PART V

THE LOCAL HEALTH AUTHORITY SERVICES

Services Provided Before 1948

England and Wales

Maternity and Child Welfare Services

592. Before the introduction of the National Health Service, the maternity and child welfare services were provided not as a duty, but as a power, by more than 400 local welfare authorities including 60 county councils, 83 county borough councils, 162 borough councils, 63 urban district councils and 10 rural district councils, and in London the Common Council of the City and the 28 metropolitan borough councils. The service was designed to provide medical and general advice and attention (but not treatment except for minor ailments) for expectant and nursing mothers and for children under 5 years. For this purpose, the welfare authorities provided ante-natal and post-natal clinics and welfare centres, and employed health visitors to give advice in the home.

593. A domiciliary midwifery service, which had grown up under the Midwives Acts 1902–1936, was also provided by local "supervising authorities" which for historical reasons were not necessarily the same as the welfare authorities. In fact, the "supervising authorities" consisted of 62 county councils, 83 county borough councils, 39 borough councils and 4 urban district councils. The service was provided either directly by employing midwives or by arrangement with voluntary organisations.

Home Nursing Services

594. The power of local authorities to employ home nurses was limited to provision for the nursing at home of patients suffering from infectious diseases, expectant or nursing mothers or children under 5 years suffering from various conditions. Although the local authorities employed a small number of home nurses directly, they tended usually to use the services of voluntary organisations by whom the majority of home nursing was provided. The voluntary organisations derived their income from donations and subscriptions, payments made by patients directly or through contributory schemes, and from grants made by local authorities.

Domestic Help

595. Before the inception of the National Health Service, welfare authorities were able to provide domestic help as part of their maternity and child welfare services, and in 1944 local authorities generally were empowered under a Defence Regulation to provide help for the sick and the infirm. In 1948 therefore, there was a nucleus of a home help service in most parts of the country, but not on a scale in any way comparable with the provision made under the National Health Service Acts.

Scotland

596. The services in Scotland were provided through 55 major health authorities, and followed generally the pattern of the services provided in England and Wales. The domiciliary maternity service in Scotland,[1] however, was based on the services of both doctor and midwife, while the English service was based primarily on the midwife alone.

[1] Provided under the Maternity Services (Scotland) Act, 1937.

Services provided under Part III of the National Health Service Act, 1946

England and Wales

597. The National Health Service Act, 1946, empowers local health authorities (the county and county borough councils of England and Wales exercising their functions through statutory health committees) to provide the following services :—[1]

(a) *Health Centres.* The local authority's function is to provide premises at which general practitioner services, hospital services and/or local health services may be provided under one roof.

(b) *Care of Mothers and Young Children.* This includes the provision of ante-natal and post-natal and infant welfare clinics; of dental care for expectant and nursing mothers and young children; and of day nurseries.

(c) *Domiciliary Midwifery.* Midwives are provided to attend mothers who are confined in their own homes.

(d) *Health Visitors.* Health visitors are employed to give advice in the home generally, particularly as to the care of young children, sick persons and expectant and nursing mothers.

(e) *Home Nursing.* Home nurses are provided to attend to persons who require nursing in their own homes.

(f) *Vaccination and Immunisation.* Local health authorities make arrangements for vaccination against smallpox and immunisation against diphtheria through general practitioners or at their own clinics. In some areas there are also arrangements for immunisation against whooping cough.

(g) *Ambulance Services.* Ambulances and sitting-case cars are provided for the conveyance of the sick to and from hospital when they are unable to travel by ordinary transport.

(h) *Prevention of Illness and Care and After Care.* This includes arrangements for the loan of sick room equipment, provision of extra nourishment in kind, and arrangements for preventive or convalescent recuperation.

(i) *Domestic Help.* Local health authorities may provide domestic help for households where there is illness or a confinement or where it is needed because of the presence of old people or young children.

(j) *Mental Health.* This includes the ascertainment of mental defectives and their supervision while they are living in the community.

598. The functions of a local health authority may be exercised only after the Minister of Health has given his approval to detailed proposals for providing the service concerned. After such approval it becomes the duty of the authority to provide the services in accordance with the proposals. The provision of services for the prevention of illness and the care and after care of the sick is permissive, except in relation to persons suffering from tuberculosis for whom local health authorities have been directed to make such arrangements. The provision of domestic help is also permissive. For the rest the Act imposes a duty on the local health authorities to provide the service. But the provision of health centres has not proceeded beyond the experimental stage and in other services development has been dependent on finance and for example, on ability to recruit the necessary staff.

The chief administrative officer of the local health authority's health committee is the Medical Officer of Health.

[1] See sections 21–29 of the National Health Service Act, 1946.

Financial arrangements—Exchequer grant

599. One half of the net expenditure of a local health authority in carrying out the functions mentioned above, is met by grant from the Exchequer, the balance falling on the local rates.

Local health authorities are required by statute to keep separate accounts of their transactions as such authorities and these accounts are subject to audit by the district auditor.

At the beginning of each financial year local health authorities submit estimates of their expenditure during the year, and, after examination in the Department, these estimates are adopted as the basis for making advances of grant at two monthly intervals up to a total of approximately 90 per cent of the grant expected to be due for the year. After the end of the year, a formal claim for grant is submitted. This statement, after certification by the district auditor, is examined in the Department. The balance of grant due to the authority, after allowing for advances already made in the year, is then paid to the authority.

Charges

600. The majority of the local health services are provided without charge to the user, but authorities have power to make charges to persons using some of the services; e.g. :—

(*a*) for the use of residential nurseries, for meals or articles supplied, and for the use of day nurseries (until the Act of 1952, charges so far as day nurseries were concerned, were limited to meals, but that Act empowered the authorities to make a general charge for the use of day nurseries);

(*b*) in respect of arrangements for the prevention of illness, care and after care;

(*c*) for domestic help provided.

These charges are not prescribed, but are at the discretion of the local health authorities who normally adopt a local standard scale of charges varying in accordance with the means of the persons concerned.

The cost of the Local Health Services

601. In Part I of our Report (tables 26 and 27) we have reviewed the rising cost of the local health services since the Appointed Day, and have shown how the increase has been due partly to the development of some of the services provided under Part III of the Act, and partly to a general rise in wages and prices. There was a fall in the cost of the midwifery service and also in the cost of the services for the care of mothers and children (see table 27).

Exchequer control

602. In the day-to-day running of the various services which they provide, local health authorities have a large measure of freedom within their approved proposals. The basis of grant aid for the services leaves 50 per cent of the cost as a charge to the local rates, and there is thus a substantial inducement to economical administration on the part of the authority. The Exchequer interest in the financial arrangement is, however, further safeguarded :—

(*a*) by the requirement that proposals for the provision of the services must be submitted to the Minister of Health and are approved only after such modification as the Minister considers necessary;

(*b*) by the Departmental control of the capital building programmes which are required to be submitted each year by the local health authority;

(*c*) by the submission and examination of annual estimates of expenditure; and

(*d*) by the requirement that the accounts of local health authorities and claims for grant are subject to audit by the district auditor.

Scotland

603. The local health authorities in Scotland are the county councils and the town councils of the large burghs; and these authorities, through statutory health committees, are responsible for the provision of the local health services under the Act of 1947. Their main functions are the same as those of the corresponding authorities in England and Wales except that the provision of health centres and of the ambulance service is the responsibility in Scotland of the Secretary of State. The reason for these exceptions lies in the fact that Scotland has a relatively large number of local health authorities; and, if responsibility for the provision of health centres and ambulance services had been placed upon them, it would have been difficult to organise an efficient, economic, and integrated service.

POINTS RAISED IN EVIDENCE

Organisation and finance

604. It will have been observed that the organisation and finance of the local health services differ in two important respects from those of the hospital and family practitioner services. In the first place, the local health services are administered by local authorities and not by *ad hoc* bodies appointed by the Health Ministers; and secondly, they are financed, not wholly by the Exchequer, but partly by the local rates and partly by the Exchequer. It is important to consider therefore whether these differences have had any undesirable effect on the development of the Health Service and whether they have hindered progress and efficiency in any way.

Organisation[1]

605. We have no hesitation in concluding that the provision of the domiciliary health services is essentially a local authority function, and that it would be a mistake to transfer that function to any other authority. This view was in fact made clear in Part II of our Report in which we discussed the proposed unification of all the health services under one statutory authority. In our view, it is desirable that all types of public health work should remain with the local authorities and that there should be the closest

[1] We have taken note of the statement made by the Minister of Housing and Local Government in the House of Commons on 22nd March, 1955 about certain proposals for the improvement of local government organisation which have been agreed between representatives of the local authority associations. The Minister said that these proposals would have to be discussed with the associations and with the Ministers concerned, and that the Government would then examine the proposals as a whole and consider their attitude towards them. The Minister added that a review by the Government of local government finance was also likely to be necessary before long, and that the possible scope of the review was now under consideration (see *Hansard, volume* 538, *No.* 58, *columns* 172 *to* 174). We wish to make clear that our conclusions about the organisation and finance of the local health authority services and the welfare services have been reached on the basis of conditions as they now exist. We have no knowledge of what may be the outcome of the Government's examination of the proposals for the improvement of local government and for the reorganisation of local government finance.

possible integration of the domiciliary health services provided under Part III of the National Health Service Act, 1946 (and of the Scottish Act of 1947), and the welfare services provided under Part III of the National Assistance Act, 1948.

606. We appreciate that, strictly, our terms of reference do not relate to the welfare services, but there are points where the welfare services are so closely related to the Health Service—particularly in relation to the care of the aged—that we cannot deal properly with our remit without paying some regard to their provision. We have noted with interest that a number of authorities have taken steps with satisfactory results to combine the administration of their local health and welfare services under one committee (the health committee) of the council. In the majority of areas however, these services are still administered by two separate committees of the county council or county borough council—i.e., the health committee and the welfare committee.

