the present arrangements will significantly distort the distribution. It suggests that over a period of three or four years inflation in doctors' lists may reach an average of between 1½ per cent. and 3½ per cent.; at the end of this period about 5 per cent. of doctors would have little or no inflation on their lists (and so be significantly under-paid), and on the other hand something like the same proportion would have about double or more the average inflation (and so be significantly over-paid), and that both the average percentage of inflation and the dispersion about the average will steadily increase. As time goes on the amount of distortion also will increase. It is accepted that the degree of distortion would be very greatly reduced, even if not entirely eliminated, by an alphabetical index.

We would add that this is a matter of some urgency owing to the degree of inflation which has already taken place in doctors' lists. Indeed, it would appear that in the areas of some Executive Councils the number of persons recorded on doctors' lists already exceeds the estimated population of those areas.

THE GENERAL PRACTITIONER AND THE HOSPITAL SERVICE

504. A great deal has been written since the Appointed Day about the need for close co-operation between the general practitioner and the hospital service. This was one of the subjects considered by a Committee of the Central Health Services Council in 1952(1) who pointed out, in our view quite rightly, that "the need for co-ordination was emphasised by but not created by the National Health Service". In the same year, this subject was also dealt with very fully in a Scottish Report(2) on the General Practitioner and the Hospital Service, and more recently by the Report of the Cohen Committee on General Practice. (See Section xx.)

505. In welcoming the recommendations made in the Scottish Report and the Cohen Committee's Report for improving the integration of the general practitioner and hospital services, we wish to associate ourselves in particular with the following recommendations which we consider of great importance :—

(i) General practitioners should have at their disposal hospital beds where they can retain responsibility for their patients, many of whom are admitted to hospital because home conditions do not permit of their being treated at home. This applies particularly to the provision of hospital maternity beds.

(ii) Clinical assistantships should be more widely offered to, and accepted by, general practitioners mainly for their educational value. General practitioners should be encouraged also to do part-time hospital work in the normal hospital medical grades. The practitioner undertaking part-time work in hospital must be a member of the hospital team and not a supernumerary member of the staff with no specific duties. The development of group practice should undoubtedly enable more general practitioners to take appointments in the hospital service.

(The implementation of this recommendation would help to remedy a situation in which, to an increasing extent, under-graduate teaching is carried out by those who have no experience of general practice.)

(iii) Hospital authorities should make diagnostic facilities—particularly for X-rays and pathological examinations—directly available wherever possible to general medical practitioners.

(iv) There should be the closest possible liaison between hospital doctors and general medical practitioners. General practitioners should endeavour to remain aware of what happens to their patients in hospital and should be informed promptly by the hospital authorities when a patient is discharged, and be advised where necessary with regard to further treatment.

(v) In the organisation of the hospital and specialist services full regard must be had to the needs of the general practitioner.

(vi) The role of the hospital out-patient department should in the main be *consultative*. Patients should be referred back to their general practitioners at the earliest possible opportunity, and should not be asked to return for treatment as out-patients unless the treatment is of such a nature that it cannot be provided by the general practitioner.

(1) In their Report on Co-operation between the Hospital, Local Authority and General Practitioner Services. (H.M.S.O. 1952.)
(2) Scottish Health Services Council—Report by a Joint Sub-Committee of the Medical Hospital and Specialist Services and General Practitioner Services Standing Advisory Committees. (H.M.S.O., Edinburgh, 1952.)

(vii) The general hospital should be established as a centre of medical endeavour where the general practitioners in the area have acknowledged right of entry and where they can meet their hospital colleagues on terms of equality.

506. Our main concern with this aspect of the National Health Service is that the service should operate in the most efficient and economical way possible. It is desirable that whenever practicable patients should be treated in their own homes by the general practitioner and the local health services, instead of being admitted to hospital where the running costs are so high; and that when a patient is admitted to hospital, he should be discharged at the earliest possible date, any necessary follow-up treatment being provided either in the hospital out-patient department or at home by the general practitioner and the home health services.

507. If the general practitioner is to carry out his proper role in the Service on these lines, he must have direct access to the hospital's diagnostic facilities, and adequate home health services (health visitors, home nurses, domestic helps etc.) provided by the local health authority to enable him to treat his patients in their own homes. With closer co-operation between the general practitioner, the hospital doctor, the hospital almoner, the health visitor and the home nurse, each will add to the other's knowledge and all will become better equipped to carry out their several duties. This would be to the benefit of the patient himself as well as of the professions.

We might add that the increasing use of the part-time services of general practitioners in hospital would offer a valuable means of lessening the shortage of hospital medical staff in the junior grades.

508. In an earlier section of our Report dealing with joint consultation on medical matters at regional level, we have already recommended that general practitioners should be represented on the medical consultative committees which we suggest might with advantage be appointed for each Hospital Region. General practitioners are also represented on the Group Medical Advisory Committees which offer medical advice to Hospital Management Committees. If our recommendation for the appointment of medical consultative committees is adopted where necessary, we feel that adequate machinery will be available to ensure that the general practitioner's view is brought to the notice of hospital authorities both at the group and regional levels.

The General Practitioner and the Local Health Services

509. We deal with the relationship of the general practitioner to the local health services in Part V of our Report.

MEDICAL MANPOWER

510. At the time when we were hearing oral evidence, the medical profession were pressing for a review of medical manpower within the National Health Service with a view to determining the level of intake of medical students each year required to meet the needs of the Service. The Cohen Committee on General Practice also drew attention to this problem in para. 110 of their Report.

The Minister of Health and the Secretary of State for Scotland have since announced the appointment of a Committee, under the Chairmanship of the Rt. Hon. Henry Willink, M.C., Q.C., with the following terms of reference:—

"To estimate, on a long-term basis and with due regard to all relative considerations, the number of medical practitioners likely to be engaged

in all branches of the profession in the future, and the consequential intake of medical students required."

We are not called upon therefore to express any view on this very important matter.

THE GENERAL DENTAL SERVICES

The position before 1948

511. Under the National Health Insurance scheme, many but not all of the insured persons qualified for "dental benefit", i.e., they were entitled to a money payment covering the whole or part of the approved cost of dental treatment. The payment was made by the Approved Society out of its surplus funds, and it was the amount of the surplus which in fact determined whether or not the insured person would qualify for this additional benefit. It has been estimated that, of the 13 million people who were probably eligible for the benefit, only some 6 per cent. or 7 per cent. actually claimed it in any given year. Dental treatment itself was not of course provided directly as a public service under the National Health Insurance scheme. The onus was on the individual to obtain treatment for himself from any dentist who was willing to treat him on the conditions and scales of fees negotiated centrally by the scheme.

512. Dental treatment for expectant and nursing mothers and where necessary for children under five was also provided, in varying degree, by most of the local welfare authorities. The service was provided either in local authority clinics or by arrangement with private dentists or hospitals. No charge was normally made for fillings or extractions, but it was the practice of most authorities to recover what the mother could reasonably be expected to pay towards the cost of any dentures provided.

