

ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

APPENDIX

TO

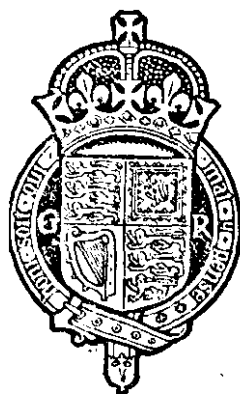
MINUTES OF EVIDENCE

TAKEN BEFORE THE

ROYAL COMMISSION ON NATIONAL HEALTH  
INSURANCE.

PART III.

Statements submitted by certain Approved Societies, Medical Associations,  
Representative Bodies, etc.



LONDON :

PRINTED & PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.

To be purchased directly from H.M. STATIONERY OFFICE at the following addresses :  
Adastral House, Kingsway, London, W.C.2; 28, Abingdon Street, London, S.W.1;  
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1925

*Price 10s. 6d. Net.*

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# ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

## APPENDIX XL.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL FEDERATION OF EMPLOYEES' APPROVED SOCIETIES BY MR. HENRY LESSER, LL.B., PRESIDENT OF THE FEDERATION. See Minutes of Evidence of the Twenty-Fourth Day, Questions 13,370 to 13,668.

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### PERSON GIVING EVIDENCE.

1. Evidence will be given on behalf of the National Federation of Employees' Approved Societies by:—

Henry Lesser, LL.B. (Barrister-at-Law), Chairman of the Joint Committee of the National Federation of Employees' Approved Societies and the National Federation of Rural Approved Societies, President of the National Federation of Employees' Approved Societies, Member of the Consultative Council, Vice-Chairman of the Insurance Committee for the County of London.

### PRELIMINARY.

2. The National Federation of Employees' Approved Societies was founded in 1913. Membership consists of Approved Societies formed by and for the benefit of workpeople employed in the same industrial undertaking.

3. Most of these societies, known formerly as "Works Sick Clubs," were in existence for a great many years before the advent of National Health Insurance, in some cases dating from the early years of last century.

4. At the present time there are altogether 200 Employees' Approved Societies, with an aggregate membership of about 400,000 insured persons, spread over a great variety of firms and industries throughout the country.

5. Each society affiliated to the Federation is an independent unit (save in some cases for valuation purposes) managing its own affairs. The Federation acts only in an advisory and consultative capacity.

### CONSTITUTION OF AN EMPLOYEES' SOCIETY.

6. The constitution of an Employees' Society varies according as it is—

(1) An Employer's Provident Fund within the meaning of section 31 of the National Health Insurance Act, 1924; or

(2) A society on the governing body of which the employer has no statutory right to representation.

7. (1) In the case of an Employer's Provident Fund, the employer undertakes one of the following liabilities, namely:—

(a) to make himself responsible for the solvency of the fund or for the benefits payable thereout; or

(b) to pay substantial contributions towards, or substantially to supplement the benefits payable out of the fund.

The employer is then entitled to a share in the management of the society to an extent not exceeding one-fourth of the representation on the governing body.

(2) The first of these alternatives is that which has been generally adopted by Employer's Provident Funds. The employer is required to give a bond with sureties for the due discharge of his liabilities. The legal instrument drawn up for this purpose by the Ministry allows the employer the right to give notice shortly after the publication of any valuation report that he proposes to withdraw from his responsibilities, after the following valuation has taken place and any deficiency it may disclose has been liquidated.

(3) The constitution of an Employer's Provident Fund must provide for the election of the members of the Committee of Management (other than the employer's representatives) by ballot.

(4) Another characteristic of this type of society is that it is prohibited from refusing to allow a member who is discharged from or leaves the employment of the employer and is unable to obtain admission to another Approved Society on account of the state of his health, to continue a member. On the other hand any member has an absolute right to transfer to another society should he so desire.

(5) Membership of the society must not be made a condition of employment.

8. In a large number of societies the employer did not undertake the liabilities applying to an Employer's Provident Fund, and therefore is not entitled under the Act to any statutory representation on the governing body. In this case the status of the society is that of either a registered or an un-registered Friendly Society. It should be mentioned, however, that even in many of these societies the workpeople have welcomed the co-operation of employer's representatives by electing them honorary members of the society, and members of the Management Committee. In some cases provision is made to that effect in the society's rules.

9. In every type of employees' society the intention is the same, namely, that persons who work together for the same employer shall themselves administer National Health Insurance Benefits through their own society in order to suit the particular needs of the members concerned.

### MEMBERSHIP.

10. Membership of these societies varies to-day from fifty in a small firm to over thirty thousand in a large undertaking.

## ADMINISTRATION.

11. The administration of an Employees' Society is free from many of the difficulties which beset the ordinary Approved Society. The members are, as fellow employees, in direct personal touch with the governing body of the society. Facilities provided by employers enable the contribution cards to be collected in bulk, and for benefits to be paid to sick members at the pay office of the firm in the same way as wages. In a few cases, however, benefits are paid either by the sick visitors or are sent by post.

12. In many societies the whole or part of the administration expenses are paid by the employers, and in such cases the sums that would otherwise be available for that purpose under the Acts remain in the societies' Benefit Funds. In many other respects facilities are provided by the employer with a view to the more economical and efficient management of a society's business.

13. The co-operation of employers and employed persons in the administration of the National Health Insurance scheme fosters the human element in industrial relations, and promotes goodwill among all concerned. As evidence of this we quote the words of Dr. Charles Carpenter, President of the South Metropolitan Gas Company, at the Annual Meeting of the Company as reported in "The Times" of 14th February, 1924:—

"The working of our society has been eminently satisfactory, and all its members highly appreciate the advantages it secures for them. The Company, on its part, has taken an intelligent interest in its operations, and has furthered them by every means in its power. There can be no doubt that were Approved Societies more generally identified with industries throughout the country, the benefits to insured workers would be more direct and substantial, and that human touch, so desirable in administration, more effectively established."

And again, from the workers' side, the following is a copy of a resolution recently received by the Federation from a large Railway Company's Employees' Approved Society:—

"That we approve the attitude and principle expressed in the circular issued by the Federation of Employees' Societies with reference to improving the understanding and co-operation of employers and employees, and instruct our delegates to the Federation to continue their efforts to that end."

## VALUATION.

14. Employees' Societies have administered the Act with marked success, and substantial surpluses were disclosed at the first valuation.

15. Employer's Provident Funds are exempt from pooling for valuation purposes, notwithstanding that the membership of the society is below the limit fixed for societies entitled to be valued separately, i.e., 5,000 originally, under the Act of 1911, but 1,000 since the Act of 1918 came into operation.

16. Societies of this type are also exempt from the provisions of the National Health Insurance Act of 1924 as to the pooling of Contingencies Funds on valuation in the case of a small society which has not joined an Association. Where such a society shows a deficiency on valuation the employer is not required to make good the deficiency except in so far as the society's Contingencies Fund is insufficient for the purpose (section 76 (7) National Health Insurance Act, 1924).

17. It is worthy of note that an Employer's Provident Fund cannot, save by the most remote possibility, have any claim whatever on the Central Fund, to which, nevertheless, its members contribute equally with other insured persons.

18. A pooling scheme for valuation purposes was formed by the Federation for affiliated societies whose solvency was not guaranteed by the employers. All societies affiliated to that scheme disclosed surpluses at the first valuation.

## ADDITIONAL BENEFITS.

19. The majority of Employees' Societies are distributing their available surpluses by the payment of additional cash benefits and treatment benefits. A few societies pay additional cash benefits only, whilst others have limited their schemes to treatment benefits. In some societies the disposable surplus was applied in the reduction of the contributions of members entitled to additional benefits. The arrangements made under the various schemes approved by the Ministry of Health are working smoothly, and are giving satisfaction.

## MEDICAL BENEFIT.

20. The service given by panel practitioners appears to be on the whole satisfactory, but the experience of our societies would suggest that the quality of the service varies in different parts of the country. There can be no doubt that there is a feeling amongst many insured persons that they are treated by some practitioners with less consideration than if they were private patients.

21. The medical service available under the Act is inadequate. Our societies have almost daily experience of the need of further medical services, such as electrical treatment, massage treatment, testing of eyesight, operations both major and minor, and specialist consultations for known diseases, or where the panel practitioners cannot diagnose the trouble from which the patient is suffering. It is felt that all these services should be included in medical benefit which an insured person would be entitled to receive under arrangements made by the Insurance Committees. To some extent our societies are able to meet the demands upon them by referring members to hospitals, infirmaries, or charitable institutions, to which the societies, individual members, and their employers respectively, make donations, and in this way the most necessitous cases are relieved.

22. The list of prescribed appliances is also too restricted, and should be extended to include artificial limbs, trusses, and hearing apparatus for the deaf.

23. Complaint is also made that panel practitioners too frequently fail to observe the Medical Certification Rules, thereby causing delay in the admission of claims and much unnecessary correspondence and other trouble both to societies and insured persons.

24. We are of opinion that persons aged 60 and upwards, who cease to be employed and do not continue in full insurance as voluntary contributors, should be entitled to continue in insurance for medical benefit only, paying until age 70 an appropriate contribution to entitle them to that benefit for the rest of their lives.

## TREATMENT BENEFITS.

25. These have proved to be popular among our members, particularly dental and optical treatment.

26. The sums available out of surplus are not sufficient to enable all members desiring treatment to take advantage of the proportion of the cost paid by the society.

27. In our opinion there has not yet been sufficient experience of the operation of dental schemes to enable a safe estimate to be made of the cost of a complete dental service available to all insured persons. For that reason we are not prepared at the present time to recommend the adoption of dental treatment as a normal statutory benefit under the State scheme.

## ARREARS.

28. The present arrears scheme does not present any administrative difficulties to our societies.

29. If any Approved Society desires to assist its members to pay up arrears it now has the right to do so out of any disposable surplus available for the purpose.

30. In our opinion the Prolongation of Insurance Act has served a useful purpose as a temporary measure, but it should be discontinued as soon as normal conditions of employment are restored.

#### CLASS K MEMBERS.

31. The societies in the Federation have experienced no difficulty in administering the benefits to which married women in Class K are entitled, and they recommend that the present arrangement be not disturbed.

#### DEPOSIT CONTRIBUTORS.

32. We are of the opinion that the Deposit Contributors Fund, though apparently anomalous in a general scheme of insurance, serves a necessary and useful purpose, and we have no alteration to recommend.

#### TRANSFERS.

33. We are of opinion that insured persons should be free to transfer from one society to another as they may think fit, and that members so transferring should not lose their rights to any additional benefits to which they may be entitled out of surpluses in their old society, just as they remain liable on transfer for any deficiency disclosed on a valuation of that society.

#### FINANCE.

34. We are of opinion that societies, if they so desire, should be entitled themselves to invest the whole of the moneys standing to their credit in the Investment Account, instead of one-half only as at present.

35. We objected originally to the creation of the Central Fund, and are strongly opposed to any

extension of the "pooling" principle. Our view is that under the existing scheme an Approved Society is for all practical purposes an independent self-governing entity. It carries its own risks. That was the contract undertaken quite voluntarily by every Approved Society. If, therefore, a society has actually earned a surplus, it would be nothing less than confiscation to appropriate that surplus, either wholly or in part, for the purpose of making good the deficiencies of other self-governing societies.

#### CONCLUSION.

36. In conclusion, we are of opinion that the scheme of National Health Insurance as contained in the Act of 1911 was well planned, and that the system of administration of benefits through Approved Societies and Insurance Committees is chiefly responsible for the conspicuous success with which so gigantic a measure was launched in this country. Insured persons to-day take a far greater interest in health matters than ever before, whilst the outlook of the governing bodies of Approved Societies has been considerably widened as a result of the matters with which they have been called upon to deal in administering the Act.

We feel that any fundamental reconstruction of the Scheme upon its administrative side would deprive the health insurance system of some of its most distinctive merits. Administration on a territorial basis through local authorities would involve the rigid and unsympathetic officialism which rightly or wrongly, has become associated with Poor Law administration and certain other public services. The present system allows freer play for those who are chiefly interested, namely, the insured persons, to take a more direct and personal interest in the management of their own affairs in the light of their particular needs.

## APPENDIX XLI.

STATEMENT OF EVIDENCE AS TO THE NUMBER AND NATURE OF THE ENQUIRIES MADE BY INSURED PERSONS AT THE INQUIRY ROOM OF THE MINISTRY OF HEALTH DURING THE YEARS 1922-1924, SUBMITTED BY THE MINISTRY OF HEALTH. See Minutes of Evidence of the Twenty-Fourth Day, Questions 13,669 to 13,741.

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#### PRELIMINARY.

1. One of the main duties of the staff of the Inquiry Room at the Head Office of the Ministry of Health is to give simple oral explanations with reference to the numerous difficulties on which insured persons in and around London require advice and assistance. The volume of enquiry shows clearly that the arrangement is of great value. Similar assistance is given at the local offices of the inspectorial staff of the Ministry in the principal provincial centres.

2. It is thought that a general description of the number and nature of these enquiries may be of value to the Commission as giving some indication of the views of the average insured person which cannot easily be obtained in any other way.

#### NUMBER AND NATURE OF ENQUIRIES.

3. An average of over 3,000 persons visit the Ministry of Health Inquiry Room each year with health insurance queries. Two-thirds of these queries are disposed of by oral explanation, but the remainder require further action, and reports are sent to the appropriate branch. An analysis of the subjects of these cases for 1922, 1923 and 1924 follows.

Nature of case.	Number of Cases.		
	1922.	1923.	1924.
Disputed title to benefit ... ..	169	225	216
Membership ... ..	57	58	86
Refunds ... ..	224	202	264
Lost or destroyed cards ... ..	128	92	97
Insurability ... ..	39	24	28
Applications for Exemption ... ..	34	6	9
Deposit Contributor ... ..	62	31	36
Navy and Army Fund ... ..	22	6	10
Non-stamping ... ..	116	128	167
Miscellaneous ... ..	51	71	63
	902	843	976

4. In addition, over 3,000 telephone calls are received annually on the subject of insurance. These

are mainly from employers, and can be divided approximately into insurability, dental treatment and rates of benefit in the ratio of 4:1:2.

#### CONTRIBUTIONS.

**5. Method of Payment of Contributions.**—Apart from one proposal that a stamp should be issued to cover both Health and Unemployment Insurance, no suggestions have been received from employers or employed contributors as to any change in the method of payment of contributions.

**6. Insurance of Young Persons under 16.**—No suggestions have been received that young persons below 16 years of age should be included in the scheme.

**7. Emergency Contribution Cards.**—A proportion of the non-stamping which occurs (especially in the case of domestic servants) appears to be due to ignorance of the existence of Emergency (Y) Cards.

**8. Payment of Total Contribution by Employer.**—The voluntary payment by the employer of the total contribution has come to light in more instances than might be expected, especially in the case of domestic servants.

#### MEDICAL BENEFIT.

**9. Own Arrangements for Medical Benefit.**—Comparatively few insured persons appear to be aware of the provisions by which they may make their own arrangements for medical benefit.

**10. Change of Insurance Practitioner.**—The recent arrangement by which transfer of doctor may be made at any time does not appear to be well known.

When mentioned to insured persons, however, it is appreciated, and appears to give confidence in the medical service.

**11. Drugs.**—The impression that doctors may only prescribe a limited number of drugs or drugs of cheap quality is still prevalent.

**12. Treatment as Private Patients.**—Insured persons, including a large proportion of deposit contributors, usually express surprise when informed that nothing is saved by not attending the insurance practitioner. It is probable that an appreciable number of persons receiving attention as private patients are under the impression that, by so doing, they will be able to draw a greater amount of sickness and other benefit.

