724. These weaknesses apart, and allowing for the manifold shortcomings and imperfections inherent in the working of any human institution, we have reached the general conclusion that the Service's record of performance since the Appointed Day has been one of very real achievement. As is shown in Part I of our Report, the rising cost of the Service in real terms during the years 1948 to 1954 was less than many people imagined; and moreover, many of the services provided were substantially expanded during the period. This is not the place to summarise all the developments referred to in our Report, but we would mention in particular the up-grading of many hospitals, the expansion of hospital in-patient and out-patient treatment, the increase in the number and the better distribution of consultants, the development of the health-visiting, home help and ambulance services, and the improved care of the aged.

725. The administrative organisation of the hospital service, with its Boards and Management Committees composed entirely of voluntary members, may be a novel one (particularly having regard to the size of its annual budget); but the experience of the last seven years does not suggest that the organisation has failed to cope with its heavy responsibilities or to control, with greater regard for economy than is commonly credited, the large sums of Exchequer money which have been devoted annually to the Health Service. As we have already pointed out, the annual capital allocations for the hospital service have, in our view, been inadequate, but there can be no doubt that the hospital authorities have made very good use of the limited sums made available to them. Any charge that there is widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence.

726. Looking to the future, it is clear that there are long-term problems of high importance confronting the National Health Service, not a few of which can only be solved by the medical profession itself; and which will call for all the qualities of statesmanship and adaptability that it can command.

727. Our detailed review of the hospital, Executive Council and local health authority services has strengthened us in the view which we first expressed in Part II of our Report—namely that the Service now requires a period of stability during which all the various authorities and representative bodies will be able to plan ahead on the basis of the experience gained in the last seven years.

We hope that the comments and suggestions we have made in our Report may be helpful in pointing the way for future developments, and also in weighing the merits of the many proposals put forward, both from within and outside the Service, for improving the efficiency and economy of the National Health Service.

PART VIII

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

728. Before setting out in summary form the recommendations we have made in the main body of our Report we wish to draw attention to a consideration which has been present in our minds during the whole of our deliberations. The National Health Service has only been in operation now for seven years, and no doubt in due course there will be further developments which cannot at present be foreseen. We regard our recommendations

as those which are appropriate in the light of the circumstances as we find them; and we are fully conscious of the fact that with the passing of time new conditions will arise which could call for recommendations of a different character. In making our own recommendations it has been neither our intention nor our desire to prejudge what may be found necessary in the future.

THE COST OF THE NATIONAL HEALTH SERVICE

729. In Part I of our Report we review, with the aid of a Memorandum by B. Abel-Smith and R. M. Titmuss, the present and prospective costs of the National Health Service in England and Wales. The main conclusions of the review are summarised in paragraph 92. The cost of the Health Service in Scotland is analysed in Appendix 2.

THE GENERAL STRUCTURE OF THE NATIONAL HEALTH SERVICE

730. In Part II of our Report, after reviewing the basic organisation of the National Health Service and the main proposals put to us for radical alterations, we arrive at the following conclusions:—

(1) *Proposed unification of the Health Services*

We do not favour the suggestion that statutory ad hoc health authorities should be appointed to administer the hospital, family practitioner and local health authority services. Other reasons apart, we consider this suggestion unacceptable because it would remove from the local health authorities their important domiciliary health services and would create a division between different types of public health work at least as serious as the present divisions within the National Health Service. It would, moreover, drive a wedge between the home health services now provided by local health authorities under Part III of the National Health Service Act and the welfare services provided by local authorities under Part III of the National Assistance Act—a division which would, in our view, be very undesirable. In our view, the only form of major reorganisation which calls for serious discussion is one which would integrate the three branches of the National Health Service without depriving the local authorities of their existing domiciliary health functions—i.e., a reorganisation which would add responsibility for the hospital service and/or the Executive Council services to the present duties of the local health authorities. (paras. 113–116.)

(2) *Proposed transfer of the Hospital Service to Local Health Authorities*

We do not feel that a convincing case has been made out for transferring the hospital service to the local health authorities. Some form of regional authority will always be required for the efficient planning of a national hospital service, and if the service were to be managed by the local authorities, Joint Boards (or some similar bodies) would be necessary to carry out this planning function. The service would then be administered through the Health Departments, Joint Boards, local authorities, and presumably hospital managing committees. This administrative structure would not be calculated to improve the co-ordination of the service either at the national level or at the officer level; and would simply create new problems in the relationship between Joint Boards and local authorities.

As for the practicability of the proposal, we doubt very much whether the local authority machine would be able to carry the additional burden

of the hospital service. A great deal still remains to be done by the local authorities in the development of their home health and welfare services, and it seems to us that their energies might be expended more profitably in this direction than in attempting to take on the whole of the hospital administration in addition. Bearing in mind also that some local authorities themselves would be reluctant to accept responsibility for the hospital service; that the bulk of the medical profession would be opposed to the suggestion; and that the financial burden would be intolerable unless the Exchequer grant were so substantial that it would render local government responsibility merely illusory, we feel confident that, whatever the merits of the proposal, it is not a practical proposition at the present. (paras. 117–129.)

(3) *Proposed transfer of certain classes of Hospitals to Local Health Authorities*

We do not favour the proposal that all maternity, tuberculosis, chronic sick and infectious diseases hospitals and all mental deficiency institutions should be transferred at once to the local health authorities. It seems to us that the hospital service would be hopelessly disrupted if responsibility for its provision were divided between Regional Hospital Boards and local health authorities. (paras. 130–131.)

(4) *Proposed transfer of the work of Executive Councils to Local Health Authorities or to Regional Hospital Boards*

We agree that there is need for the closest possible co-operation between the family practitioner, local health authority, and hospital services, in the interests of patients, the profession, and the Exchequer; but we do not believe that this co-operation would be achieved simply by transferring the work of Executive Councils either to the local health authorities or to the Regional Hospital Boards. Where integration is lacking the reasons are probably to be found more in the personalities concerned than in any defects of organisation. Moreover, so long as the general practitioners are paid under a contract for services, no major savings are likely to be achieved by changes in organisation. (paras. 132–141.)

(5) *The appointment of a National Board or Corporation*

We do not agree with the suggestion that a National Board or Corporation should be appointed to administer the National Health Service. We are satisfied that a service which costs the Exchequer more than £400 million per year must be accountable, through a responsible Minister, to Parliament. There is no proper analogy with the nationalised industries which are revenue earning. A great merit of a National Board, so far as the hospital service is concerned, would be to make possible the interchange of staff between the central body and the authorities at other levels of hospital administration. We do not believe, however, that this advantage would justify the appointment of a new Board or Corporation whose constitution alone would pose a host of difficult problems. Nor do we believe that the appointment of a National Board would in itself improve the integration of the health services.

We conclude that the Minister of Health and the Secretary of State for Scotland should continue to remain directly responsible to Parliament for the administration of the Health Service. (paras. 142–146.)

(6) *General conclusion on the structure of the National Health Service*

We believe that the structure of the National Health Service laid down in the Acts of 1946 and 1947 was framed broadly on sound lines, having

regard to the historical pattern of the medical and social services of this country. We are strongly of opinion that it would be altogether premature at the present time to propose any fundamental change in the structure of the National Health Service. It is still a very young service and is only beginning to grapple with the deeper and wider problems which confront it. What is most needed at the present time is the prospect of a period of stability, in order that all the various authorities and representative bodies can think and plan ahead with the knowledge that they will be building on firm foundations. Some of the strains and stresses of the National Health Service are attributable to the difficulty experienced by many, who had grown up under the old system, when called upon to operate a service administered on different lines. Longer experience of the working of the Service and the gradual emergence of a new generation may make comparatively simple many things which now appear difficult or impracticable.

What is essential is the recognition that the hospitals, the general practitioners and the local authorities have each an indispensable task to fulfil in their respective spheres. They are, however, each severally only a part of a single National Health Service; and the efficiency of the Service depends not merely on the quality and quantity of the work that each of these branches operates within its own sphere, but on the degree to which they co-operate with one another to accomplish the ends for which the Service as a whole exists. (paras. 147–152.)

(7) *The meaning of an "Adequate Service"*

We also consider in Part II of our Report what is meant by the provision of an "adequate" Health Service. We conclude that in the absence of an objective and attainable standard of adequacy the aim must be, as in the field of education, to provide the best service possible within the limits of the available resources. It is clear that the amount of the national resources, expressed in terms of finance, manpower and materials, which are to be allocated to the National Health Service, must be determined by the Government as a matter of policy, regard being had to the competing claims of other social services and national commitments, and to the total amount of resources available. The development of the National Health Service is one among many public tasks in which objectives and standards must be realistically set and adjusted as time goes on both to means and to needs.

It is still sometimes assumed that the Health Service can and should be self-limiting, in the sense that its own contribution to national health will limit the demands upon it to a volume which can be fully met. This, at least for the present, is an illusion. It is equally illusory to imagine that everything which is desirable for the improvement of the Health Service can be achieved at once. (paras. 94–98.)

THE HOSPITAL AND SPECIALIST SERVICES

731. In Part III of our Report we review the organisation and finance of the hospital and specialist services both before and after the Appointed Day (paras. 153–180) and, in the light of the evidence submitted to us, we arrive at the following conclusions and recommendations:—

(1) THE ROLE OF THE TEACHING HOSPITALS

We do not feel that a convincing case has been made out for transferring the teaching hospitals in England and Wales to the Regional Hospital Boards. It seem to us that one of the dangers of a national hospital

system lies in over-standardisation and uniformity. There is a distinct advantage therefore in preserving the separate status of the teaching hospitals outside the Regional Hospital Board framework. In the past, the great advances in medical techniques and knowledge have come from the teaching centres, and these benefits have accrued thereafter to the non-teaching hospitals. In our view, it would be a short-sighted policy now to subordinate these institutions, upon which so much depends for the future development of the service, to the Regional Hospital Boards. While we support the separate administration of teaching hospitals through the Boards of Governors, we would stress that their separate status brings with it a heavy responsibility both for the fullest co-operation with other organisations in the Health Service and for the most efficient and economical management within the teaching hospitals themselves.

Accordingly we recommend that the teaching hospitals in England and Wales should continue to be administered by Boards of Governors appointed by and responsible to the Minister of Health. We do not desire to recommend any change in the existing organisation in Scotland where the teaching hospitals are administered by Regional Hospital Boards. (paras. 181–193.)

(2) Powers and Functions of Hospital Authorities

(i) We consider two levels of management—i.e. the regional and group levels—to be essential for the efficient administration of a service which deals with more than 3,000 hospitals in England and Wales and some 400 in Scotland. The service undoubtedly requires both regional authorities covering areas large enough for purposes of planning and general supervision, and also group management authorities with responsibility for the day-to-day running of the service. We are of the opinion that the primary need now is to give more emphasis, in England and Wales, to the Regional Boards' responsibility for the general oversight and supervision of the service (in addition to their planning functions), though without in any way detracting from the Hospital Management Committees' direct responsibility for day-to-day management. We conclude that Regional Hospital Boards should be told, and Hospital Management Committees should accept, that the Regional Boards are responsible for exercising a general oversight and supervision over the administration of the hospital service in their Regions. It is a corollary of this recommendation that the Ministry should leave the task of supervising the Hospital Management Committees to the Regional Boards and should not itself undertake this task over the head of the Boards. (paras. 194–212.)

(ii) We review the procedure whereby Regional Hospital Boards and Boards of Governors are required to seek the prior approval of the Health Departments to capital works costing more than £10,000, and also whereby the Health Departments are required to seek the prior approval of the Treasury to capital works costing more than £30,000. For the reasons set out in our Report, we recommend that these limits be raised to £50,000 and £100,000 respectively. (paras. 213–217.)

(iii) We do not recommend any relaxation of the existing controls by the Health Departments and the Treasury over the acquisition of land and buildings by hospital authorities. (para. 218.)

(iv) We recommend that the existing controls over the appointment of consultants and junior hospital medical staff in England and Wales

be retained, but that the controls over other categories of staffing establishments be relaxed as far and as fast as possible. In recommending the relaxation of certain of the staffing controls, we wish to emphasise the desirability that hospital authorities themselves should carry out reviews of their staffing establishments at regular intervals.

Whilst we appreciate the reasons why the Ministry found it necessary to send out their own review teams in the early years of the Service to fix hospital staffing establishments in certain categories, we do not think it desirable that this practice should be repeated in future. Henceforth, responsibility for ensuring economy in the use of hospital staff should remain fairly and squarely with the Regional Hospital Boards and Boards of Governors—with the proviso that the Boards must seek the authority of the Ministry to any additional consultant appointments. (paras. 219–222.)

(v) We recommend that the Department of Health for Scotland should consider the desirability of adopting a similar procedure for the control of staffing establishments to that suggested for England and Wales, at least so far as the appointment of consultants is concerned. (para. 223.)

(3) Medical Consultation at Regional Level

We urge the Boards in all Regions to review their arrangements for joint consultation with the medical profession, and to consider whether medical consultative committees could with advantage be set up at regional level to ensure that decisions on medical matters of wide general import are not taken without proper consultation with those who will be affected by them. It is so important to integrate the medical aspects of the hospital, local health authority and general practitioner services, that we feel that the inclusion of representatives of the Universities, the Medical Officers of Health and the general practitioners on each regional consultative committee would be of great value. We therefore suggest that Regional Boards should give prominence to this aspect when reviewing their arrangements for joint consultation with the profession.

We do not, however, favour the establishment of statutory Medical Advisory Councils for all Regional Hospital Boards. (paras. 224–228.)

(4) Issue of Circulars by the Health Departments

With the regular consultations which now take place between the Chairmen and officers of Hospital Boards and representatives of the Ministry, and between Regional Hospital Boards and their Management Committees, it is most unlikely that a Ministry circular on an important matter of policy would now be issued without the knowledge of, and without taking account of the views of, the hospital authorities concerned. No doubt therefore this will be a source of less irritation in the future than it has been in the past. Beyond recommending that the Health Departments should keep the number of directions to a minimum, we have no wish to add any further comment on this matter. (paras. 229–231.)

(5) Regional Hospital Board Areas

From the evidence we have heard it would seem that the present areas administered by Regional Hospital Boards are generally satisfactory despite the wide variations in size and population. Moreover, a considerable amount of planning of consultant and other services has been carried out in the last seven years on the basis of the existing Regions; and any extensive rearrangement of regional boundaries or the creation of new Regions would,

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in our view, be wasteful and undesirable. We offer no recommendation therefore for the revision of the existing Regional Hospital Board areas. (paras. 232–234.)

(6) HOSPITAL GROUPINGS

We suggest that the time has now come for Regional Boards to review their hospital groupings and in particular to consider whether it would be in the interests of sound and economical management to split up some of the large groups, and to amalgamate some of the very small groups. By the very small groups we mean those which consist of one hospital unit with relatively few beds, and for which a separate Hospital Management Committee would seem to be unnecessary. We favour the "satellite" type of group as being the one most suited in size and function to management by a single Hospital Management Committee, and we would prefer that the larger groups be broken down, wherever practicable, to bring them into line with this concept of the ideal hospital group. We appreciate that this proposal is likely to involve the appointment of additional Management Committees but the extra cost would be relatively small and, in our view, would be outweighed by increased efficiency in the administration of the service. In cases where it is found impracticable—perhaps for reasons of geography—to split up one of the larger groups, we would recommend that the Management Committee should delegate more responsibility to the hospital secretaries in the group or, if this does not fully meet the case, should be allowed to strengthen the position of some of its House Committees.

Where a larger group is found to be essential, it is open to question whether the group secretary can also carry out the duties of hospital secretary in the largest hospital of the group, without detriment to the efficient administration either of the group, or the hospital, or both. Whilst it may be argued that a group secretary, without any hospital appointment, may become too remote from hospital affairs and too engrossed with committee work pure and simple, there would be less likelihood of this danger arising if it were made a requirement that all group secretaries should have served for a specified period as hospital secretaries; if the status of the hospital secretary himself were improved; and if the office of the group secretary was situated in the main hospital of the group so that he might be easily accessible to the hospital staff and, in particular, to the senior medical and nursing staff.

With regard to the mental hospitals and mental deficiency institutions, the weight of our evidence would seem to be in favour of these hospitals and institutions being managed separately under their own Management Committees and not in combination with one or more general hospitals. This is in fact the normal pattern in the hospital service. (paras. 235–241.)

(7) THE ROLE OF THE HOUSE COMMITTEE

In the ideal hospital group, we feel that there is insufficient room for two bodies (i.e. a Management Committee and a House Committee) with executive and spending powers. We are of the opinion, therefore, that the principles enunciated in circular R.H.B.(49)107 are generally sound. The pressure for increased delegation of powers to House Committees in some hospital groups may be due to the fact that the group is too large and that there has been insufficient delegation of powers to hospital secretaries at each of the unit hospitals.

Only in the very exceptional cases where the retention of a large hospital group is found to be unavoidable should there be need to consider the strengthening of House Committee powers.

We fully endorse the view that House Committees are doing excellent work in the hospital service, particularly in furthering the welfare of patients, in retaining the interest of the local community in their hospitals, and in preventing hospital staffs from becoming too isolated from their managing bodies. The House Committees can also form a useful link with the Leagues of Friends who are making such a valuable contribution in the voluntary field to the work of the hospitals. (paras. 242–248.)

(8) VOLUME OF COMMITTEE WORK

We recommend that all Management Committees and Boards of Management should now review their arrangements with the aim of simplifying their committee structure and reducing the volume of work, for example, by increased delegation of authority to responsible administrative officers. We are confident that this delegation would be facilitated if the hospital secretary were given a higher status in hospital administration and if the post of hospital secretary were to become a normal starting point to a hospital administrative career at group or regional level.

Any unnecessary committee work is an unmixed evil; it absorbs the time and energies of many people who ought to be carrying out their primary duties; and it slows down decisions and delays action which otherwise could and should be taken more promptly. (paras. 249–250.)

(9) APPOINTMENT AND COMPOSITION OF HOSPITAL BOARDS, MANAGEMENT COMMITTEES AND BOARDS OF MANAGEMENT

We agree that the Health Ministers must reserve the sole right to decide who shall be appointed to the Regional Boards, and that members must be selected solely for the contribution they can make to the efficient running of the hospital service. The present system is an essential corollary of a service organised on an agency basis. The Minister must aim to preserve a certain pattern of membership which will take account of all the interests concerned in the Service, but he could not accept an arrangement which would bind him to accept the nominations of the outside bodies concerned.

On the question of medical membership, we do not think it would be proper, in a service of this kind, to exclude medical members from Hospital Boards, Management Committees or Boards of Management. It is true that Hospital Management Committees, Boards of Management and Regional Hospital Boards already have machinery for obtaining medical advice at the group and regional levels, but this does not, in our view, make it any less desirable to have on the Boards and Committees themselves a proportion of medical members who can join in the discussions and exercise a vote. Their inclusion gives invaluable advice to the lay members on medical aspects of hospital management, and in return it helps the doctors to understand more fully the broader administrative problems in the hospital service.

We recommend, however, that the total number of medical members on a Regional Board, Management Committee or Board of Management should not exceed 25 per cent. save in exceptional circumstances. (paras. 251–264.)

(10) HOSPITAL FINANCE—CURRENT EXPENDITURE

(i) *Method of Allocating Revenue Funds*. We agree that the main weakness of the present system of allocating revenue funds to hospital authorities is the apparent lack of a consistent long-term objective, and we consider whether any formula might be devised (related to regional populations, number of beds and/or other factors) which

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might serve as a guide to the Health Departments when sharing out the annual allocations to Regional Boards. Any national formula, however, would have to be weighted to take account of such a wide range of variables in Hospital Regions that it cannot be considered as a practical proposition at least for the present. On balance, therefore, we conclude that the existing system, though it has certain weaknesses, is probably the best that can be devised in present circumstances; and we are confident that, with the growing experience of Regional Boards and the Health Departments in examining annual estimates, the system can be made to achieve its object of securing that the available sums are distributed where they are most needed in the interests of the efficient working of the service as a whole. (paras. 281–283.)

(ii) *Rewards for efficient and economic management.* We conclude that it would be impracticable to give direct financial rewards for underspendings to one Hospital Management Committee in a Region without doing an injustice to other Committees which have budgeted closely and spent up to the limit of their estimates. Moreover, we think it is a misconception to suggest that financial incentives of this kind are a proper way to ensure the efficiency of Hospital Management Committees. (paras. 284–286.)