513. Dental inspection and treatment for school children was provided by local education authorities, in varying degree, as part of the school medical service. The work was carried out usually in clinics (or in the schools in certain rural areas) by school dental officers, dental attendants and other staff appointed directly by the authorities.

General Dental Services provided under the National Health Service

England and Wales

514. Under the National Health Service general dental services are provided by dentists who have contracted with Executive Councils to treat patients in the Council's area. A patient is free to go to any dentist of his choice for each course of treatment, and dentists are not required to accept any particular applicant. The general dental services are not, and did not set out to be, a comprehensive service on a par with the general medical services.

515. Dentists are required to prepare estimates showing the scope and cost of the treatment necessary for those patients whom they accept, and where these estimates provide for the supply of dentures (and certain other work), the prior approval of the Dental Estimates Board must be obtained before work is commenced. Dentists may however carry out a wide range of treatment, including emergency treatment and nearly all conservative work, without obtaining prior approval.

516. At the inception of the Service, the only charges paid by patients were for dental treatment which was more expensive than was strictly necessary, and for replacements due to carelessness.

517. The Dental Estimates Board is responsible for the examination of estimates and for the authorisation of fees for payment. Payment of the fee is, however, made by the Executive Council with which the dentist is in contract.

Dentists' remuneration

518. Payment to dentists practising in their own surgeries is made by way of fees on a prescribed scale.(1) The scale of fees introduced on 5th July, 1948, was intended to give effect to the recommendations of the Spens Committee on the remuneration of general dental practitioners, but it soon became clear that many dentists were earning very much higher sums, partly, though not wholly, because of the long hours which they were working in order to cope with the demand.

Revision of fees and introduction of charges

519. The following measures were taken during the succeeding years in an effort to bring dentists' earnings more into line with what had been intended and to reduce the cost falling upon the Exchequer :—

(i) Early in 1949, as an interim measure, dentists' gross fees in excess of £400 per month were halved. This measure lasted for a period of five months.

(ii) A reduced scale of fees was introduced from 1st June, 1949.

(iii) A 10 per cent. reduction on all fees earned (on the reduced scale) was imposed from 1st May, 1950. (This reduction was cancelled with effect from 1st May, 1955, as an interim measure pending the formulation of a new scale of fees. The new scale will be designed to give dentists a net income comparable, having regard to the volume of work done, with what they would have received in 1952–53 had the 10 per cent. reduction not then been in force.)

(iv) Following upon the decision to keep the cost to the Exchequer of the Health Service for Great Britain below £400 million in 1951–52, it became necessary to ask users of some parts of the Service to meet part of the cost; and from 21st May, 1951, under the Act of 1951, charges for dentures varying from £2 to £4 5s. (roughly half the cost) have had to be paid by patients. We understand that the object of introducing the charges was not only to relieve the Exchequer directly of part of the cost, but also indirectly to discourage unnecessarily frequent applications for replacements of dentures.

(v) The Act of 1952—intended to help keep the cost to the Exchequer of the Health Service for Great Britain in 1952–53 also below £400 million—extended, with effect from 1st June, 1952, the range of charges payable by patients to include all dental treatment (except the supply, repair or replacement of certain appliances, the arrest of bleeding, the clinical examination of a patient or the provision of domiciliary visits). The amount of the charge payable by a patient under this Act is the current authorised fee for any treatment or £1, whichever is the less. A patient who is under 21 years of age or is an expectant or nursing mother is normally exempt.(2) Where charges are also payable under the 1951 Act in respect of dentures the total charges payable must not exceed £4 5s. 0d. Patients may apply to the National Assistance Board for financial help in cases of hardship arising from the charges introduced by both the 1951 and 1952 Acts.

(1) Dentists providing general dental services in health centres are paid by salary and not per item of service.

(2) The exemption does not extend to charges for relining or additions to dentures.

Priority Services

520. Priority dental services for mothers and young children are provided by local health authorities as part of their maternity and child welfare services under Section 22 of the National Health Service Act, 1946. The dentists employed in these services are paid by salary and not per item of service.

The Cost of the General Dental Service

521. In Part I of our Report we have reproduced tables (Nos. 22 and 23) showing the trend in the cost of the general dental service since the Appointed Day. We concluded from these tables that :—

(i) The cost of the general dental service was falling before charges were introduced, partly because of the reduction in the rates of payment to dentists, and partly because of a decline in the number of dentures supplied under the service.

(ii) The amount of non-denture work has been steadily increasing since 1948, with one slight setback in 1952–53 after the introduction of the charge for dental treatment. We understand that the amount of conservative work has increased each year (except for the temporary recession in 1952) and that it now accounts for about 50 per cent. of all work, i.e., in terms of fees paid to dentists.

The Dental Estimates Board

522. The Dental Estimates Board consists of a Chairman and Vice-Chairman who are both dental practitioners, and seven members of whom five are dental practitioners.

The functions of the Board are to approve estimates for dental treatment and to carry out the duties imposed on them by regulations. The Board approves the dentists' claim for payment of fees and furnishes the Executive Council concerned with the necessary authority for payment. It also refers to Dental Officers of the Ministry cases for investigation of the treatment proposed or carried out.

523. Table 47 shows for each of the years 1948–49 to 1953–54 the expenditure of the Dental Estimates Board and the number of staff, including part-time staff, at the end of each year.

TABLE 47
Dental Estimates Board
England and Wales

Year	Expenditure	Staff at the end of Year (including part-time)
	£	
1948–9	207,287	729
1949–50	364,655	816
1950–1	407,145	849
1951–2	*547,135	894
1952–3	*611,314	889
1953–4	514,188	898

* Substantial capital expenditure was incurred in these years mainly on the provision of accommodation for the Board. This largely explains the abnormally high level of expenditure during 1951–2 and 1952–3.

The General Dental Service in Scotland

524. The arrangements for the provision of general dental services in Scotland are similar to those in England and Wales, but there is a separate Scottish Dental Estimates Board for the examination of estimates and the authorisation of fees for payment. The Board consists of a Chairman who is a dental practitioner, and five members of whom three are dental practitioners.

525. Executive Councils in Scotland are empowered, with the approval of the Secretary of State, to make special arrangements with dentists for the provision of general dental services in areas where otherwise only a most inadequate service would exist. So far, this power has been used in certain Highlands and Islands areas only. The inducement given is a payment of the dentists' travelling expenses and compensation for loss of time spent in travelling. In addition, in certain Highlands and Islands areas where there are no resident dentists, Executive Councils have been authorised to arrange with doctors to undertake emergency dental treatment for the relief of pain at the fee payable to dentists.

526. The trend in the cost of the Scottish service is illustrated in Appendix 2 of our Report, in table 62.

Table 48 gives the expenditure of the Scottish Dental Estimates Board for each of the years 1948–49 to 1953–54, together with the number of staff, including part-time staff, at the end of each year :—

TABLE 48
Dental Estimates Board
Scotland

Year	Expenditure	Staff at the end of Year (including part-time)
	£	
1948–9	37,917	130
1949–50	67,995	180
1950–1	75,358	201
1951–2	95,454	171
1952–3	83,342	169
1953–4	80,773	172

POINTS RAISED IN EVIDENCE

Man-power shortage

527. From the evidence we have heard, it is clear that the fundamental problem in the dental service is the acute shortage of trained dental manpower, which appears to be growing more serious each year. We understand that there are now 15,000 dentists on the Dentists Register (kept by the Dental Board of the United Kingdom) and that the number engaged in the general dental services in England, Wales and Scotland is approximately 11,000. We have been told that the latter figure probably represents all the effective general dental practitioners available, the remainder being retired or serving in the school dental service, in the Forces, or abroad.