**13. Emergency Medical Treatment.**—The arrangements by which new entrants and other persons not in possession of medical cards can obtain medical benefit do not appear to be generally known.

**14. Insurance Medical Services.**—At least a each year have recently been under treatment by an insurance practitioner, and surprisingly few complaints against the medical service are received, although the object of these visits is to bring forward an insurance grievance. Every mention, however casual, of dissatisfaction with the medical benefit is always discussed with the complainant, and it has been noted that with very few exceptions those persons who speak to the detriment of the insurance medical service have never been under the treatment of a panel practitioner.

#### OTHER BENEFITS.

**15. Extension of Benefits.**—With the exception of dental benefit, on which comment is made below, neither employers nor insured persons evidence any desire for an extension of the Act.

**16. Dental and other Additional Benefits.**—Additional benefits other than dental do not appear to be well known, and when mentioned arouse little enthusiasm. Dental benefit, however, is in popular demand. Surprise is often expressed by both insured persons and employers at hearing that only certain sections of the former are entitled to participate in this benefit. It is not infrequently suggested (usually

by employers) that dental treatment should be a general, and not an additional benefit, often on the ground that it is merely an extension of medical treatment. Although no record is kept it is estimated that at least 10 per cent. of the 3,000 insurance telephone calls received each year by the Inquiry Room (the majority of which are from employers) deal with dental benefit.

**17. Free Year.**—Very few insured persons appear to have knowledge of the "free year of insurance" and the announcement of the existence of this makes a very effective counter to the not infrequent applications for refund from persons no longer insurable.

**18. Maternity Benefit.**—Maternity benefit is often relied upon for payment of the midwife's fee, and it would appear that a large number of insured women are attended by a midwife only.

#### GENERAL QUESTIONS.

**19. Late Notification of Incapacity.**—Some amount of benefit is lost each year by reason of late notification of incapacity, especially in the case of new entrants to insurance. This appears to be due to ignorance rather than to negligence and is liable to cause a sense of grievance, especially where no claim is made until recovery and a comparatively large sum is involved.

**20. Recovery of Benefit Lost by Default of Employer.**—Very few employers or insured persons seem to be aware of the existence of this provision. The latter are often afraid to take advantage of the remedy when it is brought to their notice, however, partly on account of the initial cost involved in taking legal action and partly on account of ignorance of procedure and distrust of the law's workings. It is very effective when brought to the notice of negligent employers who visit the Inquiry Room in order to clear up late-stamping.

**21. Society Membership.**—Among new entrants into insurance, and some deposit contributors, there exists the impression that membership of an Approved Society entails money payments in addition to the normal health insurance contributions.

**22. Insured Person's Right of Appeal against Society's Decision.**—Cases of dispute between an Approved Society and a member, where brought to the notice of the Ministry, can often be adjusted by giving the insured person a verbal explanation of the position, or by correspondence with the Society.

Some instances have been brought to the Inquiry Room, however, where the Department could not properly intervene, and in which the member was informed that he could appeal under the "disputes" rule of the Society.

This, however, usually involves the deposit with the Society of a sum of money, ranging from ten shillings to a pound. Such a sum is often beyond the means of the insured person, more especially when any small savings have been depleted by the charges incidental to the illness. Thus the member may not be able to pursue his appeal.

**23.** It cannot be claimed, of course, that any great proportion of cases which have come under notice appeared to be likely to be successful on appeal, but the member is liable to feel a sense of grievance in being unable, on account of insufficient means, to take his dispute to independent arbitration. Further, persons proposing to contest a Society's decision normally do so in the belief that they will be successful.

**24. Agents.**—Members of the large Approved Societies not infrequently experience difficulty in their dealings with agents whose principal work and main source of income is industrial insurance. Lack of knowledge and of interest on the part of the agent causes delayed or lost benefit.

**25. Record Cards.**—Many cases occur each year of acceptance of contribution cards by Society agents without a receipt being given in the record card. A large proportion of the record cards examined in

the Inquiry Room each year (approximately 1,500) are incomplete in this respect.

**26. Arrears Penalty.**—It appears that the use of the word "Penalty" is liable to cause lack of appreciation of the provision. It is not realised that the arrears payment is really a privilege and that the penalty is only incurred upon failure to exercise the privilege.

**27. Persons over 70.**—Persons over 70 (Society members) are usually surprised to learn that medical benefit continues for the remainder of their lives. They seem to value this highly, and the fact is used in discussion with visitors as an effective reply to any refund argument.

**28. Refunds.**—The impression that refunds are made of contributions properly paid is prevalent, and is fostered by Unemployment Insurance practice.

**29. Continuance of Benefits.**—The general feeling of persons over 70 appears to be in favour of continuance in insurance, at least for as long as employment continues, not infrequently for four or five years.

#### SPECIAL CLASSES.

**30. Voluntary Contributors.**—The average member appears to know very little about the voluntary contributor provisions.

**31. Deposit Contributors.**—If the deposit contributors with whom the Inquiry Room deals can be taken as representative, this class would feel little concern at wholesale compulsory transfer into Approved Societies. Elderly persons and "bad lives" would welcome such an arrangement.

**32. Class K Provisions.**—It is not clear that the title to maternity benefit in respect of the first confinement occurring within two years after marriage is widely known, and no doubt a proportion of Class K members fail to make application for this benefit when the confinement occurs in the second year. Where known, the provision is appreciated. The low rate, and short duration of sickness benefit, however, does not usually satisfy enquirers who have in mind the former credit refund on marriage.

**33. Employers and Exemption.**—Inquiries as to exemption are frequently made by employers, who appear to place a distinct value upon the allocation of their contribution to the employee in the form of medical benefit.

Occasionally the equity of making the employer pay contributions in respect of a person who voluntarily goes out of insurance is questioned, but the reply—that this practice is intended to prevent any preference being given in the labour market to persons with a private income—is always accepted.

**34. Exempt Persons.**—Applications for information on exemption come, generally speaking, from two classes; from charwomen, daily domestic workers, &c. (women who are in receipt of War pensions or who could claim on the ground of being dependent upon their husbands) and from persons with comparatively

large private incomes (such as young men learning a business, ex-officers, &c.).

The latter group welcomes any opportunity of escaping from the insurance scheme, and the former, upon learning what benefits are foregone by the exempt person, usually does not proceed with the application.

#### PRINTING ON RECORD CARDS, &c.

**35.** At least 1,500 visitors per year to the Inquiry Room produce record cards for examination, for substantiation of claim, etc. Very few of these insured persons have any knowledge of the subject matter printed on the card.

When pressed on the point it is found that they have either failed to grasp the meaning of the sentences and tables, or have never read the card.

This may indicate that the arrangement and wording is not sufficiently elementary for the average employed contributor.

The same difficulty arises in other documents intended for circulation to insured persons. In the case of Memorandum 230/X employed contributors often fail to understand clearly the intention and wording.

#### CO-OPERATION OF INSURED PERSONS.

**36.** Insured persons have not that interest in the Health Insurance scheme which they have in their life and fire insurances. Investigation of the past insurance history of a large number of insured persons confirms this.

This lack of interest seriously affects the proper working of the scheme and is responsible for mislaid or improperly surrendered contribution cards, late notification of illness, etc., which, individually, merely cause inconvenience to a member, but collectively, affect materially the smooth running of the machinery as a whole, and are ever centres of disaffection. Stories of lost or delayed benefit, by constant repetition, soon acquire a "snowball" movement. The prompt settlement of claims is not so well advertised, unfortunately, and does not counter this.

If each insured person were to do his small share (consisting merely of punctual surrender of contribution card with record card, prompt payment of arrears penalties, and immediate notification of incapacity), cause for complaint should be almost eliminated.

These facts, of course, are familiar to the Department, but they are stated as a necessary preface to the suggestion that were the active co-operation and interest of insured persons obtained, many difficulties in the operation of the scheme would be obviated.

**37.** It has been found, for example, that members do not realise that comparatively enormous sums can be obtained in the form of sickness and disablement benefit.

In order to obtain some confirmation of this the questions set out below were addressed to 35 insured persons (not visitors to the Ministry), and their replies were noted. They comprise four deposit contributors, one Navy and Army member, and 30 Society members. The following table is a summary of the replies:—

Questions.	Number of replies indicating:—		
	No knowledge whatever.	Vague knowledge.	Accurate knowledge.
To what amount of sickness benefit are you entitled—			
(a) After 26 contributions, etc.? ... ..	20	8	7
(b) After 104 contributions, etc.? ... ..	13	13	9
For how long are these payments continued? ... ..	18	10	7
Do you get any further benefit at the end of these periods, and if so, what amounts—			
(i) In the case of (a) above? ... ..	26	7	2
(ii) In the case of (b) above? ... ..	24	5	6
For how long are these payments continued? ... ..	20	8	7
Are you aware of any other cash benefits from insurance?—			
(a) Replies referring to maternity benefit ... ..	11	17	7
(b) Replies dealing with additional benefits... ..	12	14	9

38. If aware of the value obtainable for the premiums paid, insured persons would take greater care to see that their insurance affairs were in order.

39. Dissatisfied insured persons and employers visiting the Inquiry Room have the possible benefits impressed on them. This is very effective, and hardly ever fails to disarm opposition; an instance on the following lines is usually given.

Insured person aged (say) 35 (male).

#### PAYMENTS.

For two years only. (104 weeks).

Insured person at 5d. per week	} Total £4 10 0
Employer at 5d. per week ...	

#### BENEFITS.

*Past.*—During past two years, as many visits to doctor as necessary (without payment of at least 2s. 6d. per visit assuming this to be a minimum private visit fee). Free medicine, with no restriction as to quality.

If member falls ill now, he will receive sickness benefit for 26 weeks at 15s. £19 10 0

If still incapacitated, then disablement benefit at 7s. 6d. per week (till age of 70 if necessary), *i.e.*

£19 10 0 per annum for next 35 years (until insured person attains the age of 70) which amounts to ... .. £682 10 0

Possible Total Cash Receipts ... £702 0 0

Cash payments by member and employer ... .. £4 10 0

Over £700 received in return for less than £4 10 0 paid in premiums.

Any mention of additional and other benefits is usually omitted, in order to make a clearer impression.

#### PUBLICITY.

40. Constant publicity, in the Press and by means of leaflets to members, printing on record cards, etc.,

would keep well before the minds of employers and employees the good value they are getting and would be a stimulus to ensuring prompt and correct payment of premiums. Late notification without satisfactory reasons should become almost unknown.

41. Not infrequently one sees paragraphs in the Press suggesting that insurance practitioners give inefficient service, are negligent, etc. Occasionally a report of the removal of a doctor's name from the panel is noted. Generally speaking, very little in praise of National Health Insurance is published, and the effect on the public mind tends against the scheme rather than in its favour.

42. It is suggested that the true facts of the medical service, and of the insurance scheme in general should be given as much Press publicity as possible, constantly and in interesting form, not as an official announcement in official language, but as an interesting "news item" in topical wording.

The desirability of this is emphasised under the heading "co-operation of insured persons."

43. Apart from such news paragraphs, for which no payment would be made, periodical "display" advertisements in attractive form, similar in type to those issued by the National Savings Committee, might be published in papers with large circulations among insured persons (*e.g.*, certain Sunday newspapers).

44. Short articles, setting out information for employers and employed persons, might appear in weekly journals having an extensive sale (such as "Answers"), and in employers' trade publications. Brief talks might also be broadcast by wireless.

45. Any expense incurred should be compensated by the saving in societies' administration costs, resulting from the members' increased interest in the scheme, and by some slight increase in the contributions collected. Further, there would ensue greater goodwill towards National Insurance.

## APPENDIX XLII.

### STATEMENT OF EVIDENCE SUBMITTED BY SIR THOMAS MORISON LEGGB, M.D., SENIOR MEDICAL INSPECTOR OF FACTORIES. See Minutes of Evidence of the Twenty-Fourth Day, Questions 13,742 to 13,953.

1. My evidence comes under the words in the Terms of Reference of the Royal Commission on National Health Insurance, "alterations, extensions or developments" of that scheme. My suggestions have reference mainly to the medical services coming into relation with factories and workshops and principally with the work of the 1771 Certifying Factory Surgeons, whose duties I should like the Commission to consider, with a view to the possibility of incorporating them in the administration of the National Health Insurance Act.

2. The number of factories is 139,920, and of workshops 140,850, employing approximately (as compiled from figures obtained under the Workmen's Compensation Act, in 1923) a total of 5,103,240, of which 3,324,481 were males and 1,778,759 were females. If docks, mines, quarries, constructional works, and railways were added, the total would be increased to 7,342,311. Of the persons employed in factories in 1923, 300,814 were young persons, under 16 years of age.

3. I have prepared a chart to bring out the medical services coming into relation with factories and workshops (and also in schools, as being the feeders to both—a part of the public health administration). The whole factory system, and all the workshops, with all the elementary schools between, are shown. Below runs the stream of the medical profession, broken up into sections representing the panel practitioners (much the largest), the public health service, represented in three groups, with the Medical Officer of Health in the centre, the School Medical Officer to the left, and the Tuberculosis Officer to the right, and, lastly, the section representing five full-time Medical Inspectors of Factories and the part-time Certifying Factory Surgeons.

4. The arrows pointing from factory and workshop to the panel block are all directed away from the factory, indicating that the workers stream from the factory to their panel doctors when they become ill. There is no return stream from the panel into the factory to try to prevent sickness claims arising



there, which must ultimately fall on the National Health Insurance Funds.

5. Taking the Public Health service next, the Medical Officer of Health gets little further than the door of the factory, as his duties are confined to "suitable and sufficient sanitary accommodation." He goes further into the workshop, because the administration of the sanitary provisions of the Factory Act (cleanliness, lime washing, general ventilation, drainage of floors) falls to him.

6. The School Medical Officer does not go into the factory at all, neither does the Tuberculosis Officer. The stream is again to the Tuberculosis Officer from the factory, when phthisis cases have become open. The School Medical Officer has the right sort of periodic medical supervision, examining the children perhaps three times in the course of their school career, with a view to finding out and remedying their physical disabilities and fitting them for their work in life.

7. The Home Office has its five Medical Inspectors, who have access everywhere, and, in addition to them, are 200 lay Factory Inspectors (men and women) distributed in divisions and districts covering the whole country, who also have access everywhere, in both factories and workshops. Indicated also are the Certifying Factory Surgeons, with their fourfold duties.

8. The whole country is divided up into districts, and a Certifying Factory Surgeon must be appointed for each district. Their duties are:—

- (1) To examine young persons of 14 to 16 years of age within seven days of their employment in factories and a few selected classes of workshops, with power of attaching conditions as to the nature of the work upon which the young persons may be employed;
- (2) To make periodic examination of the workers in certain dangerous and unhealthy industries;
- (3) To examine and report on all cases of industrial poisoning notified under section 73 of the Factory and Workshop Act, 1901 (lead, phosphorus, arsenic, mercury, carbon bisulphide, anilin and chronic benzene poisoning; toxic jaundice, anthrax, epitheliomatous or chronic ulceration);
- (4) To grant certificates entitling workmen to compensation for scheduled diseases under the Workmen's Compensation Acts, 1906 and 1923.

They have power to enter a factory and examine any process upon which it is proposed to employ young persons presented to them for examination under section 61 (6) of the Factory and Workshop Act, 1901.

9. No better qualified medical men could be associated with the factory than the type of medical man who is appointed as Certifying Factory Surgeon. He knows the people in their own homes, treats them, generally as panel patients, for ailments contracted in the factory or workshop, which a full time administrative officer could not do. He can carry out what is wanted in the factory—preventive medicine on clinical lines.