(iii) *The Block Grant and Carry-Over of Unspent Balances.* We are of the opinion that the weight of argument is against the adoption of block grants to meet current expenditure in the hospital service, and that the same conclusion holds good with regard to the proposal that Regional Hospital Boards and Hospital Management Committees should be empowered to carry over unspent balances. Advocates of block grants for the hospital service often cite the analogy of the system of quinquennial grants for the current expenditure of the Universities administered by the University Grants Committee but, in our view, the analogy is not really a valid one.

As regards the carrying forward of unspent balances, we fully appreciate the great importance of encouraging and stimulating true economy in the hospital service, but, in our view, the stimulus should be provided by methods which are less open to objection than the simple carrying forward of unspent balances. The amount of money included in the annual estimates of a hospital authority is not the year's income of that authority, but merely the limit of permission to spend. In any event, hospital authorities would do well to remember that the services they administer form only a part of the National Health Service and that any underspending on hospital estimates may serve to balance some overspending in another subhead of the National Health Service Vote, e.g., on the pharmaceutical service. Underspendings on the hospital service are not necessarily "lost" to the National Health Service as a whole. (paras. 287–293.)

(iv) *Approval Subheads.* We do not recommend any alteration of the existing practices in England and Wales and Scotland for the approval of annual estimates under various subheads of expenditure. (paras. 294–298.)

(v) *Audit of Hospital Accounts.* The revised procedure, adopted in 1954, for auditing hospital accounts in England and Wales and Scotland seems to us to provide the right solution to the problem of hospital audit. It leaves the Minister and the Secretary of State with the duty of carrying out the audit itself, and properly associates the

Regional Boards with the follow-up of points raised in the auditors' reports. The proposal to introduce a "regional efficiency audit" is not in our view relevant to this matter. It is clearly part of the duty of a Regional Board to ensure that money is spent by Hospital Management Committees on purposes for which it is authorised; also to encourage Hospital Management Committees to compare their costs and continually to be seeking explanations for varying levels of expenditure. This is part of the normal function of management and is already being exercised—perhaps in varying degrees—in all Regions. It is a function which will no doubt be emphasised more successfully when departmental costing is introduced into the service. But it is not a function which need be associated with the technical audit of accounts. We see no objection therefore to—indeed there is considerable advantage in—reserving the audit to the Minister of Health and the Secretary of State for Scotland, so long as the Regional Boards are closely associated with the follow-up of the auditors' reports. (paras. 299–308.)

(11) Hospital Finance—Capital Expenditure

(i) *Level of Hospital Capital Investment.* In making recommendations on the size of the annual capital sum to be allocated to the hospital service, we are fully aware of the over-riding importance of the general economic situation of this country, and of the fact that a capital programme for the National Health Service must depend upon the economic policy adopted by the Government of the day in the light of that situation. It has also of course to be viewed in terms of the relation which the capital needs and current costs of the National Health Service bear to other fields of capital and current expenditure for which the Government is responsible. Subject to these considerations, having regard to the advanced degree of obsolescence of many hospitals in this country and to the very large arrears of capital expenditure resulting from the virtual cessation of hospital building since 1938, we are of opinion that £30 million annually would be a desirable rate of capital expenditure for the National Health Service at which to aim over the seven years succeeding the year 1957–58. We recommend further that out of this annual capital allocation of £30 million, some 10 per cent. or about £20 million in all should be earmarked specifically for revenue-saving schemes during the course of the seven year period, 1958–59 to 1965–66.

We appreciate that it is an essential corollary to this recommendation that there should be an increase in the current annual allocations to meet the consequential increase in the annual running costs of the service.

We record our agreement with the present arrangement whereby each of the Health Departments retains a central reserve for financing large capital schemes which cannot be carried out by individual Boards on their own capital programmes. Indeed, as more capital is made available to the service in the coming years, we would suggest that a due proportion be set aside to increase the amount of the central fund held for this purpose. (paras. 309–319.)

(ii) *Finance of Capital Works by Loan.* For the reasons stated in our Report, we do not favour the raising of funds for capital purposes in the hospital service by means of loans. (paras. 320–322.)

(iii) *Maintenance of Capital Assets.* It seems to us that there is a strong case for making Regional Hospital Boards responsible for allocating sums annually to Hospital Management Committees for the specific purpose of maintaining capital assets and for that purpose only. Regional Boards and Hospital Management Committees should therefore be asked to work out schemes designed to ensure that proper standards of maintenance are observed in their Regions. The proper maintenance of these capital assets is a matter of the greatest importance in the long run. It appears to us right that the Regional Hospital Boards which are the agents responsible to the Health Ministers for the allocation of public money (including capital) to the Hospital Management Committees should also be responsible for ensuring that the fabric of the hospitals in their Regions is being suitably maintained. (paras. 323–325.)

(iv) *Block Grant and Carry-Over of Unspent Balances.* Although we agree that there is more substance in the arguments for the block grant and carry-over of unspent balances on capital account than on current account, we feel nevertheless that they are not strong enough to warrant a recommendation from this Committee which would involve a revolutionary change in Government finance. We are strengthened in this view by the fact that Regional Boards are now finding considerably less difficulty in spending up to the limit of their capital allocations than in the early years of the Service when the machine had not been fully adapted to cope with the annual programmes, and when their execution was hampered by building restrictions, licensing requirements, etc.

We conclude that no sufficient case has been made out for the block grant nor for the carry-forward of unspent capital balances.

We have noted that, when making their announcement of the Government's plans for increasing the rate of hospital building for England and Wales and Scotland the Health Ministers gave an indication of the capital allocations likely to be made available for the hospital service not only for the current year 1955–56, but also for the two succeeding years 1956–57 and 1957–58. We welcome the adoption of this procedure which will enable Hospital Boards to be notified of the annual amounts of capital likely to be allocated to them over a three year period and not, as previously, for one year only. We appreciate that any forward notification must be provisional and might have to be modified if there were to be a sudden national emergency. But an indication of the amounts likely to be forthcoming annually in a three year period would, we feel, go some way to meeting the difficulties experienced in the past by Regional Hospital Boards, and in particular would facilitate the forward planning of hospital building works. (paras. 326–330.)

(v) *Distinction between Current and Capital Expenditure.* We do not favour the suggestion that the present distinction between current and capital expenditure should either be abolished or considerably relaxed to enable hospital authorities, e.g., to use any savings on their current account to finance small capital works. It seems right to us that a clear distinction should be drawn between current and capital expenditure in the hospital accounts, and that there are obvious dangers—not the least of which would be the inflation of annual estimates—if Management Committees or Boards of Management were encouraged to effect savings on the one account to finance capital works on the other.

We have noted that in Scotland any purchase of furniture or equipment etc., costing more than £20 is treated as capital expenditure whether the article purchased is a replacement or an addition. In England and Wales the cost of replacing furniture and equipment etc., is treated as current expenditure and only the cost of furnishing and equipping new accommodation is treated as capital expenditure. The practice followed in England and Wales seems to us to be the more desirable of the two, and we recommend the Department of Health for Scotland to consider the adoption of the definition of capital now employed in England and Wales. (paras. 331–333.)

(12) HOSPITAL COSTING

We review in detail the history of hospital costing and the reports made on this subject by the King Edward's Fund, the Nuffield Trust, the Regional Hospital Board Treasurers, and the Working Parties appointed by the Ministry of Health and the Department of Health for Scotland. We conclude that a good case has been made out for the introduction of departmental costing into the hospital service and that it should be started experimentally in the first instance in a limited number of hospitals and expanded subsequently in the light of experience. Whilst we would agree that the subjective accounts must be retained at least for the time being, we would suggest that their retention be reviewed at a later date, after departmental costing has been expanded in the hospital service, to see if their continued retention is in fact essential. We are not concerned at this stage whether full departmental costing (as recommended in the "main scheme" of the English Working Party's report) is to be preferred to a costing system based on prime costs only (as recommended in the Scottish Working Party's interim report). Indeed, there are many advantages in our view in carrying out experiments on two different schemes in England and Wales and Scotland, so that experience may be gained over a wider field and future extensions of hospital costing devised in the light of that experience. We would welcome, therefore, the adoption of the two Working Parties' reports broadly in their present form.

We are convinced that the present system of relying entirely on subjective costing is unsatisfactory because it fails to reveal to the heads of hospital departments how the annual expenditure of their departments varies in time and space; and, more important still, how the actual expenditure of the department at the end of the financial year compares with the budgeted expenditure at the beginning of the year. We would urge the importance therefore of establishing at the hospital and departmental levels a system of effective budgetary control which will enable hospital managements in suitable cases to set their standards of efficiency each year and to judge at the end of the year whether those standards have been achieved. It is at the unit hospital level where economies can be effected, and it is essential that all hospitals should have a system of accounts which will make their budgetary control effective. As soon as practicable, hospital departments should forecast annually how they propose to spend with maximum efficiency the money allocated to them, and should be required to account for any considerable discrepancies at the end of the financial year. By this means we believe that the heads of hospital departments will be given a sense of responsibility to see that, as far as may be, their forecasts are achieved.

It should be the concern of the Health Departments vis-à-vis the Regional Hospital Boards and Boards of Governors; of the Regional Hospital Boards vis-à-vis their Management Committees; and of the Hospital Manage-

ment Committees vis-à-vis their unit hospitals, to see that these budgetary controls are properly exercised throughout the hospital service.

We trust that all concerned with hospital administration—not least the doctors—will co-operate to the utmost in order to make a success of this vital aspect of hospital management. Costing schemes should be regarded not as a means of imposing restrictions on the service but as a means of ensuring that the best value is obtained for the money spent. We have little doubt in our own minds that departmental costing will more than repay the cost of its introduction in promoting increased efficiency and a fuller sense of responsibility for spending among all those concerned with the running of hospitals. (paras. 334–354.)

(13) Other Measurements of Hospital Efficiency

We appreciate that hospital costs alone do not necessarily reflect the efficiency of hospital management and that they are better examined with other statistical indices such as bed occupancy, length of stay of patients, bed turn-over, turn-over interval, waiting time, staffing ratios etc. It is one of the problems of management—and a particularly difficult one in the case of the hospital service—to find the right indices for measuring efficiency.

We review the steps which have been taken to solve these problems in the hospital service and welcome the efforts which have been made, and are still being made, both centrally and locally, to make hospital authorities and heads of hospital departments aware of their standards of efficiency, not only in the spending of money, but in the management of the service generally. When the right information is made available to responsible officers, and at the right levels of management, the stage is set for the examination of standards of performance in hospital departments both internally and in relation to other comparable departments elsewhere. This work may entail the appointment of additional administrative, clerical and statistical staff, but it would be a short-sighted policy to criticise such expansion of staffs as is required for this essential piece of hospital administration. Indeed in a later recommendation, we suggest that the Ministry of Health and the Department of Health for Scotland should set up a "Research and Statistics Department" which would devote the whole of its time to statistics and operational research generally. This piece of administrative machinery (which we describe in Part VII of our Report) would, in our view, speed up considerably the seeking out of new indices and would provide material which would be helpful to the Departments' administrators in the formulation of new policies.

We should regard it as unfortunate if opposition to the compilation of departmental costs or similar data were to be based on the mistaken idea that any conclusions could be drawn from these figures as to the professional standards or competence of doctors in different hospitals. (paras. 335–367.)

(14) Use of Non-Exchequer Funds in the Hospital Service

In our view it is entirely appropriate that appeals for voluntary contributions should continue to be made by voluntary bodies (for purposes mutually agreed between the bodies and the hospital concerned) but not by Management Committees, Boards of Management, Boards of Governors or Regional Hospital Boards themselves. There is need for the closest possible co-operation between hospital authorities and voluntary organisations in this and in all other matters concerned with voluntary services; and this is a field in which the House Committee can play an important part.

We note that many hospitals are now spending endowment moneys on purposes for which Exchequer money could properly be used; and we see no reason why they should not continue to do so.

At this point in our Report, we take the opportunity of paying a warm tribute to the work which has continued to be carried out by voluntary bodies in the hospital service since the Appointed Day. There were many who thought that the introduction of a National Health Service would mark the end of voluntary effort in the nation's hospitals; but the experience of the last seven years has proved that the link of voluntary service between the public and their hospitals has been renewed and in some cases strengthened, particularly in the last few years. It seems to us that the continuance and further expansion of voluntary service is one of the surest ways of maintaining the essential humanity and vitality of the hospital service and preventing the development of that enemy of human welfare—institutionalism. (paras. 377–383.)

(15) Hospital Boarding Charge

Having regard to the relatively low yield likely to be obtained from a hospital boarding charge (after all the probable exemptions have been taken into account), and to the practical difficulties, the cost of collecting the charge, and the strenuous opposition which would be aroused on humanitarian grounds against its introduction, we feel that the case in favour of imposing a hospital boarding charge has not been made out and we do not recommend its introduction. (paras. 384–390.)

(16) Hospital Staffing

(i) *Recruitment and Training of Administrative Staff.* We regret that there should still be no provision nationally for recruitment and training in respect of the administrative side of the hospital service, and we recommend that such provision be made at the earliest possible date. In our view, it should include methods of entry into the service; avenues of promotion; training; a structure and salary grading of posts such as will provide sufficient people of the right calibre at all levels of hospital administration; and proper arrangements for publicising and advertising posts. When the service has developed a proper career structure with adequate provision for training and promotion, it should not, save in very exceptional circumstances, be necessary to fill the higher designated posts from persons drawn from outside the service.

As we believe that the hospital secretary holds one of the key positions in the hospital service, we recommend that steps be taken to ensure that the prospects, responsibilities, salary, and other conditions of service of hospital secretaries are such as to attract persons of the right quality to these highly important posts. (paras. 391–397.)

(ii) *Whole-time and Part-time Consultant Appointments.* After considering the many suggestions and views which we have received on the subject of whole-time and part-time consultant appointments, we conclude that, in the interests of the hospital service, there is a valid case under existing conditions for the retention of part-time consultant appointments in addition to whole-time appointments. We consider it very desirable, however, that Regional Boards should be free to appoint whole-time consultants in cases where it is deemed to be necessary in the interests of the service. We trust that joint consultation between Regional Boards and the medical consultative committees (to which we have referred in para. 227 of our Report)

will lead to agreement between the Boards and the medical profession, and will prevent the emergence of differences of opinion over the conditions of appointment such as have been known to occur in the past.

We are also of opinion that it is undesirable that the financial arrangements relating to the consultant service should be such as to provide a financial inducement to a consultant to apply for a part-time rather than a whole-time appointment. (paras. 398–404.)

(iii) *Hospital Medical Staff*. We welcome the suggestion that, as part of the re-organisation of hospital medical staffing, provision should be made for a new specialist grade, below the grade of consultant, which would offer a permanent position in the career structure of the hospital service. (paras. 405–406.)

(17) Hospital Medical Administration

On the subject of medical administration in the hospital service, we warmly endorse certain recommendations of the Committee on the Internal Administration of Hospitals, which relate to the service in England and Wales, and which we trust will be implemented without delay. (paras. 407–411.)

We note that Scottish tradition has always favoured placing the medical administration of hospitals in the hands of a medical superintendent, and that this practice has continued since the Appointed Day. We have no wish to disturb the practice which has, by tradition, been followed in Scottish hospitals for many years. Our evidence suggests, however, that it is becoming increasingly difficult to recruit men of the right calibre to undertake the work of hospital medical administration, and it has been put to us strongly that the remuneration of medical superintendents is insufficient to attract the right sort of men. It is outside our scope to make any specific recommendations on this matter; but it is clearly one that is of great importance for the efficient working of the service. It should certainly be investigated and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment, they should be revised. (paras. 412–414.)

(18) Amenity Beds and Pay Beds

We accept the provision of private accommodation in National Health Service hospitals, both for patients who need it on medical grounds and for those who are prepared to pay for it, either in the form of an amenity bed or a pay bed. So long as the present shortage of hospital accommodation continues, however, we would deprecate any expansion in the number of amenity beds and pay beds which would be at the expense of the available free beds in the service. In reaching this conclusion we have borne in mind that the total number of "private" beds (whether for use under section 4 or section 5 of the National Health Service Act, 1946) represents a very small proportion of the total available beds in the Health Service.

In the interests of efficiency and economy, it is clearly desirable that all hospital beds, whether free or not, should be used to the fullest extent possible, and we hope that all concerned will continue to seek means to achieve the highest occupation rates practicable.

With regard to the basis on which pay bed charges are calculated, we do not believe that it would be advisable to depart from the principle that the user of a pay bed, having contracted out of the free hospital service, should pay the full cost of the accommodation and services provided, while

making his own arrangements for paying the consultant of his choice. Hence we do not recommend the adoption of an arbitrary charge which would be demonstrably lower than the actual cost of the facilities provided. No doubt pay beds would be used more widely by paying patients if the charges were reduced, but we believe that the charges would have to be reduced very substantially to effect any large increase in demand—so much so that the net effect would most probably be a loss to the Exchequer as compared with the present position.

We have carefully considered whether the adoption of regional or national average charges for particular categories of hospital would be preferable to the present system, but on balance, we see no real advantage in their adoption. (paras. 416–424.)

(19) Hospital Supplies

As a special committee of the Central Health Services Council has been appointed "to investigate and report on the organisation of all forms of hospital supplies, including their purchase, storage and issue, throughout the National Health Service", we do not propose to offer any recommendations on the question of hospital supplies.

We record the impression, however, from our limited evidence on this subject, that hospital authorities generally have not yet taken full advantage of the great volume of knowledge and well tried practices in supplies-purchasing which are already common to all large undertakings in this country. In our view, it is desirable that these practices should be ascertained and applied wherever practicable to the hospital service to ensure that the best value is obtained for the money spent. It is true that this process has been under way in the hospital service since 1948, both centrally and in certain of the Hospital Regions, but progress appears to us to have been slower than might have been expected. (paras. 425–426.)

THE FAMILY PRACTITIONER SERVICES

732. In Part IV of our Report we review the organisation and finance of the family practitioner services and, in the light of the evidence submitted to us, we arrive at the following conclusions and recommendations:—

(1) Administrative Organisation

The administrative organisation of the family practitioner services, both before and after the Appointed Day, is described in paragraphs 427–437.

(i) *Amalgamation of Executive Council Areas*. After reviewing the case for and against the amalgamation of Executive Council areas, we conclude that the existing pattern of Executive Council areas is broadly right, on the grounds that their boundaries should generally be co-terminous with those of the local health authorities, so as to strengthen the link between the general practitioner and domiciliary health services. There may be a few areas in England and Wales where amalgamation might be effected without detriment to the Service, and we suggest that the possibility of marginal adjustments of this nature might be borne in mind by the Health Departments when reviewing the structure of the Executive Councils; but we do not believe that the savings achieved by such amalgamations would be substantial. (paras. 438–443.)

(ii) *Membership of Executive Councils*. We are of opinion that in general the Executive Councils have carried out their duties well

and efficiently and that no case has been made out for altering the balance of their membership.

In the larger Executive Council areas in England and Wales (particularly in London), we understand that it is difficult to find a sufficient number of lay members who can spare the time to attend all the meetings of the disciplinary committees. Accordingly we recommend that the existing disciplinary regulations in England and Wales be amended so that, in the case of the largest Executive Councils, provision might be made for additional deputy lay members to be appointed, with the Minister's approval. (paras. 444–447.)

(2) THE GENERAL MEDICAL AND PHARMACEUTICAL SERVICES

We review the general medical and pharmaceutical services provided before and after 1948, and the measures taken since the Appointed Day to check the growing cost of the pharmaceutical services. (paras. 449–475.)

(i) *The General Practitioner and the Patient.* We have received no evidence of substance which would lead us to make any recommendation within our terms of reference with regard to the relationship of the general practitioner and the patient. (paras. 476–478.)

(ii) *Limited List of Prescribable Drugs.* For the reasons set out in our Report, we are not in favour of the introduction at the present time of a limited list of prescribable drugs in the National Health Service. The recommendations of the Cohen Committee on Prescribing, the action taken by the Health Departments on those recommendations, and the publication of Prescribers' Notes, etc. have contributed to make doctors more cost conscious in their prescribing of drugs, and to cause them to review their prescribing habits. Every effort should continue to be made to keep doctors informed about the cost of prescribing generally, and in particular to stimulate them to review carefully their prescribing of expensive drugs and the quantities prescribed; while patients in their turn should, as far as possible, be educated out of the " bottle of medicine habit ". We are of opinion that these and similar measures, reinforced by the methods of controlling prescribing which are already being employed by the Health Departments and which have been set out in detail in paragraph 471 of the Report, represent the most practicable line of approach to this problem. (paras. 479–481.)