In view of the very close relationship which exists between the domiciliary services provided under the National Health Service Acts and the National Assistance Act, and bearing in mind the close connection between the services for the aged under the National Health Service and the provision of residential accommodation for old people under the National Assistance Act, we recommend that all authorities who have not yet done so should review the working of their health and welfare services to see whether their efficiency might be improved, and the interests of patients better served, by combining their administration under one committee of the council, or under a joint sub-committee.

607. As for the authorities themselves, we are satisfied that the county councils and county borough councils are the right authorities—bearing in mind the areas they serve and the resources they command—to plan and administer the local health and welfare services in co-operation with the hospital authorities and local Executive Councils. In some county areas in England and Wales, we appreciate that there has been a certain amount of decentralised administration through divisional sub-committees of the county health committee, in varying degree and with varying success. In their evidence to the Committee, the Association of Municipal Corporations supported the case for decentralised administration in all county areas, but the County Councils Association, on the other hand, expressed doubts about the value of the arrangements for decentralised administration now made in some of the county areas. This would seem, therefore, to be a question which might best be settled locally in each county in the light of the circumstances ruling in the area; and it is not a matter on which we would wish to make a definite recommendation.

The outstanding problem of organisation which has still not been solved in many areas is, of course, how to effect a proper integration of the local authority services with the hospital and family practitioner services, and we return to this question in a later section of our Report.

Finance

608. Our evidence has suggested that some of the local health services have not been developed as far as they might, because of:—

(*a*) lack of staff. (This appears to be a limiting factor in the development of the health visiting service and, in some areas, of the domestic help service. In future years it may also affect the home nursing services);

(*b*) the refusal on the part of the Ministry to approve some of the development proposals put forward by local health authorities;

(*c*) unwillingness on the part of the local authorities themselves to increase the burden on the local rates.

Different factors appear to operate with varying force in different areas; but we have the impression that the strongest limiting factor generally may be the lack of finance. We have been asked to consider therefore whether an increase in the rate of Exchequer grant, which now stands at 50 per cent., would do anything to remove the unwillingness mentioned in (*c*) above, and help to encourage the development of certain of the home health services—and particularly the domestic help service—so as to ease the load on the hospital service and to increase the efficiency of the National Health Service as a whole. As some of our witnesses have pointed out, there may be a reluctance on the part of some local authorities to develop their services, and thereby to increase the local rates, when the practical effect would be to relieve the pressure on the hospital service (e.g., in the case of the chronic sick and mental patients) which is 100 per cent. Exchequer financed.

609. From the evidence we have heard however, we doubt whether a small increase in the rate of Exchequer grant—say to 60 per cent.—would have any material effect on the development of the local health services in many areas. On the other hand, the view is held in many quarters that a rate of grant over and above 60 per cent. would not be in the best interests of local government—a view which was shared by a number of local authority representatives who gave evidence to the Committee.

After careful consideration we have reached the conclusion that there are good grounds for leaving the financial arrangements as they now stand i.e., with the cost shared equally between the local rates and the Exchequer.

610. It is equally important to consider whether the development of certain of the welfare services provided by county councils and county borough councils under Part III of the National Assistance Act, 1948, is being impeded by the lack of any Exchequer grant towards the net running costs incurred in their provision. We have in mind particularly the provision, under section 21 (1) of the Act, of "residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them". At present the local authorities receive an Exchequer subsidy, on the lines of a housing subsidy, towards the capital cost of providing new residential accommodation under this section, and they also receive weekly payments from residents in accordance with section 22 of the Act; but the net running costs attract no direct Exchequer grant. To the extent that a proportion of the payments made by residents may be derived from Exchequer sources through the National Assistance Board, it is of course true that the running costs are already being aided to some extent by the Exchequer.

611. We have already indicated that we regard the division between the hospital and local authority services for the care of the aged as one of the most serious divisions in the whole Service, and we shall deal more fully with this matter when considering the arrangements for the care of the aged generally. For the moment, we are content to make the point that the lack of any Exchequer grant towards the running costs of local authority residential accommodation for the aged will become increasingly an obstacle to the smooth development of the hospital and local authority services, and may be expected ultimately to distort the pattern of the Service as a whole.

612. Accordingly we recommend that, as soon as financial circumstances permit, the existing Exchequer subsidy towards the cost of providing new residential accommodation under section 21 (1) of the National Assistance Act be abolished, and that instead the net expenditure (both capital and

current) incurred in providing all residential accommodation of this type should attract a 50 per cent. Exchequer grant. In return, the Minister of Health and the Secretary of State would be able to require local welfare authorities to develop their services, as and when the state of the national economy will permit, on a scale commensurate with the needs. The necessary powers are already available under section 34 of the National Assistance Act, 1948, which empowers the Ministers to approve local authority schemes either in the form in which they are submitted or with such modifications as the Ministers think fit.

613. In the financial year 1953–54, we understand that the net cost to the rates of providing welfare homes in England and Wales was about £9½ million (in very approximate terms). The corresponding figure in Scotland was £0·8 million. If our recommendation had been adopted in that year, therefore, the additional cost to the Exchequer would have been in the order of £4¾ million in England and £0·4 million in Scotland. We appreciate that expenditure on welfare homes has increased since 1953–54 through the provision of additional homes, and owing to increases in salaries and wages and other costs. The income has also increased, however, because of the increased number of residents in welfare homes (each of whom pays at least the prescribed minimum charge from his own resources, or is assisted by the National Assistance Board if necessary) and because from April, 1955 the prescribed minimum charge was increased from 26s. 0d. to 32s. 6d. per week.

614. Although the case for an Exchequer grant might be held to apply with equal force to the welfare services provided by local welfare authorities under section 29 (1) of the National Assistance Act, 1948 (i.e. for the blind, deaf, dumb and crippled persons, etc.), we have refrained from making any comment on this matter as we understand that it will be considered by the Piercy Committee[1] which was appointed in 1953 to "review in all its aspects the existing provision for the rehabilitation, training and resettlement of disabled persons, full regard being had to the need for the utmost economy in the Government's financial contribution, and to make recommendations".

PREVENTIVE HEALTH

615. One of the functions of the local health authority is to "make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons"[2] and "to make provision in their area for the visiting of persons in their homes by visitors, to be called 'health visitors', for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection".[3] This is the appropriate point, therefore, to consider the criticism which has often been made against the Health Service that it has laid too great an emphasis on cure and too little on prevention. We have heard a great deal, for example, about the increasing pre-occupation of chest physicians with the clinical and curative aspects of tuberculosis, to the detriment of the preventive services which are the concern of the Medical Officer of Health; and indeed about the failure of the clinicians in

[1] The Committee on the Rehabilitation of Disabled Persons appointed in 1953 under the Chairmanship of Lord Piercy.
[2] Section 28 of the National Health Service Act, 1946; section 27 of the National Health Service (Scotland) Act, 1947.
[3] Section 24 (1) of the National Health Service Act, 1946; section 24 (1) of the National Health Service (Scotland) Act, 1947.

the hospital service generally to take a sufficiently active interest in preventive health and particularly the prevention of cross-infection in hospitals. There has been criticism too of the small proportion of the National Health Service budget which is devoted to the preventive services, as compared with the heavy annual cost of the hospital service. In their most extreme form, these criticisms have suggested that the order of the two expenditures should be reversed so as to put prevention and cure in their proper order of priority.

616. In order to see this question in its proper perspective we must try to define at the outset what we mean by "preventive health", and how far its promotion is a matter of direct concern to the National Health Service and its cost to the National Health Service Vote.

(i) In the first place there are a great many preventive health measures which lie outside the National Health Service but which nevertheless will have an important effect on its cost, e.g., the provision of good housing, school meals and free milk for children, clean food, clean air, efficient sewage, prevention of road accidents, etc., etc. Many of these services are the concern of local authorities but their provision is not covered by the National Health Service Acts. No doubt very considerable additional sums of money could be spent on some of these measures (e.g., on the elimination of air pollution[1]) which could be of ultimate benefit to the National Health Service; but this expenditure would not fall on the National Health Service Vote, and does not come directly within our terms of reference. We can only refer to these measures and point out that their promotion might be expected in the long run to reduce some of the burden on the hospital and family practitioner services.

(ii) Another kind of preventive medicine is the prevention of the progress of a disease. This is largely a matter of early diagnosis and early treatment and is the primary concern of the general practitioner, with such assistance as the hospital service can provide either by specialist second opinion or by the provision of diagnostic aids such as X-rays and pathological examinations. Here the problem seems to be mainly one of developing and tying together the existing strands in the Health Service, to which we have already made reference. In any event, the expenditure involved is not likely to be very substantial, on the assumption that there will not be a large scale development of health centres in the near future.[2]

(iii) There is also the question of preventing lasting disability. This is the question which is now being examined by the Piercy Committee and which covers the whole field of physical and mental rehabilitation to the highest possible level, followed by retraining for employment if necessary and the provision of suitable work. We have already indicated that the Piercy Committee will also be considering the services provided by welfare authorities under section 29 (1) of the National Assistance Act, for the blind, deaf, dumb and crippled persons, etc. (see para. 614). We have therefore regarded these matters as being outside our terms of reference.

(iv) Again, there is the prevention of the occurrence of disease or injury by such means as vaccines and other immunisation agents; health education (including maternity and child welfare instruction and dental health education); the health visitor and her domiciliary preventive work; the social worker, and to some extent the general

[1] See the Report of the Committee on Air Pollution. Cmd. 9322—H.M.S.O., 1954.
[2] We discuss the question of health centres in paras. 623–630.

practitioner in his ordinary practice. This is a field in which the local health and welfare services have an important part to play in conjunction with the general practitioner. We appreciate that, owing to the size of their lists, many general practitioners may be unable personally to take a very active part in this aspect of preventive health, but they can at least make more use than they now do of the domiciliary services provided by the local health and welfare authorities. This again is a question of closer integration between the general practitioner and local authority services, and it would help considerably if all Medical Officers of Health would keep general practitioners informed (as many of them already do) of the various health and welfare services provided by the local authorities in their areas.