10. In the factory, however, he is bound by the section of the Factory Act, which does not require him to examine the young person so as to find out his deficiencies and rectify them; all he is called upon to do is to state that the young person "is not disabled by disease or bodily infirmity for working for the full time allowed by law" and if the young person is not blind, or deaf or dumb, and not obviously suffering from disease, disablement, or uncleanness, he may have difficulty in refusing a certificate of fitness to the extent required.

11. In 1924 a Departmental Committee on Medical Examination of Young Persons for Factory Employment was asked to report on the provisions of the Factory and Workshop Acts for medical examination of young persons as to their fitness for employment. The terms of reference were as follows:—

"To consider—

- (a) whether the existing requirement of a certificate of fitness limited to a particular factory should be modified; whether any other changes should be made in the examination and certificate; and what arrangements should be adopted for the future;
- (b) what measures should be taken for linking up the examination of young persons under the Factory and Workshop Acts with their examination under the school medical inspection service, and, if considered desirable, with other public health services of the country;
- (c) what arrangements could best be made for providing medical supervision of young persons (where such supervision is considered necessary by the Department) during employment in factories or processes where the conditions of work are unfavourable to health or physique."

12. The Committee was not asked to report on the other duties of the Certifying Surgeons. They concluded that the granting of certificates for employment in a particular factory is of value and should be retained, and that in addition to other points—

- (1) the age for examination should be raised from 16 to 18 years.
- (2) the form of the certificate should be positive instead of negative.
- (3) the Surgeon should be able to grant at his discretion a qualified certificate to which conditions may be attached respecting the nature of the work on which the young person may (or may not) be employed, the remedial or other measures which are to be taken in regard to the young person or whether the certificate should be conditional upon re-examination within a stated period on account either of the physical state of the young person or of the industrial conditions.
- (4) the examination should be conducted at the factory.
- (5) the Surgeon should have the duty of acquainting himself in every factory with the process on which the young persons are proposed to be employed.

They emphasise the need for medical supervision in conditions of work unfavourable to health or physique, and of the adolescent in industry generally. They suggested that the work of the Certifying Surgeons in examination for certificates of fitness should be taken over by the Local Authorities and run like schemes for maternity and child welfare, school medical inspection, and tuberculosis work, as part of the Public Health Administration.

13. The Medical Officer of Health is an administrative officer appointed to protect the health of individuals affected by influences under the control of the Local Authority. Factories and workshops are not under the control of the Local Authority, and he has no opportunity of studying the effects of industry on living persons, nor could that be made to fit in with his other duties. A Medical Officer of Health could not survey the influence of industry from the standpoint only of his particular area. He might properly, however, be a member of the Local Medical Committee or Insurance Committee and so be in touch with the activities of the National Health Insurance Act.

14. Factory administration would lose its value if handed over to officers responsible to Local Authorities and not to a Central Department.

15. The duties of the Medical Inspectors of Factories include:—

Supervision of the work of Certifying Factory Surgeons and Appointed Surgeons; special inquiries into dangerous and unhealthy industries; inspection of works under regulations (particularly those involving periodic medical examination); all questions concerning injury to health of workers; first aid in factories; drafting of new regulations dealing with dangerous and unhealthy industries.

16. They are expected to keep in touch with Medical Officers of Health, and to make themselves acquainted with the authorities of universities, colleges, laboratories, hospitals and other institutions engaged in the treatment or study of industrial diseases or engaged in work of research or investigation into medical questions bearing on matters within the province of the Department.

17. The Senior Medical Inspector considers all reports made by the other Medical Inspectors, with a view to publication or departmental action before submitting them to the Chief Inspector of Factories. He takes an active part in general medical inspection, and keeps in touch, as far as possible, with foreign developments. He supervises the action to be taken following on notification of industrial poisoning and disease under section 73 of the Factory and Workshop Act, 1901, and always prepares statistical tables of the cases notified which are published monthly in the *Labour Gazette*. He also advises the Home Office in all medical difficulties arising out of administration of section 8 (Industrial Diseases Section) of the Workmen's Compensation Act, 1906 and 1923.

18. In the diagram is represented a factory with a whole time Medical Officer, of which there are in this country probably not more than 50. In this factory system is a medical man keeping an eye on all conditions affecting health.

19. In Great Britain all the other services described enter, but in large factories and plants in America, in the absence of a National Health Insurance Act, employers have voluntarily engaged what they call "industrial physicians or surgeons" to supervise medically their workpeople, and, in connection with such medical service—whole time and part time, according to the size of the factory, sickness and other benefit provision is made.

20. The thing to aim at, I think, is to utilise the clinical knowledge of the panel practitioners in this country in preventive work in the factories. I am sure there is no chance of the creation of a new whole-time service of medical men as factory surgeons in this country, in the same way as was done in the appointment of a full-time service of School Medical Officers in 1908. The only way, therefore, in which the services of those who have the clinical experience suitable for the medical supervision can be obtained is, I believe, by some broadening of the National Health Insurance Act, so that in industrial areas certain practitioners should be given, as their panel work, the duty of keeping the industrial worker as far as possible from succumbing to illness and so becoming a charge on the insurance funds.

21. The powers originally given under section 63 of the National Health Insurance Act, 1911, to deal with excessive sickness, *e.g.*, in a particular factory, have not been put into operation (see page 99 of Part I of the Appendix to Minutes of Evidence).

22. Employers in this country cannot be expected to engage and pay for the services of a medical officer of their own, in view of the contribution they already pay per head per week under the Insurance Act. Further, I am convinced that even if they wished to, or tried to, such a system could never become general, as trade unionists, in the majority of cases, would not accept examination by a doctor paid by, and working, as they would think, in the interests

of the employer, to find out their secrets with a view to getting rid of them when opportunity presented.

23. I believe that on the other hand both employers and trade unionists would welcome medical supervision in the factory by a medical man for whose services they both contributed, as they do now under the National Health Insurance Act. Such a scheme of medical supervision would naturally need to be definitely linked up with the Employment Exchanges, so that the workers are looked after and work found for them, and not merely cast adrift—as no doubt is the case with most of the workers who are considered to be unfit in large works in America where industrial physicians and surgeons are employed.

24. The matters which would come under a proper system of medical supervision in the factory would be:—

- (1) Initial detailed medical examination, not only of young persons, but of all applicants for work, attaching where necessary conditional certificates either on personal grounds or as to the nature of the work on which the person was to be employed.
- (2) Re-examination of such persons as the surgeon considered needed it, including periodic medical examination of the tuberculous and of others known to be affected with chronic illness which, if not watched, might prove incapacitating.
- (3) Periodic medical examination of workers in dangerous processes.
- (4) Inspection periodically to see that first aid and ambulance equipment was maintained and properly used.

25. The following is a rough indication of the way in which workpeople may be affected in their employment, and, briefly, the clinical signs which would show if they were affected:—

Intoxications (poisonings) acute and chronic.	Varies according to substances used, but generally quite definite.
Dust ... ..	Upper air passages, lungs, eyes and skin.
Contact with oils, chemicals, dusts, etc.	Affections of the skin, constitutional diseases—cancer, jaundice.
Aggregation of workers in workrooms.	Consumption, epidemics of influenza, etc.
Fine work... ..	Eye-strain, headache, depression.
Abnormal position and constant standing.	Eye-strain, lateral curvature, contraction of chest, flat feet, knock-knee, varicose veins and ulcers, swelling of legs and feet.
Radiant heat. ... ..	Eye changes (cataract), arterial degeneration.
Moist heat... ..	Rise of body temperature, fatigue.
Noise ... ..	Deafness.
Vibration ... ..	Central nervous system.

(1) *Poisonings—lead industries.*—In addition to the industries already covered by regulations requiring periodic medical examination, quarterly medical examination would be desirable in all lead industries for persons exposed to contact with (a) molten lead and (b) dust from compounds of lead. Extension in this way would include (1) lead burners or chemical plumbers using the oxy-hydrogen blow-pipe; (2) stereotypers in printing works; (3) file hardeners; (4) mixers in indiarubber works; (5) coach painters; (6) red-leaders in shipbuilding yards; (7) tempering springs; (8) metal sorters; (9) makers of shot; (10) glass polishers; and (11) mixers of the ingredients of glass.

The following is a rough indication, alphabetically arranged, of the industries (omitting lead industries)

in which poisoning may occur, and in which, therefore, medical supervision would be desirable:—

Alkali manufacture.  
Ammunition.  
Anilin dye factories.  
Antiseptic dressings.  
Arsenic acid.  
Artificial silk.  
Barometers and thermometers.  
Benzol.  
Brass foundries.  
Brass polishing.  
Brass lacquer.  
Brigette factories.  
Bronzing with nitrate of mercury.  
Ceramic industry.  
Chemical industry.  
Chlorine organic products.  
Chromo-lithography.  
Disinfectants.  
Dyeing and dyo works.  
Electric lamps.  
Explosives.  
Felt Hats.  
Furriers' processes.  
Incandescent electric lamps.  
Indiarubber.  
Insecticides.  
Mercury compounds.  
Metal polishing.  
Metal refining.  
Phosphorus manufacture.  
Sheep Dip.  
Turkey red dyeing.

(2) *Dust*.—Periodic medical examination, say, at half-yearly intervals, of all employed on grinding wheels or in polishing shops would do more than anything else to secure efficient administration of section 74, and it would be this examination which would reveal consumption if present.

(3) *Contact with oils, etc.*.—In this case, actual suggestions for treatment of the affections of the skin found could be made.

(4) *Crowding together*.—This is a difficult matter. No general examination of individual workers would be possible, but all those who had had tubercle and had recovered would be known (as a result of notification and sanatorium treatment). These, and others who were suspected, could be examined by the surgeon, both as to their physical condition and as to the suitability of work and place of work decided on.

(5) *Fine work*.—Much might be done in the examination of workers for errors of refraction and for their correction by glasses.

26. I need not stress the amount of sickness and incapacity, much of it believed to be preventable, occurring among industrial workers. It will suffice to refer to the published statements of the Chief Medical Officer of the Ministry of Health, 1919-20, pages 30-37, and 1922, pages 29-32, on "Sickness and Invalidity," and the Report of the Ministry of National Service on "Physical Examination of Men of Military Age" (Cmd. 504).

27. Further, the report of Sir Alfred Watson on the "Valuations of the Assets and Liabilities of Approved Societies," published in 1922, indicates the manner in which sickness experience has varied according to locality (Table XIII.). This shows:—

- (a) The Percentage of Actual to Expected Cost of Sickness.
- (b) Net Surplus per Head in County groups (Men's funds only).
- (c) Increase or decrease respectively in percentage of Employed Men (in County groups) engaged in Agriculture as shown by Census of 1911; and

(d) Percentage of Employed Men (in County groups) engaged in heavy labour occupations as shown by Census of 1911. Similarly decrease or increase.

The table naturally suggests that heavy sickness and disablement claims which have reduced the profits and, in some cases, caused loss in the valuation of the funds of Approved Societies, are apposite to the point I wish to press.

28. In regard to the Manchester Unity of Odd-fellows figures (1893-1897), he established "that the proportion of members sick during any year varies with the occupation," and that "the element of occupation is of greater importance in determining the contribution for sickness benefit than that of locality."

29. In regard to mortality from phthisis, I show a chart giving the comparative mortality figure, taken from the Registrar-General's Decennial Supplement on Occupational Mortality in the three years 1910-1912. It shows that the comparative mortality figure for phthisis was 142, for All Occupied and Retired Males, and that for persons in comparatively easy circumstances, in the open air, and in the three large industries of coal-mining, cotton and wool, the figure was below 142. Something is present there (possibly the less close aggregation of workers together in factory employment) to account for this. Above All Occupied Males occurs a block of indoor occupations, where aggregation of workers is prominent—hosiers, hatters, tailors, printers, shoemakers. Later on in the chart come other factors—injurious dusts, which play a much more important rôle than aggregation of workers.

30. Although the subject dealt with is sufficiently important, it is paradoxical that the relation of occupation to health is entirely excluded from the medical curriculum, and men and women obtain their qualifications to practise as general practitioners without ever having had their attention called to the most important factor affecting the health of their patients, namely occupation.

31. I do not regard industrial hygiene and industrial medicine as an entity in itself, but simply as a specialised part of general medicine and surgery, from which they cannot properly be detached. Early clinical evidence of disease predisposed to, accentuated, or produced by, industry is wanted (1) for diagnosis, (2), for prevention, and (3) for treatment.

32. When dealing with the words, "Alterations, extensions or developments" in the National Health Insurance Act, it is impossible not to refer to the statistics of compensation under the Workmen's Compensation Acts, 1906 and 1923, relating mainly to the seven great groups of industries in which returns are called for from employers under section 12, namely:—mines, quarries, railways, factories, docks, construction works and ships. The great number of persons coming within the provisions of the Act has already been stated—7,342,311. The total number of cases in which compensation was paid in 1923 was 480,035, and the total amount of compensation was £7,134,096. Regarding the duration of compensation, there is a marked difference between the figures for accidents and disease in the number of cases lasting less than four weeks. More than half the cases of accidents last less than four weeks and less than 10 per cent. for 13 weeks or over, whereas only 1/3rd of the cases of disease lasted less than four weeks, and 34 per cent. over 13 weeks. The bulk of the cases of compensation for industrial diseases occurred in the mining industry. In 1923, some 10,000 cases of nystagmus, including old and new cases, received compensation, involving probably expenditure of over a million pounds.

33. As emphasising my point of the need of taking steps in the direction suggested (1) I quote the recommendation made at the International Labour Conference at Washington in 1919 by the Commission on Unhealthy Processes, and (2) I append the very apposite — not to say convincing — expressions of opinion on the subject of medical supervision in the

factory and workshop by the Health of Munition Workers Committee:—

(1) “. . . Further, following up the wish formally expressed by all the members represented, the Committee is convinced of the necessity for the International Labour Conference suggesting to the Governments which have not already set up medical organisation of the kind, that they should make provision for a service specially charged with the duty of safeguarding the health of the workers, in addition to a system of efficient factory inspection.”

“The Commission on Unhealthy Processes . . . expresses the hope that medical inspection to safeguard the health of the workers will be instituted in all countries. . . .”

34. I suggest that my proposals might be incorporated in a section of the Act, in substitution for the existing section 63, seeing that section has been nugatory.

35. I am not prepared with a precise wording of the section, but imagine that it will be drawn up on somewhat similar, but wider, lines to that of clause 91 of the Factories Bill, 1924 (Cmd. 2237). In the case of persons other than young persons, however, the conditions of the certificate would have to be less stringent than in the case of young persons. Power of re-examination in their case is what is specially wanted. Naturally, too, transference of the duty of arranging for medical examination would be to the Ministry of Health and not to the Local Authority. The clause is as follows:—

“Certificate of fitness of Young Persons for Employment.

91. (1) Subject to the provisions of this section, a young person shall not be taken into any employment in a factory unless he has been examined by the appointed doctor within the prescribed period and certified by him to be fit for that employment.

(2) The certificate by the appointed doctor may be given:—

(a) in respect of employment—

- (i) in a particular factory;
- (ii) in any group, class, or description of factories;
- (iii) in a particular process or class or description of work; and

(b) upon condition that the person concerned shall not enter on the employment unless and until any physical defects specified in the certificate have ceased to exist, or that he shall be subject to re-examination after an interval specified in the certificate, or on both those conditions.

(3) The Secretary of State may by order transfer to the Local Authority the duty of arranging for the medical examination and certification of young persons under this section.