(iii) *Pricing of Prescriptions*

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

We also conclude that there would be no advantage in pricing prescriptions fully in selected areas for periods of 12 months instead of for one month at intervals as now. (paras. 482–486.)

(iv) *Container Deposit.* From the evidence we have heard on this subject we are satisfied that no convincing case has been made out for the reintroduction of the returnable cash deposit for containers, and we do not recommend any change in the existing arrangements in this matter. (paras. 487–489.)

(v) *Stock Orders Scheme.* We endorse the hope expressed by the Cohen Committee on General Practice that the stock orders scheme may yet be given a trial in England and Wales. It seems to us that the introduction of such a scheme would contribute to economy in prescribing. (para. 490.)

(vi) *Investigation into the Cost of Pharmaceutical Products.* From the limited evidence we have heard, it would be impracticable for us as a Committee to express a view about the level of profits now being earned by the pharmaceutical industry as a result of its sales to the National Health Service. Our main concern has been to consider whether the present arrangements are satisfactory—i.e. for reaching agreement about the prices to be paid by the National Health Service for pharmaceutical products—and whether the arrangements could be improved in any way.

We note that negotiations between the Departments and representatives of the industry have been under way for some considerable period; and that there has been public criticism of the delay in reaching agreement. The issues on both sides are, however, large and of great importance; while the Departments have had to feel their way in a new and, for them, largely unexplored field. We trust that these negotiations will speedily be brought to a definite and mutually acceptable conclusion. (paras. 491–494.)

(vii) *Central Register of National Health Service Patients.* We endorse the view that the existing Central Register is inadequate and that, in the absence of any suitable alternative, the provision of a central alphabetical index would appear to be desirable on the grounds of efficiency, economy and equity. (paras. 495–503.)

(viii) *The General Practitioner and the Hospital Service.* We emphasise the need for the closest possible co-operation between the general practitioner and the hospital service; and we endorse a number of recommendations on this subject made in the Scottish Report on the General Practitioner and the Hospital Service and in the Cohen Committee's Report on General Practice.

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

We suggest further that the increasing use of the part-time services of general practitioners in hospitals would offer a valuable means of lessening the shortage of hospital medical staff in the junior grades. (paras. 504–508.)

(ix) *Medical Manpower.* We welcome the appointment of a committee, under the Chairmanship of the Rt. Hon. Henry Willink, M.C., Q.C., " to estimate, on a long-term basis and with due regard to all relative considerations, the number of medical practitioners likely to be engaged in all branches of the profession in the future, and the consequential intake of medical students required." (para. 510.)

(3) THE GENERAL DENTAL SERVICES

We review the dental services provided before and after the Appointed Day in paragraphs 511–526.

(i) *Shortage of Dental Manpower.* We draw attention to the acute shortage of trained dental manpower (which appears to be growing more serious each year) and welcome the appointment of an Inter-departmental Committee under the Chairmanship of Lord McNair "to ascertain the reasons for the lack of candidates of suitable calibre for training as dentists and to indicate possible directions in which remedies might be sought."

The shortage of dental manpower makes it the more important to consider every means possible for reducing the amount of dental disease requiring treatment, and making the best use of the trained manpower available. (paras. 527–530.)

(ii) *Prevention of Dental Disease.* Oral disease is one of the most common of all diseases, and we suggest that the opportunities for preventive health in this field are outstanding. The main suggestions made to us for its development are the fluoridation of water supplies; increased research into the causes and prevention of oral disease; more dental health education; and more efficient dental services for mothers, young children and school children. (para. 531.)

(iii) *Fluoridation of Water Supplies.* We understand that the Health Departments are now making arrangements for pilot demonstrations of fluoridation to be carried out in a few selected areas, and we hope that these will be pressed forward with all possible speed. If the amount of dental caries in the population can be reduced by a preventive measure of this kind without any undesirable side effects on the population, then the door will be open to one of the most welcome means of economy in the Service, i.e., one which will at the same time improve the health of the public and reduce the cost to the Exchequer. (para. 532.)

(iv) *Research.* We stress the great importance of research work generally in the field of dental health. (para. 533.)

(v) *Dental Health Education.* We suggest that the promotion of dental health by dental health education is a matter no less important than research; and we draw attention to the importance of the local authority clinics and the health visiting service in this aspect of preventive health. (para. 534.)

(vi) *Dental Services for Mothers and Children.* We review the organisation of the dental services for mothers and children and discard the proposal that responsibility for the clinic dental services should be transferred from the local authorities to the Health Departments.

We suggest that one of the lessons to be learnt from the last seven years is that, if the local authority services and the general dental service are to be developed in step, then it is essential that some balance should be kept in the levels of remuneration in these two branches of the Service. (paras. 535–540.)

(vii) *Employment of Dental Ancillaries.* At a time when there is such an acute shortage of dental manpower, we agree that there are good grounds for maintaining that the existing resources would be used to the best advantage by allowing fully trained dentists to take charge of dental departments (particularly in the priority dental services) in which they would supervise the work of dental nurses

and oral hygienists. Such an arrangement would relieve the fully trained dentist of much of his routine work and enable him to employ his skills to better advantage. It may be that there are professional matters here which lie outside our competence; but in our judgment there would seem to be a prima facie case for the employment of dental ancillaries in the dental service.

We add the important proviso that, owing to the limitations imposed by finance and especially by manpower, it will be impossible to contemplate an expansion of the dental service sufficient to meet all desirable needs, whether by training more dentists or dental ancillaries. The aim for the present must be to make the best use of the available limited resources. (paras. 541–545.)

(viii) *Dental Estimates Boards.* We doubt whether the work of the Dental Estimates Boards could be carried out in any other way which would be less expensive in terms both of money and of trained dental manpower. (para. 546.)

(4) THE SUPPLEMENTARY OPHTHALMIC SERVICES

We review the eye services provided both before and after the Appointed Day in paragraphs 548–557.

(i) *Proposed Comprehensive Hospital Eye Service.* We are of opinion that the weight of the evidence presented to us is against the abolition of the supplementary ophthalmic service and its replacement by a comprehensive hospital eye service. To accomplish this would involve additional capital expenditure in constructing, expanding and equipping eye clinics all over the country; it would also entail a considerable addition to the number of qualified ophthalmologists. Having regard to the fact that both more capital and more skilled manpower are urgently required in other parts of the Service, it does not seem to us that it would be wise to embark on a programme of expansion of the hospital eye service merely in order to replace the supplementary services. There is certainly scope for some further development of the hospital eye service in various parts of the country under existing conditions; and due account should be taken of this by Regional Boards in planning the hospital services in their Regions. We recommend accordingly that the supplementary ophthalmic services and the hospital eye service should continue to function side by side. (paras. 560–562.)

(ii) *Provision of National Health Service Lenses in Private Frames.* We conclude that, on balance, the case for restricting the fitting of National Health Service lenses to National Health Service frames is not strong enough to warrant a recommendation to that effect from this Committee. There is considerable uncertainty whether any appreciable saving of public funds would in fact be achieved by this means; and in any case the total amount of the country's resources devoted to the provision of spectacles would not be reduced by such a recommendation; only the division between the public and private provision would be affected. (paras. 563–566.)

(iii) *Keeping of Records.* We agree that a fruitful source of economy might be found in a review of the records now kept by Executive Councils for their supplementary ophthalmic services.

We welcome the review which we understand has already been started by the Ministry of Health to find out which records, if any,

are now redundant. This is a process which might with advantage be repeated from time to time. (para. 567.)

(iv) *Reminders for Sight Tests.* We have no reason to believe that the issue of reminders by opticians to patients is leading to abuse of the service, and we are strengthened in this view by the fact that the patient himself now has cause to consider whether a change of spectacles is worth while, bearing in mind the substantial proportion of the cost which he must pay himself. In our view, however, the question is closely linked with the payment of charges, and if the charges should be abolished at any time in the future, it might be necessary to review the practice of issuing reminders. (paras. 568–569.)

(5) Charges for the Family Practitioner Services

We explain the principles we have applied in our consideration of the Health Service charges generally in paragraphs 571–576. In considering proposals for the introduction of new charges in the National Health Service, we have judged each proposal strictly on its merits, i.e. whether it would or would not contribute materially to the efficiency and economy of the Service—and we have in fact concluded that no convincing case has been made out for the imposition of new charges. This conclusion applies to the hospital and local health authority services as well as to the family practitioner services.

When considering the charges that already exist in the Service, we have borne in mind that they operate both to reduce demand and to contribute to meet the cost; and we have not felt able to recommend the reduction of charges except in cases where this benefit appears to us to be offset by some appreciable distortion of the Service itself. In so far as charges deter substantial numbers of people from enjoying benefits which the Service is able to provide, we consider that a high priority should be given to modifying them, so soon as other conditions permit. The conclusions we have reached have been drawn from our evidence as to the effects which the different charges have had on the working of the Service, and hence the benefit which might accrue to the Service as a result of reducing or modifying in some way any of these charges.

(i) *Charges for Dentures.* We recommend that the present charges for dentures be retained so long as the number of dentists remains insufficient to meet the potential demands upon their services. (paras. 576–577.)

(ii) *Charges for Dental Treatment.* It seems to us that the charge for dental treatment is impeding a number of people from making use of the general dental service; and, so far as the existing charges in the Service are concerned, we would regard the reduction of the incidence of this charge as having the highest priority when additional resources become available. We do not recommend the abolition of the charge at the present time since, so long as there is a shortage of trained dentists in the service, it would be unwise to encourage a large-scale expansion of the general dental service which could only be made at the expense of the priority dental services. We do, however, strongly favour the proposal that if financial conditions permit, the dental treatment charge should be refunded to patients who have received comprehensive treatment, been made dentally fit, and have sought treatment within a specified period of time (say, once every 12 months). If this proposal were adopted, it would enable those people who are prepared to keep themselves dentally fit to contract as it were into a free service for dental treatment. It would overcome many of the objections to the existing charge and would at the same time make an effective contribution to preventive health. (paras. 578–582.)

(iii) *Charges for Spectacles.* It seems to us that the level of the charge for spectacles is such as to constitute a barrier to a proportion of the people who need to make use of the service; and we recommend that, when the resources become available, a fairly high priority (second only to an adjustment of the dental treatment charge) be given to a substantial reduction in the amount of the charge for spectacles.

We do not favour the suggestion that free spectacles should be provided for all old age pensioners as a class. It seems right to us that all users of the service should be required to pay the appropriate charges and that those in need should make out their case for help to the National Assistance Board. (paras. 583–587.)

(iv) *The Shilling Prescription Charge.* Although our evidence is not wholly conclusive on this matter, we have no reason to think that the shilling prescription charge hinders the proper use of the Service by at least the great majority of its potential users and we do not consider that its removal at the present time would improve the working of the Service to an extent commensurate with its cost, having regard to the other developments which we foresee or recommend in this Report. (paras. 588–590.)

THE LOCAL HEALTH AUTHORITY SERVICES

733. In Part V of our Report we review the local authority health services provided before and after the Appointed Day (paras. 592–603) and arrive at the following conclusions and recommendations:—

(1) Organisation

We conclude 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. 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.

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 that we cannot deal properly with our terms of reference 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. 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. (paras. 604–607.)

(2) Finance

We conclude that, in the best interests of local government, the arrangements for financing the local health services should remain unchanged, i.e. with the cost shared equally between the local rates and the Exchequer.

We are of the opinion, however, 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. 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. (paras. 608–614.)

(3) Preventive Health

After considering what is meant 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, we conclude 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 certain directions in which further improvements might be effected: in particular, by developing the home health services and integrating them more closely with the general practitioner, hospital and welfare services; secondly, by promoting enquiries designed to reveal the broad fields in which preventive medicine might be extended profitably in the future; and thirdly, by a development of the chiropody service under the National Health Service as and when conditions permit. (paras. 615–622.)

(4) Health Centres

We consider 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.

The formal health centre is not, however, 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 could 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 will be thought out by those responsible for the provision of the general practitioner and local authority services locally. At a later date it will be possible to review the working of the health centres and other local experiments, and to judge how far they have improved the integration of the services and the quality of general practice, and how far they have justified the expenditure on their provision. It is too early yet to arrive at any firm conclusions. (paras. 623–630.)

(5) Maternity and Child Welfare Services

Our evidence indicates 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. 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.

As there are medical issues involved in this matter which we are not competent to judge, we do not find ourselves in a position to make any clear cut pronouncement on this subject. We would suggest, however, that the following principles might be borne in mind by any Committee which may be appointed to review the maternity services:—

(*a*) 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.

(*b*) 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.

(*c*) 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.

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 (*a*) to (*c*) above. (paras. 631–639.)

(6) CARE OF THE AGED

We 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 service which has led some to conclude that there is a need for "half-way houses" 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.

We refer to the Chronic Sick Survey now being carried out by the Ministry of Health in certain areas, and welcome the interpretation of statutory responsibility adopted by the Ministry in relation to the hospital and local authority services. (paras. 643–644.) This interpretation seems to us to resolve many of the practical difficulties and doubts which have been referred to in our evidence. It makes clear beyond doubt that there are circumstances in which old people may properly be given nursing care in welfare homes; it guards against the reappearance of the old "infirmary wards" in local authority residential accommodation; and it provides a comprehensive service with no gaps between the hospital and local authority responsibilities.

When the Survey has been completed, it will be possible 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.

We suggest that the following pattern emerges for the future development of the domiciliary, hospital and local authority services for the aged. The first aim should be to make adequate provision wherever possible for the treatment and care of old people in their own homes. 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. The hospital authorities should aim to provide sufficient geriatric units where old people referred for treatment might be sorted into two main categories—first, those who will need prolonged hospital treatment and attention, and secondly, those who can be rehabilitated and returned either to their own homes or to residential accommodation provided by local welfare authorities. The role of the welfare authority is to provide residential accommodation (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, 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 above in favour of the introduction of an Exchequer grant towards the cost of financing this type of 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 can be made available to the health and welfare services. We add the proviso 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. (paras. 642–652.)

(7) THE AMBULANCE SERVICE

(i) *Transfer of Administrative Responsibility.* After reviewing the organisation of the ambulance services in England and Wales (paras. 653–655) we consider the suggestion that administrative responsibility for its provision should be transferred from the local health authorities to the hospital authorities; and we conclude 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 would be materially reduced if it were controlled by the hospital authorities themselves. (paras. 656–658.)

(ii) *Transfer of Financial Responsibility.* We consider the proposal that hospital authorities should pay to local health authorities the cost of ambulance transport provided for hospital patients; but we are not satisfied that any material savings would accrue from this proposal and we do not therefore recommend its adoption. (paras. 659–661.)

(iii) *Suggestions for Improved Efficiency.* We draw attention to a number of means by which local health authorities and hospital authorities may, through co-operation, achieve further economies in the ambulance service. In particular we recommend that all hospital authorities 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. We suggest also that all hospitals which have not already done so should review their arrangements to ensure that recurring out-patient visits are reviewed regularly to find out which patients, if any, are fit enough to use public transport. On the local authority side, we are strongly of opinion that all authorities who have not already done so should consider the advisability of introducing radio control in the ambulance services in their areas. These and other suggestions are made in paras. 663–667.

(iv) *Ambulance Charge.* We conclude that the introduction of a charge for ambulance journeys could not in any event be justified on financial and administrative grounds. (paras. 669–671.)

(v) *Patients' Travelling Expenses.* We do not recommend any change in the existing arrangements for the payment of patients' travelling expenses to and from hospital in cases of hardship. (para. 672.)

(vi) *Charge for Stand-by Service.* It seems right to us that local health authorities should be able to make a charge when ambulances are provided to stand-by at motor race meetings etc., and we recommend that the statutes be amended if necessary to make clear beyond any doubt that they have the power to do so. (para. 673.)

(vii) *Scottish Ambulance Service.* We review the organisation of the Scottish Ambulance Service in paras. 674–678.

WHITLEY COUNCIL MACHINERY

734. In Part VI of our Report we review the working of the Whitley Council machinery and the suggestions made to us in evidence for improving its efficiency; and we arrive at the following conclusions and recommendations:—

(1) *Rigidity of Whitley Council Scales of Remuneration*

We conclude that, in any national service, there must be some form of national machinery for agreeing centrally the salaries and gradings of the staff employed, and the Whitley system, although capable of improvement in detail, seems to be generally appropriate for this purpose. The loss of the local autonomy formerly enjoyed by hospital authorities in this field is an inescapable result of the introduction of a National Health Service.

The Whitley Council agreements themselves, however, need not be rigid and inflexible in their terms; provision could be made in the agreements for a certain measure of elasticity to meet variations where the need arises. We suggest that the Management Sides and the Staff Sides of the Whitley Councils might profitably explore the methods which have been used by other large-scale undertakings to introduce flexibility into national agreements, and should consider whether something more might be done in this way to increase the flexibility of Whitley Council agreements. (paras. 691–693.)

(2) *The Composition of the Management Sides*

In general terms, it seems to us that the employing authorities in the hospital service are under-represented on the Whitley Councils particularly in comparison with the Health Departments; and we recommend that the representation of Regional Hospital Boards and Hospital Management Committees be substantially increased. This will have the dual effect of bringing greater experience of hospital management to Whitley Council discussions and also of helping the Management Sides to carry the hospital managers along with them in implementing their decisions. (paras. 694–695.)

(3) *Consultation with Hospital Managements*

We recommend that the Health Departments should review the present arrangements for consultation with Regional Hospital Boards, and should invite Regional Hospital Boards to review their arrangements with Hospital Management Committees, in order to make certain that the Management Sides of the Whitley Councils are as fully aware as possible of the views of these authorities before decisions are reached on matters which will affect them. (para. 696.)

(4) *Delays*

As the burden of Whitley Council work decreases, as further experience is gained, and as the consultative machinery becomes more effective, we are hopeful that the Whitley system will be able to operate more smoothly and speedily in the future than it has done in the past. If further provision can be made in national agreements for local variations to meet local needs, a considerable amount of work may be saved and frustration avoided —and this in turn will help to make the Whitley machinery more efficient and more acceptable to the people operating the Service than it has been in the past.

We have heard some criticism of the practice whereby the Health Departments are required to consult the Treasury in advance about the financial commitments arising from proposed increases in salary scales. Whilst appreciating the reasons for the criticism, we do not consider that the Departments can divest themselves of this requirement since the National Health Service is financed out of moneys voted by Parliament. In the last resort, the decisions reached in Whitley Council procedure must be acceptable to the Government if they are to be approved by Ministers for general application throughout the Health Service. (paras. 697–698.)

GENERAL

735. In Part VII of our Report we deal with a few items of general interest and arrive at the following conclusions and recommendations:—

(1) *Proposed Research and Statistics Department*

We are of the opinion that the knowledge at present available about the working of the National Health Service is inadequate and should be considerably extended and improved, since it is only on the basis of such knowledge that the right decisions can be made for the future development of the Service. Accordingly we recommend the Health Departments to set up a Research and Statistics Department which would devote the whole of its time to statistical investigation and operational research in general, and would consider what information is now lacking as to the working of the National Health Service and how this information might best be produced. We see no reason to think that a large staff would be needed for this purpose since we have in mind that, once the Research Department had established that an enquiry into a particular aspect of the Service was desirable, such bodies as the Medical Research Council, the Nuffield Trust, the King Edward's Fund, the Social Survey, or the National Institute of Economic and Social Research would normally be invited to do the necessary research work—as in fact they have done on numerous occasions in the past. Public funds, in so far as they are needed, should be made available for this purpose.

The Research and Statistics Department would function as the Intelligence Branch of the Health Departments, working in the closest co-operation with the Departments' administrative and medical staff; and would be constantly engaged in the search for facts and information which would enable administrators to make right decisions for the future development of the Service. (paras. 699–703.)

(2) *Co-operation within the National Health Service*

We review the background history of co-operation within the National Health Service since the Appointed Day and agree with the statement made in the Report of the Central Health Services Council on Co-operation that "the need for co-ordination in the health service was emphasised but was not created by the National Health Service." We record our view that too little credit may have been given in the past to the degree of integration achieved through the introduction of the Health Service itself in 1948 and through the steps subsequently taken by the statutory authorities concerned to improve the co-ordination of the three branches of the Service.