617. We have heard a great deal from the Health Departments about the efforts made in recent years to build up the idea of a "domiciliary team" of local authority workers under the clinical leadership of the general practitioner, the aim being to place at the disposal of the patient in his home equally with the patient in hospital a co-ordinated team acting under the clinical guidance of his personal medical attendant. The team is composed of the general practitioner, the home nurse, the health visitor, the midwife, and the domestic help, and should of course be closely linked with the maternity and child welfare clinics provided by the local health authorities, and with the local hospitals. We agree that much still remains to be done by the domiciliary team to increase the understanding of parents and families of such matters as the prevention of disease and of mental illness, the spread of infection, accidents in the home, early recognition of disease and the need for prompt medical attention. Moreover, by close co-operation with hospitals, through hospital almoners and consultant staffs, the domiciliary team may be able to prevent the relapse of many patients (and especially mentally ill patients) discharged from hospital who are still in need of after-care or have other problems to face on returning home.(1) Where the family is in need of statutory or voluntary services outside the scope of the National Health Service, it should be the task of the health visitor or social worker to see that the appropriate authority or organisation is informed. This is genuine preventive work of a type which would increase the efficiency of the National Health Service, without imposing any excessive burden on the Exchequer and the local rates. What is needed is a greater interest in this aspect of social medicine; a greater will to co-operate; and readiness on the part of the local authorities to provide domiciliary services on the scale required. In areas where a close interest is taken in preventive work of this type, the services are already working well and there is no reason why they should not do so elsewhere. These are matters for arrangement locally between general practitioners, hospital staff, and the officers of local authorities who are directly concerned.

Future Development

618. In the first 50 years of public health, it was a comparatively simple matter to chart the fields in which preventive health measures were needed and could be guaranteed to produce the most striking results, e.g., in the prevention of cholera. It is now becoming increasingly difficult, however, to ascertain the broad fields where further action might prove to be equally fruitful. Immunisation continues to be a promising field, as shown by the highly successful results of the campaign for diphtheria immunisation. Generally speaking, however, bacteriology has now ceased to be the happy

(1) See "Hospital and Community" by Ferguson and MacPhail—Oxford, 1954.

hunting ground of preventive medicine. Increasingly, it is in the home, the family and the everyday way of life, where we may have to look for the basic deficiencies which are leading to ill-health, and particularly to mental ill-health, in the community—e.g., the feckless mother who is unable to care properly for her children and has no idea of the services which are available to help her. It is here that the local health and welfare services have an important part to play—no less important in its way than the development of efficient water and sewage systems in the earlier days of public health. It should be added that it is in the home also where so many preventible accidents occur especially to young children. There are others too, besides the home health workers, who may be involved in this field of preventive health—e.g., the Children's Officer, the Probation Officer, and the School Attendance Officer to mention only a few. There is need for the closest co-operation between all who are concerned with the welfare of the family (including the voluntary organisations) to ensure that the family's basic problems are elicited and tackled at their source; and that there is no unnecessary overlap in the home visiting by the officers concerned.(1)

A great deal of illness—and particularly mental illness—may be prevented by early and effective team work in the sub-standard home; and we welcome the steps which have been taken by many local authorities since the war to improve the co-ordination of their services with this end in view.

619. The Medical Officer of Health should feel therefore that his place in the National Health Service remains an important one, and he should be able to look to the future with the knowledge that he still has an essential and indispensable role to play in improving the health of the people of this country.

620. There are two further points we should like to add before leaving the subject of preventive health:—

(i) The public should consider whether they themselves are developing an attitude of mind to the Health Service which is more "disease conscious" than "health conscious". It should be clearly understood that every individual in the country has a responsibility for keeping himself well as far as possible, for keeping himself informed of the facilities provided by the National Health Service, and for learning how to use those facilities intelligently. Indeed one of the tasks of the domiciliary team might be to educate people how to use the Service with foresight and intelligence. We appreciate that there are some families who will always need the assistance and guidance of the domiciliary workers (and it may be that, in the process of time, the domiciliary team will have to devote an increasing proportion of their time to them), but there are many who could be educated to a proper use of the Service without the continued help of the domiciliary team.

(ii) A great deal of research remains to be done to find out why people come to need medical treatment (whether by a general practitioner or a hospital) and what steps might have been taken to prevent that need. A certain amount of research has already been carried out on these lines, both in the general practitioner and hospital fields, but more remains to be done. We believe that it might be profitable, for example, to examine all the patients in a number

(1) We would emphasise that this observation relates to all the health and welfare services which are concerned with the visiting of people in their own homes. Constant vigilance will be required to ensure that the efficiency of the services is not impaired by unnecessary duplication of home visits.

of selected hospitals to discover the precise reasons for their admission or re-admission to hospital and to see if any significant pattern is revealed which might point the way for further preventive measures on a broad scale.(1) It is from a close study of case histories (including the patient's background at home and at work) that we feel some clue might be found to the future development of the preventive services. As some have suggested, such studies might reveal a series of "danger signals" which indicate the vulnerable families where ill-health is likely to arise in the future.

Conclusion

621. We conclude then that, so far as the National Health Service Vote is concerned, we know of no wide fields in which large sums of money might be expended at the present moment in order to bring the preventive health services more "into line" with the curative services. To this extent, we would say that those who have criticised the Health Service for spending far too much on disease and far too little on prevention have tended to overstate their case. It is true that a number of preventive health measures could be initiated, with advantage, outside the National Health Service, one of the most important of which might be the elimination of air pollution. It is true also that some of these measures might cost a great deal of money. Within the Health Service itself, however, there appear to us to be two main directions in which further improvements might be effected:—

(i) By developing the home health services and integrating them more closely with the general practitioner, hospital and welfare services, not forgetting the work of the voluntary organisations and other statutory services relating to the care of children and the welfare of the family. An efficient and integrated medico-social service would not only prevent illness, but would also ease the burden on hospitals generally, and on mental hospitals in particular—e.g., by preventing the need for admission of some patients to hospitals and by facilitating the early discharge of others.

(ii) By promoting enquiries designed to reveal the broad fields in which preventive medicine might be extended profitably in the future.

We have no wish to under-rate the importance of (i); on the contrary, we have made clear throughout our Report the importance which we attach to the development of the domiciliary services, and to preventive health generally. All that we do suggest is that there is no reason to suppose that vast sums of money must be spent on these services in order to give preventive health its proper place in the National Health Service. The amount of money involved need not be great; what is more important is that the services provided should be properly integrated, and we return to this question in Part VII of our Report. Again, the cost of the enquiries mentioned in (ii) would be very small in relation to the total cost of the National Health Service.

622. There is one exception to our general conclusion on preventive health which might be mentioned at this point. We understand that a chiropody service (which was already being provided by some local authorities before the Appointed Day) has not been allowed to expand under the National Health Service owing partly to the lack of finance and partly to the shortage of chiropodists.

An expanded chiropody service would, we feel, make an effective contribution to preventive health particularly in so far as it would enable

(1) cp. "Hospital and Community" by Ferguson and MacPhail—Oxford, 1954.

old people to remain mobile; and the evidence we have heard does indeed testify to the value of a chiropody service in those areas where local authorities have been able to maintain it. We recommend therefore that, when more resources become available to the Service, consideration might be given to the further development of the chiropody service under the National Health Service. We presume that the service would be provided by local health authorities as part of their services for the prevention of illness, care and after-care etc., under section 28 of the National Health Service Act, 1946, and section 27 of the Scottish Act. It has been suggested to us that an extension of the chiropody service might involve expenditure of the order of £1 million a year equally divided between the Exchequer and the local health authorities.

HEALTH CENTRES

623. It will have been noted that the work of the domiciliary team can only be developed satisfactorily if there is the closest possible co-operation between the general practitioner, the local authority and the hospital services; and we have considered very carefully therefore the suggestion made by a few of our witnesses that the problems of liaison between the three branches of the Service will only be solved satisfactorily in health centres where general practitioners can be brought into direct contact with the local authority services; where the Medical Officer of Health is associated with the general practitioner and hospital services within the one building; and where the prospects of preventive medicine generally might be greatly improved. This was a view which was shared by a great many people, including quite a large proportion of the medical profession, before the inception and during the first few years of the National Health Service.

624. In more recent years, however, there has been a marked swing of opinion against any wide-scale provision of health centres, and there are many who now doubt the wisdom of expending any large amounts of money for this purpose at least until more experience has been gained about the working of the existing centres. Indeed, the great majority of our witnesses have taken the line that health centres must for some time remain in the experimental phase, and that meantime other experiments should be carried out to discover how far group practice, working in close association with maternity and child welfare and school clinics, might be able to provide some at least of the benefits of a health centre at a much lower cost. Future developments should then be based on the experience gained from both the health centre and group practice experiments.

625. It has been suggested that patients may prefer to visit their doctor locally in his own surgery instead of attending at a health centre, if this is farther away from where they live. This is no doubt one of the reasons why doctors working in health centres have been anxious to retain their outside surgeries, fearing that they might lose a number of patients from their lists if their practices were transferred en bloc to a health centre. The Cohen Committee, in paragraphs 69–71 of their Report on General Practice(1) mention other reasons why doctors have sometimes shown little enthusiasm for the establishment of a health centre, for example:—

(*a*) It is the local health authority which must, to some extent, be in control of the health centre; and this "at once causes misgivings in the minds of many general practitioners".

(1) Report of the Committee on General Practice within the National Health Service—H.M.S.O., 1954.

(*b*) "If a general practitioner agrees to practise from a health centre, he will, by doing so, agree to transfer his practice, or at least part of it, from his private surgery to the centre; but once he has done this, he will have lost much of his independence because his patients may become attached to the centre and would not then, in the main, follow him back to other premises if he decided to break his connection with the centre."