(4) The Secretary of State may make rules for prescribing—

- (a) the manner in which and the place at which examinations under this section shall be conducted;
- (b) the form of certificate under this section;
- (c) the facilities to be afforded by occupiers of factories for the purpose of examinations under this section;
- (d) any other matter which the Secretary of State may consider desirable for the purpose of giving effect to this section.

(5) It shall be the duty of every local education authority under the Education Act, 1921, to arrange for the production to an appointed doctor, for his confidential information, of so much of the school medical record of a young person as may be necessary to enable him to carry out effectively the examination under this section, and the Minister of Health may, in consultation with the Secretary of State, make rules for the purpose of securing the observance of the provisions of this subsection or may arrange that the Board of Education may make such rules on his behalf.

(6) For the purposes of this Act the expression “local authority” means as respects a county, the council of the county, and as respects a county borough, the council of the borough.

(7) The Secretary of State may by order exempt from the operation of this section any factory or class or description of factories in which mechanical power is not used.

#### MEDICAL SUPERVISION IN FACTORIES.

##### *Extracts from the Health of Munition Workers Committee's Report on Medical Examination.*

Page 7.

. . . Therefore, as the problems to which reference is made in this report concern the future as well as the present, so also they are concerned with the new preventive medicine which has as its object the removal of the occasion of disease and physical inefficiency combined with the husbanding of the physical resources of the worker in such a way and to such a degree that he can exert his full powers unhampered, and with benefit to himself and all concerned.

Page 14.

. . . As to the injurious effects of industry upon women and young persons, reliable data may be said to have been almost wholly lacking, as they are equally lacking in respect of the relation of fatigue to disease.

. . . In the Committee's view it is necessary to make arrangements without delay for a national scheme of industrial medical research, and to accord fuller recognition to the importance of industrial hygiene.

Page 20.

. . . Owing to the factory employment of many workers for the first time, and of increased numbers of women, often at a distance from home, arrangements must be made for individual supervision and the maintenance of their health. The employment of boys also calls for special vigilance and attention.

. . . Unless industrial life is to be guided in the future—(i) by the application of physiological science to the details of its management, and (ii) by a proper and practical regard for the health and well-being of

our workpeople in the form both of humanising industry and improving the environment, the Nation cannot hope to maintain its position hereafter among some of its foreign rivals, who already in that respect have gained a present advantage.

#### INDUSTRIAL EMPLOYMENT OF WOMEN.

Page 23.

(d) for making appropriate provision for effective medical supervision, both on entrance to the factory (in heavy and exceptional occupations) and subsequently, by means of the services of medical officers (women preferred) and nurses, and in the form of suitable accommodation as to rest rooms, first-aid appliances and well-equipped surgeries.

Page 28.

(b) Adequate and suitable medical supervision, including the provision of rest-rooms, surgeries and first-aid appliances, properly staffed.

(c) The careful selection of women for work within their capacity, the heavier work being allocated to the younger women.

#### LOST TIME AND INCENTIVE.

Page 51.

. . . They are disposed to place the health and physical fitness of the individual worker as the first necessary condition of output, and to that end they desire to lay emphasis upon the extreme value of all factory conditions which contribute to such health—good lighting, effective ventilation, sufficient heating, cleanliness, rest-rooms, proper canteen accommodation, protection from industrial poisoning and dangerous machinery, surgeries, suitable welfare work within and outside the factory—all these are conditions of first and fundamental importance from the point of view of health and incentive to work.

#### SICKNESS AND HEALTH.

The whole of this section, but especially:—

Page 63.

275. At the foundation of any sound system of dealing with industrial diseases lie two elementary principles: First, that prevention is better than cure; and, secondly, that for treatment to be imposed effectively it must deal with the beginnings of disease. Bearing these in mind, the preliminary safeguard should be to provide for the medical examination of all workers in order to secure as far as may be their physical fitness for employment. In some munition works, and especially in those where dangerous substances are manipulated, a preliminary medical examination of all workers is usual. Dental treatment is also sometimes provided. Such examinations are specially important at the present time owing to the strain involved by the conditions of employment and owing to the large number of persons who are taking up industrial employment for the first time; but such examinations are always likely to be desirable where the work involves any special strain, and particularly so in the case of women. Apart from their value in detecting early signs of ailment or defect, medical examinations are valuable as affording convenient opportunity for the inculcation of sound doctrines as to personal hygiene, cleanliness and healthy habits. Periodic re-examination is practically confined to certain dangerous trades and processes, the workers in which have to be periodically examined under the regulations of the Home Office or the Ministry of Munitions. Where they can be arranged for, such examinations might usefully be extended to workers engaged in other processes involving special strain or risk.

276. It is true under section 63 of the Factory and Workshop Act it is necessary for every boy and girl under 16 to be certified by the Factory Certifying Surgeon as physically fit for employment in the

factory. Unfortunately, this certificate is not always adequate for its purpose. The decision of the Surgeon has normally to be based simply on one brief examination. More often than not he has no previous knowledge of the boy or girl, and, generally, the records of the School Medical Service are not available. After a young person has once been admitted to a factory, no further medical examination is required except in the rare instances where the Factory Inspector may specially require it. In view of the strain which industrial employment may often impose on growing boys or girls, it would undoubtedly be an advantage if arrangements could be made for their periodic re-examination. It may be pointed out that the Departmental Committee on "The Night Employment of Male Young Persons" emphasised the need for such periodical examinations once at least in every six months, and recommended that records of the results should be kept.

278. Thirdly, arrangements should be made for adequate medical and nursing schemes. Medical attendance is obtainable under the National Insurance system, or may be made available by the special provision of a medical and hospital service for the factory. Nursing can only be obtained by the employment of one or more trained nurses to undertake duties in the factory by night as well as by day. Such arrangements have been instituted in many munition factories, especially where women are employed, and have proved of great value to employers and workers alike. The duties of the factory nurse may include:—

- (a) Supervision of the health of the workers.
- (b) Superintendence of the rest-room for those who are temporarily indisposed.
- (c) Following up cases of sickness at home.
- (d) Taking charge of First-Aid treatment of injuries.
- (e) In the absence of medical advice, observing and controlling in its initial stages any threatened outbreak of the influenza type of sickness, which, if it extends, may temporarily paralyse output.

279. . . . In factories engaged upon the manufacture or manipulation of poisonous substances and gases, 51 medical officers are at present employed. Of these 14 are whole-time officers and 37 part-time. Their duties include the preliminary medical examination of the workers, the supervision of their health while at work, a constant inspection of the working conditions of the factory, and the regulation of suspensions. In addition, they are constantly concerned with other matters more or less directly affecting the health of the workers. They report periodically to the Ministry on medical problems arising in their work. At many of these factories dentists are employed by the management to treat new workers, who require to have carious teeth removed before they can be safely employed. In other factories the employment of medical officers is still rare, though it is increasing and development is likely to be encouraged through the need for securing the proper supervision and maintenance of the first-aid appliances, the provision of which is required by the recent Home Office Order.

#### INJURIES AND ACCIDENTS.

The whole of this section.

#### EYE INJURIES.

The whole of this section especially:—

Page 72.

308. When operatives are being engaged for fine work their eyesight should be tested by a medical officer, or, if he is not available, a nurse or welfare supervisor should apply simple eye tests to discover whether the vision is normal. Any worker who fails to reach the standard adopted should be referred to an ophthalmic surgeon or eye hospital for regular

examination, and if necessary be supplied with glasses. When workers are examined for glasses, the nature of the work to be performed should be specified whenever possible. For many people, and particularly those past middle life, the glasses which give the best acuteness of distant vision would not enable the owner also to do fine work at close range and *vice versa*. Workers who complain of frequent headaches, pain in the eyes, or show signs of conjunctivitis should also be tested.

#### SPECIAL INDUSTRIAL DISEASES.

The whole of this section especially:—

Page 78.—*T.N.T.*

328. . . . (g) A constant medical supervision should be exercised not only by formal medical examination, but also by scrutiny of the workers while at work. The medical officer should have power of immediate suspension where necessary. Careful health records should be kept.

Page 80.—*Lead.*

333. The manifestations of poisoning can be detected by a medical man, and their presence indicates that the worker should be transferred to other work. The Home Office Regulations require employers to have persons engaged in various lead industries examined periodically by a surgeon who is entrusted with powers of suspension from work. This medical supervision has been found of much value, and has been widely adopted even in industries not governed by regulations. It may be usefully extended to all factories where the use of lead oxides or other of its many compounds, may have been introduced into the manufacture of munitions. In the handling of metallic lead, *e.g.*, bullets, the risk of poisoning is very slight, and medical supervision is less important.

Page 81.—*Aeroplane Dope.*

336. . . . (a) Periodic medical examination of all workers should be provided for.

Page 71.—*Poisonous Gases.*

338. . . . (a) The appointment of a medical officer for each factory.

(b) The medical examination of all workers before engagement, and at frequent intervals during employment.

(c) Suitably equipped ambulance stations in charge of a trained nurse and under the constant supervision of the medical officer.

(d) Hospital accommodation for special cases.

Page 82.—*Fulminate of Mercury.*

341. . . . (d) Where exposure is marked, periodical medical examination.

#### WELFARE SUPERVISION FOR BOYS AND MEN.

Page 108.

483. . . . 7. To overlook the general conditions and health of the boys, and where necessary, arrange for medical inspection.

Page 111.

488. . . . The weekly visit of the Home Office Certifying Surgeon calls for the supervisor's presence, especially when boys are examined as to their fitness for night employment. He is in a position, from the knowledge gained at his preliminary interviews with the boys, to draw the doctor's attention to any physical weakness which, while of little importance in itself, may prove a danger to the boy as a result of his employment. He can arrange for a re-examination of boys whose health seems to be affected by working at night, and keeps a record of all cases

where boys are declared unfit for any work other than in the daytime, so that arrangements may be made, if necessary, for the transfer of a boy to a department where there is no night employment.

#### SUMMARY OF CONCLUSIONS.

Page 120.

533. . . . While the Committee have of necessity been primarily concerned with the health and physical efficiency of the munition worker under the abnormal conditions created by the war, they are strongly of opinion that the principles underlying right action at the present time are permanent and not merely transitory in importance, and should be accepted also as fundamental to all schemes for industrial health and betterment after the war. One of the vital and pressing problems before the country at the present moment and in the immediate future is the question of the health and contentment . . . .

Page 121.

iii. . . . It is only within the last 20 years that medical officers have been appointed to the Factory Department of the Home Office, and the limited number of those officers has made it inevitable that their activities should be largely confined to questions of immediate administrative importance. It is greatly to be hoped that permanent provision will be made for a wider and more continuous investigation of the influences of industry upon health than has hitherto been practicable.

x. Certain conditions of employment are essential if the risk of future breakdown is to be avoided, including short hours of work conveniently arranged, medical supervision (including rest-rooms, first aid, etc.), careful selection of workers, good food, a favourable factory environment, sympathetic management and supervision.

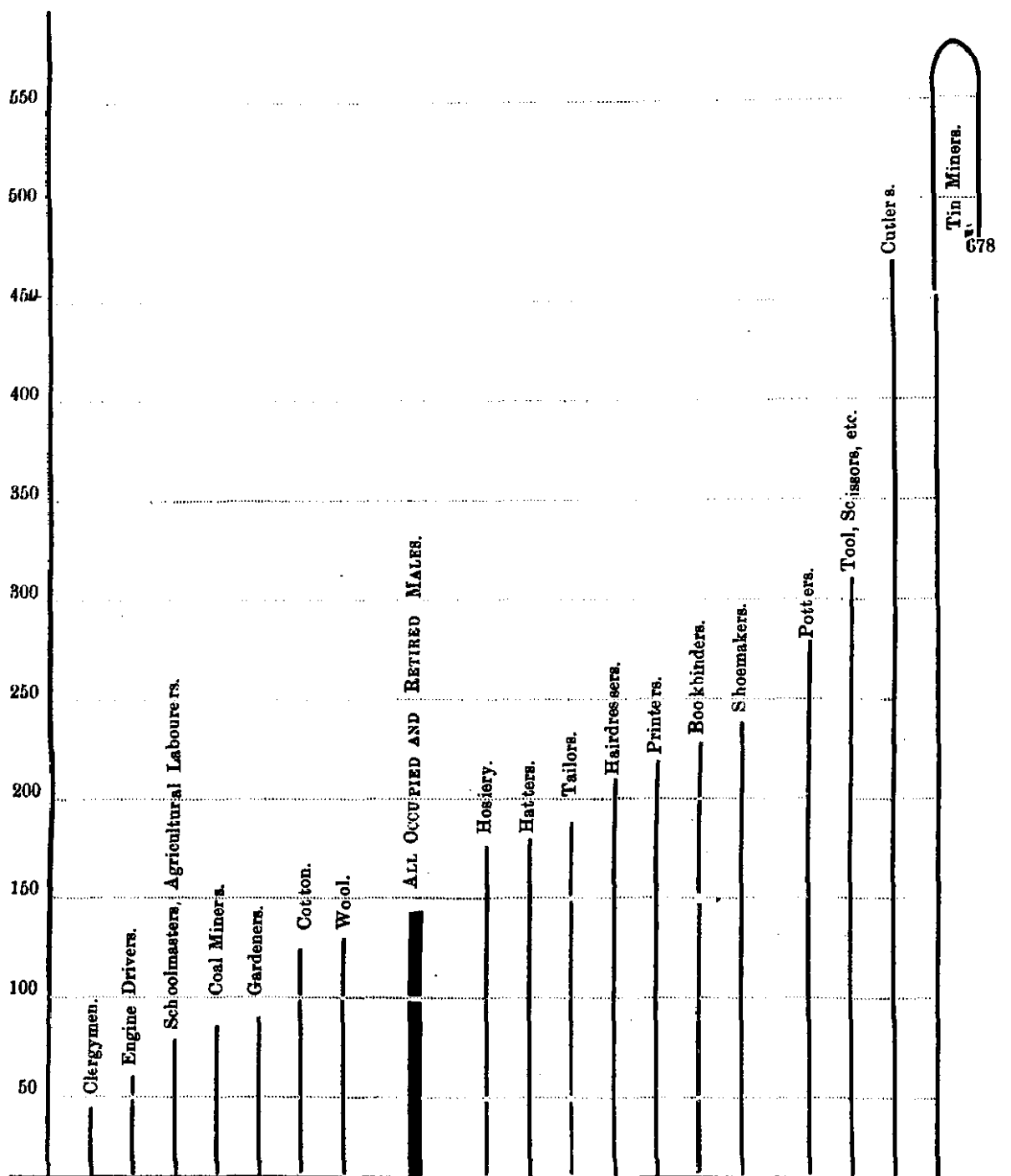
Page 124.—*Sickness and Ill-health.*

Conditions of industrial occupation may affect health by reason of long hours of work, cramped and constrained attitudes, prolonged or excessive muscular strain, bad ventilation and lighting, dust and fumes. To the influences of occupation upon health must be added the pre-disposition to disease arising from the absence of personal hygiene.

Any sound system for dealing with industrial disease must be based on the principles, first, that prevention is better than cure, and secondly, that the treatment, to be imposed effectively, must deal with the beginnings of the disease. It follows that the preliminary safeguards should be to extend to all workers the preliminary medical examination already provided for in certain munition works and especially in those where dangerous substances are manipulated. Such an examination is especially necessary at the present time owing to the strain involved by present conditions of employment and owing to the large number of persons who are taking up industrial employment for the first time; but such examinations are likely to be always desirable where the work involves special strain and particularly so in the case of women. There is similar need for the periodic re-examination of such workers.