528. In 1944, the Interdepartmental Committee on Dentistry concluded that a yearly intake to the Dental Schools of 900 was needed to raise the dental manpower of the country to a satisfactory level. In fact, since the war, the intake has fallen far short of this target and has generally been decreasing year by year (see table 49).

TABLE 49
Annual Intake to the Dental Schools
United Kingdom

1946	641
1947	654
1948	647
1949	611
1950	606
1951	592
1952	537
1953	466
1954	478

The average intake during the years 1931–39 was approximately 360, but it was to be expected that the intake in subsequent years would be higher owing to the financial assistance now provided for students.

Since some 40 per cent. of the dentists at present in practice are aged fifty-five years or over the retirement rate is likely to be abnormally high for some years. Unless the present tendencies are reversed, the number of entrants into the profession will be substantially less than the wastage through retirement.

Taking the 466 students admitted to Dental Schools in the year 1953, and allowing for those who do not complete their training or do not remain in the United Kingdom, the number actually reaching the Dentists Register will probably not exceed 400. Moreover, if the additions to the Register in future years average about 400, it has been estimated that the net annual reduction in the Register will probably exceed 300. It is important to remember that a number of the students in British Dental Schools come from overseas and will probably return to practise in their country of origin.

529. The shortage of dental manpower is a matter of most serious concern, and it is one which has an important bearing on the organisation and cost of the Service. We welcome therefore the appointment of an interdepartmental committee, under the Chairmanship of Lord McNair, which has recently been appointed with the following terms of reference : " To ascertain the reasons for the lack of candidates of suitable calibre for training as dentists and to indicate possible directions in which remedies might be sought ".

530. A word of caution should perhaps be added at this point. It is one thing to take steps to prevent the decline in the number of dentists engaged in the Service ; but it is quite another matter to secure the expansion of the dental services to meet all the needs. There may be differing views as to what constitutes an " adequate " dental service, but there will be general agreement that the provision now made in the National Health Service falls short of " adequacy " in terms of the dental needs of the whole population. Moreover, as the total resources available to the National Health Service are limited, any large-scale development of the dental services would be made at the expense of some other part of the Service.

The shortage of dental manpower makes it the more important to consider every means possible for reducing the amount of dental disease requiring treatment, and making the best use of the trained manpower available.

Prevention

531. Oral disease is one of the most common of all diseases ; it is liable to occur acutely in children and to leave a lifetime effect. We are informed that nine out of every ten persons in the country suffer from the effects of dental caries, and we need hardly add that oral disease in its turn may have an injurious effect on bodily health generally.

The opportunities for preventive health in this field are therefore outstanding, and the main suggestions which have been made to us for its development are:—

(i) The fluoridation of water supplies.

(ii) Increased research into the causes and prevention of oral disease.

(iii) More dental health education.

(iv) More efficient dental services for mothers, young children and school children.

We now proceed to consider these four suggestions in turn.

Fluoridation of water supplies

532. Some of our witnesses have said that if the fluoridation of water supplies were introduced in Great Britain and if the dental health of the public were to improve to the same extent as is claimed to be the case in the United States and Canada, the need for dental treatment in this country would be considerably lessened and the cost of the dental service thereby reduced either in terms of money or increased efficiency. We understand that the Health Departments are now making arrangements for pilot demonstrations of fluoridation to be carried out in a few selected areas, and we hope that these will be pressed forward with all possible speed. If the amount of dental caries in the population can be reduced by a preventive measure of this kind without any undesirable side effects on the population, then the door will be open to one of the most welcome means of economy in the Service, i.e., one which will at the same time improve the health of the public and reduce the cost to the Exchequer.

Research

533. We agree with those who have said that dental research properly carried out might prove to be one of the greatest economies in the dental service. There are differing views, however, about the adequacy of the research now being done. Some of our witnesses have suggested that the time has come to develop dental research (fundamental and clinical) on a much wider scale than heretofore and "on a national basis"; and have recommended that, as a first step, a dental sub-committee should be appointed to the Clinical Research Board of the Medical Research Council. Others have said that sound research is already being carried out under the existing organisation, by the Medical Research Council, dental teaching hospitals, and University Dental Schools, and is making useful progress year by year. Moreover, as the Medical Research Council already has its own Dental Research Committee, which we understand has been re-organised within the last two years, this would hardly seem to be the time to embark on any further re-organisation.

Beyond stressing the great importance of research work generally in this field, we therefore offer no specific recommendation on this matter.

Dental health education

534. A matter no less important than research is the promotion of dental health by dental health education. Clearly, the more we know about the causes of dental disease and its prevention, the more effective will be our dental health education; but enough is already known to enable preventive measures to be taken through a variety of channels—e.g., the radio, television, films, magazines, leaflets, display sets, etc., and above all through the school and maternity and child welfare clinics and the health visiting service. If it is to be really effective, dental health education must start

with the expectant mother and the care of her unborn child. It must deal not only with oral hygiene but also with correct diet, both for the mother and for her child. Hence the importance of the local authority clinics and the health visiting service in this aspect of preventive health. The health visitor sees the mother at the time when she is in the most receptive frame of mind, and should be able to do a great deal to capture her interest in the care of her own and her children's teeth.

The machinery and the information are already available for the promotion of dental health education, and all that is needed is a regular review to see that they are being used to the extent required. It is important to consider, for example, how far the decrease in the number of attendances of expectant mothers at ante-natal clinics since the Appointed Day has led to a diminution in the amount of dental health education, and whether the deficiency has been made good by health visitors giving advice in the mother's home, by the school clinics, or by other means.

We welcome the comprehensive circular[1] on the subject of maternity and child welfare dental services which was issued by the Ministry of Health to all local health authorities in June, 1955, and which contains a number of practical suggestions for the improvement of dental health education.

Dental Services for Mothers and Children

535. The proper role of the maternity and child welfare and school clinics in the dental services is to do what they can to ensure first that as many children as possible are born with good teeth and secondly that they are regularly and carefully examined while their teeth are growing. The provision of an efficient dental service for mothers and children is clearly a sound investment against the prevalence of dental disease in later life. It is important to consider therefore whether the present organisation of the service is contributing as much as it should to its proper development.

536. The dental services for mothers and young children are provided by local health authorities as part of their maternity and child welfare arrangements; and the school dental service is provided by local education authorities. The work is carried out by dentists who are paid by salary and not per item of service as in the general dental service. We understand that the normal arrangement is for the school dental officer to give a proportion of his time to the maternity and child welfare service.

Mothers and children may, of course, also be treated under the general dental service if they so desire.