(*c*) As a result of these and other difficulties, "an assurance that they will co-operate in a health centre must normally be obtained from local doctors before the construction of the centre is started. This assurance is not easily obtained. In practice, the doctors will naturally not commit themselves until they can see a contract which shows them what they are offered, what they will have to pay, and what security they will get; and such a contract is not easy to work out in an agreed form between the three interested parties—the practitioners, the local health authority and the local Executive Council."

(*d*) "the amount which doctors should be asked to pay for accommodation and facilities in a health centre is itself an intensely vexed question . . . ; if the doctors are asked to pay an economic rent, this is too high to be acceptable; if the local health authority is ready to accept a lower rent, doctors who are not proposing to use the centre may object that this is unfair."

626. We have noted with much interest the experimental health centre ("Darbishire House") provided by Manchester University which was officially opened in June, 1954. We understand that the centre is provided in adapted premises which cost £41,000 to purchase, adapt and equip. The costs of purchase and adaptation were met by the Nuffield Provincial Hospitals Trust and the cost of equipment by the Rockefeller Foundation. The net running costs are borne by Manchester University with the assistance of a grant from the Manchester Corporation. This is not therefore a health centre provided by a local authority under section 21 of the National Health Service Act, 1946.

"Darbishire House" is a three-storey building. On the ground floor there are four general practitioner suites and office accommodation; on the first floor maternity and child welfare clinics, X-ray room, clinical laboratory, and rooms for minor operations and physiotherapy; and on the second floor, a school health clinic and staff room. The special features of the centre are as follows:—

(*a*) It is intended to demonstrate a proper integration of the local authority, hospital and general practitioner services and full facilities will be made available for this purpose.

(*b*) Special emphasis will be laid on the social aspects of ill-health, and an attempt will be made to demonstrate the use of health centres for socio-medical research. The aim will be to integrate the preventive and curative health services.

From the careful study and record of the influence of social and economic factors on illness and disablement in an urban population it is hoped that a basis will be found for research methods under the guidance of the Department of Social and Preventive Medicine in the University.

(*c*) From 1956, we understand that the general practitioners in the centre will undertake to accept medical students and to train them

under the University's general guidance (but without interfering with the general practitioner's practice arrangements). Eventually all students are to pass through the centre.

(*d*) The general practitioners will ultimately have paid posts as clinical assistants in hospitals, and paid appointments in the local authority health and education services at the centre.

(*e*) Three district nurses, in addition to performing their normal home nursing duties from the centre, will also run a treatment room for injections, minor injuries and, later, physiotherapy. It is hoped that health visitors will also work from the centre under the supervision of the family practitioners.

It is too early yet to assess the results and achievements of "Darbishire House" but it is clearly an important experiment which will repay the closest examination when sufficient time has elapsed to enable the services to get under way.

Our own view

627. It seems clear to us that, while resources at the disposal of the National Health Service are limited, progress in the provision of health centres must inevitably be slow. It is unlikely that any future health centre will be provided on the scale of the Woodberry Down Centre at Stoke Newington which cost £178,000[1] and the Sighthill Centre near Edinburgh which cost £160,000; but the cost of providing comprehensive health centres on a wide scale would nevertheless be very large, and would lay a heavy burden on the Service. Indeed, it may perhaps be fortunate that progress in this field has not been more rapid in the opening stages of the Service. A great deal still remains to be learnt about health centres, their advantages, their proper design, and most economical provision. A number of lessons have already been learnt, for example, from the Woodberry Down Centre, which will be invaluable in the planning of any future centre at more moderate cost—particularly in making use of the same accommodation for a variety of purposes instead of providing separate clinics, general practitioners' suites etc., for each purpose.

628. We consider therefore that the wisest course to pursue at the present moment is to continue an experimental approach towards the development of health centres and to accumulate information about the experience gained from the centres already in operation. Where there is an urgent need for new maternity and child welfare clinics and surgery accommodation—e.g., in areas of new housing development, or in heavily populated industrial communities where the existing facilities are clearly inadequate, there would seem to be a valid case for developing health centres.

629. The formal health centre, provided under section 21 of the National Health Service Act[2] is moreover not the only means of linking the general practitioner and local health authority services. In some areas doctors might wish themselves to provide group practice premises in which arrangements might be made with the local health authority to provide maternity and child welfare and school clinics. In others, the local health authorities might wish to provide the accommodation for these purposes, the general practitioners renting such part of the accommodation as they would need for group practice. There may be other alternative methods, too, which

[1] The cost in this case included the provision of certain facilities (e.g., a day nursery and a child guidance clinic) not ordinarily provided at a health centre.
[2] In Scotland, section 15, National Health Service (Scotland) Act, 1947.

will be thought out by those responsible for the provision of the general practitioner and local authority services locally. The more varied the experiments at this stage the better.

We would emphasise however that, while group practice in itself is a development which is to be welcomed on its own account, it cannot make any contribution to this problem unless the group practice in question is closely associated with the local authority services.

At a later date it will then be possible to review the working of the health centres and other local experiments, and to judge how far they have

(*a*) improved the integration of the services, particularly the general practitioner and local health authority services;

(*b*) improved the quality of general practice;

(*c*) justified the expenditure on their provision.

It is certainly too early yet to arrive at any firm conclusions.

630. We have noted in particular the following recommendation of the Committee[1] appointed by the Central Health Services Council in December, 1948, "to consider and make recommendations on the lines along which health centres should be developed under section 21 of the National Health Service Act":—

> "The services of specialists or other services provided for out-patients requiring special accommodation etc., should be provided at health centres only where the demand would ensure the accommodation and equipment being used to such an extent as to be in all the circumstances economical, including the specialist's time. In particular X-ray apparatus—other than dental X-ray—should not be provided if adequate facilities are readily available elsewhere."

We have reason to doubt whether it is in fact economical in most cases to provide in health centres facilities for diagnostic and pathological investigation, and we trust that this aspect will not be overlooked when the work of the existing health centres is reviewed.

MATERNITY AND CHILD WELFARE SERVICES

631. Many of our witnesses have told us that the division of the health services into three branches has had its most serious impact on the maternity and child welfare services. Responsibility for providing these services is now divided between the hospital authorities, local Executive Councils and local health authorities as follows:—

(i) The hospital authorities are responsible for the provision of hospital maternity beds and out-patient ante-natal and post-natal treatment in teaching and non-teaching hospitals.

(ii) The local health authorities are responsible for the provision of a domiciliary midwifery service and ante-natal and post-natal clinics.

(iii) The Executive Councils are responsible for making contracts with general practitioners who undertake to provide maternity medical services. These services involve the provision of prescribed ante-natal and post-natal care, with attendance at the confinement if necessary or if the doctor desires to be present.

[1] See the Report of the Central Health Services Council for the year ending 31st December, 1950—H.M.S.O., 1951.

A general practitioner obstetrician (i.e., a general practitioner who has been admitted to the obstetric list) may provide maternity medical services to any expectant mother; but a doctor not on the obstetric list may provide such services only for a woman on his own list.

(iv) The position is further complicated by the arrangements for providing emergency medical aid for practising midwives. If a doctor is called by a midwife to an emergency under the medical aid scheme (i.e., to the confinement of a woman for whom he has not undertaken to provide maternity medical services) the doctor's fees are paid by the local health authority and not by the Executive Council.

632. Even within this general division of responsibility, there appear to be wide variations in the way the services are now being provided between one local authority's area and another. In some areas, the ante-natal clinics are still manned by medical officers of the local authority, even though many of the expectant mothers attending the clinics may have booked a general practitioner to provide them with maternity medical services. In other areas, the medical services at the clinics are provided by general practitioners employed by the local health authority on a sessional basis. In others, the clinics may have ceased to provide a medical service at all and are concentrating increasingly on the development of the educational aspects of ante-natal care, i.e., mothercraft (and even fathercraft), diet, hygiene, relaxation exercises, etc. Or again, the general practitioners may be providing "clinic sessions" in their own surgeries, with the local authority midwives in attendance.

633. Our witnesses have expressed varying views about the drawbacks of this divided responsibility and its effect on the efficiency of the service. Some have pointed out that the maternity services have been made to work smoothly in some areas by close co-operation between the authorities and officers concerned; and that other areas could achieve the same results if only the people concerned had the will to co-operate. Others have suggested that the services should be brought under the undivided control either of the hospital authorities or the local health authorities. The Royal College of Obstetricians and Gynaecologists, for example, said that the present division "tends to produce an atmosphere of competition not co-operation between the various components of the Service," and recommended, among other things, the appointment of a statutory authority at regional level with executive powers to administer all the obstetric services. The College also recommended that:—

(*a*) The number of new admissions to the obstetric list should be related to the amount of domiciliary work to be done.

(*b*) Means should be devised to ensure that the general practitioner obstetrician has time for his obstetric work. This may mean a restriction in the number of patients on his list.

(*c*) All midwives should come under one employing authority and be subject to the same range of terms and conditions of service.

634. The witnesses who have favoured unified control of all the maternity services have pointed out that it would be possible by this means to secure a proper balance between the institutional and domiciliary confinements. There is disagreement, however, as to what should be a "proper balance". In 1952, the proportion of institutional confinements in England and Wales was 64·1 per cent. as compared with 58·4 per cent. in 1949—the rise being due in the main to the fall in the birthrate itself: as the falling birthrate

was not balanced by a reduction in the number of hospital maternity beds, the fluctuations in demand have been absorbed entirely by the local authority domiciliary services. We have been told that in some areas the proportion of institutional confinements may now exceed 80 per cent. and yet in other areas may not exceed 45 per cent. It is noteworthy that these figures do not necessarily reflect the quality of the housing or the needs of the patients in the areas served. In areas with bad housing, etc., the proportion of hospital beds may be low; in areas with good housing the proportion may be high.