The present provisions of the Factory Act for the certification of the physical fitness for employment of children and young persons can hardly be regarded as adequate. The factory's Certifying Surgeon has seldom any previous knowledge of the case. The value of his certificate would be greatly increased if it were only given after consideration of the medical records in the possession of the School Medical Service, and closer co-operation appears to be desirable. At present these records are seldom available. Provision is now seldom made for periodic re-examination, but it is extremely desirable having regard to the effect of entry into industrial life. The Departmental Committee on the Night Employment of Male Young Persons emphasised the need for periodic examinations once at least in every six months, and recommended that records of the results should be kept.

## COMPARATIVE MORTALITY FIGURE FROM PHTHISIS 1910-1912.



## APPENDIX XLIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL SAILORS' AND FIREMEN'S UNION OF GREAT BRITAIN AND IRELAND BY MR. T. CHAMBERS, C.B.E., EXECUTIVE OFFICER IN CHARGE OF THE WORK OF THE UNION AS AN APPROVED SOCIETY. See Minutes of Evidence of the Twenty-Fifth Day, Questions 13,954 to 14,058.

## CONSTITUTION AND GOVERNMENT.

1. The Society is a registered Trade Union, number 1498, and is approved for Health Insurance purposes as a whole for men, number 128, operating in England, Scotland, Wales and Northern Ireland. As a Trade Union it has an approximate membership of 58,000, including 170 women-stewardesses. Its membership revenue for 1923 was approximately £150,000, increasing for 1924 to about £3,200 per

week. Its capital value at end of 1923 was £286,642. Apart from head office staff the Union has 172 full-time officials with 70 clerical assistants working in 53 ports of Great Britain and Ireland, all of whom are required to look after the interests of the Approved Society. They issue and collect insurance cards; they accept claims for benefit for remission to Head Office; and they pay out and take receipts for such moneys as are sent to them for payment to the members. There are also branches and

agencies at ports on the Continent and in the U.S.A. Cards can be handed in at these ports and insured members are entitled to such assistance from the officials as they may require. The membership register is centralised at headquarters, and all benefits are administered from headquarters through the branch representatives.

2. The government of the Union is vested in an Annual General Meeting of delegates elected by and from the members resident in or sailing from defined geographical areas. This meeting is the supreme authority for Trade Union and Health Insurance matters.

3. The general management is at the hands of a Committee called the Executive Council, part of which is *ex officio*; part elected by the Annual General Meeting; and part elected direct by the members. The Council supervises both the Trade Union and Health Insurance work. Under the rules it has power to accept transfer of engagements of other Approved Societies and has taken over Society 2236, the Hull Seamen's Union Approved Society, and Society 362, the Port of Hull Trawl Fishermen's Approved Society. The Council has power under the rules to make a contract payment for the administration of the Approved Society and such a contract has been made. Reference to the effects of such contract on the work of the Society under the prescribed administration allowance will be made lower down.

4. The immediate administration of benefits and the control of finance is at the hands of the Finance Committee as provided in the rules. This Committee consists of the Executive Officers and the Trustees.

5. It is suggested that the machinery of organisation which has been built up as the result of many years' experience provides for the actual control of all the activities of the Union by its members and is machinery particularly adapted for dealing with an organisation of seafarers.

6. On the separation of the Health Insurance system of the Irish Free State from Britain and Northern Ireland 1,600 insured members were transferred to the Irish Trade Union Congress Health Insurance Society. There are now 30,900 insured members of the Union, that is members of the Trade Union who have made the Union their Approved Society.

#### VALUATION RESULTS.

7. The valuation as at the 31st December, 1918, showed a surplus of £45,466, of which £21,512 was carried forward, and £20,954—say 12s. 10d. per head—was certified as disposable, and certain additional benefits are being paid out of the disposable surplus. No claim for treatment benefit on behalf of any member who has a title to additional benefit has ever been refused.

#### SPECIAL PROVISIONS FOR SEAMEN.

8. To those familiar with the industrial conditions of the seafarer it will be obvious that special provisions would be necessary in any Health Insurance scheme, based on employment, in order to deal equitably with the personnel of the Mercantile Marine. The seafarer is always a special problem within every national industrial problem. Accordingly special provisions have been made in the Health Insurance Acts for the mercantile mariner. These provisions were set out in section 48 of the 1911 Act, which were amended in subsequent Acts from time to time. They have been consolidated in sections 62-64 of the Act of 1924. In the main they work fairly well but improvements might be made.

9. Questions of insurability arise out of employment at sea which do not arise out of employment on shore. Difficulties arise out of the question of domicile (section 62 (4)). Certain types are very much concerned about Unemployment Insurance, but take no interest in Health Insurance until the need arises.

10. There is the question as to whether certain work done on board ship when the rate of remuneration exceeds the net value of £250 per year is employment by way of manual labour or not. Practical difficulties arise during the course of a voyage. A man may start the voyage as a junior engineer with remuneration below £250 per annum and no question arises as to whether that employment is by way of manual labour or not. During the course of the voyage he may be temporarily promoted to a higher rating with remuneration beyond £250 per annum with the question arising as to whether his employment is by way of manual labour. It might be determined, on appeal to the Ministry, that the new employment was not by way of manual labour and consequently he would cease to be insurable. The cause which contributed to his temporary promotion might be removed during the course of the same voyage and he would go back to the junior rating where he would be insurable. Although we have no actual cases, as we have no seagoing engineers on our registers, I am informed by an engineer's society that there are cases where men are both in and out of insurable employment during a continuous voyage. This difficulty might be met by a ruling, by way of regulation or otherwise, that if a member of the crew starts on a foreign-going voyage in insurable employment his employment during the continuation of that voyage should remain insurable employment regardless of the amount of remuneration.

11. We meet a few difficulties in other matters of excepted employment, particularly where young men, employed in the sea service, take temporary or short service in excepted employment, for instance, in the Corporation of Trinity House. If the temporary or short service in such employment extends over one year the benefit of previous insurance is lost to the contributor and on his discharge from excepted employment and re-entry to insurable employment he has to start entirely afresh.

12. Our member number 69,414 was first employed after attaining the age of 16 years on the 15th September, 1919. He remained in that employment until the 11th September, 1922, when he entered the service of the Corporation of Trinity House. He was so employed until the 14th March, 1924. He resumed insurable employment on the 7th June, 1924, as an entirely new entrant. He has lost the qualifying period for additional benefits on the 1923 valuation, he is subject to an entirely new waiting period for maternity sickness and disablement benefits, and, of course, for a time will only get a reduced rate of sickness benefit. Is it not possible to provide a remedy for hardship arising out of this and similar cases?

13. Although not specially connected with the Mercantile Marine this may be the place to raise the question of men otherwise unemployed who are employed on relief work. It is evident that if men can be employed on relief work they are fit to undertake insurable employment if it can be obtained. If a health card were stamped in respect of such employment it would keep in insurance those who are not otherwise entitled to be kept in under the Prolongation of Insurance Act. Cards should be stamped for relief work just as for ordinary employment.

#### CONTRIBUTION AND ARREARS CARDS.

14. The general work of a society whose members are mainly employed in the Mercantile Marine differs materially from the work of a society which has no such members. With the ordinary employed contributor the Approved Society gets a card in respect of his employment for each half-year. With a man employed in the Mercantile Marine on Western Ocean voyages lasting three weeks the society might get seven or eight separate cards during the course of a half year. On the other hand the man might be employed on a long voyage and a card might not be due to be surrendered for a period of three years or more. Article 10 of the Regulations of 1924 provides for the method of dealing with the card under



the present system. It would be useful to Approved Societies if the master of the ship delivered the card of a person deserting his ship or dying during the period of his engagement, to the Consular Officer at the first opportunity afforded, instead of retaining the card until the termination of the voyage as now set out in paragraph (3). In the event of a seaman being left on shore on grounds of his unfitness or inability to proceed to sea the master should be required to deliver the card duly stamped to the seaman whether the place at which he is left is a British possession or not. Paragraph (2) provides that the card is only given to the seaman in such cases when he is discharged in a British possession. So long as the present arrangements remain, it is possible for a man to be left on shore in a foreign country owing to his inability to proceed to sea, and no provision made for the proper delivery of his stamped card until eighteen months or may be two years after the man has been left behind.

15. The effect of the necessary different method of dealing with Mercantile Mariners, in the way of collection of contributions, means extra work in the preparation of arrears cards at the proper time. By regulation an Approved Society is required to send an arrears card to each of its members who has not the necessary number of contributions at the end of a contribution year to entitle them to full benefit during the next benefit year. This year our Society, in accordance with that regulation, had to despatch arrears cards to 18,465 members. It may be possible that a number of the men were on long voyages, cards were not due to be surrendered, and when such cards are ultimately surrendered they may cancel all the arrears. On the other hand additional cards surrendered as soon as possible after the end of the voyage, although not cancelling all the arrears, might reduce them and a new arrears card would have to be despatched.

16. Suggestions have been made as to a different method of the collection of Mercantile Marine contributions which would render it unnecessary for the men to handle the cards at all. Instead of preparing and stamping cards it is suggested that the shipowner or his representative should prepare certain schedules; such schedules, with the cash representing the contributions, to be passed over to the officer at the Mercantile Marine Office on the discharge of the vessel. That office to send the schedules with the remittance to the Ministry of Health and the Ministry to distribute the credit of the contributions to the various Approved Societies of which the members of the crew might be members. It is certain that by this means a present leakage of contributions in respect of foreign-going seamen would be stopped. Various estimates have been given as to the amount of that leakage but it is very difficult to estimate its actual extent.

17. So long as the present system of collection of Mercantile Marine contributions continues the regulations should be strictly carried out. Unless this is done difficulties arise. Our member, number 22179, served on a certain vessel on a continuous voyage trading on the China Coast, commencing in December, 1921. The engagement terminated at Tientsin, North China, the member arriving in this country on the 23rd October last, the vessel remaining in the East. When wages were paid neither Health nor Unemployment stamps were available, and the men were informed by H.M. Consul that the owners would forward the cards to their home addresses. Up to the 10th November, 1924, this particular member had not received his cards. The facts were brought out on his receipt of an arrears notice from us. Member number 78503 served part of the time in the same vessel, namely, from the commencement of the voyage until he was left sick at Hong Kong on the 18th June, 1923. No cards were handed to him, but on the 25th October, 1923, the Health and Unemployment Insurance cards were sent to the member addressed to the Sailors' Home, Cardiff. Our local representative made a round of the various Sailors' Homes in that port and the letter was eventually traced on the 4th December, 1923. Seamen do not always return to the same Sailors' Home at which

they resided before the commencement of a particular voyage, and action should be taken to ensure that the cards are dealt with in the proper way, as provided by the regulations, so that there is no danger of Health Insurance cards lying for long periods unclaimed in Sailors' Homes or boarding houses.

#### PAYMENTS TO DEPENDANTS.

18. Under the proviso to section 62 (1) sickness benefit may be paid to the dependants of seamen during the period which the owner of the ship, under section 34 of the Merchant Shipping Act, 1906, is liable in respect of certain expenses. There is not much difficulty in settling the question of incapacity when the seaman is an inmate of a hospital abroad, but difficulty arises in obtaining evidence of incapacity after the man leaves hospital and before the date of his actual arrival in this country.

19. If the seaman is sent home by H.M. Consul under a Conveyance Order such order should state his condition when he leaves for home. If a medical officer is carried on the ship on which the seaman returns to this country a certificate as to his condition during and at the end of the passage home signed by that officer should be attached to the Conveyance Order. Information as given thereon should be available through the Board of Trade to Approved Societies. If no medical officer is carried on the ship a certificate by the master should answer the same purpose.

#### SECTION 63 OF THE 1924 ACT.

20. It is with considerable diffidence that I make any comment on section 63, but as the organisation I represent is concerned with seamen only I venture to mention one or two matters of principle.

21. This Society often receives accounts from medical practitioners in respect of services rendered to the members under the impression, on the part of those practitioners, that the arrangements for medical benefit of our members are the same as those for the members of the Seamen's National Insurance Society. As far as we know, the ordinary medical benefit arrangements work as well for seamen as for any other section of insured persons. I do not remember receiving any complaint that any of our members could not get medical attention whenever it was required through any fault in the medical benefit arrangements. As far as our experience goes there would appear to be no reason for any special arrangement regarding the medical benefit of men employed in the Mercantile Marine.

22. It is submitted that any society for seafarers only should be constituted in exactly the same way as all other Approved Societies, and that its control should be in the hands of its members. At the commencement of National Health Insurance, before the special fund for seamen (section 64) was established, there might have been some reason for employers to have representation on the committee of management of the special seamen's society, seeing that that society had control of moneys which were contributed by employers only. The control of these particular moneys now having passed from the special society to the special fund for seamen, there does not appear to be any reason why shipowners should have any more share in the management of an Approved Society for seamen than millowners should have a share in the management of an Approved Society for cotton spinners. There would appear to be no reason for any third party, e.g., the Board of Trade, being brought into the management of a seamen's society. It is found through our own experience that seamen are quite capable of looking after their own interests.

#### SEGREGATION OF SEAMEN IN ONE SOCIETY.

23. Suggestions have been made for segregating the whole body of seamen in one Approved Society. I see grave difficulties in the way of such segregation. An insured seaman does not always commence his industrial life as a seafarer. He may come into the sea service, as he often does, after two or three

years of other employment. After a few years he may leave the sea service and seek other employment. Segregation, to be effective, would mean the compulsory transfer of all insured persons employed on board ship from the particular society of which they might be members to the special society, and on their leaving the sea service it might mean their compulsory transfer to another society. These compulsory transfers would interfere with the right to additional benefits. In any event the control of any special society should be in the hands of its members. I would welcome any arrangement which can be made whereby men regularly employed in the Mercantile Marine might be induced to come together in one society in as large a number as possible.

#### SECTION 64 OF THE 1924 ACT.

24. The pension arising out of the employers' contributions paid in respect of seamen who are not domiciled in the United Kingdom (section 64) is very much valued by old seafarers. It would seem, however, that a very large sum of money is being accumulated, and consideration might be given to questions as to (a) whether the amount paid as an individual pension could not be increased, (b) to extending the pensions to old seafarers who are at present excluded under sub-section (4), (c) to the permanent addition to the State Old Age Pension.

25. It is submitted that the Special Fund itself is well able to afford the cost of its own administration and sub-section (5) should be repealed. At present societies may be made liable for expenses of administration over which they have no control.

#### ADMINISTRATION ALLOWANCE.

26. In paragraph 3 above I made reference to the administration allowance. It is almost self-evident

that the work of administration of an Approved Society mainly composed of seafarers is of necessity more difficult and more expensive than the work of administration of an ordinary Class A. Society. This Society has a contract arrangement with the parent Society through which the services of all officials and employees of the Union are available for Health Insurance work. The Society could not have had the full benefit of that service in any other arrangement, and to provide for efficient administration in any other way would have meant a very considerable deficit on the administration account. The administration allowance in respect of Mercantile Marine members should be a larger amount than the administration allowance in respect of Class A.1

#### MEMBERS IN INSTITUTIONS.

27. An amendment of section 17 (3) seems to be called for. We have had cases where members have been in an institution for long periods, and while in the institution no one has taken any interest in them, yet on death claims have been made by next-of-kin for the considerable sums of benefit which have accumulated. Where insured persons have dependants, benefit is, of course, paid to such dependants during the period of incapacity, but it is these cases where there are no dependants to which I desire to direct attention at the present time. I suggest that a limit to the amount payable to next-of-kin should be made in such cases. It does not seem to be right that a person should be able to make a profit out of the death of any other person by reason of sums of money which have been paid in part by the insured person's employers and in part by the State.