537. In the early years of the Service, when there was a heavy demand for free dentures under the general dental service, the local authority dental services lost about 25 per cent. of their dental officers who left the local authorities to take up more remunerative work in contract with the Executive Councils. This was a severe blow to the so-called "priority dental services". When, however, the earnings of dentists in the general dental service declined, (owing mainly to the reduction in the rates of payment and to the decline in the amount of denture work) and when the salaries of the local authority dental officers had been improved, the trend was reversed and the local authority services have now recovered most, if not all, of the lost ground. We understand that the number of dental officers employed by local authorities in England and Wales has now almost reached the 1,000 mark from which it started at the inception of the National Health Service. In Scotland the number at present employed is 172, the highest on record.

[1] Circular 11/55 issued on 9th June, 1955.

538. One lesson to be learnt from these last seven years is that if the local authority services and the general dental service are to be developed in step, then it is essential that the relationship between the two types of remuneration should be kept in balance. We appreciate that this is not a simple matter, as earnings in the general dental service, apart from depending on the circumstances and capabilities of the individual practitioner, will fluctuate in accordance with the demands made on the service and these in turn will be affected by the incidence of charges.

539. Some of our witnesses have suggested that the dental services for mothers and children will never be developed to the extent required so long as the local authorities are responsible for their provision. We have been told that the type of work done, and the quality of the facilities provided, in many local authority clinics are not calculated to offer dentists an attractive career, and that local authorities themselves hold widely varying views about the need to develop their dental services. The suggestion has been put forward therefore that responsibility for providing the school dental service and the priority dental services for mothers and young children should be transferred to the Health Departments.

540. Other witnesses have expressed the view—with which we are more disposed to agree—that children's dentistry is a special art and that it can be provided most efficiently and economically in relationship with the maternity and child welfare and school clinics, where the work can be properly organised and supervised. One of the characteristics of dental disease is that the people who need treatment do not always demand it, and an element of persuasion is necessary to coax the unwilling patient into the dentist's chair. We feel confident that a greater proportion of expectant mothers and children will be persuaded to accept treatment if it is provided as an integral part of the maternity and child welfare and school services than if they were referred for treatment elsewhere in the general dental service. We do not recommend therefore the transfer of responsibility for the clinic dental services from the local authorities to the Health Departments.

Making the best use of available manpower

541. When there is a shortage of trained manpower in any field of professional work, it is a well established practice to seek some means of devolving the simpler duties to ancillary workers who can ease the burden on the fully trained professional man. A Bill was introduced into Parliament (but has not yet reached the Statute Book), which included a provision to enable ancillary workers to perform some of the simpler dentistry, e.g., for children, on the model of the scheme for the employment of dental nurses in New Zealand. The period of training for a dental nurse would be two years as against the five years required to train a dentist.

542. We are aware that there are many in the dental profession who are strongly opposed to the introduction of dental ancillaries, and the following are among the reasons they have put forward for their opposition :—

(i) There would be some danger to the public in allowing ancillary workers, after only two years' training, to carry out some part of the normal work of a dentist whose course of study lasts nearly five years.

(ii) Recruitment to the dental profession would be still further curtailed, as a proportion of the potential recruits might well be attracted to the two years' course for the ancillary workers in preference to the full five years' dental course.

(iii) The proposal itself would be financially unsound. The majority of ancillary workers would be women whose working life in the service, owing chiefly to the marriage rate, would be very much less than that of the qualified dentist. The emphasis should therefore be on the training of dentists rather than ancillaries of the New Zealand type.

543. On the other hand, there is evidence to show that the scheme for the employment of dental nurses in New Zealand has worked well, without any detriment to the quality of the service provided. We need only refer to the Report(1) of the United Kingdom Dental Mission on New Zealand School Dental Nurses and to the Report(2) of an Experiment in Dental Care made under the auspices of the World Health Organisation in 1951. One of the conclusions of the former Report was as follows :—

> "We are of the unanimous opinion that the training of the New Zealand school dental nurses has resulted in a high standard of technical efficiency in the treatment of children within the limits laid down and we further consider that, subject to the staffing limitations, the dental nurse system in New Zealand meets an urgent need."

544. Moreover, at a time when there is such an acute shortage of dental manpower, there are good grounds for maintaining that the existing resources would be used to the best advantage by allowing fully trained dentists to take charge of dental departments (particularly in the priority dental services) in which they would supervise the work of dental nurses and oral hygienists. Such an arrangement would relieve the fully trained dentist of much of his routine work and enable him to employ his skills to better advantage, in the same way that doctors have gradually devolved a great deal of their work to medical ancillaries in the past.

545. It may be that there are professional matters here which lie outside our competence; but in our judgment there would seem to be a prima facie case for the employment of dental ancillaries in the dental service, and we hope that the profession itself will consider the matter afresh in all its aspects—national as well as professional.

As we have already said, it is important to remember that, owing to the limitations imposed both by finance and by manpower, it will be impossible to contemplate an unlimited expansion of the dental service whether by training more dentists or dental ancillaries. The aim for the present must be to make the best use of the available resources within the annual budgets approved by Parliament; and the introduction of dental ancillaries appears to us to be a sensible means of increasing the effectiveness of this part of the National Health Service.

Dental Estimates Boards

546. Some of our witnesses have asked us to consider whether the work of the Dental Estimates Boards might be carried out in any more efficient and economical way. We have not received a great deal of evidence on this aspect of the service, and we hesitate therefore to make any firm recommendation. From the evidence we have heard, however, it would seem that some form of check is required on the work of the general dental service and that the Dental Estimates Board machinery is probably the most appropriate method of providing it. It is indeed doubtful whether the work of the Board could be carried out in any other way which would be less expensive in

(1) Published by H.M.S.O. 1950—para. 115.
(2) Experiment in Dental Care—Results of New Zealand's use of School Dental Nurses—J. T. Fulton. W.H.O.—Geneva 1951.

terms both of money and of trained dental manpower. At a time when trained dentists are in such short supply, it is clearly undesirable to set up some other form of supervisory machinery which would make greater demands on the country's trained dental manpower.

Dental charges

547. We consider the dental charges under the general heading of " Charges for the family practitioner services " (see paras. 576–585 below).

THE SUPPLEMENTARY OPHTHALMIC SERVICES

The position before 1948

548. Under the National Health Insurance scheme, about 50 per cent. of the insured persons (i.e., some 25 per cent. of the population) were eligible for " ophthalmic benefit ". The benefit was paid by the Approved Societies and included:—

(*a*) the cost of ophthalmic treatment up to a maximum amount,

(*b*) the cost of an authorised ophthalmic examination, and

(*c*) the whole or part of the cost of spectacles if needed.

Apart from the ophthalmic treatment provided for school children through the school medical service, the only public facilities available for patients were provided through the out-patient departments of certain hospitals, or through the Poor Law. Otherwise, patients had to make their own private arrangements for treatment.