635. Some of our witnesses have suggested that hospital authorities should take a more strict view as to the "medical needs" of patients applying for institutional confinement so that more beds may be made available for "social cases", and so that in some areas the total number of maternity beds might be reduced and a proportion released for more urgent purposes. There was a general feeling among these witnesses that in most areas 50 per cent. would represent an adequate provision for hospital confinements—a view which is shared by the Ministry and has been enunciated in advice circulated to hospital authorities in England and Wales. The Royal College of Obstetricians and Gynaecologists, on the other hand, recommended that "institutional confinement provides the maximum safety for mother and child, and therefore the ultimate aim should be to provide obstetric beds for all women who need or will accept institutional confinement".

636. All our witnesses are in agreement that the proportion of expectant mothers attending local authority ante-natal clinics has fallen since the Appointed Day, in some areas quite substantially. This may have been due to the introduction of a maternity medical service, and the feeling on the part of the mother or the doctor that attendance at the local authority clinic, as well as the doctor's surgery, is not necessary. Attendances at the child welfare centres, on the other hand, have remained at a fairly constant level.

Our own view

637. As there are medical issues and disagreements involved in these arguments which we as a Committee are not competent to judge, it is clearly out of the question for us to make any clear-cut pronouncement on this very complex issue. Our evidence does, however, indicate that the maternity services are in a state of some confusion, which must impair their usefulness, and which should not be allowed to continue. The present structure appears to represent a not very satisfactory compromise between the services which were in existence before the Appointed Day and the new maternity medical service which was introduced with the National Health Service.(1) It seems to us that the time has now come for an appropriate body to review the whole of this field to find out precisely what services—medical and educational—are needed for mothers and young children and how they can best be provided through the framework of the National Health Service.

New thought is needed as to the proper role of the local authority clinic, the general practitioner and the hospital out-patient department in the provision of an efficient and comprehensive maternity service. Many local

(1) cf. the following extract from an Address given by Professor Leslie Banks at the Second Health Services Conference of the Institute of Public Administration in October, 1953:—

"Thus an expectant mother may be examined in her own home, at a doctor's surgery, at a local health authority clinic, or at a hospital, and then be delivered at another hospital. It is therefore possible for her to be advised by a general practitioner, a district nurse-midwife, a health visitor, a medical officer of the local authority, a hospital sister and a consultant, not one of whom may be responsible for ensuring continuity of care through pregnancy, confinement, the post-natal period and the vital first year of infant life." (*Making the Most of the Present Resources*, p. 35.)

authority clinics, for example, are clearly changing in character. One of the reasons for their creation originally was no doubt the need to provide free medical advice for mothers who could not afford to pay for a doctor themselves. Under the National Health Service, however, free medical treatment is available to all; and it is significant that many local authority clinics are turning increasingly to the educational aspects of their work.

638. We do not consider it necessarily a bad thing that the organisation of the maternity services should have shown divergent trends in different areas, since the varied experience gained will be of great value in considering what should be the right lines of development in future; but we do think the stage has been reached when an authoritative inquiry should be set on foot to evaluate the work now being done and to arrive at some conclusions as to the most efficient forms of provision.

While it is not for us to prejudge the work of any committee that might be appointed to review the maternity services, we would suggest that the following principles might be borne in mind:—

(i) Preventive medicine begins with the expectant mother and her unborn child. It is vitally important that all expectant mothers should receive advice on mothercraft, diet, care of the unborn child etc., and that the responsibility for providing this advice should be clearly known to the authorities and officers concerned. The appropriate measures taken at this time of the mother's life will have a beneficial effect on the health (including the dental health) of future generations.

(ii) As the numbers of women attending local authority ante-natal clinics have fallen since the Appointed Day, it may be that many women are now failing to receive the instruction they need in preventive health, and steps should be taken to make good this omission. If, for example, a woman has booked a doctor to provide maternity medical services, the doctor should be responsible either for providing *the whole* of the necessary instruction himself or (and this is most likely to apply in the majority of cases) advising the woman to attend the local authority clinic. The same obligation should lie on the hospital which has booked a maternity case, i.e., either to provide *the whole* of the appropriate instruction at the hospital or to arrange for its provision through the local authority clinics. As we understand it, there are at present only a few hospitals which provide training in mothercraft as well as medical ante-natal and post-natal treatment.

(iii) The role of the local authority clinic may have changed in recent years, but it is just as important now under its new guise as it was under the old; and we should consider it a most retrograde step if the organisation of the maternity services under the National Health Service were to discourage mothers from attending the clinics, without at least providing equivalent services by some other means.

639. Accordingly, we recommend that the organisation of the maternity services under the National Health Service be reviewed at an early date, bearing in mind the principles outlined in (i) to (iii) above.

THE CARE OF THE AGED

640. We have heard a great deal of evidence about the difficulties which have arisen since the Appointed Day in the provision of adequate services for the treatment and care of the aged under the National Health Service Acts and the National Assistance Act. Some of our witnesses—and particularly those representing the local authorities—have suggested that the difficulties have been accentuated by the division of responsibility between (*a*) the hospital authorities who are responsible for the provision of chronic sick beds, (*b*) the local health authorities who are responsible for the provision of home nursing, domestic help, health visitors, etc., (*c*) the local welfare authorities who are responsible for the provision of "residential accommodation", and (*d*) the Executive Councils who are responsible for the general practitioner service. These witnesses have added that a more efficient service (and one more suited to the needs of the patients) could be provided if a single statutory authority were made responsible for all the institutional and domiciliary services relating to the care of old people. They have pointed out that it is the duty of the hospital authorities at present to provide accommodation for the chronic sick who are in need of "treatment" and of the local welfare authorities to provide accommodation for the aged infirm who are in need only of "care", but that, in practice, it is often difficult to decide in which category an individual patient should be classed—and indeed many old people may be in need of care one week and of treatment the next. We have been told that the division of administrative responsibility has therefore given rise to a great deal of hardship among old people first in denying them the accommodation they need, and secondly in causing their removal at intervals from one type of accommodation to another. It has also left a "gap" in the statutory provision which can only be filled by providing "half-way houses"(1) to which old people might be admitted who fail to qualify either for hospital treatment or for local authority care. These problems, we were told, did not arise when local authorities were responsible for providing hospital beds as well as residential accommodation for the aged, and when the Relieving Officer was under a statutory obligation to make provision for any person in need.

641. Other witnesses have maintained that the problems now arising in the services for the treatment and care of the aged arise not so much from the form of administrative organisation as from the inadequacy of the services provided. The "gaps" in the Service have arisen not because of any loophole in the statutory duties imposed on the authorities, but because the demand for the services has greatly exceeded the supply. Moreover, the demands have been increasing—and will continue to increase—firstly because of the continued increase in the proportion of old persons in the community year by year (see table 36 in Part I of our Report) and secondly because the quality of the accommodation provided for old people both by hospital authorities and welfare authorities has been rising steadily since the Appointed Day and has in its turn stimulated the demand. There is less reluctance now to seek admission to many chronic sick hospitals or to small local authority old folks' homes of the modern pattern than there was before the war. These witnesses have added that the demand for institutional accommodation may have been increased still further in the post-war years by poor housing conditions, and by the fact that the housewife in many households is now going out to work and cannot devote her time to the care of an aged relative.

642. We ourselves agree with the view that it is the "inadequacy" of the services, and not the form of administrative organisation, which is the root cause of the problems relating to the care of the aged. Clearly a great deal more of the country's resources would have to be devoted to the local authority and hospital services to make them fully "adequate" in this respect. It is perhaps the inadequacy of the services which has led some to conclude that there is a need for "half-way houses"(1) to fill the "gap" between the local authority and hospital provision. In our view, however, the introduction of a third type of accommodation would be more likely to confuse than to clarify the position. This should not be taken to mean that we wish to criticise the half-way houses which have already been set up by voluntary organisations and others. On the contrary, we appreciate the very useful work which has been done in this way, and welcome the additional beds which have been made available to old people by these means. But we do not wish the notion to be allowed to develop that there is a gap between the hospital and local authority services for the treatment and care of the aged which can only be filled by the provision of the "half-way houses" to which we have referred in para. 640 above. What is most important is that the statutory authorities concerned should have a clear conception of where their duties lie in the provision of accommodation for the aged, and should plan to make good the present deficiencies as and when their resources will permit. Clearly it should be the responsibility of the hospital authorities to provide convalescent homes to the extent required for the care of old people.

Chronic Sick Survey

643. We have noted with interest the Chronic Sick Survey which is now being carried out by the Ministry of Health in certain areas with the following objects in view:—

(*a*) To ascertain the nature, quality and adequacy of the in-patient and out-patient facilities for the chronic sick.

(*b*) To ascertain the categories of patients now occupying chronic sick beds.

(*c*) To assess the validity and significance of hospital waiting lists for chronic sick.

(*d*) To discover the effectiveness of admission arrangements to hospital.

(*e*) To assess the arrangements for liaison between the hospital services and the home health services of the local health authority and the welfare homes of the welfare authorities.

(*f*) To assess the number of persons in hospital chronic sick units who are considered fit for discharge, and the number of persons in welfare homes who are regarded as needing admission to hospital.

The results of the Survey are not yet known to us, but clearly the Survey should do much to resolve any disputes about patients wrongly accommodated in hospital or local authority accommodation (about which we have heard many complaints in our evidence) and will enable the authorities to judge how far, and in what respects, the provision now being made under the National Health Service Acts and the National Assistance Act is failing to meet the needs.

(1) The term "half-way house" is used here to denote a special type of accommodation where old people would be cared for as long-stay patients. In our view, the provision of such accommodation would only add to the existing confusion by creating yet another category of aged patient and adding to the difficulties of defining borderline cases. We would point out that the term "half-way house" has also been applied to convalescent homes for the aged through which old people may pass on their way from active hospital treatment either to their own homes or to local authority welfare homes. We see no objection whatever to this latter type of provision for the aged, which forms a proper part of the hospital service.

(1) See footnote on page 214.