It seems to us that if the National Health Service is to work properly, co-ordination is needed at three levels—first, centrally, so as to ensure that all three branches of the Service are associated together in carrying out a single national policy; secondly, at the level where the national policies are applied to local circumstances; and thirdly, at the personal level where individual workers in the Service must co-operate to help a particular patient.

The first of these requirements can be met through the central administration of the Ministry of Health and the Department of Health for Scotland. The second and third have been achieved by a variety of means and with varying success, in different parts of the country; but we have no doubt that there is still room for improvement in many areas. We agree, however, with those who have expressed the view that any marked improvement is unlikely to be achieved by the introduction of new co-ordinating machinery. In the areas where co-operation is still lacking, what is now needed more than anything else is a change of attitude among those concerned, and particularly, we feel, on the part of the hospitals.

We make two practical proposals for improving co-operation within the Health Service:—

(*a*) The Medical Officer of Health or a member of his staff should be given an honorary appointment on the medical staff committee of a hospital; and he should be able, as of right, to take charge of outbreaks of infection (e.g., food poisoning) arising in hospitals. From this closer contact between hospital medical staff and the Medical Officer of Health, we are hopeful that each may come to understand more fully the other's problems in the administration of the Health Service and both may come to work together towards the more efficient organisation of a unified National Health Service.

(*b*) Regional Hospital Boards should review their arrangements for consultation with the medical profession and should consider the appointment of medical consultative committees at the regional level containing representatives of the consultants, the University, the Medical Officers of Health and general practitioners in the Region. The appointment of such committees in Regions where machinery of this type is lacking at present, could do much to improve the integration of the hospital, general practitioner and local health authority services.

For the rest, we can only re-iterate that the Health Departments, the hospital authorities, Executive Councils and local health authorities should continue to give prominence to the need for co-operation in their constant endeavours to achieve an integrated National Health Service. (paras. 704–717.)

(3) *National Insurance and the Health Service*

We have been continually reminded in our evidence that a great many people still believe that they pay for the National Health Service through their National Insurance contributions; and that, having paid their contributions, are entitled to take the greatest possible advantage of any free facilities available under the National Health Service Acts. We wish to emphasise strongly that the National Health Service is not an insurance scheme, and that its benefits do not depend on the payment of insurance contributions by the users of the Service. (paras. 718–719.)

(4) *Our Final Comment*

Having concluded that in practice there is no objective and attainable standard of " adequacy " in the health field, and that no major change is needed in the general administrative structure of the National Health Service, we have sought to ascertain where, if anywhere, there is opportunity for effecting substantial savings in expenditure, or for attracting new sources of income, within the existing structure of the Service; but we have found no opportunity for making recommendations which would either produce new sources of income or reduce in a substantial degree the annual cost of the Service. In some instances—and particularly with regard to the level of hospital capital expenditure—we have found it necessary, in the interests of the future efficiency of the Service, to make recommendations which will tend to increase the future cost.

In considering the more distant future there are a large number of factors at work, some of which will lead to an increase in the cost of the Service, while others will operate in the opposite direction. It is quite impossible at the present time to forecast which of these tendencies will ultimately prevail; though it is obvious that, so far as financial cost is concerned, in the sense of the amount of money spent on the Service, a great deal will depend upon what happens to the value of money and therefore upon the future trend of prices and wages.

There are defects in the present organisation and administration of the National Health Service to which we have drawn attention throughout our Report; but these weaknesses apart, we have reached the conclusion that the Service's record of performance since the Appointed Day has been one of real achievement. The rising cost of the Service in real terms during the years 1948–54 was kept within narrow bounds; while many of the services provided were substantially expanded and improved during the period. Any charge that there has been widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence.

Looking to the future, it is clear that there are long-term problems of high importance confronting the National Health Service, not a few of which can only be solved by the medical profession itself; and which will call for all the qualities of statesmanship and adaptability that it can command.

We hope that the comments and suggestions we have made in our Report may be helpful in pointing the way for future developments, and also in weighing the merits of the many proposals put forward, both from within and outside the Service, for improving the efficiency and economy of the National Health Service. (paras. 720–726.)

We wish to express our deep appreciation of the services of our Secretary, Mr. E. Halliday, throughout our enquiry and especially in the preparation of our Report. His untiring and self-sacrificing devotion to his task, his skill in drafting and his experience of the working of the National Health Service have been of the greatest assistance to us.

We are indebted to Mr. R. P. Fraser of the Department of Health for Scotland, who has acted as our Scottish Secretary, for much valuable aid in general, and in particular with regard to those sections of our Report which are primarily concerned with Scotland.

Finally, we desire to express our gratitude to Mr. N. Illingworth, who has carried out the duties of Assistant Secretary with unfailing efficiency.

(Signed) C. W. GUILLEBAUD (*Chairman*).
J. W. COOK.
B. ANNE GODWIN.*
E. J. MAUDE.*
GEOFFREY VICKERS.

E. HALLIDAY (*Secretary*).

16th November, 1955.

* Signed subject to the Reservations on pp. 270—286.

RESERVATION ABOUT THE ROLE OF THE TEACHING HOSPITALS IN ENGLAND AND WALES; ABOUT NATIONAL HEALTH SERVICE CHARGES; AND ABOUT HOSPITAL PATIENTS' TRAVELLING EXPENSES

The Teaching Hospitals in England and Wales

1. I am of opinion that teaching hospitals in England and Wales should be integrated into the Regional structure.

2. It is argued that the continued segregation of the teaching hospitals is justified in view of their special position in relation to the Universities and their responsibility for maintaining the highest standard in relation to their teaching function. It is suggested that a Regional Hospital Board in its anxiety to meet day by day obligations towards the sick, might overlook these special responsibilities.

3. I have no reason to think that the responsible and informed individuals who serve on Regional Hospital Boards would be less aware than independent Boards of Governors of the supreme importance of maintaining the conditions under which a high standard of teaching and medical practice can be secured. I accept that to ensure such a standard, the teaching hospitals must have what at first sight appears to be more than their fair share of the resources available.

4. Whilst allowing for the maintenance of a high standard, I have the impression that the teaching hospitals, in their comparative isolation, have not been so acutely aware of the need for economies and the means of securing them as the non-teaching hospitals. This statement is based only in part on the figures in para. 181 (ii) of the Report, on the costs of teaching hospitals on an occupied bed basis. Their costs must always be higher than those in non-teaching groups but when this has been accepted and due allowance made, there is a strong presumption and a degree of evidence to indicate that expenditure in fields in no way related to the teaching function is on a higher level than elsewhere. Close association with the problems of Regional Hospital Boards would ensure a better appreciation of the financial facts of life.

5. The working economies that might be hoped for from this integration are however less important than the improvement in overall planning that could be expected. Under the present system the Regional Hospital Board makes plans for its Region on the basis of the anticipated requirements of its population. Within the Region, the teaching hospitals also proceed with development plans, based on other factors. We are informed that in the majority of cases consultation takes place between the two elements but there is no obligation to harmonise development plans and there have been unfortunate instances of a lack of consultation. The planning function of the Regional Hospital Board should cover the whole Region.

6. We are told that the prestige of the teaching hospitals is such that they have no difficulty in securing the staff they require. This seems to be particularly true in relation to nurses, where the assumption appears to be that training at a teaching hospital is of a higher character than elsewhere If this is a fact it leads to the conclusion that we are maintaining two standards within the National Health Service. It has been the aim of Regional Hospital Boards since the inception of the service to raise the standard of their hospitals by providing medical facilities not previously available. The pull of the teaching hospitals will always be great but I believe that pull is accentuated by their isolation and militates against the establishment or maintenance of high standards over the service as a whole.

7. We have been advised by some witnesses that the problems of integrating the London teaching hospitals would be very great. As far as the non-metropolitan Boards are concerned, only one teaching hospital operates in a Region. I suggest that integration might commence with the provincial teaching hospitals and that experience should be gained on the problems arising before any steps are taken in the Metropolitan Area.

National Health Service Charges

New Charges

8. I fully share my colleagues' conclusion that no convincing case has been made out for new charges.

Existing Charges

(*a*) Subject to the exception set out below, I am unable to agree that there is a case for retaining even on a temporary basis the charges (including charges for appliances other than dentures and spectacles) imposed since 1948.

(*b*) In view of the serious shortage of dentists I accept as a temporary measure the need for a continued charge on dentures, and the Report's proposals for dealing with charges for conservative treatment. I do so because the serious shortage of dentists makes it impossible at present to provide an adequate dental service for everyone, and without charges it would therefore be extremely difficult to preserve the priority services. In no circumstances should the charges be regarded as permanent. Every effort should be made to overcome the present shortage of dentists, which I regard as the only justification for their retention.

Revenue from Existing Charges

9. The Report rejects new charges strictly on merit, i.e., because they would not materially contribute to the efficiency and economy of the Service. Continuation of existing charges, on the other hand, is supported on the grounds of the additional revenue thus obtained, and reduced demand. This distinction appears to me wrong in principle, and to be based not so much on any inherent difference between existing and possible new charges, as unwillingness to forego additional revenue. In 1953–54, charges yielded approximately £19 million and their abolition would clearly call for increased Exchequer expenditure (see para. 572 of the Report). I am, however, strongly of the opinion that the money needed to provide an adequate Service should be made available without recourse to charges. Existing charges were imposed to meet budgetary requirements largely unconnected with the efficiency and economy of the Service. They should, in my view, be considered in a clear field, without regard to the revenue which they are at present yielding to the National Health Service.

Reduction of Demand

10. The aim of the Health Service is to provide the full range of medical treatment and appliances necessary on health grounds; any reduction of such provision brought about by existing charges does not in itself contribute to efficiency. This can only be the case if it is shown that existing charges have:—

(*a*) Reduced unreasonable demand;

(*b*) Enabled better use to be made of available resources, manpower or material, i.e., priorities.

Unreasonable Demand

11. While we have received no evidence that unreasonable demand is at all widespread, I fully recognise the need for preventing abuse of available resources. There is, however, little or no evidence that existing charges are effective for this purpose. On the other hand, the figures given in paras. 49 and 55 of our Report show that prior to the imposition of charges, the demand for certain services, e.g., dental and optical, was falling, and there was a prospect of a genuine reduction in demand.

Optical Charges

12. I find it difficult to believe that anyone embarks unnecessarily on the wearing of spectacles. They are not merely an aid to living but in a very large number of cases an aid to working. Total expenditure in this field is not high, and within that expenditure the possibility of abuse is, in my view, limited to replacements arising from changes in vision, an abuse which Executive Councils, through their Ophthalmic Services Committees, should be able to check.

Appliances

13. The need for an appliance is decided by the doctor and the possibility of abuse appears to me to be limited. On the other hand, the lack of an appliance, for example, a surgical boot or corset might well be crippling. The field of expenditure is small and the charge is unjustified either as a revenue raiser or a deterrent.

Prescription Charge

14. This charge appears to have reduced demand to a lesser extent than any other charge. While the number of prescriptions has declined (in part due, no doubt, to an increase in the number of items on each prescription form), the total cost of prescriptions has increased. The authors of "The Cost of the National Health Service in England and Wales", quoted in para. 22 of the Report, state that at a guess they would put the reduction in the gross cost of the pharmaceutical service attributable to the charge at £4 million. In 1954 the total cost of prescriptions in England and Wales was £45,969,621.

15. There is no statistical evidence as to what part, if any, of the reduction is due to a reduction in unreasonable demand, but it is fair to assume since the charge is non-selective, based on ability to pay and not medical need, that the reduction has been mainly at the expense of those least able to afford payment. Without conclusive evidence that it has had no adverse effect on the medical care of children, of old people, of the chronic sick, of those on low incomes generally, the charge must be regarded as a dangerous experiment, imposing a financial barrier between doctors and patients who need their services at a key point of the National Health Service.

16. I am strongly of the opinion that no case can be made out for the charge on the grounds that it prevents abuse. The right way to check abuse is to check over-prescribing, and this is the responsibility of the medical profession.

Priorities

17. Where overall demand cannot be met because of a shortage of man-power or materials, a system of priorities may be necessary in order to secure the proper allocation of the resources available. Charges which discriminate between users of the Service on the basis of ability to pay, not medical need, are clearly unsuitable for this purpose. The most effective method of ensuring a proper allocation based on medical need is to make the Health

Service itself responsible for determining the necessary priorities, and for their application by the branch of the Service concerned.

18. In conditions of exceptional shortage, however, such as exist at present in the dental service, the operation of such a system would be extremely difficult. For this reason I accept, as stated above, the need for dental charges as a temporary measure.

Travelling Expenses

19. At present the only provision made for payment of patients' travelling expenses incurred in obtaining hospital treatment is by way of application to the National Assistance Board, who apply the ordinary Assistance scale. While recognising the need for avoiding abuse, there is in my view a strong case for making special provision for payment of travelling expenses otherwise than through the Assistance Board in certain cases. The present arrangement can result in substantial hardship, particularly where patients have to make repeated journeys, or have to travel long distances. In the case of children who have to be accompanied by a parent or other adult, substantial expense may fall repeatedly on small incomes.

(Signed) B. ANNE GODWIN.

16*th November,* 1955.

RESERVATION ABOUT THE STRUCTURE OF THE NATIONAL HEALTH SERVICE

1. I have signed the foregoing Report in the belief that within the general framework laid down by the National Health Service Acts our recommendations, if adopted, would effect substantial improvements and that in present circumstances an attempt to recast the system more radically would be inadvisable. I have reached the latter conclusion with some hesitation, since, for reasons which I set out below, I attach more importance than do my colleagues to weaknesses which seem to me to be inherent in the administrative structure of the Service.

Hospital and Specialist Services

2. I agree that it would be premature to form any final judgment on these services, which have been in operation for little more than 7 years. Nor do I doubt that there is now a much more adequate provision for the sick in hospital and for specialist advice in the home than the country has ever before enjoyed. But I attribute this more to the efforts of those engaged in the service backed by a great deal of new and constructive thinking on questions of hospital management and by a lavish expenditure of money than to the merits of the system under which the services operate.

3. So far as I know the agency system on which these services are based is (with the possible exception of some war-time arrangements) unique in this country as a constitutional device for securing the provision of a public service. We are accustomed to services—the General Post Office, the Ministry of Labour and so forth—which a Minister responsible to Parliament operates —usually with the help of one or more advisory committees—through a body of officers responsible to him and subject to his orders. We are accustomed also to the local government services where Parliament has placed the responsibility for the actual administration in the hands of local authorities while giving a Minister supervisory functions within limits strictly defined by the governing Act. The hospital and specialist services appear to lie somewhere between these two systems. It is the duty of the Minister "to promote the establishment in England and Wales of a comprehensive health service . . ." but so far as the hospital and specialist services are concerned he is required to do so through three sets of agents—the Regional Hospital Boards, Hospital Management Committees and Boards of Governors of teaching hospitals. In law his power to issue directions to these agents gives him complete control; in practice he finds his powers limited to an undefined and indefinable extent by pledges given in Parliament when the proposed legislation was before it, by the general terms of the legislation as passed and by public opinion which would resent the idea of large bodies of men and women who are selected for their knowledge and experience of public life and administration and give unpaid service being required automatically to carry out Ministerial instructions. There is a wide difference between a service carried on by a Minister through agents of this type and one administered by paid officers whose duty it is to offer their Minister advice but when a decision has been taken to carry it out, whatever their private opinions may be, without public protest or comment—a difference which perhaps was not fully realised when the legislation was under discussion.

4. However that may be, the Minister has found himself subject to a constant crossfire, the statutory "agents" on the one hand alleging that he has not left them the freedom of action (which implies a freedom to make occasional mistakes) that Parliament intended and public opinion would endorse, and on the other the House of Commons through the Comptroller and Auditor General, and the Public Accounts and other Committees questioning what they regard as misconceived or extravagant courses of action taken by the Minister's agents—action for which the Minister must take full responsibility and whose financial consequences fall wholly on the Exchequer. Some of our witnesses sketched out as reasonable and desirable a more limited system of control which in fact bore a fairly close resemblance to that normally exercised by a Minister over a local government service—broadly the right to control capital expenditure, to inspect and examine the responsible authority's operations (if necessary, by way of public enquiry), to audit accounts, and in the last resort to default the authority if it fails to maintain a proper standard of service. The question whether a looser control of this kind is a practicable device in a service which looks wholly to the Exchequer for its finances is one which in my view still awaits an answer; and if the answer is in the negative, whether the present system is really compatible with the degree of diversity of action and freedom to experiment which a service of this kind should allow its local administrators.

5. The relation between the Regional Hospital Boards and the Hospital Management Committees gives rise to problems of a similar kind. In law the Boards have complete control over the actions of Management Committees by their power to give "directions" subject always to the overriding powers of the Minister. In practice, policy on this matter has varied. The conflicting opinions which we have heard from representatives of these two types of authority on this subject are summarised in our Report and we recommend that the Boards should exercise a general oversight and supervision over the hospital service in their Regions. A relation between two authorities based on a distinction of function of this kind appears to me to involve the risk of an overlap which may prove expensive (e.g. the employment by both of technical advisers to survey and report on the condition of buildings and equipment) and the converse danger of responsibility being dispersed between the two and not fully accepted by either. In a service such as the hospital service where the cost of buildings and equipment plays so large a part, there is much to be said for upkeep and maintenance being the undivided responsibility of the Authority owning the property.

6. A further weakness lies in the gulf between those responsible for the administration of the services—the Minister's "agents"—and the paymaster who has to find the money. Under the old system, whether in voluntary or municipal hospitals, the two responsibilities lay in the same hands. Those who spent the money had to find it from subscribers or rate payers, as the case might be. If it was not forthcoming, they had to do the best they could without it. As our Report indicates, the evidence we received does not bear out any charge of widespread extravagance. None the less there is a difference between finding money and making out a strong case for its being found. The point was put to us in the following terms in one of the memoranda submitted:—

> "What does seem eventually to emerge from any discussion of the administration of the Health Service is the gradual disappearance of incentive. It is well-known that the present budget system often does as much to encourage spending as the reverse. Every hospital authority must inevitably seek to spend all it can while it can. It has been said earlier that the present hospital boards and committees are largely made up of persons who served the hospitals before the Health Service. They grew up in a system where expenditure depended on the income

they could themselves obtain either from voluntary sources or fought for at close quarters in a local authority. This close concern with income as well as expenditure imposed the incentive to spend carefully, and encouraged a great awareness of costs. The present system does not to the same extent call forth that incentive and that awareness."

7. The system appears to me to make extravagant demands on the services of the diminishing number of men and women who are able and willing to do unpaid work for the State. Again in some respects it appears to combine the disadvantages of a centralised administration with those of local government. On the one hand the fact that the service is wholly based on the Exchequer and subject to the continuous scrutiny of the committees of the House of Commons necessitates an elaborate system of reports, returns, etc. (some of which our witnesses have regarded as extravagantly time-wasting) and on the other the system of statutory " agents " involves the expense of calling large numbers of persons together and of printing and circulating voluminous agenda papers, minutes, reports, etc., the preparation of which together with attendance at meetings occupies a large proportion of the time of the officers engaged in the service. It is also worth remarking that the service does not have the elasticity which military or civil departments derive from their power of moving their officers from one post or station to another as circumstances require.

The Tripartite Division of the Service

8. In my opinion a more serious weakness of the present structure lies in the fact that the National Health Service is in three parts, is operated by three sets of bodies having no organic connection with each other and is financed by three methods one of which differs radically from the other two. The evidence made it clear that this feature of the scheme is universally regarded as a handicap, but that there is a wide difference of opinion as to the practical importance of the matter. Some regard it as a major flaw in the scheme, others as no more than a piece of administrative untidiness. As our Report states, the great majority of authorities and organisations who submitted evidence to us considered that it would be in the best interest of the Service to leave the present administrative structure undisturbed.

The representatives of the medical profession were almost unanimously of this opinion, though the Society of Medical Officers of Health and its Scottish branch, not unnaturally, took a contrary view and the members of the Scottish Committee of the British Medical Association were divided on the point. None the less the impression which the evidence left on my mind was that this division of the Service is causing misgivings in medical as well as in lay circles. The issue is clearly put in the memorandum submitted to us by the Scottish Committee referred to.