Eye Services provided under the National Health Service

England and Wales

549. Under the National Health Service, any patient may have his eyes tested and be supplied with glasses where necessary through the supplementary ophthalmic services which are administered and controlled financially by Executive Councils acting through the statutory Ophthalmic Services Committee. Patients requiring further investigation or treatment outside the scope of the supplementary service are referred to the hospital eye service.

How the Eye Services are provided

550. The supplementary ophthalmic services are provided by:—

(*a*) Ophthalmic medical practitioners who undertake the testing of sight.

(*b*) Ophthalmic opticians who test sight and in most cases also supply glasses. (We understand that there are about 6,400 establishments[1] manned by ophthalmic opticians in England and Wales.)

(*c*) Dispensing opticians who only supply glasses. (We understand that there are about 670 establishments in England and Wales, where glasses are supplied by dispensing opticians on prescriptions issued by ophthalmic medical practitioners.)

551. On the first occasion only when a person wishes to make use of the service, a recommendation for a sight test must be obtained from a general medical practitioner. This recommendation may be taken to any ophthalmic medical practitioner or ophthalmic optician on the list of an Executive Council, who, if he accepts the applicant, makes the sight test and forwards the report to the Ophthalmic Services Committee. If glasses are prescribed as a result of the test, an authorisation to obtain the glasses is sent by the Committee to the applicant who may take it to any optician on the list of an Executive Council who dispenses glasses. Payment for the testing of sight and for the supply of glasses (except for any charges payable by the patient) is made by the Executive Council concerned.

[1] The " establishments " are generally shops, and occasionally consulting rooms.

Charges

552. No charge is made to a patient for the testing of sight; and, until May, 1950, ten different types of spectacle were also available to patients free of charge (a further seven types could be obtained if the patient was willing to pay the extra cost). The patient is required to pay the cost of repairs when glasses are damaged owing to carelessness.

From May, 1950, however, the free range of spectacles was reduced to four types. A year later, under the Act of 1951 (as part of the arrangements for trying to keep the cost of the Health Service for Great Britain below £400 million), patients were required to pay in respect of all spectacles 10s. per lens and the actual cost of frames supplied as a result of sight tests carried out after 21st May, 1951. Patients may apply to the National Assistance Board for financial help in cases of hardship; and Executive Councils can reduce the charges in connection with repairs and replacements where these would cause hardship. Glasses for school children remain free of charge if frames are chosen from the standard range of children's glasses.

Fees

553. For the testing of sight, ophthalmic medical practitioners and ophthalmic opticians receive fees at specified rates; and, for the supply of glasses, in addition to the actual cost of the glasses supplied, an optician receives a dispensing fee to cover his professional services, general overheads and profit. The fees which were originally agreed with the professions concerned were based on the experience of the arrangements in force under the National Health Insurance scheme, but they have been revised from time to time in the light of experience gained in the operation of the new service.

The Cost of the Supplementary Ophthalmic Services

554. We have already outlined in Part I of our Report the trends in the cost of the supplementary ophthalmic service year by year, up to 31st March, 1954, and the reasons for those trends (See tables 24 and 25). The following further statistical information may also be of interest:—

(i) Table 50 shows the number of sight tests given, the number of glasses authorised for supply, and the number of glasses actually supplied annually up to 30th June, 1954.

TABLE 50

Supplementary Ophthalmic Service

England and Wales

Number of sight tests; and of glasses authorised and supplied	5.7.48–30.6.49	1.7.49–30.6.50	1.7.50–30.6.51	1.7.51–30.6.52	1.7.52–30.6.53	1.7.53–30.6.54
	Million	Million	Million	Million	Million	Million
Number of sight tests given	7·2	5·3	4·9	3·4	3·9	4·4
Number of glasses authorised for supply	9·1	6·2	5·6	3·5	4·0	4·5
Number of glasses supplied	5·1	8·1	7·0	3·3	3·5	3·9

It will be seen that glasses are now being supplied at the rate of about 4 million pairs per year as compared with an average of nearly 7 million pairs in the first three years of the Service. The reduction in the number of sight tests (for which no charge is

31519 G13

made) has not been so great, however, and it may be that in some cases glasses prescribed after a sight test under the National Health Service have been supplied under private arrangements.

(ii) Excluding the cost of sight-testing, the average cost to the Exchequer of a pair of glasses before the 1951 charges were introduced was rather more than £2; at the middle of 1954, it was about 19s. 3d.

(iii) In Appendix 8 we reproduce figures showing how the costs of a typical prescription for one and two pairs of glasses were shared between the Exchequer and the patient before and after the introduction of charges.

The Hospital Eye Service

555. The hospital eye service is administered through Regional Hospital Boards and Boards of Governors and deals with the diagnosis and treatment of ocular disease (or of general disease with ocular signs or symptoms), together with a certain amount of refraction work. The service is staffed by consultants and by other medical personnel with a few ophthalmic and dispensing opticians all working on a sessional basis of payment.

The out-patients using the service are required to pay the same charges for spectacles as those laid down for the supplementary ophthalmic service, and may apply to the National Assistance Board for financial help in cases of hardship. In-patients are exempt from the charge.

556. The supplementary ophthalmic service was originally intended to serve as an interim measure pending the development of a full hospital eye service. The intention of the National Health Service Act, 1946, was that ultimately the examination of sight and the provision of spectacles would be entirely the function of the hospital service, and section 41 (4) of the Act provides for the Minister to make orders discontinuing the supplementary eye service where an adequate hospital service is available. Hospital clinics staffed by consultants assisted by ophthalmic opticians working as refractionists and by dispensing opticians would carry out all the work; and the whole service would then be based on medical examination with medical specialists in charge.

We understand, however, that, in fact since the Appointed Day, there has been little development of the hospital eye service, apart from the absorption of certain work connected with the school eye service.

The Eye Services in Scotland

557. The scope and organisation of the supplementary ophthalmic services in Scotland are the same as in England, with the one exception that the services are administered through five Joint Ophthalmic Services Committees. We have reviewed the cost of the Scottish services in Appendix 2 of our Report (table 63). Table 51 gives details of sight tests and numbers of glasses supplied annually up to 30th June, 1954.

TABLE 51

Supplementary Ophthalmic Service

Scotland

	5.7.48–30.6.49	1.7.49–30.6.50	1.7.50–30.6.51	1.7.51–30.6.52	1.7.52–30.6.53	1.7.53–30.6.54
Number of sight tests given	830,372	535,901	509,168	277,267	333,395	396,311
Number of glasses authorised for supply	*	*	*	360,700 (approx.)	367,631	435,281
Number of glasses supplied	569,909	951,456	825,932	320,306	322,463	382,081

* Not available.

POINTS RAISED IN EVIDENCE

General

558. In the evidence to the Committee, representatives of the opticians expressed the view that the supplementary ophthalmic service is now providing a satisfactory service at a relatively low cost and that no major organisational changes are called for at this stage.

It is true that, in the early days of the Service when the demand was very heavy indeed, there were lengthy delays in the supply of glasses. With the declining demand in subsequent years, however, the arrears have been cleared off and there are now no undue delays.