644. In carrying out the Survey, the Ministry have adopted an interpretation of the statutory responsibility of hospitals and local authorities which seems to us to resolve many of the practical difficulties and doubts which have been referred to in our evidence. Where old people are in need of treatment or care beyond the range of services which can be provided in their own homes, the division of responsibility between the hospital authorities and the welfare authorities has been defined by the Ministry as follows:—

Welfare Authorities

Apart from the active elderly person who is in need of residential care and who is clearly the responsibility of the welfare authority, the latter's responsibility also extends to the following:—

(i) Care of the otherwise active resident in a welfare home during minor illnesses which way well involve a short period in bed.

(ii) Care of the infirm (including the senile) who may need help in dressing, toilet, etc., and may need to live on the ground floor because they cannot manage stairs, and may spend part of the day in bed (or longer periods in bad weather).

(iii) Care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months) and who would, if in their own homes, stay there because they cannot benefit from treatment or nursing care beyond what can be given at home, and whose removal to hospital away from their familiar surroundings and attendants would be felt to be inhumane.

All these are persons for whom any necessary nursing care would be given by relatives, etc., with the help or advice of the home nurse if they were living in their own homes. In welfare homes that care should be given by attendants, assisted or advised by the visiting home nurse in the small welfare home, or by a small staff with nursing qualifications or experience in the larger homes.

It is *not* regarded as the responsibility of the welfare authority to give prolonged nursing care to the bedfast (except those in (iii) above), nor as desirable that separate "infirmary wards" should be created in large homes in which patients from other homes are concentrated.

Hospital Authorities

Apart from the acute sick and others needing active treatment, who are clearly the responsibility of the hospital authority, the latter's responsibility also extends to the following:—

(i) Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years.

(ii) Convalescent care of the elderly sick who have completed active treatment but are not yet ready for discharge to their own homes or to welfare homes.

(iii) Care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home.

It is *not* regarded as the responsibility of the hospital authority to give all medical or nursing care needed by an old person, however minor the illness or however short the stay in bed; nor to admit all those who need nursing care because they are entering on the last stage of their lives.

645. The advantages of this definition of responsibility seem to us to include the following:—

(*a*) It makes clear beyond doubt that there are circumstances in which old people may properly be given nursing care in welfare homes. This will do much to prevent the hardship and suffering caused by the movement of old persons from welfare homes to hospital during minor illness, and when they are entering upon the last stages of their lives.

Some of our witnesses, representing the local authorities, have told us that doubts have been expressed about the power of local authorities to employ nurses in their welfare homes. If these doubts do exist, then it is important that they should be clarified as soon as possible and local authorities informed not only that it is within their power, but also their duty to provide nursing care for old people in such circumstances.

(*b*) It guards against the reappearance of the old "infirmary wards" in local authority residential accommodation, which all our witnesses have agreed would be an undesirable development in the service.

(*c*) It provides a comprehensive service with no gaps between the hospital and local authority responsibilities.

Future pattern of development

646. From what we have said above, the following pattern emerges for the future development of the domiciliary, hospital and local authority services for the aged.

Domiciliary services

647. The first aim should be to make adequate provision wherever possible for the treatment and care of old people in their own homes where, as the Phillips Committee said in their Report(1), "they can continue to be happy and useful members of the community in touch with their relatives and neighbours". This is a matter of providing the right type of housing and adequate domiciliary services (e.g., health visitors, home nurses, domestic helps, etc.), working in close association with the general practitioner, the hospital geriatric services, and the voluntary organisations. All that we have said about the work of the domiciliary team in paragraphs 615–622 above, is particularly relevant to the treatment and care of old people in their own homes. The development of the domiciliary services for this purpose will be a genuine economy measure, and also a humanitarian measure in enabling old people to lead the sort of life they would much prefer.

There is great scope here, too, for voluntary workers who can do so much to make tolerable the lot of lonely old people in their homes, and thereby prevent their physical and mental deterioration. We welcome the invaluable work which has been carried out in this connection by the old people's welfare committees, through the provision of visiting services, Darby and Joan Clubs, chiropody services, "meals on wheels"; and also the very praiseworthy efforts made by members of youth organisations (such as the St. John and British Red Cross Society Cadets, Girl Guides, etc.), to help old people with their shopping and other daily tasks.

(1) Report of the Committee on the Economic and Financial Problems of the Provision for Old Age (Cmd. 9333) H.M.S.O., 1954.

Hospital services

648. The hospital authorities should aim to provide sufficient geriatric units where old people referred for treatment might be sorted into two main categories:—

(i) Those who will need prolonged hospital treatment and attention.

(ii) Those who can be rehabilitated and returned either to their own homes or to residential accommodation provided by local welfare authorities.

Our evidence has shown what striking results can be achieved by an efficient geriatric unit where there is enthusiasm for the work and a determination to see that the three branches of the Service are made to work harmoniously and constructively together. Clearly there must be the closest co-operation between the units, the domiciliary services and the welfare homes if the efforts of the geriatric unit are to be used to maximum effect. After an intensive course of rehabilitation in a geriatric unit, there is always the danger that a patient may relapse into his earlier condition on return to his home or to local authority residential accommodation, unless really adequate provision is made for any necessary follow-up treatment.

649. When the Ministry's Chronic Sick Survey has been completed, it may be possible to estimate the number of additional geriatric units still required in the hospital service, and the approximate number of long-stay hospital beds that will be needed to accommodate the patients mentioned in (i) above. As the Phillips Committee have already pointed out, "There are encouraging signs that modern methods of geriatric treatment will reduce the numbers who up to now have been retained in both general and mental hospitals. It would be premature to embark on long-term building plans for the accommodation of increasing numbers of chronic sick and other old patients in hospitals until there has been more experience of recent developments."(1)

650. The figures in table 52 illustrate the progress made by hospital authorities since the Appointed Day in the development of their services for the chronic sick:—

TABLE 52

Development of Chronic Sick Services in England and Wales

	1949	1953	1954
Chronic Sick beds* (available staffed beds)	50,300†	53,871	53,998
Outpatient attendances	Not available	12,627	14,175
Discharges and deaths	81,167	101,352	103,921

* The number of beds "allocated" for this purpose has in fact exceeded the number staffed and available.

† Estimated.

Similar progress has been made by the hospital authorities in Scotland. The number of beds specifically assigned for the aged and chronic sick has increased from some 4,000 in 1949 to 4,600 in 1954; in addition there are substantial numbers of patients of the same kind in general hospital wards. In most areas joint surveys of requirements and resources have been carried out by the Regional Hospital Boards in conjunction with local welfare authorities and Executive Councils as a basis for future planning.

(1) Report of the Committee on the Economic and Financial Problems of the Provision for Old Age (Cmd. 9333): para. 326.

Welfare authorities

651. The role of the welfare authority is to provide residential acccommodation (including nursing care in certain circumstances) for those who are unable to live in their own homes, but are not in need of hospital treatment. Our evidence suggests that there is a marked shortage of this accommodation and that until recently the shortages may have been due in part to the restrictions imposed by the Health Departments on capital development generally. When the capital position becomes easier(1), however, there is reason to believe that further progress may be hindered by the unwillingness of some local authorities to increase still further their rate burden. It is for this reason that we make our recommendation in paragraph 612 above in favour of the introduction of an Exchequer grant towards the cost of financing this type of residential accommodation.

The numbers of persons in residential accommodation provided either directly by local authorities or through arrangements with voluntary organisations, increased from 47,931 at the beginning of 1949 to 65,933 at the beginning of 1954 (England and Wales); and from 3,602 in June, 1949, to 5,780 in June, 1954, in Scotland. Even with the limitations imposed by finance and capital investment, therefore, the progress made by local authorities since the Appointed Day has not been insignificant.

652. It will be observed, therefore, that the pattern we suggest for the future development of the health and welfare services for the care of the aged follows generally the lines suggested by the Phillips Committee, with the one exception that we do not favour the provision out of public funds of a special category of old people's homes "intermediate between hospital and local authority residential accommodation".

In conclusion we repeat the warning that it would be unrealistic to suppose that the deficiencies in the services for the treatment and care of the aged can be made good overnight. The responsible authorities can only aim to make good the deficiencies, on the lines we have suggested, as and when an increased proportion of the country's resources is made available to the health and welfare services. We would add the proviso, however, that the authorities concerned should make sure that the needs of the aged are given their due priority in the allocation of additional resources and are not overlooked amid the pressure of other competing needs.

THE AMBULANCE SERVICE

England and Wales

653. The ambulance service in England and Wales is provided by the local health authorities who are required by section 27 of the National Health Service Act, 1946, "to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or mental defectiveness or expectant or nursing mothers from places in their area to places in or outside their area". The authorities may carry out this duty either by providing the

(1) At one period of our discussions it seemed that the capital position was easing throughout the country generally. We have since taken note, however, of the statement made by the Chancellor of the Exchequer in the House of Commons on 25th July, 1955 about the country's economic situation in which he said, inter alia, "I must also seek a lightening of the pressure of local authorities' capital expenditure upon the economy. I appeal to the local authorities to hold back their schemes for capital expenditure as far as they can, and the Ministers concerned will now adopt a stricter attitude towards proposals by local authorities for capital expenditure for all but the most essential purposes . . ." (see *Hansard, volume* 544, *No.* 35, *columns* 826 *to* 835).

vehicles themselves or by making arrangements with voluntary organisations to undertake the work on their behalf. The arrangements with voluntary organisations include the provision of a "hospital car service" manned by voluntary workers who are reimbursed on a mileage basis for journeys made on behalf of the local health authority.

654. We have been told that the demands on the service rose substantially in the early years of the National Health Service, but have now begun to level off. Our evidence suggests that this rise in demand has been due in the main to the provision of transport for increasing numbers of hospital out-patients, many of whom have to be taken for out-patient treatment at regular intervals and sometimes as often as two or three times per week. As many of our witnesses have pointed out, it is desirable in the interests of economy and efficiency that patients should, wherever possible, be treated as hospital out-patients in preference to being admitted to a more expensive in-patient bed; and this factor should not be overlooked when the rising cost of the ambulance service is considered. It is part of the price which must be paid for expanding the out-patient facilities in the hospital service, in preference to providing more hospital beds which would in the end cost a great deal more.