T. CHAMBERS.

3rd December, 1924.

## APPENDIX XLIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE LOYAL ORDER OF ANCIENT SHEPHERDS (ASHTON UNITY) FRIENDLY SOCIETY (APPROVED SOCIETY No. 122), BY MR. JOHN GRIEVE, DEPUTY CHIEF SHEPHERD, AND MR. ALFRED J. E. SAUNDERS GENERAL SECRETARY. See Minutes of Evidence of the Twenty-Fifth Day, Questions 14,059 to 14,250.

## GOVERNMENT.

1. The Loyal Order of Ancient Shepherds, Ashton Unity, Friendly Society was established in the year 1826; it is registered under the Friendly Societies Act, and provides sickness and funeral benefits for male, female and juvenile members; for the purpose of National Health Insurance it is an Approved Society operating under the number 122.

2. The Society is an International Society, operating through 842 Lodges and 37 Districts distributed throughout the United Kingdom, nearly one-half of the membership being in Scotland.

3. The following table gives particulars of the membership of the Society on its private side and National Health Insurance side:—

Table showing Voluntary and State Membership in the United Kingdom.

(As at 31st December, 1923.)

Country.	Voluntary Only.	Voluntary and State.	State Only.	Total Membership.
England ...	18,060	38,217	39,761	96,038
Wales ...	3,960	8,708	8,524	21,190
Scotland ...	21,522	42,635	46,921	111,078
Ireland ...	462	301	569	1,332
Totals ...	44,004	89,861	95,775	229,638

## SUMMARY OF MEMBERSHIP.

United Kingdom, Voluntary only ...	44,004
"    Voluntary and State ...	89,861
"    State only ...	95,775
Foreign and Colonial Members ...	4,696
Unity Members ...	33
Juvenile Members ...	100,785
Wives and Widows ...	65,019
Honorary Members ...	3,201
	403,374

4. For the purposes of National Health Insurance, the Lodges and Districts have been grouped into eighteen areas called Centralised State Districts, the area being the unit for accounting and valuation; and, with the object of securing more efficient administration, the State-insured members are attached to the registered Lodges, and these Lodges act as agents to the Centralised State Districts for the purpose of issuing and collecting stamped cards, paying benefits, and sick visiting. Supervision and scrutiny of all claims is carried out at the District Offices, which notify the Lodges as to when claims are in order, and authorise the payment of benefits.

5. At the inception of National Health Insurance (in July, 1912), the Society was composed of 963 Lodges, which became the accounting units for National Health Insurance, and these Lodges were under the supervision of 85 Districts and the Order Executive.

6. In the year 1913 consideration was given to the desirability of bringing about some measure of centralisation for the purpose of securing more efficient

administration with the result that as from 11th January, 1914 (i.e., the end of the sixth quarter of National Health Insurance), the whole of the Lodges were grouped into 22 areas, and the administration was transferred to these areas, which were termed Centralised State Districts, each having upwards of 5,000 members with the exception of four areas, where unusual conditions prevailed.

7. Nine Districts whose State-insured membership exceeded 5,000 were allowed to become Centralised State Districts and to carry on voluntary and State work jointly under one Executive body. The State-insured membership in the remaining Districts was grouped into 13 specially-constituted Centralised State Districts to deal only with National Health Insurance; four of these have since been amalgamated with larger areas.

8. All insured members have the right of attending any meeting of the voluntary Lodge to which they are attached, called for the purpose of considering any matter dealing with their interests as State-insured members.

9. The District is governed by a representative body of delegates appointed by the Lodges comprising the District. Some Districts meet quarterly, others half-yearly, and some annually. At the Annual Meeting the Officers and Executive are elected for the ensuing year from nominations made by the Lodges.

10. The Districts appoint representatives to the Annual Meeting of the Society (termed "Annual Movable Conference") which meets during Whit-week in each year at a place decided upon by the preceding Annual Meeting.

11. At the Annual Movable Conference three Officers are elected, together with six other members, and these, along with the General Secretary, constitute the Executive of the Order, four of whom retire annually. The Order Executive meets quarterly, and at such other times as any special business may require.

12. Our system whereby the members of the Centralised State districts are attached to lodges, enables the retention of the Friendly Society spirit by allowing the local officers to keep in personal touch with the members and also ensures prompt payment of claims. It is estimated that at least 80 per cent. of the officers throughout the Society are themselves State-insured persons, and therefore have a personal interest in the welfare of National Health Insurance.

## VALUATION.

13. The membership of the Society at the first valuation (31st December, 1918) was: men, 154,889; spinsters and widows, 31,805; married women, 6,709; Class "K," 234; total membership, 193,637. The total disposable surplus was £105,939, and, in addition, £98,937 was carried forward as reserve. No district was in deficiency, and only one had no disposable surplus. The following table shows the number of members brought into the valuation as at 31st December, 1922, and gives particulars of the valuation results throughout the Society as at 31st December, 1918, and as at 31st December, 1922.

Districts.	National Health Insurance.					Valuation Results as at 31st December, 1918.							Valuation Results as at 31st December, 1922.			
	Membership.					Surplus Revealed.			Additional Benefit Schemes in Force.				Total Surplus.	Amount taken to Reserve.	Surplus Available for Benefits.	
	Men.	Spinsters and Widows	Married Women.	Class K.	Total.	Total Surplus.	Amount taken to Reserve.	Disposable Surplus.	Cash Benefits.		Treatment Benefits.					
					£	£	£	s. d.	s. d.	s. d.	Nature of	Yearly Allocation.	£	£	£	
<b>ENGLAND.</b>																
Bristol, Bath, &c, Head Office Branch	9,485	2,171	532	176	12,364	14,800	7,617	7,183	1 0	0 6	2 0	Dental ...	750	42,850	13,982	28,868
East Anglia	8,469	768	186	63	9,486	17,707	6,679	11,028	2 0	1 0	5 0	Dental ... Surgical Appliances. Optical ...	455 151 151	43,067	13,392	29,675
Essex	5,352	535	198	43	6,128	8,362	3,370	4,992	2 6	1 3	5 0	—	—	21,992	6,888	15,104
London	4,162	817	250	64	5,293	7,969	3,312	4,657	1 0	0 6	2 0	Dental ... Optical ...	500 200	21,114	6,515	14,599
Manchester	4,965	1,414	527	70	6,976	6,779	4,106	2,673	1 0	0 6	2 0	—	—	22,687	7,549	15,138
Midland Counties	8,158	1,308	418	88	9,972	3,540	3,540	—	—	—	—	—	—	18,978	7,257	11,721
Newcastle	6,205	860	115	86	7,266	4,492	3,491	1,001	—	—	—	Want or Distress.	300	12,732	4,748	7,984
West Lancashire	6,512	1,726	532	95	8,865	6,253	4,897	1,356	—	—	—	Dental ...	406	20,582	7,556	13,026
Yorkshire	9,203	1,928	726	128	11,985	13,739	7,348	6,391	1 6	0 9	3 0	—	—	39,429	12,972	26,457
	62,511	11,527	3,484	813	72,335	84,308	44,676	39,632	—	—	—	—	—	243,431	80,859	162,572
<b>SCOTLAND.</b>																
Aberdeen	9,874	3,328	227	288	13,717	15,419	6,691	8,728	2 0	1 0	4 0	—	—	34,129	11,077	23,052
Clyde	5,697	1,276	72	94	7,139	12,094	4,247	7,847	2 0	1 0	4 0	Want or Distress.	745	26,512	8,114	18,398
Dundee	5,435	2,238	587	170	8,430	15,018	5,213	9,805	2 0	1 0	4 0	Dental ...	1,240	31,830	9,807	22,023
Edinburgh and Leith	7,176	1,614	115	157	9,062	9,978	4,009	5,969	2 0	1 0	2 0	Maintenance in Hospitals and Convalescent Homes. Nursing ...	375 57	23,595	7,432	16,163
Fife	2,729	679	74	70	3,552	2,446	1,443	1,003	1 0	0 6	2 0	—	—	6,115	2,167	3,948
Glasgow	38,803	9,482	656	700	49,641	52,210	23,308	28,902	2 0	1 0	4 0	—	—	111,650	37,463	74,187
	69,714	18,617	1,731	1,479	91,541	107,165	44,911	62,254	—	—	—	—	—	233,831	76,060	157,771
<b>WALES.</b>																
North Wales	7,105	1,194	86	86	8,471	7,599	4,163	3,436	1 6	0 9	3 0	—	—	16,977	5,975	11,002
South Wales	7,796	831	58	76	8,761	5,515	5,022	493	—	—	—	—	—	19,114	7,076	12,038
	14,901	2,025	144	162	17,232	13,114	9,185	3,929	—	—	—	—	—	36,091	13,051	23,040
<b>Grand Totals</b>	<b>147,126</b>	<b>32,169</b>	<b>5,359</b>	<b>2,454</b>	<b>187,108</b>	<b>204,876</b>	<b>98,937</b>	<b>105,939</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>513,353</b>	<b>169,970</b>	<b>343,383</b>

## AGE LIMITS.

14. We suggest that the present age limits, viz., 16 to 70, be retained. Enquiry has been made through the branches of this Society for any evidence as to the desire for an extension of the age limits. The reply in every case has been that they have no evidence of a desire by either old or young persons for an extension.

15. Further, having regard to the growing volume of opinion in favour of half-time workers between 14 and 16—and also the considerable advocacy of the raising of the school-leaving age to 16, we suggest that it is undesirable to reduce the age for commencing National Health Insurance. At the other end of the scale it is very difficult to supervise the sickness of persons over 70 years of age, and its cost is very difficult to measure.

## INCOME LIMIT.

16. It is suggested that the income limit for compulsory National Health Insurance should be raised from £250 to £350, and thus put it on a level with the limit in the Workmen's Compensation Act.

## SOURCES OF REVENUE.

17. The surplus disclosed by the 1922 Valuation shows that the contributions are more than adequate for the normal benefits of the Act, and will permit an even wider use of additional benefits than obtained as a result of the 1918 valuation.

## MONEY BENEFITS.

18. The normal cash benefits are not considered adequate by themselves, but we think they are high enough for State Insurance purposes.

19. We believe it is to the best interests of the individual that National Health Insurance should be supplemented by voluntary insurance, and we are of opinion that the promoters of National Health Insurance held this view. If State benefits are increased it would require to be a flat rate, and we think it would be better to leave it to the individual to make extra provision according to his means and requirements.

## MAXIMUM FOR ADDITIONAL CASH BENEFITS.

20. We favour the limitation of additional cash benefits out of surplus to 3s. per week sickness benefit, 1s. 6d. disablement and 6s. maternity.

We believe the best form of thrift is that of a voluntary character, and State benefits ought not to be so high as to take away the inducement to make some voluntary provision.

## MEMBERS IN POOR LAW INSTITUTIONS WITHOUT DEPENDANTS.

21. The original Act precluded the payment of sickness and disablement benefit to insured persons without dependants who were inmates of Poor Law Institutions.

Poor Law Authorities are debarred from claiming the benefits due to a member whilst he is an inmate of a Poor Law Institution, presumably because he is maintained out of Public Funds.

22. We suggest that where the member has no dependants he should be debarred from claiming benefit whilst being maintained out of Public Funds. In effect, although admitted to a Workhouse on the grounds of destitution, he may, under present conditions, be saving 7s. 6d. or 15s. per week normal benefits, as well as any additional cash benefits payable by his Society.

## MARRIED WOMEN: CLASS K.

23. We are of opinion that where a married woman has not resumed work within three months after marriage she should receive a special payment of, say, three guineas, and her membership terminated forthwith.

## DEPOSIT CONTRIBUTORS.

24. This Society favours the abolition of the present system of deposit contributors. The arrangement for deposit contributors under the 1911 Act was intended to be a temporary one.

25. We do not think the setting up of a separate society for deposit contributors is desirable.

26. The Ministry state that the majority of deposit contributors are in good health. This being so they should be given a time limit in which to join an Approved Society, and where they did not do so we think it should be possible to devise a scheme of apportionment among existing Approved Societies.

27. We recognise the difficulty of apportioning unhealthy lives, but submit that the existing Approved Societies should undertake the direct liability of their quota of these lives. If a separate Approved Society be set up we think it fair to assume that when the good lives realised their funds were being exhausted by the benefit claims of the unhealthy portion of members, and they realised the probability of getting additional benefits by joining another Approved Society, they would do so.

28. If our assumption proved correct then the Deposit Contributors' Society would, we anticipate, be in deficiency, and as this deficiency would probably have to be made good out of the Central Fund then the Approved Societies as a whole would indirectly be called on to meet the liability, and may as well meet the liability direct by admitting them into membership.

29. We recognise that the abolition of deposit contributors may necessitate giving up the right of expulsion, and we are prepared to face that issue.

## APPROVED SOCIETY METHOD OF ADMINISTRATION.

30. We are strongly in favour of the retention of the Approved Society method of administration. It is the nearest approach to the Friendly Society system which was closely followed in the framing of the National Health Insurance Act, 1911. It is desirable and to the advantage of all concerned that voluntary thrift and National Health Insurance should be closely associated.

31. The Approved Society system affords the insured person an opportunity of joining a society whose principles and method of administration appeal to him.

## WORKMEN'S COMPENSATION.

32. The administration of National Health Insurance involves a close scrutiny of all claims for sickness benefit to ascertain whether the incapacity for work is due to an accident or an industrial disease. Considerable experience has been obtained by Approved Society officials as a result of this scrutiny, and in assisting members with regard to claims.

33. We suggest that serious consideration should be given to the possibilities of administering Workmen's Compensation on similar lines to National Health Insurance.

## PUBLIC MEDICAL SERVICE.

34. We favour the scheme for a Public Medical Service as adopted by the National Conference of Friendly Societies at the Annual Meeting in Oxford in September, 1924.

## EXTENSION OF MEDICAL BENEFIT TO DEPENDANTS OF INSURED PERSONS.

35. We are of opinion that a first step towards the establishment of a Public Medical Service could be made by extending medical benefit to dependants of insured persons. We believe our members would be willing to pay an increased contribution for this purpose. The average man is more concerned to know that his dependants are provided with proper medical attention than he is about himself. Since the inception of National Health Insurance, although

entitled to free medical attention for himself, he finds it more difficult to provide for his dependants owing to the increased fees now charged by the Medical Profession for private service.

#### ADMINISTRATION OF TREATMENT BENEFITS.

36. We have heard suggestions that all treatment benefits should be administered by Insurance Committees. We believe that the most effective manner to improve the health of the nation would be to establish a Public Medical Service, and in order to avoid any addition to the numerous conflicting interests standing in the way of this ideal, we desire the Approved Societies to continue to administer treatment benefits until such a service is set up.

#### DENTAL TREATMENT.

37. We do not consider the time opportune to make dental benefit one of the normal benefits under the Act. Most of our Branches utilised the disposable surplus arising out of the 1918 Valuation in the provision of cash benefits. Consequently we feel that we have not sufficient experience as to the value of particular treatment benefits.

In some parts—where optical or other treatment benefits may be of more value than dental—if dental were made a normal benefit it might so reduce the surplus as to prevent the provision of other treatment benefits out of disposable surplus.

38. We desire the freedom to provide additional benefits out of surplus in such manner and in such proportions as local conditions and experience direct us.

#### REGIONAL MEDICAL OFFICERS.

39. We are of opinion that the establishment of the scheme of regional medical officers has been fully justified.

40. We understand there have been cases where a panel doctor has also officiated as a regional medical officer. We think this a most undesirable practice which could only be justified in very exceptional circumstances.