> " It is chiefly ", they write, " in the local sphere that the organisation and administration of the Service have been criticised. In particular much criticism has been directed towards the tripartite nature of the system which has been adopted. In this connection it is interesting to recall the conclusion of the Cathcart Committee, following from their study of the problems of local administration of health services which was: ' It is essential, we think, to bring the general practitioner and other medical services under one administration ' (Report on Scottish Health Services, 1936). It is averred by many that this divided responsibility is a principal cause of the exaggeration of the already existing tendency to separation of medical practice into isolated branches —an undesirable trend which has been widely noted and deplored. We have given much consideration to this aspect of the review, but without being able to reach a unanimous conclusion. That there is need for a close co-ordination between the three main branches of medical practice —General, Specialist and Public Health—is agreed by all. It is as to the means by which this is to be achieved that differences of opinion arise."

9. It may be worth while to recall briefly the earlier history of this matter. At the end of the war the local authorities were burdened with heavy commitments in their educational and other services, and controls and restrictions of every kind complicated the transaction of even the simplest business. The hospitals of the country had in effect been nationalised during the war under the Emergency Medical Service, and the view was taken that a reversion to the pre-war position was impracticable. It was common knowledge that the voluntary hospital authorities and their medical staffs viewed with disfavour the idea of falling into the sphere of local government, which was in itself in a transitional condition, since a complete review of local government areas had been promised and was about to be undertaken. In these circumstances and granted the necessity for the immediate establishment of a full-blown health service, it may well be that there was no practicable alternative to the present system. None the less the policy ran counter to that of successive Governments of all parties over the past 60 or 70 years. When the present century opened the borough and district councils had powers to provide " places of reception for the sick ". This was generally interpreted as being limited to the treatment of infectious disease and it led to a network throughout England and Wales of infectious disease hospitals.[1] One or two of the large towns took a broader view of their functions and set up general hospitals. Responsibility for mental hospitals lay with the county and county borough councils. The only other public hospital provision was that of the poor law administered by Boards of Guardians in infirmaries usually attached to workhouses. Broadly speaking, the remaining hospital accommodation (which included much of the best and some of the worst) was in the hands of voluntary bodies operating under charitable trusts. In the course of the next 40 years Parliament laid on local authorities a wide variety of health functions, quite outside the range of the 19th century sanitary services—supervision of midwives (1902 and 1915) and provision of a midwifery service (1936); school medical service (1907); notification of births (1907–15); maternity and child welfare service (1914); care of mental defectives—institutional and domiciliary—(1913); care and after care of tuberculosis patients (1912–21); supervision of nurses (1918); treatment of venereal disease (1917) and of cancer (1938); transfer of poor law treatment (hospital and domiciliary) to county and county borough councils (1929) and general power for these councils to provide hospital accommodation.

In many instances the councils were permitted and encouraged to discharge their responsibilities by making use of the accommodation and services of voluntary bodies—hospitals, sanatoria, district nursing and the like—but the underlying principle that health services whether curative or preventive should be the responsibility of a single local administration was throughout maintained.

10. What was probably the most important of these measures, the transfer to local government of the poor law medical services by the Local Government Act, 1929, had been recommended in the Minority Report of the Royal Commission on the Poor Law in 1909. This recommendation was endorsed in 1918 by a committee under the chairmanship of Sir Donald Maclean[2]

[1] The county councils also had power at this date to provide infectious disease hospitals under the Isolation Hospitals Act but these Acts were seldom operated.

[2] 1918, Cd. 9817.

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and again in the same year by Lord Haldane's Machinery of Government Committee.(1) The terms of the recommendation in the 1909 Minority Report on this point were as follows:—

"That the medical service of the Public Health Authorities which now extensively treats disease and actually maintains out of the rates a steadily increasing number of the sick poor is based on principles more suited to a State Medical Service than that of the Poor Law. These principles which lead in practice as well as in theory to searching out disease, securing the earliest prompt diagnosis, taking hold of the incipient case, removing injurious conditions, applying specialised treatment, enforcing healthy surroundings and personal hygiene and aiming always at preventing recurrence or spreading of disease—in contrast to the mere relief of the individual—furnish in fact the only proper basis for the expenditure of public money on a Medical Service."

As an account of what was in fact happening in the public health service of the day this language may seem exaggerated; as a compendious statement of what a national health service should aim at it may still be thought relevant.

The one exception to the policy of placing new health services in the hands of local authorities—and an important one—is to be found in the National Health Insurance Scheme under the Act of 1911. That scheme was based on Friendly Society practice and (as described in paragraph 427 of our Report) the administration of general practitioner treatment (medical benefit) was entrusted to new bodies, the Insurance Committees, which represented in the main the Approved Societies whose funds, with Exchequer assistance, paid for the service and whose members were alone entitled to it.(2) The other "treatment" service which the Act provided (sanatorium benefit) was similarly administered, though the actual provision of sanatoria was left to the local authorities and voluntary effort.

11. It is difficult to avoid the conclusion that the twenty years delay in carrying out the recommendation of the Minority Reporters of 1909, a recommendation which received the assent of leading men in all parties, has profoundly affected the evolution of a National Health Service in this country.(3) If the county and county borough councils had had 30 years to study hospital administration and—more important—to get on terms with the influential members of the medical profession who guided the fortunes of the voluntary hospitals of the day, the outcome might, as Dr. Rowland Hill hinted in his evidence before the Select Committee,(4) have been different. As things turned out, the nine years which elapsed between the commencement of the Act of 1929 and the outbreak of war—a period beginning with a financial crisis and retrenchment in every field of public life and ending with the pressure of hurriedly improvised preparations for war—proved insufficient.

12. Another step which would have helped to integrate the health service by bringing general practitioners into closer touch with preventive and social medicine was narrowly missed in the inter-war period. Our Report refers (para. 132) to the Royal Commission on National Health Insurance whose report was published in 1926 and recommended, amongst much else, the

(1) 1918, Cd. 9230.

(2) A small number of insured persons who failed to become members of Approved Societies were also entitled to medical benefit as deposit contributors.

(3) An explanation of this delay is offered in "Fifty Years of Medicine" published by the British Medical Association, London, 1950, pp. 229–230.

(4) See para. 123 of our Report.

abolition of the Insurance Committees. The Commission, after pointing out that contrary to the original intention the arrangements for medical benefit were made centrally by discussion between the Departments and representative bodies of practitioners and chemists, continue "Thus what might have been a very responsible and difficult piece of work has in fact, so far as the Insurance Committees are concerned, been reduced to a routine capable of being performed by the local officials under a minimum of supervision by the Committees. The really responsible part of the duty is performed by the Central Departments." The Commission excepted from their description of "routine" the complaints procedure operated by the Medical and Pharmaceutical Service Committees. They regarded this as important work of a judicial kind (though at that time small in volume) but pointed out that similar investigating committees could equally well be set up by the local authority. The Commission reported (para. 395) that the British Medical Association (which had laid before them a plan for a unification of medical services) had agreed that their plan would involve the disappearance of Insurance Committees and had expressed the view that "the local administration of all health services should be in the hands of a local authority established *ad hoc*." The recommendations of the Royal Commission were approved by the then Minister of Health (Mr. Neville Chamberlain) who submitted to the Cabinet a programme of legislation for the 1927 session which included a Bill to give effect to them.(1) An overfull programme of legislation prevented further progress.

13. The mischiefs to which the division of the Service gives rise fall broadly under two heads (*a*) the administrative divorce of curative from preventive medicine and of general medical practice from hospital practice and the overlaps, gaps and confusion caused thereby and (*b*) the predominant position of the hospital service and consequent danger of general practice and preventive and social medicine falling into the background. In connection with the first of these it is to be remembered that while the hospital service is a new venture with less than 7 years of history behind it, this is not the case with the general practitioner service nor with the local health authority services. The former has in effect been in operation for 42 years since it does not substantially differ from the medical benefit provided under the Act of 1911, though it operates of course on a much wider scale.(2) Whilst some of the local health authority services date from the Appointed Day, a number—maternity and child welfare, care and after care of the tuberculous, home care of mental and mentally defective patients, etc.—had been in operation for some 10, 20 or 30 years before that date. Thus there is a comparatively lengthy experience of these two branches of the Service.

14. *Administrative divorce between curative and preventive medicine.* On this subject authoritative opinions have often been expressed. To cite a single example; the late Lord Dawson of Penn and his colleagues on the Minister of Health's Consultative Committee on Medical and Allied Subjects wrote in a Report published in 1920:—

"Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination. They must likewise be both brought within the sphere of the general practitioners whose duties should embrace the work of communal as well as individual medicine."

(1) See Keith Feiling's Life of Neville Chamberlain, pp. 459–462.

(2) The main differences between the two—such as the prohibition of sale of practices, the setting up of the Medical Practices Committee, the provision of superannuation, etc., do not materially affect the issues under consideration.

A more recent expression of opinion by a lay body may also be cited.(¹)

"Two obstacles to the improvement of general practice today lie in the insufficiency of personal contact between general practitioners and practitioners in other branches of practice and in the separation of both practice and administration in the three main branches of Medicine—namely General Practice, Hospital Practice and Public Health Practice.

"The necessity for separate bodies for the administration of the three Divisions of the Health Service is open to doubt. As a first step the fusion of Executive Council functions with those of the Regional Hospital Boards might well be useful means of achieving closer integration of the specialist and general practitioner services with a resulting improvement in efficiency and economy."

15. As regards the relations between general medical practitioners and hospitals on the one hand and the local health services on the other much factual information is to be found in the reports of Dr. Stephen Hadfield, Assistant Secretary of the British Medical Association, and of a Committee of the Association (the latter report being based partly on Dr. Hadfield's field survey of 200 general practices and partly on a postal survey conducted by the Committee itself) and also in a report made by Dr. Stephen Taylor on the outcome of a survey made by him under the auspices of the Nuffield Provincial Hospitals Trust.(²) At the end of his report under the heading "A General Impression" Dr. Hadfield writes:—

"My foremost impression is that of lack of unity in the N.H.S. and lack of unity in the medical profession. Both these are jeopardizing the status and effectiveness of general practice. I became aware, early on, that unless certain gaps are closed the patient will not derive the maximum benefit from the Service.

"The human gaps must be closed. The general practitioner, the consultant and the public health medical officer need to get to know each other and then to learn to work in concert. There is growing up a new generation of consultants, and a still newer one of those who will become consultants. These know little of the general practitioner and are unaware of his difficulties. Neither are they aware how easily these difficulties may be increased. Then the public health service and the general practitioner service seem to be treading different paths. Where the paths meet there is often doubt and misunderstanding.

"The other gaps are administrative. Maximum benefit for the patient cannot result from a trisected service. The feeling I derived from the survey was that bridging the gaps with liaison committees seemed less likely to be the cure than local co-operative effort. I cannot rid myself of the feeling that the gaps must be filled completely. The N.H.S. is crying out for a unified administration."

Under the heading "The General Practitioner and the Public Health Service" the B.M.A. Committee write:—

(Paragraph 165) "The Committee has little doubt that medical officers and others working in the public health service are on the

(¹) Memorandum submitted by the Chairmen of the Scottish Regional Hospital Boards.

(²) Dr. Hadfield's report is printed in the issue of the British Medical Journal of 26th September, 1953. The Committee's report is published in a supplement to the Journal of the same date. In a prefatory note to the latter it is stated that the report was ordered by the Council of the Association to be printed but is not a report of the Council and is not to be regarded as representing its views. Dr. Stephen Taylor's report was published as a Note in 1954 (Oxford University Press) under the title "Good General Practice". The relevant chapters in the book are XII and XIII.

whole perfectly ready to work in close liaison with the general practitioner in the interest of the patient. It seems tolerably certain that many general practitioners have hardly considered the possibilities, or, alternatively, look upon the public health service with suspicion.

(Paragraph 166) "The Committee believes that until there is at least a closer and more general administrative liaison between these two branches of the Service more difficulties and misunderstanding will persist."

It should in fairness be added that Dr. Taylor who cites some striking examples of co-operation and of the reverse states that "since the start of the National Health Service the gap between the General Practitioners and the local authority services has been getting less."

16. We have mentioned in our Report (para. 617) the importance now rightly attached to the idea of a "domiciliary team" under the clinical leadership of the general practitioner. These teams are no doubt operating successfully in some areas, but with the leader of the team in one organisation and the other members in another it is hardly surprising that over a comparatively long period progress has been slow.

17. A great deal of thought has been given to the question of the relation between general practitioners and the hospital service. We cite in para. 504 of our Report the three authoritative reports dealing with this subject and set out seven of the recommendations made in them with which in particular we wish to associate ourselves. The fact that the hospital authorities and the Executive Councils are two distinct and unrelated organisations seems to me to place real obstacles in the way of securing the object at which each one of these recommendations is aimed.

18. *The predominant position of the Hospital Service.* Nearly two-thirds of the money spent on the National Health Service is attributable to the cost of the hospital service. That hospital treatment must always be expensive is obvious enough, but the evidence suggested to my mind that in many quarters, medical as well as lay, there is anxiety on the questions, whether the hospital system is not bearing too much of the burden, whether (in the language used in the memorandum of the Royal College of Physicians) the general practitioner is not in danger of becoming a mere "disposal agent" and whether the locally administered health services are not dropping into a subsidiary role. The passage from the memorandum of the Royal College is as follows:—

"If the nation's needs were considered deliberately and as a whole it might be found that what is called the National Health Service could profitably devote more of its funds to public health—perhaps embracing occupational medicine which is now outside its scope. In the long run such expenditure might reduce the demand on curative services which have to deal expensively with many illnesses that could be prevented.

"The most costly form of medical care is that given in hospitals, and money would be saved if some of the cases now investigated and treated in hospital were investigated and treated by the general practitioner.

"In the technical revolution of medicine general practice has lagged behind. With the rise of specialism, the scope of the work undertaken by the average practitioner has steadily narrowed, and the public has come to believe that all but the most trivial ailments need the attention of a specialist. Since 1948, when consultations with the practitioner became free, the number of patients going to him has risen and he has

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often responded by sending more of them to hospital. Yet the introduction of various new and effective remedies has made it possible for him—given the time and the will—to treat more patients in their homes or in general practitioner hospitals of a simple kind. The Danckwerts Award should lead to an increase in the number of practitioners, to a reduction in the size of their lists and consequently to a better opportunity to practise as a doctor rather than a disposal agent. In many areas the practitioner already has direct access to pathological and radiological departments, which helps him to make his own diagnosis; but he also needs beds for the care of serious illnesses (with specialist advice where required) . . .

"Better general practice, closer contact between practitioner and specialist, and the greater use of the district nurse and the health visitors and home helps supplied by local authorities, would reduce total costs by preventing many patients from going to hospital and by allowing others to be discharged sooner to their homes."

19. The B.M.A. Committee's Report (para. 234) makes a similar point:—

"The general public", it states, "must share some of the responsibility for the failure to allow general practice to achieve its fullest scope. The growing emphasis in the public mind on hospitals and specialists at the expense of the general practitioner reached its climax at the introduction of the N.H.S., when, having been promised a complete and "free" medical service, a large proportion of patients demonstrated their opinion of general practitioners as suppliers, on demand, of prescriptions and certificates."

20. The system itself, as it seems to me, weights the scales against a reasonable economy in this matter. The patient and his relatives, freed from any anxiety about the cost of the treatment, welcome what they naturally regard as the superior treatment of the hospital doctors. Despite the reduction of sickness benefit after eight weeks in hospital which has been effected by recent legislation, in-patient treatment in hospital is likely to mean a substantial saving in the expenses of the household. The Executive Councils have no means even of knowing whether the general practitioner service is carrying its fair share of the burden of sickness. If beds are empty, it is hardly to be expected that the staff responsible for admissions will over-ride the opinion of the general practitioner and refuse the patient, unless the case is demonstrably unsuitable. Their concern is with curing or relieving the sick and, as we heard over and over again in the evidence, they are acutely conscious of the risk of claims and possible litigation if it can be plausibly argued that anything has been omitted or done amiss. It is to be noted that when a patient who could properly have been treated at home goes into hospital, the Exchequer pays twice over—once in the hospital expenditure and once in the general practitioner's capitation fee.

21. Anything approaching statistical evidence of the extent to which hospital in-patients who could be properly treated in their own homes by the general practitioners of their choice is for obvious reasons unobtainable. But such evidence as we have suggests that the additional burden thrown on the hospitals in this way is by no means negligible. A memorandum submitted to us by the Oxford Regional Hospital Board includes the following note contributed by their statistician:—

"The present load of hospital sickness is staggering. In the Oxford Regional Area (Oxford Regional Hospital Board and United Oxford Hospitals) with a population of 1,439,000 there were during the year 1952 114,068 hospital discharges and deaths and 186,394 new out-

patients, which one can express loosely on an average as 1 person in 13 of the population as an in-patient and 1 person in 8 as a new out-patient . . . This is the curative work that has been passed to the Hospital Service to do, but it is for consideration whether it all ought to be hospital work, whether some of it ought to be done by an extension of general practitioner work, and, above all, whether it cannot be reduced substantially in measurable time by preventive services . . . If one could add up all the public expenditure on genuinely preventive work and on research it would form a very small part of the National Health Service expenditure, yet it is in these fields that the best hope of reducing the hospital population lies."

Again the B.M.A. Committee write in their Report (para. 199):—

"There is little complaint [by general practitioners] of actual encroachment on general practice by hospitals. Indeed, as the investigator in the field survey [Dr. Hadfield] found, many general practitioners are only too glad to let the hospitals relieve them of some of their burden. Patients are rarely accepted in the out-patient departments without a letter from the general practitioner, but one-third of the practitioners complain that patients sent for consultations are retained for treatment unnecessarily. There was, however, a substantial amount of dissatisfaction that, after the initial treatment or after discharge from the wards, patients are required to return to the hospital at frequent intervals for inspection or aftercare which the practitioner could provide just as well in his surgery."

22. It would be unfair to give the impression that a principal cause of this additional burden on hospitals—whatever its extent may be—is to be found in general practitioners shirking their obligation to give their patients all proper and necessary treatment "not involving the application of such special skill or experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess". Many causes have been mentioned in the evidence—too long retention of patients in hospital, treatment in hospital of patients sent there for consultation only, exclusion of general practitioners from diagnostic facilities in hospitals, lack or inadequacy of these facilities, unnecessary visits of patients to hospital for dressings, inspection etc., delay in discharge caused by part-time consultants being available only on certain days of the week and so on.

Other and more fundamental causes lie in the "technical revolution of medicine" to which the Royal College refer in the passage quoted, in the gap between general practice and the local health services and in the failure of some local health authorities to make adequate provision for these services, a failure in part due to difficulty in securing staff. It can hardly be questioned that a more adequate provision of domiciliary nurses and home helps and closer co-operation with general practitioners would reduce the hospital burden.

23. The passage from the memorandum of the Royal College of Physicians is concerned rather with the narrowing scope of general practice and the danger of the status of general practice deteriorating than with the burden on hospitals. In the long run this may well be the more important issue of the two.

One other expression of opinion on this subject is to be found in the B.M.A. Committee's Report (para. 233):—

"Two obstacles to the improvement of general practice today lie in the insufficiency of personal contact between general practitioners and practitioners in other branches of practice and in the separation, in both

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practice and administration, of the three main branches of medicine—namely, general practice, hospital practice, and public health practice. From these two defects flow much of the general practitioner's difficulties. The tendencies to disunity are not new; they have been creeping on the profession for at least thirty years. They are due, historically, to the continuous broadening of the field of medicine, the consequent specialisation, and the different rates of development of the different sections of medical practice. The progress of general practice has been overshadowed by the rapidity of the growth of other branches, and the general practitioner has not shared in the limelight of his specialist colleagues or in the local publicity of the public health services."

This is essentially a matter for the profession itself and a layman cannot presume to offer a solution. A mere change of system by which hospitals and general practice were brought under the same administration would clearly not suffice by itself, but it might prove to be a useful, perhaps necessary, step in the process.