559. Our witnesses have added that there are now sufficient safeguards in the supplementary ophthalmic service to ensure that the facilities are not misused by patients, e.g.:—

(i) On the first occasion when a person wishes to make use of the supplementary ophthalmic service, a recommendation for a sight test has to be obtained from a general medical practitioner.

(ii) All prescriptions for glasses have to be approved by the Ophthalmic Services Committees.

(iii) The patient himself has to bear a substantial proportion of the cost of spectacles provided under the service.

In general, it would appear that the eye services have attracted less criticism than any other part of the National Health Service.

A comprehensive Hospital Eye Service

560. A major suggestion put to us for the re-organisation of the eye services was that the supplementary ophthalmic service should be gradually closed down and the hospital eye service developed in its stead.

On the one hand we were told that the extension of the hospital eye service would enhance the status and prestige of ophthalmic medical practitioners by enabling them to participate more actively in hospital work; would lead to a more economical use of public funds; and would enable the patient to obtain a full ophthalmic service from both the ophthalmic surgeon and the optician.

Figures were produced for our information which purported to prove that the service provided through hospital clinics would cost less than the equivalent service provided through the supplementary ophthalmic service.

The witnesses who favoured this suggestion recommended that as a first step, the financial control and administration of all the ophthalmic services should be placed with the Regional Hospital Boards who should be responsible for passing on to Executive Councils the funds required to provide the supplementary ophthalmic service pending the development of a full hospital eye service. In the meantime, hospital clinics should be established where they could be shown to be more efficient and more economic than the facilities provided by the supplementary ophthalmic service. In this way, one authority with undivided responsibility would be able to determine how best to use the funds available for the whole of the eye services within a single development plan, and how best to meet the needs of the patients. It would be the duty of Regional Hospital Boards to see whether savings might be made in the supplementary ophthalmic service in order to provide funds for the development of a comprehensive hospital eye service.

561. An entirely contrary view was expressed by the opticians and other witnesses who told us that a comprehensive hospital eye service would not

only be impracticable and extremely unpopular with the general public, but would also be considerably more expensive than the present arrangements. Substantial capital expenditure would be involved in building and equipping sufficient hospital clinics for this purpose, and even when they were provided, the clinics would be considerably fewer in number, and therefore far less convenient for the public, than the existing opticians' practices. It has been estimated that 450 hospital clinics would be required to provide a comprehensive hospital eye service; whereas, under the supplementary ophthalmic services, more than 7,000 establishments are available to serve the public (see para. 550 above). If National Health Service glasses could be obtained only from a hospital clinic, we were told that many patients would be deterred from using the service.

Figures were also produced purporting to prove that the running costs of a comprehensive hospital eye service would be more expensive than the equivalent supplementary services. Moreover, if hospital ophthalmologists were to screen all patients requiring eye tests, there would be an immense wastage of trained manpower and money. It was in the interests of efficiency and economy that the optician should refer cases to the ophthalmologist in the same way that the general practitioner referred patients for a consultant opinion.

We were advised therefore to regard the supplementary ophthalmic service and the hospital eye service as being complementary to each other, the former dealing with normal healthy people (who form the great majority of all patients) and the latter with the diagnosis and treatment of referred patients.

Our own view

562. We are of opinion that the weight of the evidence presented to us is against the abolition of the supplementary ophthalmic service and its replacement by a comprehensive hospital eye service. To accomplish this would involve additional capital expenditure in constructing, expanding and equipping eye clinics all over the country; it would also entail a considerable addition to the number of qualified ophthalmologists. If the work performed by the existing supplementary services was clearly unsatisfactory in quality, or if it entailed serious abuses and waste of public money, the need for this additional expenditure would have to be faced. But this does not appear to be the case. Our evidence goes to show that at a comparatively modest cost to the Exchequer (£7 million in England and Wales and less than £1 million in Scotland, in 1953-54) the supplementary ophthalmic services are meeting efficiently the needs of by far the greatest part of the population which obtains its spectacles through the National Health Service. Having regard to the fact that both more capital and more skilled manpower are urgently required in other parts of the Service, it does not seem to us that it would be wise to embark on a programme of expansion of the hospital eye service merely in order to replace the supplementary services. There is certainly scope for some further development of the hospital eye service in various parts of the country under existing conditions; and due account should be taken of this by Regional Boards in planning the hospital services in their Regions. We recommend accordingly that the supplementary ophthalmic services and the hospital eye service should continue to function side by side.

National Health Service lenses in private frames

563. Since the autumn of 1953, patients in England and Wales have been allowed to have National Health Service lenses provided in their privately owned spectacle frames, so long as the National Health Service lenses are

capable of being fitted into the private frames. In Scotland, however, it has always been the practice since the Appointed Day that National Health Service lenses can be provided in private frames only if the frames have been used and conform to the National Health Service pattern; though we understand this matter is now being reconsidered by the Department of Health for Scotland.

564. Some of our witnesses have suggested that substantial savings (estimated at varying amounts ranging from £300,000 to £1 million per year) could be effected in the cost of the supplementary ophthalmic services in England and Wales—without in any way affecting the quality of the service—if National Health Service lenses were authorised to be fitted only in National Health Service frames. They contend that the increased cost of the supplementary services since the autumn of 1953 has been due at least in part to the concession mentioned in the preceding paragraph. As the present range of spectacle frames available under the supplementary service is more than adequate for all clinical purposes, they have therefore suggested that any person requiring frames outside that range may reasonably be expected to pay the full cost himself, including the cost of the lenses.

565. There were other witnesses on the other hand who doubted whether any economy could be effected by this means, and who indeed feared that the withdrawal of this concession might lead to additional expenditure owing to the increasing number of people who would ask for National Health Service frames, lenses and cases to be provided, if they were told that National Health Service lenses could not be fitted into their privately owned frames. They also pointed out that the concession had been extremely popular with the public generally and that its withdrawal would cause a great deal of bad feeling.

Our own view

566. We have come to the conclusion that, on balance, the case for restricting the fitting of National Health Service lenses to National Health Service frames is not strong enough to warrant a recommendation to that effect from this Committee. There is considerable uncertainty whether any appreciable saving of public funds would in fact be achieved by this means; and in any case the total amount of the country's resources devoted to the provision of spectacles would not be reduced by such a recommendation; only the division between the public and private provision would be affected. But we have also been influenced by the consideration that the public at large in England and Wales, who have become accustomed to the present arrangements, would be very critical of a form of economy which would debar them from having National Health Service lenses fitted into suitable frames which they own or are prepared to buy themselves.

Records

567. We have been told that a fruitful source of economy might be found in a review of the records now kept by Executive Councils for their supplementary ophthalmic services. Before the introduction of charges in 1951, it was essential for Executive Councils to keep detailed records to ensure that patients did not obtain free spectacles from two or more sources at the same time. Now that patients are required to bear a substantial share of the cost, however, any abuse of the service is likely to be insignificant, and there would seem to be no purpose in continuing to keep elaborate records so long as the charges remain at their present level.

We agree with this suggestion and welcome the review which we understand has already been started by the Ministry of Health to find out which records, if any, are now redundant. This is a process which might with advantage be repeated from time to time.