41. It is most desirable that some authority should be set up to give a final decision where there is a difference of opinion between the regional medical officer (or district medical officer, as he is termed in Scotland) and the insured person's panel doctor. Approved Society Officials and Arbitration Committees find themselves in a difficult position when having to decide between two medical opinions. We therefore suggest the setting up of medical umpires.

#### EXTENSION OF MEDICAL BENEFIT TO NORTHERN IRELAND.

42. It is suggested that serious consideration should be given to the possibility of including medical benefit for insured persons in Northern Ireland. We have been informed by our Belfast District that the people of Northern Ireland are extremely desirous to have medical benefit included for insured persons, and that they are willing to pay an increased contribution for the purpose.

#### POOLING WITHIN A SOCIETY WITH BRANCHES.

43. The present Act does not permit pooling of surpluses without centralisation. This Society is strongly opposed to centralisation at Head Office, but there is a very pronounced desire to form a central pool within the Society for the provision of treatment benefits, to apply equally to all members throughout the Society.

44. It is suggested that if the Annual Meeting of a Society so decides, the Society should have the right to form a central pool made up of a certain percentage, say, up to 50 per cent. of the disposable surpluses. The central pool to be administered by the Central Executive.

## APPENDIX XLV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE ASSOCIATION OF APPROVED SOCIETIES BY MR. J. E. HILTON, CHAIRMAN OF THE ASSOCIATION, MR. ROBERT SMITH, MEMBER OF THE EXECUTIVE OF THE ASSOCIATION, AND MR. F. A. GOODWIN, HONORARY SECRETARY OF THE ASSOCIATION. See Minutes of Evidence of the Twenty-Fifth Day, Questions 14,251 to 14,500.

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#### PRELIMINARY.

- The Association of Approved Societies was inaugurated in 1912; its objects are:—
  - To promote and protect interests of insured persons, Approved Societies and other organisations established for purposes connected with National Health Insurance.
  - To promote measures for improving the health of the people, the prevention and cure of sickness, and to combine or co-operate with other organisations established for a similar purpose.
  - To enter into negotiation with the medical and nursing professions and with hospitals and other institutions with a view to the provision of greater facilities for the prevention, treatment and cure of disease.

- (4) To encourage uniformity of policy among Approved Societies.
- (5) To render legal and actuarial advice to Approved Societies.
- (6) To simplify the administration of National Insurance.
- (7) To be an Association within the meaning of section 39 of the National Health Insurance Act, 1911, and subsequent amendments thereto.
- (8) To prepare and carry into effect schemes for the provision of additional benefits for the members of affiliated societies, the cost being met from surpluses disclosed at valuation.
- (9) To arrange for visiting incapacitated members of Approved Societies and reporting thereon.

2. It represents some 150 societies of every type as follows:—

	Approximate Membership.
76 Friendly Societies... ..	880,500
7 Collecting „ ... ..	184,000
13 Trade Unions ... ..	260,800
32 Unregistered Friendly Societies	90,000
16 „ Trade Unions ... ..	70,000
3 Employers Provident Societies ...	14,500
2 Rural Societies ... ..	14,800
1 Industrial Society ... ..	7,500
	1,522,100

3. The Association is instructed to submit the following observations on behalf of its affiliated organisations.

#### MEDICAL BENEFIT.

4. Whilst hoping that the 1924 Regulations will result in an improvement in the medical service we are of opinion that provision should be made for the inclusion of specialist and consultant facilities. We suggest that the capitation fee of persons not having chosen a doctor should be devoted to this purpose.

5. We are strongly of opinion that medical services should be paid on the basis of attendances and services rendered.

6. We have for some years advocated that arrangements should be made for the provision of medical benefit for insured persons retired by condition of service at 60 or 65, subject to a prior period of insurance and would advocate a weekly payment by them for this service.

7. We suggest that if members incapable of work were instructed to attend morning surgeries it would relieve the evening congestion and enable members requiring medical attention who are continuing their work, to be seen and obtain medicine the same evening, thus helping to remove a real grievance which now exists.

#### DENTAL BENEFIT.

8. We favour if possible the inclusion of dental benefit as a Statutory benefit to be paid for out of the funds of Approved Societies and administered by societies. We consider dental benefit requires definition and that it is of first importance that the teeth should be conserved as far as possible.

9. If continued as an additional benefit, it should be left to the discretion of the Approved Society to so arrange the disposal of amount available as to spread the benefit among the largest number of members.

10. If general provision of full dental treatment and dentures is made, it would in our opinion lead to a very serious increase both in the number of such claims and the cost of each individual case, and as we have not sufficient information or experience to properly estimate the cost of such provision, some restrictions should obviously be made.

#### MATERNITY BENEFIT.

11. In practice we find that nearly the whole of the cost of maternity benefit has now to be paid to the doctors, leaving the member with little or nothing to meet other necessary expenses. We therefore advocate that fees payable for attendance by doctor or midwife, be a Statutory charge on the general medical fund.

12. We recommend that a fee of £1 1s. 0d. be paid, the member being entitled to choose service of midwife or doctor.

13. For the above reasons we do not favour any increase in cash maternity benefit.

14. Where there is satisfactory evidence that the husband is not the father of a child, maternity benefit should not be paid in respect of his insurance.

#### ADDITIONAL BENEFITS.

15. We are of opinion that the administration of additional benefits should be maintained in the hands of Approved Societies since they are contingent on surpluses of societies and in our opinion should so remain.

16. We think that one fund only be established for non-cash additional benefits and that no separate allocation for each additional benefit selected be required, thus simplifying the administration. In the opinion of the Association a much larger proportion of the surplus declared should be available for additional benefit.

#### EQUALISATION OF BENEFITS.

17. The delegates by a majority are opposed to pooling the funds for the equalisation of benefits. Where deficiencies are shown to be due to hazardous trades, if extension of benefit is required, other methods should be adopted, such as adjustment of reserve values.

#### CERTIFICATION.

18. It would be of assistance to Approved Societies if doctors attached the period of gestation to certificates bearing the word pregnancy.

19. We also suggest that the space provided on the certificates for instructing the patient when to see the doctor again, should be used in all cases on first certificates.

20. We have frequent complaints of irregular certification, such as the issue of batches of certificates bearing various dates on one day.

#### MARRIED WOMEN (CLASS K).

21. The present system of dealing with women on marriage, is still in our view unsatisfactory and we would favour the payment of a lump sum on ceasing insurable employment in consequence of marriage, subsequent re-entry into insurance being subject to the ordinary waiting periods.

#### CONTRIBUTIONS.

22. Any extension of benefit which can be provided within the present contributions we would welcome, but we are opposed to any increase of contributions from the insured person.

#### PROLONGATION OF INSURANCE ACT.

23. In our opinion the Prolongation of Insurance Act has served a useful purpose, but is now being used for purposes other than was originally intended by the legislature and should be abolished as speedily as possible. It is within our knowledge that the Act is being used to secure benefits improperly and to prolong membership which should have terminated.

#### WORKMEN'S COMPENSATION CLAIMS.

24. It would be of great advantage to Approved Societies if Regional Medical Officers could assist them in cases where there is some doubt as to whether the insured person is incapacitated by accident or

industrial disease, for which he or she should be receiving compensation.

#### RESEARCH—TUBERCULOSIS.

25. The amount provided by the Act for research should in our opinion be available to encourage research carried out by private individuals, as well as to support official research departments.

26. In this connection we deplore the fact that whilst a remedy for the cure of tuberculosis has been provided, which in the opinion of the Ministry of Health is of a most hopeful character, no financial support has been given for the provision of the means for combating this disease and Approved Societies have not been encouraged to themselves subscribe for the provision of this remedy. We have reason to believe that if this remedy was made available, claims for benefit by insured persons afflicted would be materially reduced. Approved Societies therefore are allowed to pay benefit to persons suffering, but are not allowed to pay anything towards getting rid of the disease.

#### ADMINISTRATION ALLOWANCE.

27. In the opinion of the Association, the amount allowed to Approved Societies for administration purposes, is too low and militates against efficiency without voluntary service. It may also be said to interfere with the intention of the Legislature that societies should have a large measure of independence.

28. While it is admitted that the Ministry have no knowledge of the actual cost of administration of certain societies (with a total membership of over six millions) the amount charged by the societies to administration, is used to some extent as a basis for fixing the amount allowed to societies generally. Further the amount is the same for all types of societies and takes no account of the fact that these societies, by reason of their differing constitutions etc., are bound to differ considerably in the cost of their work, no matter how keen the desire for economy. In addition, no account is taken of the average age of membership, which, affecting as it does, the incidence of sickness, must materially affect expenses necessarily incurred in the work of Approved Societies. It may here be remarked, that the Ministry of Labour, reward societies administering Unemployment Insurance, on the basis of the claims paid, thus recognising the principle that the greater the claims ratio, the greater the expense.

29. Societies with a heavy sickness experience are asked to use more frequently the services of the

Regional Medical Officer, but the expense falls upon the already depleted administration allowance, so they cannot (although the Sickness Funds would undoubtedly benefit), afford to do so to the extent which might be desirable.

30. We can further emphasise the point that Approved Societies worked on the pre-war figure of 3/5 per member until 1920 and the increases since given (and to some extent since taken away) have never been in proportion to the increased cost of stationery, salaries, rents, etc.

31. It should be noted, that the cost of administering for deposit contributors, exceeds the amount allowed to Approved Societies, although it is not possible to have cases of continued sickness common among the ordinary type of society members.

32. We would advocate such an increase of allowance as would cover the reasonable expenditure of every type of society, leaving as was originally intended, those who can administer more economically, to transfer their savings to the Benefits Funds.

#### INSURANCE COMMITTEES.

33. In our opinion it is necessary that Insurance Committees continue their function of investigating through the Medical Service Sub-Committee complaints by insured persons, Approved Societies, or medical practitioners; and that the period for making a complaint, six weeks, shall count from the time the cause for complaint came to the knowledge of the Approved Society.

34. In every case where a complaint is made and a *prima facie* case established, the member representative of the Approved Society and any relative witnesses should be paid their expenses.

#### SUPERANNUATION.

35. We are of the opinion that statutory provision should be made to entitle all persons permanently employed by Approved Societies and Insurance Committees to be paid superannuation allowance on retirement or in the event of permanent incapacity on account of ill-health after 10 years' service.

#### COMPENSATION.

36. We are of the opinion that in the event of amendments or of changes in National Health Insurance resulting in any loss, pecuniary or otherwise, to any permanent employees of Approved Societies or Insurance Committees, Statutory provision should be made for compensation to be paid to such employees for any such loss which may accrue.

## APPENDIX XLVI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE STANDING COMMITTEE OF SCOTTISH INSURED WOMEN BY Miss AMY H. CAMERON, MEMBER OF THE COMMITTEE, AND Miss MARGARET W. HAMILTON, HON. SECRETARY. See Minutes of Evidence of the Twenty-Fifth Day, Questions 14,501 to 14,592.

The following evidence is submitted on behalf of the Standing Committee of Scottish Insured Women, which was formed to promote and protect the interests of insured women in matters relating to Health Insurance. The Committee consists of Representatives of the Women's Approved Societies in Scotland and certain others having women Members in Scotland. The Constituent Societies are:—

Associated Women's Friendly Society.  
Independent Order of Rechabites (Glasgow District).

North of Scotland Women's Insurance Society.  
Scottish Clerks' Association.  
Scottish Domestic Servants' Association Friendly Society.

Scottish Farm Servants' Union Friendly Society.  
Scottish Women's Friendly Society.  
Servants' Institution.

Women's Friendly Society of Scotland.

#### PERSONS INCLUDED IN SCHEME AND COLLECTION OF CONTRIBUTIONS.

1. The Committee recommends that no change should be made in the Insurance limits either of age or means under the Scheme of National Health Insurance, and that the present arrangement, including all workers between the ages of 16 and 70 in employment, at a rate of remuneration not exceeding £250 a year, should be continued.

2. The Committee believes that it is in the best interest of the workers that the Scheme should continue to be administered by Approved Societies.

3. It is further suggested that more economy and convenience would be achieved by the use of one stamp and one card covering both Health and Unemployment Insurance, and that these cards be issued and collected by Approved Societies.



4. The Committee recommends that the issue by the Post Office of Health Insurance cards, other than emergency cards, should be discontinued, and that in future cards should only be obtainable from Approved Societies or from the various offices of the Ministry of Health. The Committee views with concern the large number of cards which find their way to the Lost Card Department, and which are never credited to the worker. It is considered that the problem of lost cards is a serious one, and it is thought that some definite steps should be taken to rectify this matter.

#### MONEY BENEFITS.

5. The Committee recommends that no change should be made in the statutory cash benefits payable under the Acts, and that the amount by which these benefits can be increased out of surplus should be limited to 5s. per week. It is considered that it is of more value to National Health to provide preventive measures by way of treatment benefits for the whole of the insured community than to increase the cash benefits, and it is always open to members to augment the sickness benefit by voluntary insurance through the Friendly Societies.

#### PAYMENTS IN RESPECT OF PREGNANCY CLAIMS.

6. Societies apparently greatly differ in their interpretation of the term "incapable of work" when dealing with claims from pregnant women. The experience of the Women's Societies is that 22 per cent. of Class E claims received sickness benefit prior to confinement. In some of these cases there was incapacity for a considerable time due to complications of pregnancy. In other cases there has been no complication, but the Societies admitted claims for a few weeks prior to confinement. The Committee is of opinion that it would be advisable for a pregnant woman to refrain from remunerative employment for a few weeks prior to confinement, and recommends that definite provision should be made for the payment of sickness benefit to insured women during the four weeks immediately prior to confinement on the production of a medical certificate.

#### PAYMENTS TO MEMBERS WITHOUT DEPENDANTS UNDER TREATMENT IN HOSPITALS OR ASYLUMS.

7. The Committee recommends an alteration in the provisions of the Act governing the administration of benefit of members without dependants in hospitals or asylums.

8. In the case of members in hospital, rate-aided or otherwise, it is suggested that, if the member so desires, a fixed proportion of the benefit might be paid direct to the member, the balance to be accumulated and paid on discharge as at present.

9. In the case of members in asylums, the Committee recommends that, if possible, arrangements should be made to pay to Asylum Authorities a certain proportion of the accumulating benefit, not in relief of rates, but to procure extra privileges or comforts for insured inmates, the balance to be paid to the insured on discharge. Where an insured person without dependants dies in an asylum, it is strongly urged that the accumulated benefit should not as now be paid to the next of kin, but, after discharging the funeral expenses of deceased, the balance should remain in the funds of the Society. The aggregate sum accumulated on behalf of insured persons apparently incurably insane, must already be very considerable, and the Committee is of opinion that such sums should not be paid on their decease to individuals who have not done anything for the insured, and who come under no obligation to use the money for any purpose included in the National Health Insurance Act.

#### PENALTIES FOR ARREARS OF CONTRIBUTIONS.

10. The Committee recommends that the Arrears Regulations should be continued, but is of opinion that the present arrears scheme is not altogether

satisfactory. It is felt that while the amount required to pay off arrears is not heavy, the failure to make payment is too heavily penalised, and it is suggested that the reduction of benefits for arrears should only take effect for a limited number of weeks of sickness in the succeeding year.

#### DEPOSIT CONTRIBUTORS.

11. The Committee recommends that if the Deposit Contributors' Fund is continued there should be no refund payable either on death or emigration of the amount standing at credit of deposit contributors, as it is considered that at present this acts as an incentive to the insured to remain or become deposit contributors.