Difficulty of apportioning resources

24. One can hardly doubt that within any foreseeable future the hospital service will continue to need the lion's share of such funds as may be available for the Health Service as a whole. We point out in our Report(1) that there has been some overstatement of the case for bringing preventive medicine more "into line" with the curative in the financial sense. None the less it is important to secure a proper balance—in status, and in man-power and expenditure—between these services, and doubly important if the available resources in both spheres are strictly limited by other national needs and are likely to remain so. The fact that two of the divisions of the Service are financed wholly by the Exchequer and the third in part by local rates seems to me to make the task of apportionment much more difficult than it need be. It has been the universal experience that local government services flourish in proportion to the assistance they secure from the Exchequer. A service which is grant-aided to the extent of 50 per cent. is unlikely to hold its own against one based wholly on the Exchequer, and the more so if, as some witnesses have pointed out, the effect of more generous expenditure in the rate borne preventive services may be to save—not to the rates but to the Exchequer—money which would otherwise have been spent on the hospital service. The only real solution in my opinion is to have a single financial system covering the hospital and the local health services alike.

25. Apart from questions of finance there is the matter of status. The very success of the sanitary and preventive measures of the 19th century has fostered the idea that little remains to be done beyond routine administration. We heard echoes of this view even from representatives of some of the local health authorities. This misconception accompanied as it has been by the spectacular advances made in recent years in medicine and surgery has unquestionably had its effect on the public health services. It was not unreasonable to expect that a National Health Service might go far to check this tendency by bringing the hospitals with their immense weight of medical prestige and authority into union with the other services. In fact the reverse has happened; recruitment to the local health services has been checked and the loss to the health authorities of their hospitals and of a number of their most experienced officers has widened the gap between curative and preventive medicine.

(1) Para. 621.

Possibilities of re-organisation

26. I agree with my colleagues in thinking that "the only form of major re-organisation is one which would integrate the three branches of the National Health Service without depriving the local authorities of their existing domiciliary health functions"—in other words of transferring the hospitals and general medical services to these authorities. I deal first with the transfer of the work of Executive Councils. Our Report sets out the arguments for and against this course in paras. 132–140 and refers to the recommendation of the Royal Commission in 1926 that the functions of the Insurance Committees should be transferred "to committees of the appropriate local authority with possibly a co-opted element". The Executive Councils have of course a much larger number of people to deal with and in addition they administer the dental and supplementary ophthalmic services. To that extent their functions are wider than those of Insurance Committees in 1926, though not perhaps of the Insurance Committees as originally set up in 1912. But the type of work which falls on them is broadly the same and for the reasons that convinced the Royal Commission and the additional reason that since the health service is no longer confined to insured persons the original *raison d'être* of a special body representing them has disappeared I think that the unanimous judgment of the Royal Commission still holds good. I should add that the Commission emphasised the fact that the Insurance Committees and their officers did their work well. The same is true today. We heard no complaints whatever on this score.

27. When we discussed the point with witnesses, it became abundantly clear that the transfer of these functions to the local health authorities would no longer be welcomed by the medical profession as a whole. One of their principal objections appears to be a fear that the reports of the Medical Service Committee (which deals with complaints against general practitioners) might become the subject of controversy—possibly on political lines—in council meetings and subsequently in the press. Whether or not this would be likely to happen, the fear is an intelligible one, but it could be met by the suggestion referred to in paragraph 134 of our Report that subject to the existing right of either party to appeal to the Minister, the Service Committee and not the Executive Council (or local authority, if the functions were transferred) should make the decision.

28. I agree that for the reasons stated in our Report it would be unsatisfactory to transfer their functions either to the Regional Hospital Boards or to the Hospital Management Committees, although the integration of the general practitioners with the hospital service is no less desirable than with the local health services. Thus the only alternative would be a transfer to the local health authority. The general practitioners would remain as now, professional men working under a centrally agreed contract to provide specified services on specified terms. The effect of these terms, as laid down in the Minister's Regulations, is to give (in my opinion rightly) to the Local Medical Committees, heavier responsibilities in the matter of professional conduct than is given to the Executive Councils. In a service in which every qualified medical man has a legal right to participate, in which direct supervision is for obvious reasons impracticable and in which the patient can have little or no idea whether the treatment he receives is good, bad or indifferent, the quality of the service must depend on the professional competence and integrity of the doctors manning it and the discipline must be that of the profession itself. It was not suggested to our Committee (nor, so far as I am aware, has it ever been suggested) that

the members of the profession who sit on the various disciplinary committees and tribunals have failed to insist on the highest standards of professional work. The transfer of the work to the local health authorities would not affect the system but would have the effect (in my view a most important one) of bringing the general practitioners into closer touch with the local health services and with the medical auxiliaries whose co-operation can so materially lighten and add value to their work.

29. The crucial matter is of course the transfer to local health authorities of the hospital and specialist services. I have reached the conclusion that to attempt under present conditions such a radical re-organisation is inadvisable. The evidence did not satisfy me that in present circumstances these authorities are, or feel themselves, able to bear the administrative and financial burden which the transfer would involve. The Association of Municipal Corporations was the only one of the local government bodies which put forward specific proposals on this point. They suggested the ultimate transfer of all hospitals to the local health authorities and as a first step the restoration to these authorities of total responsibility for tuberculosis and maternity services and the care of the chronic sick. I much doubt whether this procedure would be satisfactory. It would create a gulf, even if it was only a temporary one, between State and Municipal hospitals and the prospect of the ultimate transfer of all the hospitals would at once have a devastating effect on the present hospital administration. The remainder of the bodies representing local government in England and Scotland while making a number of criticisms of the present system did not suggest any extensive re-organisation and, as stated in our Report, it appears that some local authorities are definitely opposed to accepting a transfer. It would to my mind be essential that the individual local health authorities should be competent, financially and administratively, to take over complete responsibility for the great bulk of the hospitals,[1] though this would not necessarily involve abandoning the regional planning of the hospital service. The Maclean Committee reporting in 1917 suggested in relation to England and Wales that towns with a population of 50,000 would make suitable units for taking over the poor law medical service. In view of the immensely increased complication and expense of medicine and surgery since that date the minimum size of the unit might well now be at least double that figure. The present wide disparity between the populations and resources of the different counties and county boroughs would rule out a scheme of this kind.[2] Whether at some future date it may be found expedient to revert to the earlier conception of a unified health service organised on local government lines, time alone can show. Our Report indicates some of the difficulties. They would be great but not, I think, insuperable if an adequate re-organisation of local government administration and finance, having amongst its principal objects, the transfer to local authorities of responsibility for the National Health Service as a whole were effected.

(Signed) E. J. MAUDE.

16*th November*, 1955.

(1) I exclude from this the teaching hospitals which should in my view continue to be treated as national institutions for the reasons stated in our Report and also the large specialised hospitals—sanatòria, mental hospitals and others of the kind that have been successfully carried on in the past by joint boards.

(2) 34 county boroughs, 13 counties and 15 Metropolitan boroughs in England and Wales have populations under 100,000.

APPENDIX 1

A list of associations, organizations, etc., who submitted memoranda for our consideration. Where entries are marked by an asterisk oral evidence was given by representatives of the association, organization, etc., concerned.

Associations:

*Association of British Pharmaceutical Industry.
Association of Chief Financial Officers.
Association of Clinical Pathologists.
*Association of County Councils in Scotland.
*Association of Counties of Cities in Scotland.
*Association of Hospital Management Committees.
Association of Hospital Management Committee Group Secretaries.
Association of Hospital and Welfare Administrators.
*Association of Municipal Corporations.
Association of Public Health Lay Administrators.
Association of Welsh Executive Councils.
Association of Wholesale Manufacturing Opticians.
British Association of the Hard of Hearing.
*British Dental Association.
British Hospitals Contributory Schemes Association.
*British Medical Association.
*British Medical Association [Scottish Committee].
*County Councils Association.
*Executive Councils Association [England].
*Executive Councils Association [Scotland].
General Practice Reform Association.
Hearing Aid Manufacturers Association.
London Association for Hospital Services.
National and Local Government Officers Association.
*Royal Medico-Psychological Association.
Royal Medico-Psychological Association [Scottish Branch].
*Teaching Hospitals Association.

Boards of Governors:

St. Peter's and St. Paul's and St. Philip's Hospitals.
The Hospitals for Diseases of the Chest.
United Bristol Hospitals.
United Liverpool Hospitals.

Boards of Management in Scotland:

*County and City of Perth General Hospitals.
Dumfries and Galloway Hospitals.
*Glasgow Royal Infirmary and Associated Hospitals.
Glasgow Victoria Hospitals.
*Royal Infirmary Edinburgh and Associated Hospitals.
Scottish Borders Hospitals.

Executive Councils:

Birmingham.
County and City of Nottingham.
Isle of Wight.

Hospital Management Committees:

Bradford " B ".
East Cumberland.
North Wirral.
West Cumberland.

Regional Hospital Boards [England and Wales]:

Birmingham.
*East Anglia.
Leeds.
*Liverpool.
Manchester.
*Newcastle.
North East Metropolitan.
*North West Metropolitan.
*Oxford.
*Sheffield.
South East Metropolitan.
South West Metropolitan.
South Western.
*Welsh.

Regional Hospital Boards [Scotland]:

*Chairmen of the five Regional Hospital Boards in Scotland.
Eastern.
Western.

Others:

Astley Ainslie Hospital.
Borough of Oldham: Public Health Department.
British Health Freedom Society.
Central Midwives Board.
*Central N.H.S. [Chemist Contractors] Committee.
Charing Cross Hospital Medical School.
Charing Cross, Middlesex, Royal Free, and St. Mary's Hospitals (Medical and Teaching Staff).
Ciba Laboratories Limited.
Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom.
Dental Technicians Joint Negotiating Committee.
*Department of Health for Scotland.
Fellowship for Freedom in Medicine.
Glaxo Laboratories Ltd.
*Guild of British Dispensing Opticians.
Guild of Public Pharmacists.
Imperial Chemical (Pharmaceuticals) Ltd.
Incorporated National Federation of Boot Trades Associations Ltd.
*Institute of Hospital Administrators.
Institute of Public Supplies Officers.
Institution of British Launderers.
Institution of Professional Civil Servants [Ministry of Works Branch].
*Joint Emergency Committee [Optical Profession].
King's College Hospital Medical Committee.
King Edward VII's Hospital Fund for London.
*London County Council.
Medical Practitioners Union.
Medical Superintendents' Society.
*Ministry of Health.
National Institute of Economic and Social Research.
National Institute of House Workers Ltd.
National League of Hospital Friends.
National Old People's Welfare Committee.
Nuffield Provincial Hospitals Trust.
Queen Charlotte's and Chelsea Hospitals (Medical and Teaching Staff).
Queen's Institute of District Nursing.
Registered Pharmacists' Union.
Royal College of Obstetricians and Gynaecologists.

Others—(continued):

*Royal College of Physicians.
*Royal College of Physicians of Edinburgh.
Royal National Throat, Nose and Ear Hospital (Medical and Teaching Staff).
St. Bartholomew's and the London Hospital Medical Council.
Scottish Old People's Welfare Committee.
*Scottish Trades Union Congress.
*Society of Medical Officers of Health.
*Society of Medical Officers of Health (Scottish Branch).
The Cassel Hospital.
The Hospital for Sick Children Medical Committee.
*Trades Union Congress.
*Treasury.
University of London.
Wellcome Foundation Ltd.
Wiltshire County Council.

In addition to the bodies mentioned above, many individuals, groups of individuals, firms, etc., too numerous to list here submitted memoranda of evidence for the Committee's consideration.

APPENDIX 2

THE COST OF THE NATIONAL HEALTH SERVICE IN SCOTLAND

Tables 55 to 65 of this Appendix show the cost of the Health Service in Scotland during the years 1948 to 1954, and an analysis of the cost between the various branches of the Service. The figures have been drawn up for us by the Department of Health for Scotland as far as possible on a basis comparable with that used by the authors of the memorandum which forms the basis of Part I of our Report (see paragraph 9). There are some disparities, however, the most important of which are set out below; and these should be borne in mind when drawing comparisons between the figures for England and Wales and Scotland:—

(i) *Pharmaceutical, Dental and Supplementary Ophthalmic Services*—It has not been possible to adjust the figures to make allowance in respect of earlier years for arrears of payments not brought to account until later years. The figures given in the tables represent the actual payments in the year of account.

(ii) *Capital Expenditure*—The definition of capital expenditure differs from that used in England and Wales, the main point of difference being the inclusion in capital expenditure in Scotland of all items of equipment costing individually over £20, including replacements. It has not been practicable to make allowance for this.

We are unable to include tables for Scotland showing the costs of the Service expressed in constant prices.

TABLE 55

The capital and current costs of the National Health Service to public funds

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Capital cost (real asset expenditure)	1·5	2·0	2·6	2·4	2·6	2·2	2·1
Current cost to public funds ...	26·6	36·0	45·1	47·8	49·6	49·8	51·8
Total	28·1	38·0	47·7	50·2	52·2	52·0	53·9

* Interpolated from the 270 days for which the National Health Service operated.

TABLE 56

The current cost of the National Health Service to public funds by Services

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Service:							
Central and miscellaneous ...	0·3	0·4	0·4	0·4	0·4	0·5	0·5
Hospital	14·6	19·7	24·4	26·1	28·8	31·0	32·7
Executive Council	9·7	13·2	17·8	18·2	17·1	14·7	15·0
Local authority	2·0	2·7	2·5	3·1	3·3	3·6	3·6
Total...	26·6	36·0	45·1	47·8	49·6	49·8	51·8

* Interpolated from the 270 days for which the National Health Service operated.

TABLE 57

The current cost of the hospital service including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the hospital service	14·88	20·12	24·81	26·50	29·23	31·44	33·22
Less charges:							
(*a*) From patients:							
Section 4 beds	0·08	0·11	0·13	0·13	0·14	0·19	0·20
Section 5 beds	0·21	0·28	0·23	0·23	0·23	0·24	0·24
Supply and repair of appliances, drugs and medicines	†	†	†	†	†	0·01	0·02
(*b*) From Road Traffic Acts ...	†	0·01	0·01	0·01	0·02	0·02	0·02
Total Charges	0·29	0·40	0·37	0·37	0·39	0·46	0·48
Net cost of the hospital service ...	14·59	19·72	24·44	26·13	28·84	30·98	32·74

* Interpolated from the 270 days for which the National Health Service operated.
† Under £5,000.

TABLE 58

The current cost to public funds of different types of hospital (extracted from Section 55 Accounts)

Scotland

£m. at actual prices

	1949–50	1950–1	1951–2	1952–3	1953–4
I. General and Miscellaneous	9·81	11·34	12·27	13·17	13·80
II. Maternity...	0·81	1·03	1·19	1·29	1·34
III. Tb., Convalescent and Infectious Diseases	3·24	3·46	3·90	4·17	4·14
IV. Mental and Mental Deficiency... ...	4·92	4·77	5·01	5·45	5·94
V. Major Teaching Hospitals included in Group I	—	—	4·45	4·74	4·98

TABLE 59

The current cost of the Executive Council services including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the Executive Council services	9·73	13·16	17·79	18·25	17·56	16·06	16·83
Less charges	—	—	—	—	0·40	1·37	1·85
Net cost of the Executive Council services	9·73	13·16	17·79	18·25	17·16	14·69	14·98

* Interpolated from the 270 days for which the National Health Service operated.

TABLE 60

The current cost to public funds of the Executive Council services

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Central administration	0·20	0·28	0·23	0·25	0·36	0·32	0·31
General medical services ...	4·23	5·72	5·80	6·34	6·34	6·49	6·53
Pharmaceutical service	1·49	2·01	3·80	4·07	5·47	5·30	4·96
Dental service	2·62	3·54	5·62	5·25	4·06	2·02	2·52
Ophthalmic service	1·19	1·61	2·33	2·34	0·93	0·55	0·65
Health centre	—	—	—	—	—	†	0·01
Total...	9·73	13·16	17·78	18·25	17·16	14·68	14·98

* Interpolated from the 270 days for which the National Health Service operated.
† Less than £5,000.

TABLE 61

The current cost of the pharmaceutical service including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the service ...	1·49	2·01	3·80	4·07	5·47	5·76	5·69
Less charges	—	—	—	—	—	0·46	0·73
Net cost of the service	1·49	2·01	3·80	4·07	5·47	5·30	4·96

* Interpolated from the 270 days for which the National Health Service operated.

Table 62

The current cost of the dental service including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the dental service...	2·62	3·54	5·62	5·25	4·21	2·56	3·18
Less charges	—	—	—	—	0·15	0·54	0·66
Net cost of the dental service ...	2·62	3·54	5·62	5·25	4·06	2·02	2·52

* Interpolated from the 270 days for which the National Health Service operated.

Table 63

The current cost of the supplementary ophthalmic service including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the ophthalmic services	1·19	1·61	2·33	2·34	1·17	0·92	1·09
Less charges	—	—	—	—	0·25	0·37	0·45
Net cost of the ophthalmic services	1·19	1·61	2·33	2·34	0·92	0·55	0·64

* Interpolated from the 270 days for which the National Health Service operated.

Table 64

The current cost of the local authority services including and excluding charges

Scotland

£m. at actual prices

	5th July, 1948–9	Annual Rate* 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
Gross cost of the local authority services	2·10	2·83	2·57	3·18	3·39	3·85	3·84
Less charges	0·07	0·09	0·11	0·12	0·13	0·19	0·20
Net cost of the local authority services	2·03	2·74	2·46	3·06	3·26	3·66	3·64

* Interpolated from the 270 days for which the National Health Service operated, in accordance with the general principle followed for the purpose of these tables. [It would be more correct, however, in view of the facts that the local authority year in Scotland ends on 15th May, and the above figures relate to local authority years, to gross the 1948–9 figures up to full-year equivalent on the basis that in the year the services operated for 315 days. The full-year 1948–9 figures would then be: Gross cost £2·43 million, charges £0·08 million. Net cost, £2·35 million.]