Reminders

568. Our attention has been drawn to the fact that, under the supplementary ophthalmic services, opticians may send reminders to their patients to return for a further examination, and that this may lead to unnecessarily frequent eye tests and needless changing of spectacles. It has been suggested therefore that there should be a more strict control of reminders and of the alteration of glasses following a trivial change of prescription.

We have been told, however, that by agreement with the profession, the following conditions must be satisfied before any reminder is sent:—

(i) The re-examination must be clinically necessary.

(ii) The reminder must be sent in a sealed envelope.

(iii) The reminder should do no more than tell the patient that his eyes were last examined on such and such a date and suggest that a re-examination is now due.

(iv) Normally reminders should be sent only once every three years and there should be no follow-up action after the reminder has been sent.

569. We have no reason to believe that the issue of reminders by opticians to patients is leading to abuse of the service, and we are strengthened in this view by the fact that the patient himself now has cause to consider whether a change of spectacles is worth while, bearing in mind the substantial proportion of the cost which he must pay himself. In our view, however, the question is closely linked with the payment of charges, and if the charges should be abolished at any time in the future, it might be necessary to review the practice of issuing reminders.

Problem to the manufacturers and wholesalers

570. Our attention has been drawn to the economic difficulties caused to the manufacturing industry and to wholesalers by the violent fluctuations in demand for spectacles in the early years of the National Health Service (see tables 50 and 51).

The initial heavy demands on the service, and the decline after the introduction of charges, however, are unlikely to be repeated in the future; and it is reasonable to expect that the rate of demand for spectacles will not fluctuate wildly, at least so long as charges are retained.

CHARGES FOR FAMILY PRACTITIONER SERVICES

General

571. Before going on to consider separately the charges for prescriptions, dentures, dental treatment and spectacles, we wish to explain the principles which we have applied in our consideration of the Health Service charges generally.

As we have already indicated, we do not believe that the country will be in a position to provide a fully comprehensive health service, which is adequate for all desirable needs, in the foreseeable future. The Government's problem is how to make the best use of the available resources

and to decide which are the most urgent priorities to be met as and when more resources become available. The question of the priority to be given to the reduction of charges must, therefore, depend on the relative importance attached to other outstanding needs in the Health Service as a whole, as well as on the financial resources at the disposal of the Government for all purposes.

572. In 1953–54 the total amount yielded by the National Health Service charges was approximately £19 million, made up as follows:—

Income Yielded by National Health Service Charges in 1953-54 (1)

	England and Wales	Scotland	Total
	£m.	£m.	£m.
Pharmaceutical services	6	0·73	6·73
General dental service	6·3	0·66	6·96
Supplementary ophthalmic services	4·3	0·45	4·75
Hospital service (charges for drugs and medicines, and for the supply and repair of appliances—including dentures and glasses)	0·5	0·02	0·52
	17·1	1·86	18·96

It must of course be borne in mind that the abolition of the charges in the case of dentures and spectacles would cost the Exchequer more than the amount yielded by the charges themselves, owing to the increase in demand which would result from a free service. The abolition of all charges would therefore cost substantially more than £19 million per annum.

573. In considering proposals for the introduction of *new* charges in the National Health Service, we have judged each proposal strictly on its merits, i.e. whether it would or would not contribute materially to the efficiency and economy of the Service—and we have in fact concluded that no convincing case has been made out for the imposition of new charges. This conclusion applies to the hospital and local health authority(2) services as well as to the family practitioner services.

574. When considering the charges that already exist in the Service, we have borne in mind that they operate both to reduce demand and to contribute to meet the cost. In view of the limitation mentioned in para. 571, any addition to the revenue available for the Service is valuable and we have not felt able to recommend the reduction of charges except in cases where this benefit appears to us to be offset by some appreciable distortion of the Service itself. In particular, in so far as charges deter substantial numbers of people from enjoying benefits which the Service is able to provide, we consider that a high priority should be given to modifying them, so soon as other conditions permit.

575. We appreciate that, apart altogether from the question whether charges frustrate the proper claims of any of the users, importance can be attached to the removal of all charges as a matter of principle i.e. the establishment of a completely free service—apart from such charges as are levied, now as in the past, by local authorities. The evaluation of this principle (in

(1) Excluding the hospital charges for amenity beds and pay beds, and other miscellaneous payments to hospitals (see Appendix 4).

(2) It is true that we have recommended in para. 673 that local authorities in general should be entitled to make a charge for providing ambulances at sports meetings, motor races, etc.; but this would merely regularise what is already a practice with some of them.

terms of advantage and gain, on the one hand; and on the other hand, of the sacrifice of the alternative uses to which the funds so relinquished could have been put) raises issues of public policy on which we feel that it would be inappropriate for us as a Committee to pronounce a judgment. In what follows we have confined ourselves therefore to setting out the conclusions we have drawn from our evidence as to the effects which the different charges have had on the working of the Service, and hence the benefit which might accrue to the Service as a result of reducing or modifying in some way any of these charges.

Charges for dentures and dental treatment

Dentures

576. Almost all our witnesses, including those who represented the dental profession itself, have agreed that it would be unwise to abolish the charges for dentures so long as the present acute shortage of dentists continues; because the removal of these charges would lead to an increase in the amount of denture work at the expense of

(*a*) conservative work in the general dental service, and

(*b*) the local authority services for mothers and children.

This would not be in the best interests of the service. Although our evidence indicates that the demand for free dentures would probably not reach the peak level attained in the early years of the service when an accumulated backlog of demand was being cleared off, the expected increase would be sufficient to upset the balance of the service as indicated in (*a*) and (*b*) above.

577. We concur in this view and therefore recommend that the present charges for dentures be retained so long as the number of dentists remains insufficient to meet the potential demands upon their services.

Dental treatment

578. We have heard a great deal of criticism, however, against the charge for dental treatment (i.e., £1, or the current authorised fee, whichever is the less). Some would like to see the charge abolished altogether, on the grounds that no obstacle should be placed between the patient and any treatment he may require. Others have suggested that, if for financial or other reasons the charge cannot be abolished at present, it should be used meantime to encourage patients to take comprehensive and regular dental treatment. These witnesses have pointed out that the existing charge deters patients from seeking treatment as often as they should and is therefore discouraging early conservative work. The person who attends the dentist's surgery regularly, pays perhaps £1 each time for his treatment and probably costs the National Health Service very little more. The person who waits several years before visiting his dentist may need a long course of treatment costing the Service many pounds, towards which the patient's contribution would still be only £1. The charging provisions are therefore penalising the patient who does the right thing in trying to keep himself dentally fit at all times.

579. We have heard a number of suggestions for making better use of the dental treatment charge. The Executive Councils Association recommended that, until free treatment was restored, charges for dental treatment should be assessed as a percentage of the cost of treatment provided. If this were done, however, it would be necessary to lay down a maximum amount for payment by any one patient, so as not to discourage patients from accepting

comprehensive treatment to make them dentally fit. The maximum limit would probably have to be in the region of the existing charge—i.e. £1—and the percentage assessment would therefore apply only to the range of treatments falling within the limit.