No doubt there was also some abuse of the ambulance service in its early years, but there has been general agreement among our witnesses that the more flagrant abuses have now been eliminated.

655. In table 53 we show for each of the years 1950–51 to 1953–54 (England and Wales) the total mileage run; the number of patients carried; the average number of miles per patient, the cost per patient; and the cost per vehicle mile. Comparable figures for the earlier years are not available.

TABLE 53

The Ambulance Services in England and Wales, 1950-1 to 1953-4*

Financial Year	Mileage Run	Number of patients carried	Average number of miles per patient	Cost per patient	Cost per vehicle mile
1950–1	89,751,000	9,279,000	9·0	15s. 1d.	—
1951–2	92,441,882	11,305,000	8·3	14s. 3d.	2s. 2d.
1952–3	95,088,550	12,457,595	7·6	14s. 4d.	2s. 2d.
1953–4	98,731,649	13,632,960	7·2	13s. 6d.	2s. 3d.

* So far as possible, capital expenditure is excluded from the figures of cost. All the figures quoted in this table are approximate.

Proposed transfer of administrative responsibility

656. As the great majority of ambulance journeys are provided for hospital patients the suggestion has often been made, both in the evidence submitted to this Committee and elsewhere, that the ambulance service in England and Wales could be run more efficiently and economically if responsibility for its administration were transferred from the local health authorities to the hospital authorities. The arguments generally put forward in support of this suggestion are that the hospital authorities, being the main users of ambulance transport, should also be responsible for its control; and that, if hospital authorities had to bear the cost of ambulance transport, they would have a greater incentive to seek economies and to reduce their demands on the service.

657. On the other hand, a great majority of the witnesses who have given evidence to the Committee—both on the hospital side and the local authority side—have firmly opposed this suggestion for the following reasons:—

(*a*) Local authorities have to provide transport for a variety of purposes outside the National Health Service and are therefore able to maintain and service additional ambulance fleets more economically than individual hospital authorities. A number of local authorities, for example, combine their Fire and Ambulance Services. On the other hand, if the hospital authorities had to provide garages and maintenance depots for ambulance fleets, their overheads would be proportionately higher than those of the local authorities.

(*b*) If the ambulance service were organised by hospital authorities to cover large areas comparable to those of the county health authorities, the management of the service would be no nearer the hospital medical officers and general practitioners (who order transport for their patients) than is the local health authority, and would be in no better position to enforce economy.

On the other hand, if the management of the ambulance service were broken down to Hospital Management Committee level, the provision and maintenance of vehicles on a scale sufficient to meet the peak demands of each hospital group would be an extremely extravagant and costly undertaking. Economies in vehicles, manpower, and maintenance can more readily be achieved under a unified service covering a wider area.

(*c*) The Medical Officer of Health, being outside the hospital service, is able to keep a careful watch on the use made of ambulances by hospital authorities and to challenge any cases of abuse. Hospital Management Committees themselves would be in no stronger position to question the decision of a hospital doctor that ambulance transport was required for his patient.

(*d*) Local health authorities have built up reciprocal arrangements for the conveyance of patients by train, where appropriate, with ambulance transport at each end of the rail journey. This is an economic—and even more convenient—method of transport for patients undertaking long journeys. Hospital authorities could not readily undertake this sort of work; nor would they wish to take over the accident and emergency section of the ambulance service.

(*e*) In the event of war, it is the local authorities who would be required to operate a Civil Defence Ambulance Service integrated with the peace-time organisation.

Our own view

658. We have considered this question very carefully and have concluded that the arguments against the proposed transfer are decisive. We think it unlikely that ambulance fleets could be managed and serviced as cheaply by hospital authorities as they are by the local health authorities; and we doubt whether the demands on the service could be materially reduced if it were controlled by the hospital authorities themselves. Indeed the danger might be the other way. We have borne in mind that it is the hospital doctor in charge of the case who is responsible for deciding whether or not ambulance transport is needed for his patient. Advice has been given to hospital doctors from time to time, both centrally and locally, on the criteria to be applied when deciding whether an ambulance is necessary, and we have no reason to believe that these criteria would be applied any more strictly if administrative responsibility were transferred to the hospital authorities. The evidence

we have heard suggests that under the present arrangements the Medical Officer of Health is able to exercise a critical supervision over demands for ambulances from hospitals and general practitioners and is well placed, as the representative of an outside authority, to call for enquiries into cases of abuse. Indeed, we have found universal agreement among our witnesses that the main abuses of the service which occurred in the early days of the National Health Service have now been brought under reasonably effective control.

We do not therefore recommend any change of administrative responsibility in this case.

Financial responsibility

659. One or two witnesses have suggested that the advantages of the present administrative structure might be retained, and a sense of financial responsibility placed on hospital authorities, if the latter were required to pay to local health authorities the cost of ambulance transport provided for hospital patients. They argue that the provision of patients' transport is an integral and indispensable part of the hospital service and there is no reason therefore why 50 per cent. of its cost should fall on the rate-payer. They add that while the main abuses of the service may have been eliminated, there is still some doubt whether ambulance transport is really needed by all the out-patients who use it—particularly in the case of repeated visits. Hospital authorities would examine more closely the transport needs of every out-patient, if the hospital budget were affected by the cost of any ambulance transport provided.

660. Other witnesses, however, have criticised this proposal on the following grounds:—

(i) In some areas, local health authorities would be involved in a considerable amount of administrative work and expense in making out bills for each hospital authority in their area, and this additional cost would not be counter-balanced by savings elsewhere;

(ii) if hospital authorities were "paying the piper" they would also wish to "call the tune", and the position of the local health authority as the guardian of economy in the service would be seriously weakened.

Our own view

661. We are not satisfied that any material savings would accrue from this proposal, and we do not wish therefore to recommend its adoption. We would not favour the introduction of "cross-accounting" into the National Health Service—with all the work and expense which it entails—unless we were confident that substantial economies would be achieved thereby. If the local health authorities are to continue to run the ambulance service (as we suggest they should), then we agree that they should also finance the service, with the aid of the Exchequer grant. This strengthens the hand of the Medical Officer of Health in dealing with such abuses of the service as are brought to his notice.

In succeeding paragraphs, we draw attention to other means by which local health authorities and hospital authorities may, through co-operation, achieve further economies in the ambulance service.

662. As our terms of reference relate to the cost of the National Health Service "to the Exchequer" we should point out that, if responsibility for the ambulance service were transferred from the local health authorities to the hospital authorities, the Exchequer would have to bear the full cost of the service instead of only 50 per cent. as now. In England and Wales, this would have meant the addition of a little more than £4 million to the Exchequer

account in 1953-54 which was in fact borne by the local rates. Again, if hospital authorities were to pay local health authorities the cost of transporting hospital patients, the Exchequer would probably have to bear something in the region of 90 per cent. of the cost of the service—i.e., an addition of nearly £3½ million to the Exchequer account in England and Wales in 1953-54. Our conclusions, however, are based not on these factors, but on a comparison of the costs to public funds generally (from whatever source arising) of administering the ambulance service by the one means or the other.

Other suggestions for Improved Efficiency

663. As we see it, there are broadly two ways in which efficiency and economy in the ambulance service may be further improved:—

(i) By ensuring that only those patients who need ambulance transport are in fact provided with it.

(ii) By organising ambulance journeys in such a way that the maximum numbers of patients are carried for every mile run, and that the most economical form of transport is used in each case (e.g., sitting-case car instead of ambulance; rail journey instead of special transport, etc.).

664. With regard to (i), we have already referred to the advice which has been issued from time to time both centrally and locally to all doctors, explaining the criteria which should be applied in determining whether ambulance transport is or is not required by individual patients. General practitioners and hospital doctors are responsible for seeing that these criteria are applied, and our evidence suggests that there is still room for improvement in their application. This applies particularly to the patient who is attending the hospital out-patient department at regular intervals, and may continue to be provided with special transport long after his need for it has passed. We suggest, therefore, that all hospitals which have not already done so should review their arrangements to ensure that recurring visits of this sort are reviewed regularly to find out which patients, if any, are fit enough to use public transport.

665. With reference to (ii), the figures in table 53 above show how the local health authorities have already succeeded in organising their ambulance services more efficiently each year since the Appointed Day. Between 1951 and 1954 the average number of miles run per patient fell from 9·0 to 7·2. During the same period, the London County Council told us that the London average fell from 7·3 to 5·1 miles per patient. These reductions have been achieved by a variety of means including:—

(*a*) Co-ordination between neighbouring authorities to ensure that their combined resources are deployed to the greatest advantage.

(*b*) Co-ordination and combination of journeys through Hospital Transport Officers, to ensure that every vehicle is used to the maximum efficiency.

(*c*) The introduction and development of radio control of ambulances.

(*d*) The use of rail transport for long journeys (in London, for example, the number of rail journeys increased from 818 to 5,741 between 1949 and 1953).

666. We would urge local health authorities to apply these economy measures whenever and wherever the opportunity arises. In particular, we would suggest that the extension of radio control of ambulance fleets is a very good means of effecting further savings in the cost of the service in many areas. By this means some authorities have already been able to reduce the number of ambulances maintained in their fleets; while others have found

it possible, through radio control, to carry an increased passenger load without adding to the number of their vehicles. We are strongly of opinion that all authorities who have not already done so should consider forthwith the advisability of introducing radio control in the ambulance services in their areas. With regard to (*b*), however,—i.e., the co-ordination and combination of journeys to and from hospital—we were surprised to hear in our evidence that there are still a number of hospitals and hospital groups which have not yet appointed any Transport Officer. It seems clear to us that the appointment of a Transport Officer(1) is one of the most effective means of co-ordinating hospitals' demands for transport, and in avoiding any wastage in ambulance journeys.(2) By judicious planning of time-tables for ambulances and sitting-case cars, the Transport Officer can cut down the amount of vehicle waiting time at hospitals and can organise the collection and discharge of patients so as to make the smallest possible demands on the available vehicles, and to reduce their mileage to a minimum. We have no doubt that he can also improve considerably the liaison between the hospital or hospitals for which he is responsible and the local health authority's ambulance officer—which in turn will make for improved efficiency generally. We have noted the statement in the Ministry's Annual Report for 1953(2) that a local health authority received calls for ambulances from 22 different persons in one hospital in the course of one month. This is clearly not the way to organise ambulance transport with efficiency and economy.