Table 65

A break-down of the total expenditure of hospital authorities on new fixed capital assets

(*Scotland—5th July*, 1948 *to* 31*st March*, 1954)

	£m.	*Per cent.*
Hospitals:		
(*a*) Schemes providing for additional patients—		
(i) Hospitals vested on the Appointed Day	2·29	22·37
(ii) New hospitals	0·17	1·67
(*b*) Other schemes—		
(i) Staff quarters and amenities	1·17	11·42
(ii) Other	5·97	58·42
Administrative Offices	0·25	2·49
New Vehicles	0·14	1·39
Other Expenditure	0·22	2·12
Expenditure under agreements with other authorities	0·01	0·12
Total	10·22	100·00

APPENDIX 3

TABLE I

The current cost of the National Health Service to public funds in actual prices

(*England and Wales* 1948–9 *to* 1953–4—£'000's *in actual prices*)*

No.	Item	5th July, 1948–9	Annual Rate, 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
	I. CENTRAL AND MISCELLANEOUS							
1	(*a*) Wages ...	1,100	1,487	1,600	1,890	1,890	1,960	2,200
2	(*b*) Other ...	729	985	930	1,007	1,228	1,316	1,351
3	TOTAL I ...	1,829	2,472	2,530	2,897	3,118	3,276	3,551
	II. HOSPITAL SERVICES							
	A. MAINTENANCE							
	(*a*) Salaries and Wages:							
4	Medical (including Specialists) ...	13,866	18,745	23,246	23,554	24,972	26,047	27,217
5	Nurses and Midwives ...	27,799	37,580	45,682	48,611	51,132	56,242	59,152
6	Others ...	33,078	44,717	52,082	58,105	65,746	72,225	75,752
	(*b*) Goods and Contracts:							
7	Provisions ...	13,958	18,869	21,882	23,559	27,128	30,940	32,863
8	Staff Uniforms and Clothing ...	759	1,026	1,193	1,499	1,762	1,718	1,705
9	Patients' Clothing ...	924	1,249	1,300	1,399	1,615	1,669	1,606
10	Drugs and Dressings ...	5,329	7,204	7,645	8,785	10,431	10,112	9,647
11	Medical and Surgical Appliances ...	4,275	5,779	6,355	6,713	6,804	7,888	8,435
12	Fuel, Light and Power ...	7,425	10,037	10,103	11,267	12,601	13,867	14,728
13	Laundry ...	1,224	1,655	1,807	2,228	2,612	2,943	3,252
14	Maintenance of Buildingss ...	5,049	6,825	6,618	8,152	7,834	8,961	10,682
15	Domestic Repairs ...	5,652	7,641	7,105	7,488	7,916	8,622	8,516
16	Rent, Rates and Water ...	2,388	3,228	3,626	3,758	3,985	4,211	4,637
17	Printing and Stationery ...	1,915	2,589	2,768	1,670	2,070	2,066	1,919
18	Ambulance and Transport ...	609	823	1,076	1,067	987	1,106	1,131
19	Canteens and Shops ...	812	1,098	1,489	1,631	1,993	2,129	2,225
20	Farms and Gardens ...	873	1,180	1,174	1,262	1,434	1,548	1,595
21	User Agreements ...	906	1,225	1,321	1,334	1,290	1,342	1,346
22	Miscellaneous ...	1,639	2,216	2,271	3,447	3,695	3,827	3,981
23	General Nursing Council ...	—	—	—	—	—	1,367	1,145
24	Total (A) ...	128,480	173,686	198,743	215,529	236,007	258,830	271,534
	(*c*) Receipts:							
25	Payments of Staff ...	− 5,381	− 7,274	− 8,208	−10,812	−11,724	−13,313	−13,567
26	Payments of Patients and Road Traffic Acts ...	− 2,087	− 2,821	− 2,597	− 2,559	− 2,618	− 3,014	− 3,186
27	Local Authorities ...	− 1,773	− 2,397	− 2,479	− 2,477	− 2,553	− 2,564	− 2,540
28	Canteens and Shops ...	− 981	− 1,326	− 1,814	− 2,050	− 2,340	− 2,522	− 2,630
29	Farms and Gardens ...	− 1,596	− 2,158	− 2,478	− 2,624	− 2,848	− 3,146	− 3,320
30	Other ...	− 1,244	− 1,682	− 1,697	− 1,834	− 2,047	− 2,102	− 2,216
31	Total Receipts ...	−13,062	−17,658	−19,273	−22,356	−24,130	−26,661	−27,459
	Net Total (A) ...	115,418	156,028	179,470	193,173	211,877	232,169	244,075
	B. OTHER							
32	Non-Exchequer Funds ...	679	918	1,323	1,562	2,222	2,436	2,942
33	Administration: (*a*) wages ...	1,716	2,320	3,921	4,472	5,251	5,629	5,850
34	(*b*) goods ...	1,220	1,649	1,094	1,100	1,220	1,210	1,207
35	Hospitals not vested ...	832	1,125	1,445	1,648	1,848	2,059	2,115
36	Blood transfusion: (*a*) wages ...	231	312	407	442	506	549	615
37	(*b*) goods ...	134	181	226	268	302	365	359
38	Appliances and Invalid Tricycles ...	795	1,075	2,399	3,138	3,265	3,061	3,103
39	Bacteriological ...	563	761	665	844	937	912	944
40	Miscellaneous: (*a*) wages ...	100	135	170	212	256	263	331
41	(*b*) goods ...	1,323	1,788	1,301	1,084	1,259	1,628	1,685
42	Total (B) ...	7,593	10,264	12,951	14,770	17,066	18,112	19,151
43	TOTAL II ...	123,011	166,292	192,421	207,943	228,943	250,281	263,226
	III. EXECUTIVE COUNCIL SERVICES							
	(a) *Central*							
44	Wages ...	1,142	1,544	1,455	1,546	2,053	1,922	1,902
45	Other ...	419	566	406	398	472	417	409
46	Total (a) ...	1,561	2,110	1,861	1,944	2,525	2,339	2,311
47	(b) *General Medical Services* ...	32,715	44,226	45,683	49,934	50,496	51,985	51,865
48	(c) *Pharmaceutical* ...	20,468	27,670	33,225	38,488	44,110	42,477	39,545
	(d) *Dental:*							
49	Dental Resources ...	28,611	38,678	46,013	37,310	29,403	20,640	21,753
50	Dental Estimates Board: Wages ...	178	241	285	325	408	434	439
51	Other ...	32	43	69	74	70	67	62
52	Total (d) ...	28,821	38,962	46,367	37,709	29,881	21,141	22,254

* The figures in Tables I and II of this Appendix are reproduced from Appendix B of *The Cost of the National Health Service in England and Wales* by B. Abel-Smith and R. M. Titmuss (Cambridge, 1956) and should be read in conjunction with the published work.

Table I (continued)

No.	Item	5th July, 1948–9	Annual Rate, 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
	(e) *Ophthalmic:*							
53	Sight Testing ...	4,600	6,218	4,600	3,900	2,800	2,900	3,199
54	Supply of Spectacles ...	10,500	14,194	15,500	14,500	5,103	3,365	3,937
55	Total (e) ...	15,100	20,412	20,100	18,400	7,903	6,265	7,136
56	Total III ...	98,664	133,379	147,236	146,475	134,916	124,207	123,110
	IV. LOCAL AUTHORITY SERVICES							
57	Care of Mothers and Children ...	4,972	6,721	7,455	7,648	7,654	9,188	8,091
58	Midwifery ...	3,119	4,216	4,323	4,768	4,497	4,680	4,758
59	Health Visiting ...	1,432	1,936	2,022	2,525	2,562	2,781	3,003
60	Home Nursing ...	2,353	3,182	3,401	4,173	4,424	4,757	5,251
61	Vaccination and Immunisation ...	213	287	325	469	456	473	583
62	Ambulance Services ...	4,114	5,562	7,003	7,877	8,811	9,592	10,001
63	Prevention of Illness ...	625	845	1,081	1,323	1,584	1,721	1,891
64	Domestic Help ...	1,129	1,526	2,436	2,960	3,484	4,061	4,721
65	Mental Health ...	916	1,238	1,292	1,312	1,556	1,731	1,940
66	Other ...	83	112	70	162	101	188	179
67	Total IV ...	18,955	25,624	29,408	33,218	35,129	39,172	40,417
68	*Total Current Real Resources* ...	242,459	327,767	371,595	390,533	402,106	416,936	430,304

Table II

The Current cost of the National Health Service to public funds revalued in 1948–9 prices

(*England and Wales* 1948–9 *to* 1953–4)

(£'000's in constant prices)

No.	Item	5th July, 1948–9	Annual Rate 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
	I. CENTRAL AND MISCELLANEOUS							
1	(*a*) Wages ...	1,100	1,487	1,524	1,766	1,588	1,543	1,654
2	(*b*) Other ...	729	985	921	932	959	1,012	1,031
3	Total I ...	1,829	2,472	2,445	2,698	2,547	2,555	2,685
	II. HOSPITAL SERVICES							
	A. Maintenance							
	(*a*) Salaries and Wages:							
4	Medical (incl. Specialists) ...	13,866	18,745	23,246	23,554	24,972	26,047	27,217
5	Nurses and Midwives ...	27,799	37,580	39,381	41,906	44,079	43,939	45,154
6	Others ...	33,078	44,717	51,061	55,870	57,672	59,690	60,602
	(*b*) Goods and Contracts:							
7	Provisions ...	13,958	18,869	20,261	20,666	20,708	20,490	21,066
8	Staff Uniforms and Clothing ...	759	1,026	1,147	1,401	1,433	1,534	1,522
9	Patients' Clothing ...	924	1,249	1,250	1,307	1,222	1,439	1,350
10	Drugs and Dressings ...	5,329	7,204	7,964	9,151	9,570	9,914	10,486
11	Medical and Surgical Appliances ...	4,275	5,779	6,170	5,787	5,078	6,260	6,802
12	Fuel, Light and Power ...	7,425	10,037	9,809	10,629	11,151	11,366	11,074
13	Laundry ...	1,224	1,655	1,807	2,184	2,419	2,604	2,779
14	Maintenance of Buildings ...	5,049	6,825	6,552	7,619	6,120	6,738	8,154
15	Domestic Repairs ...	5,652	7,641	6,966	6,933	6,597	6,953	7,097
16	Rent, Rates and Water ...	2,388	3,228	3,590	3,684	3,832	3,863	4,068
17	Printing and Stationery ...	1,915	2,589	2,824	1,505	1,327	1,415	1,288
18	Ambulance and Transport ...	609	823	1,055	970	823	857	884
19	Canteens and Shops ...	812	1,098	1,474	1,568	1,779	1,774	1,766
20	Farms and Gardens ...	873	1,180	1,129	1,169	1,205	1,259	1,297
21	User Agreements ...	906	1,225	1,258	1,247	1,112	1,091	1,077
22	Miscellaneous ...	1,639	2,216	2,227	3,250	3,158	3,037	3,086
23	General Nursing Council ...	—	—	—	—	—	1,130	909
24	Total (A) ...	128,480	173,686	189,171	200,400	204,257	211,400	217,678

TABLE II (continued)

No.	Item	5th July, 1948–9	Annual Rate 1948–9	1949–50	1950–1	1951–2	1952–3	1953–4
	(c) Receipts:							
25	Payments of Staff	– 5,381	– 7,274	– 7,892	– 9,919	– 9,610	– 9,935	– 9,831
26	Payments of Patients and Road Traffic Acts	– 2,087	– 2,821	– 2,473	– 2,392	– 2,257	– 2,450	– 2,549
27	Local Authorities	– 1,773	– 2,397	– 2,361	– 2,315	– 2,201	– 2,085	– 2,032
28	Canteens and Shops	– 981	– 1,326	– 1,778	– 1,971	– 2,071	– 2,084	– 2,071
29	Farms and Gardens	– 1,596	– 2,158	– 2,406	– 2,499	– 2,455	– 2,558	– 2,699
30	Other	– 1,244	– 1,682	– 1,667	– 1,753	– 1,807	– 1,640	– 1,705
31	Net Total (A)	115,418	156,028	170,594	179,551	183,856	190,648	196,791
	B. OTHER							
32	Non-Exchequer Funds	679	918	1,272	1,420	1,807	1,860	2,263
33	Administration: (a) wages	1,716	2,320	3,844	4,300	4,340	4,398	4,333
34	(b) goods	1,220	1,649	1,083	1,019	953	931	921
35	Hospitals not vested	832	1,125	1,376	1,540	1,593	1,674	1,692
36	Blood transfusion: (a) wages	231	312	399	429	444	458	496
37	(b) goods	134	181	219	246	252	279	270
38	Appliances and Invalid Tricycles	795	1,075	2,726	3,781	3,934	4,081	3,978
39	Bacteriological	563	761	652	796	801	724	761
40	Miscellaneous: (a) wages	100	135	167	206	225	219	267
41	(b) goods	1,323	1,788	1,263	1,023	1,076	1,292	1,306
42	Total (B)	7,593	10,264	13,001	14,760	15,425	15,916	16,287
43	TOTAL II	123,011	166,292	183,595	194,311	199,281	206,564	213,078
	III. EXECUTIVE COUNCIL SERVICES							
	(a) *Central*							
44	Wages	1,142	1,544	1,426	1,487	1,697	1,502	1,409
45	Other	419	566	402	369	369	321	312
46	Total (a)	1,561	2,110	1,828	1,856	2,066	1,823	1,721
47	(b) *General Medical Services*	32,715	44,226	46,615	46,667	46,756	47,259	47,150
48	(c) *Pharmaceutical*	20,468	27,670	35,346	44,239	45,010	46,171	47,077
	(d) *Dental:*							
49	Resources	28,611	38,678	49,476	46,062	38,186	26,805	28,251
50	Dental Estimates Board: Wages	178	241	279	313	337	339	325
51	Other	32	43	68	69	55	52	47
52	Total (d)	28,821	38,962	49,823	46,444	38,578	27,196	28,623
	(e) *Ophthalmic:*							
53	Sight Testing	4,600	6,218	5,227	4,432	3,333	3,452	3,808
54	Supply of Spectacles	10,500	14,194	16,848	16,860	6,075	3,868	4,525
55	Total (e)	15,100	20,412	22,075	21,292	9,408	7,320	8,333
56	TOTAL III	98,664	133,379	155,687	160,498	141,818	129,769	132,904
	IV. LOCAL AUTHORITY SERVICES							
57	Care of Mothers and Children	4,972	6,721	7,100	7,148	6,542	7,410	6,421
58	Midwifery	3,119	4,216	4,040	4,295	3,844	3,714	3,717
59	Health Visiting	1,432	1,936	1,872	2,295	2,247	2,261	2,383
60	Home Nursing	2,353	3,182	3,149	3,726	3,749	3,746	4,071
61	Vaccination and Immunisation	213	287	301	419	386	372	452
62	Ambulance Services	4,114	5,562	6,934	7,502	7,797	7,927	8,131
63	Prevention of Illness	625	845	1,001	1,181	1,342	1,355	1,466
64	Domestic Help	1,129	1,526	2,388	2,846	3,056	3,356	3,777
65	Mental Health	916	1,238	1,196	1,193	1,365	1,407	1,540
66	Other	83	112	65	147	83	150	140
67	TOTAL IV	18,955	25,624	28,046	30,752	30,411	31,698	32,098
68	*Total Current Real Resources*	242,459	327,767	369,773	388,259	374,057	370,586	380,765

APPENDIX 4

CHARGES MADE FOR HOSPITAL SERVICES

Under the National Health Service, charges may be made for the following services and appliances, etc., provided in hospitals:—

	*Amount of income yielded in 1953–54 England and Wales £
(*a*) Supply or repair of unduly expensive appliances (the charge being the difference between the actual cost and the cost of the standard type)	7,369
(*b*) The replacement or repair of appliances necessitated by patients' carelessness (the charge being the whole or part of the cost) ...	2,699
(*c*) Dentures supplied to out-patients. Charges are the same as those for the general dental service (see para. 519 of the Report). Hospital in-patients are exempt, and the Minister also has power to relieve dental teaching hospitals from the obligation to charge out-patients for dentures required in connection with the teaching of dental students. There are no other exemptions but patients may apply to the National Assistance Board for financial help in cases of hardship.	
(*d*) Glasses supplied to out-patients. The charges are the same as for the supplementary ophthalmic service (see para. 552 of the Report). Hospital in-patients and children supplied with standard children's glasses are exempt. Patients may apply to the National Assistance Board for financial help. (Total of (*c*) and (*d*))	109,164
(*e*) Drugs given to out-patients. The charge is 1s. for drugs supplied on any one occasion. In-patients and persons to whom the drugs are supplied for venereal disease are exempt, as also persons who produce a National Assistance Order Book. Others may apply to the National Assistance Board for financial help	175,049
(*f*) The supply, repair or replacement of the following appliances to out-patients ordered or prescribed on or after 1st June, 1952:—	

	Charge for supply	*Repair*
Surgical boots or shoes, per pair	£3 0s. 0d.	1s. 6d. to 13s. 6d.
Surgicai abdominal supports, each	£1 0s. 0d.	
Elastic hosiery, per item from	5s. 0d. to 10s. 0d.	
Wigs	£2 10s. 0d.	

	£
In-patients, children under 16 or in full time attendance at school, or pensioners requiring the appliance in consequence of war disability, and persons who produce National Assistance Order Books are exempt. Others may apply to the National Assistance Board for financial help	131,190
(*g*) Amenity beds occupied at their own wish by patients not requiring privacy on medical grounds. The charges are at the rate of 4 guineas per week for a single room and 2 guineas per week for a bed in a small ward. The charges are reduced where the average cost per in-patient at the hospital is below 8 guineas per week ...	344,717

	*Amount of income yielded in 1953–54 England and Wales £
(*h*) Pay bed accommodation. The charges are designed to cover the full cost of the accommodation provided and therefore vary from one hospital to another	2,172,633
(*i*) Private out-patient treatment. The charges are fixed by regulations made for the use of certain types of hospital apparatus or services...	41,114
(*j*) Recoveries under the Road Traffic Acts from car users and insurance companies of payments which they are required to make where hospital treatment following a road accident is required	227,025
(*k*) Miscellaneous items, e.g., contributions towards maintenance made by hospital in-patients allowed to be absent during the day and obtain outside employment; also rents receivable, etc.	397,896†
TOTAL	£3,608,856

* Taken from Table 5 of the summarised Hospital Accounts. The figures quoted are on a revenue, not a cash, basis.

† This item is omitted from Table 9 in Part I of our Report. The figure for "total charges" in Table 9 is therefore shown as £3·2 million instead of £3·6 million as above.

APPENDIX 5

HOSPITAL STATISTICS

I. ENGLAND AND WALES

	Year ended 31st December					
	1949	1950	1951	1952	1953	1954
Total *available* beds(1)	448,057	453,466	461,892	468,255	473,559	476,944
Average number of daily occupied beds	397,570	402,601	406,844	416,123	424,126	427,675
Percentage occupancy(2)	88·7	88·8	88·1	88·9	89·6	89·6
Bed turnover(3) ...	6·5	6·8	7·1	7·3	7·5	7·6
In-patients treated ...	2,936,980	3,085,491	3,259,214	3,414,373	3,543,544	3,631,122
Out-patient attendances(4)	*	35,893,001	36,732,583	38,522,954	38,941,538	39,119,903
New out-patients(5)	6,147,825	6,193,156	6,298,746	6,605,765	6,730,791	6,767,612
Consultants whole-time and part-time(6)	5,189	5,649	5,882	6,250	6,406	6,510

(1) Bed complement less beds unavailable through lack of staff, etc.
(2) Percentage of average number of daily occupied beds to beds available at 31st December each year.
(3) Patients treated per bed available at 31st December.
(4) Attendances at consultant clinics, general practitioners' clinics and casualty departments. These figures exclude attendances for physiotherapy treatments, occupational therapy treatments, radiological or pathological examinations.
(5) Out-patients attending consultant clinics.
(6) Numbers employed including Board of Control and Public Health laboratory staff.
* Comparable figures not available.

APPENDIX 5

HOSPITAL STATISTICS

II. SCOTLAND

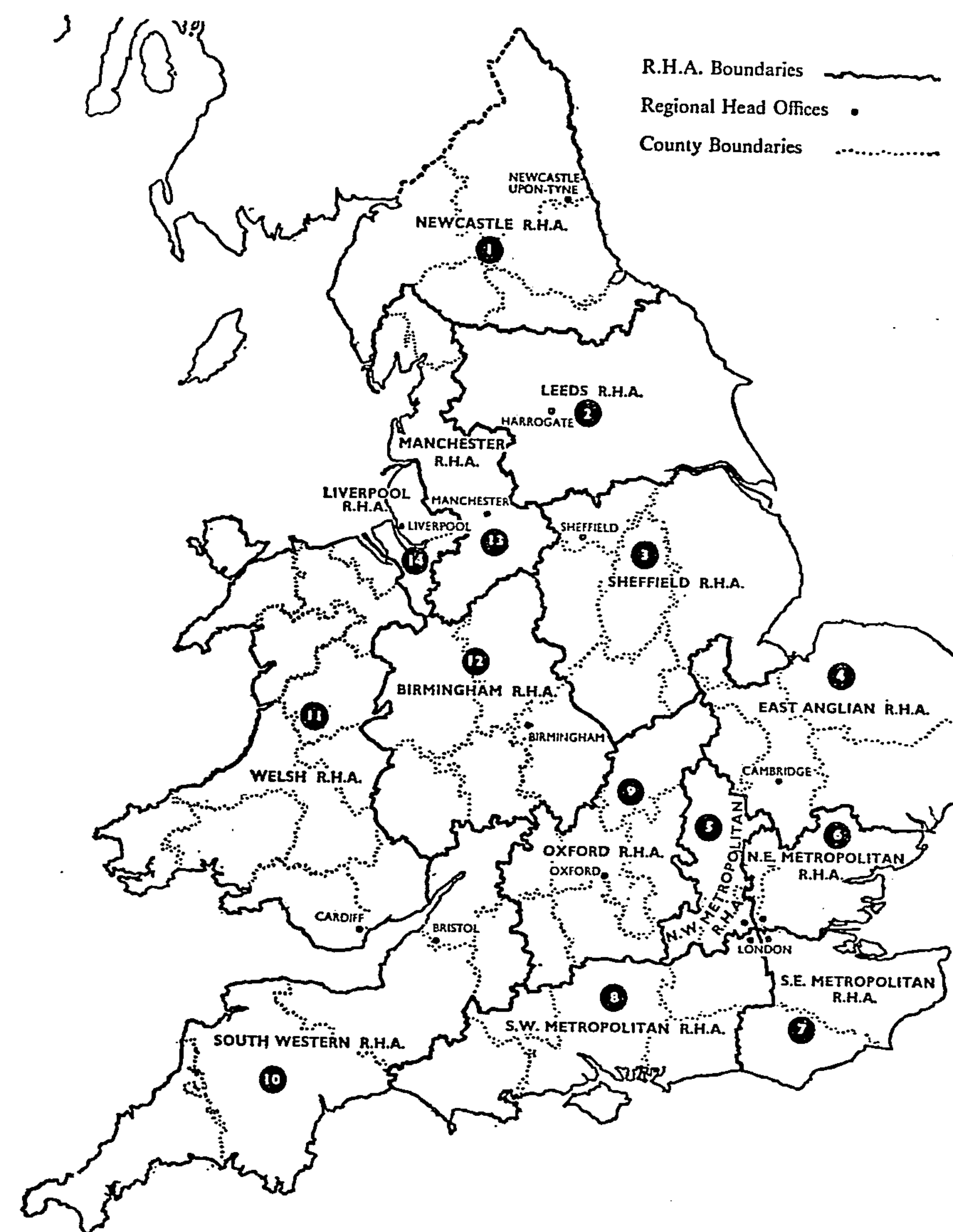
	Year ended 31st March					
	1949–50	1950–1	1951–2	1952–3	1953–4	1954–5
Total *available* beds	58,785	59,032	60,344	61,436	61,526	62,297
Average number of daily occupied beds	50,127	51,237	52,355	54,013	54,519	55,119
Percentage occupancy of hospital beds	85·3	86·8	86·8	87·9	88·6	88·5
Bed turnover ...	6·2	7·1	7·4	7·5	7·7	7·9
Number of in-patients treated ...	362,258	418,923	446,903	461,383	475,811	490,664
Number of out-patient attendances*	5,088,399	5,763,909	6,125,266	6,319,950	6,800,307	6,996,203
Number of new out-patients*	1,597,596	1,690,883	1,777,790	1,810,430	1,893,881	2,054,892

	Year ended 31st December					
	1949	1950	1951	1952	1953	1954
Number of consultants whole-time and part-time ...	653	708	731	751	810	835

* Attendance of a patient on any one day counts as one attendance irrespective of clinical departments attended, but attendances at ancillary departments such as physiotherapy, radiotherapy, radiological or pathological departments are counted separately. On the first attendance for a course of treatment in respect of any one illness a patient is recorded as a new out-patient. The figures given in the table include attendances at ancillary departments and are therefore not comparable with those for England and Wales.