The British Dental Association suggested that the dental treatment charge should be refunded to patients who have received comprehensive treatment, been made dentally fit, and have sought treatment within a specified period of time (say once every 12 months). This would be an effective preventive health measure as it would encourage regular attendance at the dentist's surgery. We understand that a system based broadly on these principles is being operated successfully in Norway and Holland.

We have heard other suggestions, e.g., to raise the age exemption from 21 to 25, or to reduce the existing £1 charge for dental treatment to 10s.

Our own view

580. It seems to us that the charge for dental treatment is in fact impeding a number of people from making use of the general dental service; and, so far as the existing charges in the Service are concerned, we would regard the reduction of the incidence of this charge as having the highest priority when additional resources become available. We appreciate that, so long as there is a shortage of trained dentists in the service, it would be unwise to encourage a large-scale expansion of the general dental service which could only be made at the expense of the priority dental services; and for this reason we would not recommend the abolition of the charge at the present time even if the cost could be met within the National Health Service Vote.

581. We do, however, strongly favour the proposal put forward by the British Dental Association that the dental treatment charge should be refunded to patients who have received comprehensive treatment, been made dentally fit, and have sought treatment within a specified period of time (say, once every 12 months). If this proposal were adopted, it would enable those people who are prepared to keep themselves dentally fit to contract as it were into a free service for dental treatment. It would overcome many of the objections to the existing charge and would at the same time make an effective contribution to preventive health.

We understand that the proposal would be administratively feasible in England and Wales and might cost something in the region of £2 million per annum. There would be a practical difficulty in applying the scheme to Scotland, as the dentists in Scotland are not required to report to the Dental Estimates Board the treatment considered necessary to make patients dentally fit. Hence we would suggest that the existing procedure for making reports to the Dental Estimates Board in Scotland be modified so as to enable our proposal to be introduced in Scotland as well as in England and Wales, as soon as conditions permit.

582. If financial conditions were to permit this proposal to be adopted, it would of course be necessary for the Health Departments to review the arrangements from time to time to find out if they were having harmful effects on the priority dental services. If it should be found at any time that the arrangements were upsetting the priority dental services owing to the shortage of available dentists, then we would agree that the arrangements themselves should be reconsidered.

Charges for spectacles

583. Representations have been made to us that the present scale of charges is deterring some people from obtaining spectacles, or changing their spectacles, as soon as they need to do so. Our attention has been drawn to the fact that 7·2 million people had their eyes tested in the year ended 30th June, 1949, as against 3·4 million in the year ended 30th June, 1952 (i.e., after the introduction of charges) and about 4 million in the following year. Representatives of the opticians told us that they regarded the present rate of sight testing as being too low for a fully adequate service.

584. Most of our witnesses agreed, however, that the charges were not the only reason for this heavy decline, which had started before the charges were introduced and was, in some degree, an adjustment to normal annual needs after the arrears of demand had been met in the early years of the Service. No doubt also, people have tended to consider the need for replacements more carefully now that they have to contribute towards the cost.

585. We have been told that there are two categories of persons who are unable to meet the existing charges:—

(*a*) the impecunious who are for various reasons unwilling to take advantage of the help available through the National Assistance Board, and

(*b*) wage earners (sometimes with large families) who just fail to qualify for help under the National Assistance Board scales of assistance.

Their numbers, we are informed, are not large but they are the very people who are deserving of special help. A high proportion might be found among the old age pensioners, and the suggestion was therefore made by some of our witnesses that spectacles should be made available free of charge to all old age pensioners.

Our own view

586. In 1953–54 the gross cost of the supplementary ophthalmic service in England and Wales was approximately £11·4 million and the charges paid by patients totalled £4·3 million—which means that users of the service were paying about 38 per cent. of its cost. We understand that the charge for the type of spectacles normally chosen by patients is in the region of 30s.,(1) and it seems to us that here too the level of the charge is likely to constitute a barrier to a proportion of the people who need to make use of the service. We recommend therefore that, when the resources become available, a fairly high priority (second only to an adjustment of the dental treatment charge) be given to a substantial reduction in the amount of the charge for spectacles.

587. So far as old age pensioners are concerned, while we recognise that many of them are likely to be at a special disadvantage in periods when the value of money is falling, we would point out that the same holds good for others who have to live on small fixed incomes. Furthermore, not all men and women entitled to draw old age pensions are needy persons. There are dangers in treating old age pensioners indiscriminately as a category of persons to be specially subsidised at the cost of the tax payer in general, and we do not favour the suggestion that free spectacles should be provided for all old age pensioners as a class. It seems right to us that all users of the service should be required to pay the appropriate charges and that those in need should make out their case for help to the National Assistance Board.

(1) If spectacles with nickel frames are supplied the charge would be less—£1 4s. 8d.; but spectacles with nickel frames are not normally chosen by patients.

The shilling prescription charge

588. The shilling prescription charge falls more widely than any other on those who use the Service and affects it at a fundamental point. On the other hand it is smaller in amount than the other charges and its incidence on the individual is normally much lighter than that of the others, whilst its contribution to the revenue of the Service is substantial. Our evidence suggests that it is now having little effect on doctors' prescribing, other than to lead to some increase in the number of items on each prescription and maybe to some increase in the quantities prescribed.

589. A number of our witnesses have expressed the view that the public generally have become accustomed to the charge and that it does not in fact discourage patients from attending the doctor's surgery when they need to do so. Others have urged the abolition of the charge on the grounds that

(*a*) it imposes a financial barrier between the patient and the doctor at a key point of the whole National Health Service scheme;

(*b*) it can bear hardly on families in the case of illnesses requiring repeated prescribing;

(*c*) it tends to encourage doctors to over-prescribe.

590. The first of these objections seems to us to be covered by the second, except in so far as it is an evaluation of the principle to which we have already referred. The third, according to our evidence, does not appear to be substantial; the cost of any over-prescribing is certainly trivial, compared with the yield of the charge. As regards the second, our evidence is not wholly conclusive, but we have no reason to think that the charge hinders the proper use of the Service by at least the great majority of its potential users and we do not consider that its removal at the present time would improve the working of the Service to an extent commensurate with its cost, having regard to the other developments which we foresee or recommend in this Report. Any higher priority which may be given to its removal must rest on the value in principle of restoring a free Service.

Financial help by the National Assistance Board

591. The following figures illustrate the amount of financial help given to patients in England and Wales by the National Assistance Board towards the cost of dentures and dental treatment:—

From May, 1951, until 28th April, 1953, 96,000 applications were made to the Board; 13,000 were totally rejected or withdrawn; but a grant for the whole amount claimed (or part of it) was made in the remaining 83,000 cases at a total cost of £290,000. This last figure compares with the total of £9 million paid during this period by patients under the two sets of charges introduced during 1951 and 1952.

Payments towards the cost of spectacles during the same period were as follows:—

281,000 applications for refunds were made to the National Assistance Board in England and Wales. 250,000 of these were granted wholly or in part and £400,000 was repaid to applicants. In the same period, the total amount paid by patients for glasses of a type for which a refund could have been claimed from the Board amounted to £7 million.