667. Accordingly we recommend that all hospitals of appropriate size and hospital groups which have not already done so should appoint Transport Officers at the earliest possible date, unless they can prove to the satisfaction of the Regional Hospital Board that they have made alternative arrangements which are working effectively and economically.

Annual Costing Returns

668. In each year since 1950–51, the Ministry have published Annual Costing Returns for the ambulance services in England and Wales. According to the Ministry's Annual Report for 1953, these returns "have given a useful basis for comparing general economy of running, and have provided a starting point for more detailed scrutiny of particular items which seem, prima facie, to have a high unit cost".

Proposed charge for ambulance journeys

669. One of the suggestions put to us for reducing the cost of the ambulance service was that patients should be required to pay for journeys taken in an ambulance or sitting-case car. We asked the Association of Municipal Corporations whether they thought a charge for ambulance journeys would be practicable, and they replied as follows:—

> "If it were decided that the institution of a charge would be desirable, and provided responsibility for payments were fixed by law where the requisition for the ambulance or sitting-case car is made by some other person on behalf of the patient carried, it is considered that it would be quite practicable to impose and collect such a charge. The experience of local authorities before the inception of the National Health Service, however, suggests that it would be desirable administratively to work on a basis of standard charges rather than to attempt to make a charge on the basis of mileage covered, and there should be no special provisions for abatement according to the means of the user. If it were decided either to work on a mileage basis or to abate the charge according to the financial circumstances of the user, it would be necessary for some department of the local authority to calculate the liability, render an account and subsequently collect the money. This would unquestionably give rise to a substantial amount of work in the office and, in view of the comparatively small sums involved, would be economically unattractive."

(1) As recommended in the Ministry's Circular 30/51, issued in July, 1951.
(2) Annual Report of the Ministry of Health, 1953, page 147.

670. It seems to us that this statement sets out the issues very fairly. A charge based on mileage would not only be extremely difficult to administer, but would also operate inequitably against patients requiring lengthy ambulance journeys for reasons quite outside their control. If a standard charge were to be imposed, however, it would be difficult to find a "standard" which would be high enough to make its collection worth while and yet low enough not to bear hardly upon individual patients. Moreover, it would be necessary to exclude certain categories of patient from the charge altogether —e.g., accident and special emergency cases—and the total amount yielded by the charge would be correspondingly reduced. In short, the only practicable course would be to levy a small charge on certain defined categories of patient, which would almost certainly not be worth the cost of collection, in terms of manpower and money.

671. Even apart from the question of the desirability of making such a charge, which seems to us very dubious, we are able to conclude that its introduction could not in any event be justified on financial and administrative grounds. This was also the considered opinion of the majority of our witnesses who expressed an opinion on this matter. In the words of the evidence of the Association of Municipal Corporations, "the Association do not consider that, however welcome financial relief may be, it is to be found by this means".

Patients' travelling expenses

672. Some of our witnesses have reminded us that, except in cases of hardship, patients have to pay their own travelling expenses to and from hospital when ordinary public transport is used. We have been told that this may lead patients to urge their doctors to recommend the provision of an ambulance or sitting-case car (for which no charge is made) even when special transport is not strictly required. These witnesses have therefore put forward the suggestion that all patients' travelling expenses should be refunded, so as to prevent any financial inducement to secure ambulance transport.

The cost of making this concession, however, would be substantial and we have no reason to believe that it would be balanced by any corresponding saving in the cost of the ambulance service. We have no wish, therefore, to alter the present arrangements. In reaching this conclusion we have borne in mind that patients may apply to the National Assistance Board for financial help in cases where the cost of public transport would cause genuine hardship.

Charge for stand-by service

673. We understand that it is the practice of some local health authorities to provide ambulances to stand-by at motor race meetings, etc., to deal with possible casualties; but there appears to be some difference of opinion whether the authorities have any power under the National Health Service Acts to charge the promoters of the meetings for the provision of this service.

It seems right to us that local health authorities should be able to levy a charge in such circumstances and we recommend that the statutes be

amended if necessary to make clear beyond any doubt that they have the power to do so.

The Ambulance Service in Scotland

674. Under section 16 of the Scottish Act of 1947 the duty of providing an ambulance service in Scotland is placed upon the Secretary of State. In the regulations setting out the functions of Regional Hospital Boards the provision of an ambulance service is included among the duties which these Boards perform on behalf of the Secretary of State. In practice however the ambulance service is provided on behalf of the Regional Hospital Boards by arrangement between the Secretary of State and a Joint Committee representing the Scottish Branch of the British Red Cross Society and the St. Andrew's Ambulance Association, the whole service being known as the Scottish Ambulance Service.

675. In table 54 we show for each of the years 1950–51 to 1953–54 (Scotland) the total mileage run; the number of patients carried; the average number of miles per patient; the cost per patient; and the cost per vehicle mile.

TABLE 54

The Ambulance Service in Scotland, 1950-1 to 1953-4*

Financial Year	Mileage Run	Number of patients carried	Number of miles per patient	Cost per patient	Cost per vehicle mile
1950–1	7,788,797	520,700	15·0	15s. 9d.	1s. 4d.
1951–2	8,382,101	690,028	12·1	18s. 5d.	1s. 6d.
1952–3	9,072,483	769,713	11·8	17s. 1d.	1s. 6d.
1953–4	9,628,768	956,935†	10·1	15s. 7d.	1s. 7d.

* Capital expenditure is excluded from the figures of cost. All figures quoted in this table are approximate.

† Some part of this increase is due to a different method of computation introduced at the beginning of 1953.

676. Although in Scotland the ambulance service is provided on behalf of the Regional Hospital Boards these Boards have not, until changes made fairly recently, taken part in the administration of the service. As in England, one of the difficulties of controlling the use of the service is that it has been largely provided by one authority and used by other agencies, the main user being the hospital service whose demands represent about 75 per cent. of ambulance journeys as against 25 per cent. for general practitioners.

677. In order to bridge the gap between the provider and the users, the Department of Health asked Regional Hospital Boards, towards the end of 1954, to form Regional Ambulance Committees composed of representatives of the Regional Boards, the Scottish Ambulance Service, general practitioners in the Region, and the Women's Voluntary Services (who run the hospital car service); and having the following functions:—

(*a*) To keep under review arrangements for the transport to hospital of all patients who are unfit to travel by public transport. The Committee will thus have within their purview the Road Ambulance Service, the Hospital Car Service provided by the Women's Voluntary Services, the Air Ambulance Service and any other forms of transport such as the provision of hired cars in place of ambulances.

(*b*) To bring to the notice of Regional Boards and Local Medical Committees, on the basis of local experience, the need for, and suitable methods of, impressing on all who order ambulance transport the importance of strict criteria in considering whether it is necessary.

(*c*) To assist the Joint Committee to ensure, subject to the need for limiting expenditure to what is necessary for the well-being of patients, that the ambulance arrangements in the Region provide a comprehensive and efficient service. This includes consideration of the distribution of ambulance vehicles and arrangements for co-ordinating journeys.

(*d*) To consider any cases of apparent misuse of the ambulance service and to make appropriate representations to whatever authority (Regional Board, Joint Committee, or Local Medical Committee) is in a position to take corrective or remedial action.

678. An adjustment in the financial arrangements relating to the Scottish Ambulance Service was also made at the same time. Previously finance had been dealt with exclusively between the Department of Health and the Joint Committee, the Regional Hospital Boards having no financial responsibility. The Boards are however now given monthly statements showing the expenditure on the service in their Regions. These statements distinguish (*a*) changes in expenditure that result from changes in operating costs, which will continue to be the concern mainly of the Joint Committee; and (*b*) changes that result from changes in demand for ambulances in the Regions, which will form the basis of much of the work of the Regional Ambulance Committees. It is understood also that Regional Hospital Boards are to be consulted in the preparation of the Estimates for the Ambulance Service. The Department of Health hope that by these means the increase in ambulance use will be arrested and mileage reduced. It is of course too early yet to judge the efficacy of the new arrangements.

PART VI

WHITLEY COUNCIL MACHINERY

Background history

679. The National Health Service inherited from local authorities, National Insurance Committees, and the governing bodies of voluntary hospitals a complex and elaborate structure of staff grades covering some 400,000 people. Only for some of these grades, notably nurses, were nationally recognised rates of pay and conditions of service already in existence. Outside this group, remuneration was determined in a wide variety of ways. Whereas the rates of pay of employees of local authorities had a relatively common standard, those of employees of voluntary hospitals showed very considerable variation. Many salaries in voluntary hospitals, for instance, were personal to the holders of the post rather than to the office itself.

Moreover, the provision of a Health Service for all residents of Great Britain curtailed for many doctors and dentists, and other professional people in related fields, the scope of private practice upon which they had hitherto either wholly or partially depended for their remuneration. Henceforward, as employees or contractors, they were to be increasingly dependent for their livelihood upon remuneration derived from work under the National Health Service.

680. The National Health Service made possible, and indeed necessitated the establishment of uniform terms and conditions of service and uniform rates of remuneration throughout the whole of Great Britain; and the Minister of Health and the Secretary of State for Scotland made it clear during the debates on the respective Bills in Parliament that suitable negotiating machinery would be set up for this purpose.