APPENDIX 6

REGIONAL HOSPITAL AREAS in England and Wales



APPENDIX 6A

REGIONAL HOSPITAL AREA STATISTICS
POPULATION (ESTIMATED), HOSPITAL MANAGEMENT COMMITTEES, HOSPITALS, CLINICS AND BED COMPLEMENTS*

ENGLAND AND WALES

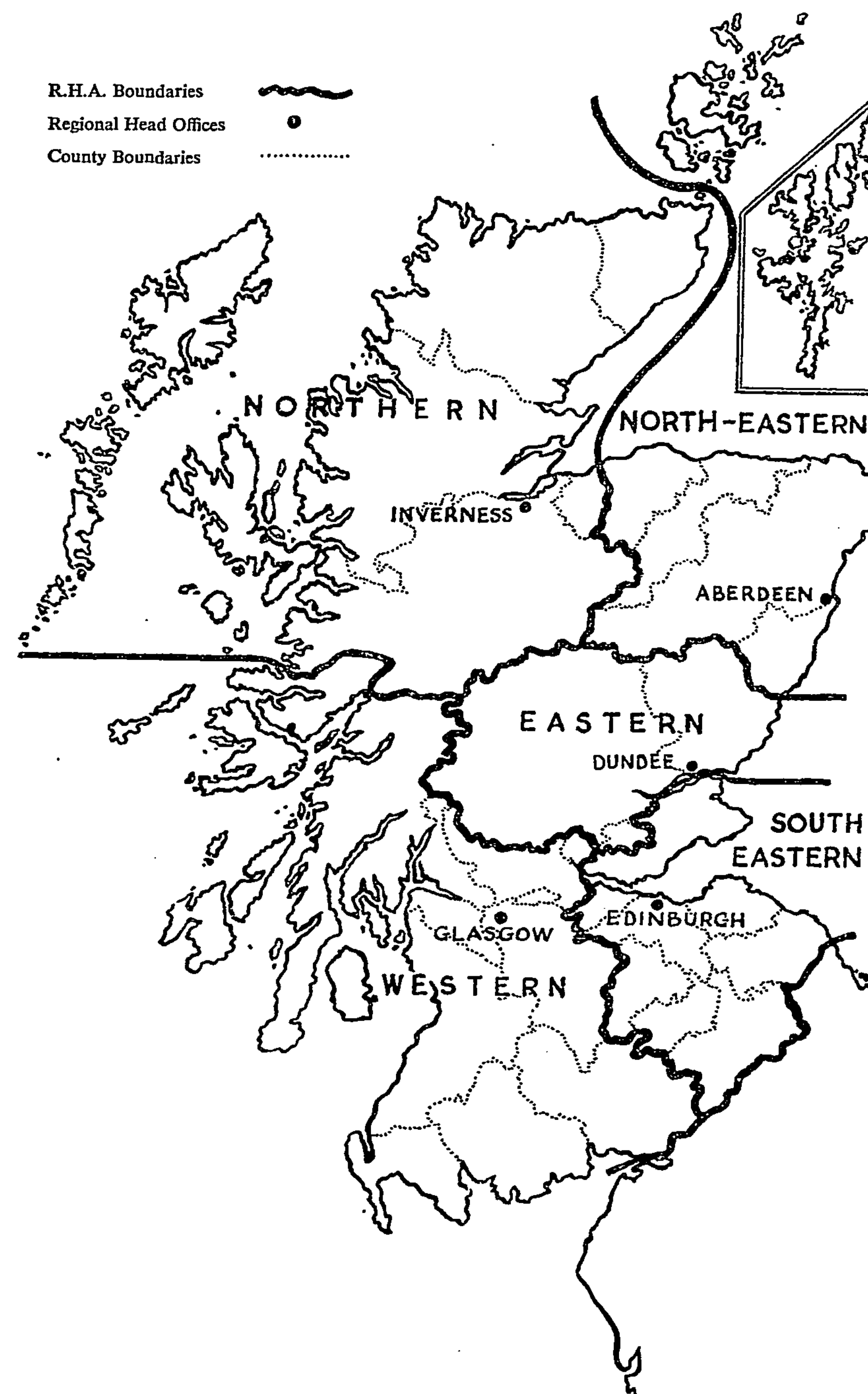
31*st December*, 1953

Regional Hospital Area	Population (mid-1953)	Hospital Management Committees	Hospitals	Clinics	Bed Complement
Newcastle	2,911,000	33	178	27	26,801
Leeds	3,045,000	23	196	46	34,906
Sheffield	4,173,000	33	215	143	36,056
East Anglia	1,463,000	14	108	17	14,584
N.W. Metropolitan	3,875,000	23	141	100	36,588
N.E. Metropolitan ...	3,040,000	27	124	113	33,792
S.E. Metropolitan ...	3,197,000	28	181	85	40,962
S.W. Metropolitan ...	4,621,000	53	266	83	67,463
Oxford	1,458,000	16	105	53	14,120
South Western ...	2,768,000	37	274	38	35,429
Wales	2,594,000	22	204	53	26,848
Birmingham ...	4,470,000	27	219	90	44,836
Manchester	4,373,000	33	192	117	45,507
Liverpool	2,103,000	19	95	21	23,549

* Excluding teaching hospitals.

APPENDIX 7

REGIONAL HOSPITAL AREAS
in Scotland



APPENDIX 7A

REGIONAL HOSPITAL AREA STATISTICS

POPULATION (ESTIMATED), BOARDS OF MANAGEMENT, HOSPITALS, CLINICS AND BED COMPLEMENTS

SCOTLAND

31*st December*, 1953

Regional Hospital Area	Population (mid-1953)	Boards of Management	Hospitals	Clinics	Bed Complement
Northern	190,000	11	29	—	2,408
North Eastern ...	493,000	12	61	1	5,693
Eastern*	411,000	9	46	5	7,341
South Eastern* ...	1,136,000	16	85	16	12,677
Western*	2,885,000	37	193	72	36,786

* Two hospitals previously forming a separate group in the Eastern Region were transferred in April, 1954; one to the South Eastern Region and the other to the Western Region where they were absorbed into existing groups. As a result of this redistribution the number of Boards of Management in the Eastern Region was reduced to 8, the number of hospitals to 44 and the bed complement to 7,085: in the South Eastern and Western Regions the numbers of hospitals were increased to 86 and 194 and the bed complements to 12,817 and 36,902 respectively.

APPENDIX 8

SUPPLEMENTARY OPHTHALMIC SERVICES—ENGLAND AND WALES

CHANGES IN COSTS TO EXCHEQUER AND PATIENT OF A TYPICAL PRESCRIPTION FOR GLASSES

Period 5th July, 1948 *to* 21*st March*, 1954

One Pair   Frame 524   Lenses {*Spherical* 2·25–4·0 *Cylindrical* 0·25–2 drs. (Curved)

Periods		Frame		Lenses	Dispensing Fee	CASE	Lens Charges under N.H.S. Act, 1951	Cost to Exchequer	Cost to Patient
From	To	Payment by E.C.	Payment by Patient						
		s. d.	s. d.	s. d.	£ s. d.	s. d.	£ s. d.	£ s. d.	£ s. d.
5. 7.48	30. 4.49	9 3	1 6	12 3	1 5 0	1 8	—	2 8 2	1 6
1. 5.49	30. 4.50	9 3	1 6	12 3	1 4 0 (1)	1 8	—	2 7 2	1 6
1. 5.50	31. 8.50	5 0 (2)	5 9 (2)	12 3	1 4 0	1 8	—	2 2 11	5 9
1. 9.50	20. 5.51	2 6 (3)	5 9	10 8 (3)	1 4 0	1 7 (3)	—	1 18 9	5 9
21. 5.51	1.11.51	—	8 3 (4)	10 8	1 4 0	1 7	1 0 0 (4)	16 3	1 8 3
2.11.51	31. 7.52	—	8 8 (5)	11 2 (5)	1 4 0	1 7	1 0 0	16 9	1 8 8
1. 8.52	1. 5.53	—	9 6 (6)	11 8 (6)	1 4 0	1 7	1 0 0	17 3	1 9 6
2. 5.53	21. 3.54	—	9 6	11 8	1 4 0	1 5 (7)	1 0 0	17 1	1 9 6

Two Pairs — Frame 524 — Lenses (i) *Spherical* 2.25–4.0, *Cylindrical* 0–25–2 drs. (Curved); (ii) *Spherical* Plano—2 drs. (Flat)

Periods		Frames		Lenses		Dispensing Fee	CASE	Lens Charges under N.H.S. Act, 1951	Cost to Exchequer	Cost to patient
From	To	Payment by E.C.	Payment by Patient	Distance	Reading					
		s. d.	s. d.	s. d.	s. d.	£ s. d.	s. d.	£ s. d.	£ s. d.	£ s. d.
5. 7.48	30. 4.49	18 6	3 0	12 3	5 9	2 10 0	1 8	—	4 8 2	3 0
1. 5.49	30. 4.50	18 6	3 0	12 3	5 9	1 14 0(1)	1 8	—	3 12 2	3 0
1. 5.50	31. 8.50	10 0(2)	11 6(2)	12 3	5 9	1 14 0	1 8	—	3 3 8	11 6
1. 9.50	20. 5.51	5 0(3)	11 6	10 8(3)	5 0(3)	1 14 0	1 7(3)	—	2 16 3	11 6
21. 5.51	1.11.51	—	16 6(4)	10 8	5 0	1 14 0	1 7	2 0 0(4)	11 3	2 16 6
2.11.51	31. 7.52	—	17 4(5)	11 2(5)	5 4(5)	1 14 0	1 7	2 0 0	12 1	2 17 4
1. 8.52	1. 5.53	—	19 0(6)	11 8(6)	5 6(6)	1 14 0	1 7	2 0 0	12 9	2 19 0
2. 5.53	21. 3.54	—	19 0	11 8	5 6	1 14 0	1 5(7)	2 0 0	12 7	2 19 0

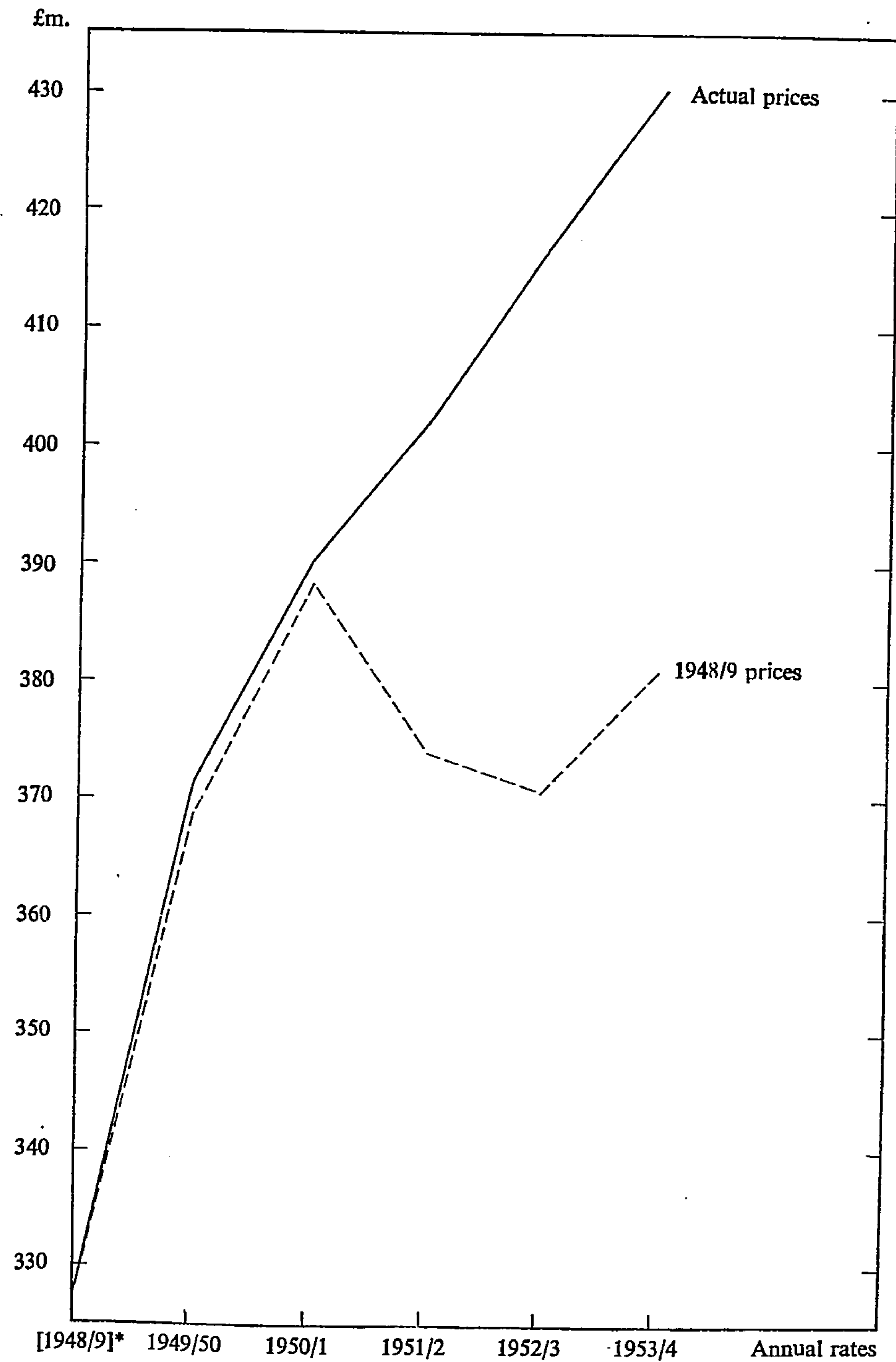
Notes:

(1) Change of fee from £1 5s. 0d. per pair to £1 4s. 0d. for first—plus 10s. for additional pair.
(2) Increase in patients' contribution towards cost of certain frames.
(3) Reduction in prices of frames and lenses of 14 per cent. overall and in payments for spectacle cases.
(4) N.H.S. Act, 1951, under which patient pays cost of frames and 10s. per lens.
(5) Increase of 5 per cent. in prices of frames and lenses.
(6) Increase of 5 per cent. in prices of lenses, 10 per cent. in prices of plastic frames like frame 524.
(7) Reduction in purchase tax on spectacle cases.

APPENDIX 9

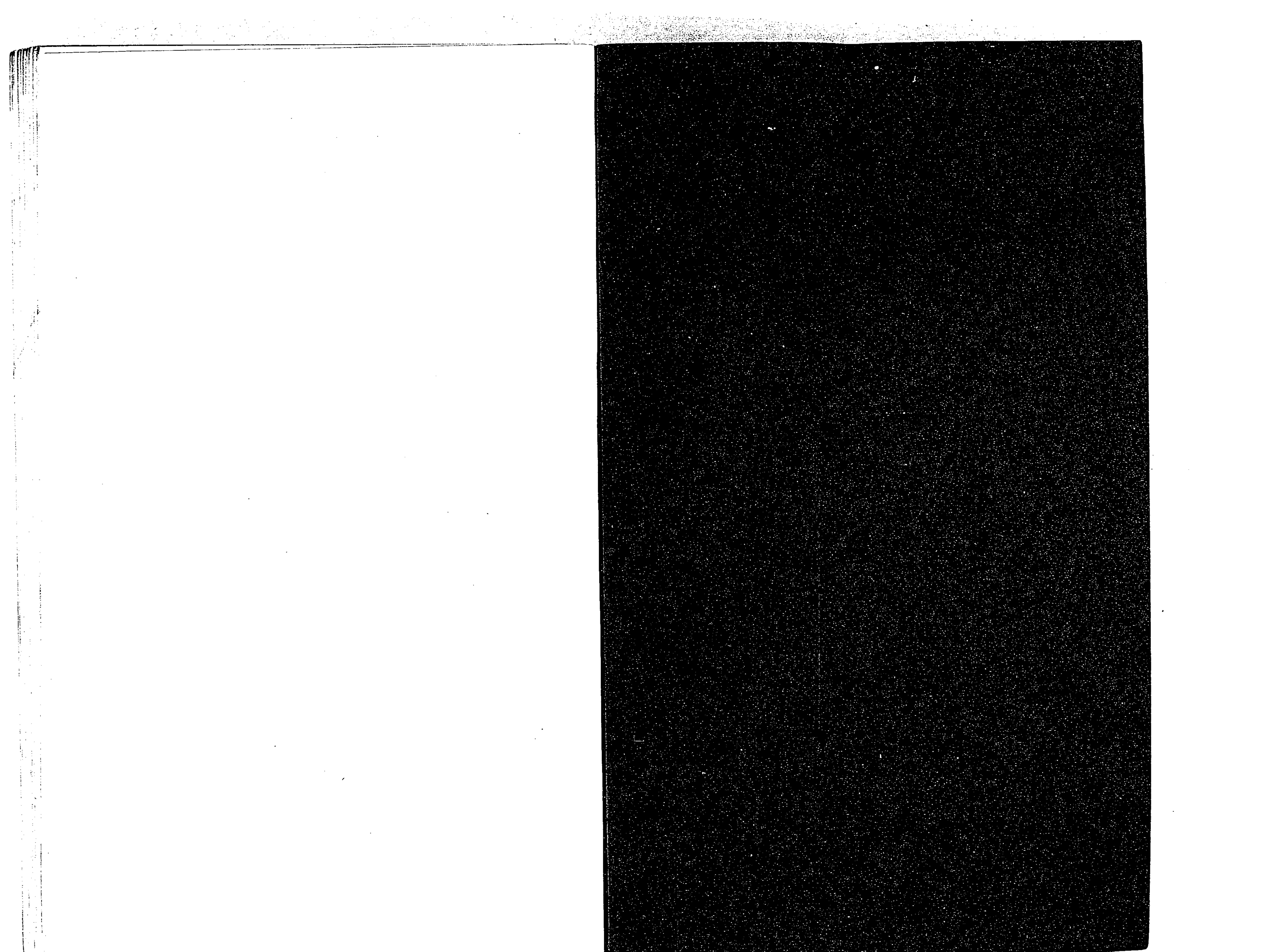
THE CURRENT NET COST OF THE NATIONAL HEALTH SERVICE TO PUBLIC FUNDS IN ACTUAL PRICES AND IN 1948/9 PRICES

England and Wales



* Annual rate interpolated from the 270 days for which the National Health Service operated.

31519 Wt. — K80 1/56 D.L.



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