#### EXEMPT PERSONS.

12. The Committee recommends that insured persons shall no longer be entitled to obtain exemption certificates relieving them of the liability of paying contributions. The Committee is against this system being continued, but if it were found necessary to retain it for any portion of the community, it is suggested that future legislation should provide that such persons shall not be entitled to any benefits under the Act, and that the employers' proportion of the contribution paid in respect of exempt persons shall be transferred to the Central Fund for the benefit of the insured in general.

#### MARRIED WOMEN.

13. In the original Act special conditions were made applicable to insured women on marriage, and in practice it was found that the administration of this section of the Act was surrounded with difficulties. In the 1918 Act, new conditions were made applicable to insured women on marriage which simplified the position, both from the point of view of the society and also from the point of view of the insured. It is felt, however, that the work and consequent expense still involved in the administration of benefits to this Class is not justified, and that further simplification is required. It has been found almost impossible to satisfy members why and how the reduction for arrears is made in the maternity benefit payable to a Class K Member. The Committee recommends that the conditions governing payment of maternity benefit should be the same for Class K as for Class E. The Committee is of the opinion that when an insured person ceases insurable employment, the same conditions should apply without any special consideration given for the reason for such cessation, and does not think that an insured woman should get any greater consideration when she ceases work on marriage than one who ceases work for other reasons, or ceases insurable employment on entering excepted employment, either by reason of the salary being raised to over £250 per annum, or otherwise.

14. The Committee recommends therefore that when an insured woman marries, the fact of her marriage should make no difference to her position in insurance, and that she should be entitled to a free year's insurance as obtains in the case of the insured in general. The Committee further recommends that, if necessary, an extra reserve value should be credited to the society as from the date of marriage in cases of all insured members who marry.

15. The experience in this matter has been carefully considered, and it has been found that, of the number of members who marry, 96 per cent. become Class K and 4 per cent. continue in employment.

16. On examining claims for maternity benefit, it has been found that 55 per cent. claimed maternity benefit. Of the claims for maternity benefit 73 per cent. claimed during the first year after marriage, and 27 per cent. in the second year. Of the total maternity claims paid to Class K members, the benefit was reduced because of arrears in 25 per cent. of the cases.

17. Only 8 per cent. of Class K members made any claim for sickness benefit, and slightly over half of those claimed their full six weeks, and were still incapable of work at the end of six weeks.

#### MEDICAL BENEFIT.

18. The Committee regards medical benefit as the most important benefit under the National Health Insurance Act, and is of opinion that every effort should be made to ensure that a thoroughly satisfactory medical service is provided for all insured persons. The service, as at present defined, is incomplete in the things it includes, and it is considered that it would be of advantage to extend the field of medical benefit to insured persons by the provision of diagnostic and laboratory facilities and, if possible financially, consultant and specialist treatment, and nursing benefit.

19. The Committee does not recommend the inclusion of attendance at confinement in medical benefit. While recognising that it would be desirable that attendance at confinement should be made available for the whole community, the Committee does not think that it can be justly charged against the National Health Insurance Funds. It might be a matter for consideration whether the whole question of provision for maternity should not be dealt with quite apart from the National Health Insurance Act.

20. The Committee is not in favour of extending medical benefit to the dependants of insured persons on account of the difficulty of proving dependency, and also on the grounds that the necessary increase of contributions would be an unfair tax on a very large number of insured women who would never benefit by the extension.

#### MEDICAL BENEFIT AFTER CESSATION FROM INSURANCE.

21. Under the existing regulations a person who has ceased insurable employment is entitled to medical benefit until 30th June or 31st December, whichever first occurs after the end of eighteen months from the date of ceasing insurable employment. Experience has shown that few insured persons avail themselves of this medical benefit after they cease insurance, and it is considered that the payment societies are required to make for this purpose into the General Medical Fund is not warranted. The Committee recommends that the title to medical benefit of insured persons should not extend beyond the end of the half-year in which their right to sickness and disablement benefit terminates.

#### ADMINISTRATION OF MEDICAL BENEFIT.

22. Insurance Committees were set up by the Act and were made responsible for the arrangement and control of medical benefit for the whole of the insured persons. It is obvious that some such organisation is required, but the Committee suggests that a number of these Committees might with advantage be combined and so reduce their total number. It is further suggested that the membership of the present Insurance Committees is unnecessarily large, and it is recommended that the membership be reduced.

#### INSURANCE FUNDS.

23. The Committee is strongly of opinion that the National Health Insurance Scheme should be independent and self-supporting and should not be subsidised by any Treasury Grants other than the State Grant of two-ninths provided for in the Acts. The

Committee recommends that no increase in the existing contribution should be made, and that any further costs which may be required for the extension of any of the benefits should be met from within the Insurance Funds themselves.

#### VALUATION.

24. The Committee recommends that the Acts be amended so as to lessen the difference of the additional benefits payable to the insured, and suggests that a percentage of the weekly contribution be transferred to the Central Fund, and that Societies which show a deficit, or a surplus not exceeding a specified amount, be entitled to draw upon the Central Fund for the provision of additional benefits to their members in the form of treatment benefits.

#### DENTAL BENEFIT.

25. The Committee thinks it advisable that dental benefit should be made available for the whole insured population, as it is generally accepted that this would be one of the best preventive measures, and would lessen the ill-health of the insured community and ultimately reduce the amount expended in sickness benefit. The Committee is of the opinion, therefore, that it should be made obligatory on societies to provide dental benefit for their members, such societies as cannot do so from their own funds being assisted in the manner referred to in the previous paragraph. The Committee recommends that the administration of dental benefit should be in the hands of Approved Societies.

#### TREATMENT BENEFITS.

26. The Committee recommends that the Act should be amended so as to give to societies powers to extend treatment benefits to all their members, if they so desire and if funds permit after providing for the statutory benefits and the cash increases thereon, and that it should not be necessary to have recourse to organisations coming under section 26 of the Act in order to administer such treatment benefits.

#### TITLE TO ADDITIONAL BENEFITS.

27. Under the regulations at present ruling, the calculation of the cost of providing additional benefits on the second Valuation will be made on the basis that the title of members to participate in these additional benefits will mature at the beginning of January of the calendar year in which the member will have completed a period of five years' membership in the society. As these regulations depart from the principle that additional benefits would only be payable to the members who had contributed towards the surplus within the Valuation period, the Committee recommends that a step further might be taken so that members would be entitled to additional benefits when they have qualified for disablement benefit, and thus reduce the waiting period from five years to two years.

On behalf of the Standing Committee of  
Scottish Insured Women,  
AMY H. CAMERON,  
Member of Committee.  
MARGARET W. HAMILTON,  
Honorary Secretary.

136, Wellington Street,  
Glasgow.

17th February, 1925.

## APPENDIX XLVII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE BRITISH MEDICAL ASSOCIATION BY DR. R. A. BOLAM, O.B.E., M.D., F.R.C.P., LL.D., Chairman of the Council of the Association, DR. H. B. BRACKENBURY, M.R.C.S., L.R.C.P., Chairman of the Representative Body of the Association, DR. H. GUY DAIN, M.B., M.R.C.S., L.R.C.P., Chairman of the Insurance Acts Committee of the Association, DR. A. COX, O.B.E., M.B., B.S., Medical Secretary of the Association, DR. H. J. CARDALE, M.B., C.M., Chairman of the London Panel Committee, MR. N. BISHOP HARMAN, F.R.C.S., Hon. Treasurer of the Association, DR. STANLEY HODGSON, M.B., B.S., M.R.C.S., L.R.C.P., LL.B., Chairman of the Salford Panel Committee. See Minutes of Evidence of the Twenty-Sixth Day, Questions 14,593 to 15,139, and of the Twenty-Seventh Day, Questions 15,140 to 15,336.

## PART I.

## AUTHORITY OF THE BRITISH MEDICAL ASSOCIATION.

In presenting its evidence before the Royal Commission the British Medical Association acts in a dual capacity (a) as representing the organised medical profession in this country as no other body is in a position to do, and (b) as representing, under a special mandate, those practitioners, in this statement called insurance practitioners, who are at the present time under contract with Insurance Committees for the provision of medical attendance to insured persons.

(a) *As Representing the Organised Medical Profession in Great Britain.*

The right, and indeed the duty of the medical profession as a whole to state its views on National Health Insurance will not be questioned. A system which for twelve years has provided domiciliary medical attendance by a method previously untried, to some 14,000,000 persons, must necessarily have a profound effect on medical practice and on the relations of the medical profession to the Government, to the community, and to the individual patient. And when it is noted that the Royal Commission is to report on "what, if any, alterations, extensions or developments should be made in regard to the scope of that scheme" those sections of the profession which have up to now been interested only indirectly or through their sense of *esprit de corps* become directly and vitally interested.

The Association has over 28,000 members, of whom some 19,000 (excluding the fighting Services) are in Great Britain. Though from the nature of things the majority of its members must be general practitioners, it contains a strong representation of every section of practice. Among its active workers are prominent physicians, surgeons and specialists, as well as members of the public health service and general practitioners.

The constitution of the Association is such as to enable it to ascertain and co-ordinate the opinions of its members throughout the country. England, Wales and Scotland are divided up into 190 Divisions, which are the units of the Association. Each of these units deals with the members in its area, calling them together for scientific and social purposes as well as to consider those matters which affect the relations of the medical profession to the community. The result of their deliberations on matters submitted to them by the Council of the Association, which is its executive body, and their opinions as initiated and formulated by them are the subject of discussion at the meetings of the Representative Body of the Association which take place annually, or oftener if required. This Representative Body consists of a representative from each constituency—generally one Division but occasionally two joined for the special purpose of electing a representative. The number of persons forming the Representative Body is about 200. Throughout the life of the National Health Insurance system the Representative Body has spent a great deal of its time in discussing the working of the system and its effects, direct and indirect, on the medical profession. In the earlier years of the system every detail was thus discussed. With the growing importance of the Conference of Local

Medical and Panel Committees (presently to be described) there has been a devolution on that body of those questions of detail affecting only Insurance practitioners, but the Representative Body has kept in its hands the discussion of those questions which affect the whole profession, especially those possible developments which would draw into the ambit of the National Health Insurance system members of the profession who at present are outside it. In addition to this process of continuous discussion the Association has, in anticipation of the presentation of this evidence, taken the following steps to ensure that every section of the profession should be consulted and that every member of the profession, whether a member or non-member of the Association, should have an opportunity of taking part in the formulation of the evidence.

In April, 1924, for the purpose of drafting this evidence the Council of the Association appointed a Special Committee, consisting of 31 persons interested in various forms of practice and including a strong representation of insurance practitioners. The Committee has been slightly varied since and now consists of 33 members, namely: Mr. Basil Hall, M.Chir. Cantab. (Bradford), Surgeon Bradford Royal Infirmary (President of the Association); Dr. H. B. Brackenbury (Hornsey), Insurance Practitioner and Chairman of the Middlesex Panel Committee (Chairman of the Representative Body of the Association); Dr. R. A. Bolam, F.R.C.P., LL.D. (Newcastle-on-Tyne), Physician to the Skin Department, Royal Victoria Infirmary, Newcastle-on-Tyne (Chairman of Council of the Association); Mr. N. Bishop Harman, F.R.C.S. (London), Ophthalmic Surgeon West London Hospital (Treasurer of the Association); Sir H. J. Waring, C.B.E., M.S., F.R.C.S. (London), Surgeon St. Bartholomew's Hospital; Sir Cuthbert Wallace, K.C.M.G., C.B., F.R.C.S. (London), Surgeon St. Thomas's Hospital; Sir Ewen J. Maclean, F.R.C.P., J.P. (Cardiff), Obstetric Physician Cardiff Royal Infirmary; Dr. W. J. Howarth, C.B.E. (London), general practitioner not on panel; Mr. E. B. Turner, F.R.C.S. (London), general practitioner not on panel; Professor H. R. Dean, F.R.C.P. (Cambridge), Professor of Pathology University of Cambridge; Mr. Somerville Hastings, M.S., F.R.C.S. (London), Surgeon Ear and Throat Department, Middlesex Hospital; Lt.-Col. F. E. Fremantle, M.P., O.B.E., M.Ch., F.R.C.P. (Hatfield, Herts), Late M.O.H. Hertford County; Dr. R. Wallace Henry (Leicester), Ophthalmic Surgeon; Dr. J. H. Badcock, L.D.S. (London), a practising Dental Surgeon; Sir Thomas Horder, Bt., F.R.C.P. (London), Physician St. Bartholomew's Hospital; Prof. A. J. Hall, F.R.C.P. (Sheffield), Physician Sheffield Royal Hospital; Mr. E. W. G. Masterman, F.R.C.S. (London), Medical Superintendent Camberwell Infirmary; Mr. H. S. Souttar, O.B.E., F.R.C.S. (London), Surgeon London Hospital; Dr. Mabel Ramsay (Plymouth), Insurance practitioner and representing Medical Women's Federation; Dr. A. D. Brenchley (London), Master of the Society of Apothecaries of London; the following insurance practitioners—Drs. T. Ridley Bailey (Bilston, Staffs.) (Chairman Staffordshire Local Medical and Panel Committees), J. W. Bone (Luton), H. J. Cardale (London) (Chairman, London Panel Committee), R. W. Craig (Midlothian), H. Guy Dain (Birmingham) (Chairman, Insurance Acts Committee and Chairman,

Birmingham Panel Committee), E. Kaye Le Fleming (Wimborne, Dorset) (Chairman of Conference of Representatives of Local Medical and Panel Committees), E. R. Fothergill (Hove), T. Wood Locket (Westbury), J. G. McCutcheon (Glasgow), (Secretary Glasgow Local Medical and Panel Committees); J. P. Williams Freeman (Andover) (Chairman Hampshire Panel Committee); with the following who are not insurance practitioners but have taken an active interest in this question—Dr. H. S. Beadles (Romford) (Secretary West Ham Panel Committee and Chairman West Ham Insurance Committee), Dr. Peter Macdonald (York), (Chairman York Insurance Committee).

This Special Committee, in conjunction with the Insurance Acts Committee next to be described, prepared the evidence now presented, and submitted it to the Council of the Association, which after consideration, sent it down in draft to the Divisions, which called meetings of the whole profession (non-members as well as members of the Association) in every area in England, Wales and Scotland. These meetings were called conjointly by the Divisions and by the Local Medical and Panel Committees, and were asked to express their opinions freely on the draft memorandum submitted to them and also to answer certain questions on points of fundamental importance.

The replies to these questions and the comments of these meetings were then returned to headquarters where the two Committees jointly considered them and revised the Statement accordingly. This Statement was then presented to the Council of the Association which, in order to ensure that the final form should have the imprimatur of the Association and of the profession generally in the most formal way, summoned a Special Conference consisting of Representatives appointed by the Divisions of the Association and Representatives of the Local Medical and Panel Committees to consider it. This was held on March 12th, 1925, and was attended by 282 Representatives from every part of Great Britain. The resolutions of this Conference were then reported to the Council at its meetings on March 25th and were finally incorporated in the Statement here presented.

(b) *As Specially Representing Insurance Practitioners.*

The institution under the National Health Insurance Act of 1911 of Local Medical Committees and of Panel Committees under the Act of 1913 created machinery for the consideration of medical questions specially affecting insurance practitioners which it was necessary to co-ordinate with the existing machinery of the Association, in order that the interests of insurance practitioners as such should be considered always in connection with those of the profession as a whole. Accordingly the Committee of the Association which had for some three years been considering the question of Health Insurance before the coming into force of the 1911 Act was, in 1913, reconstituted as the Insurance Acts Committee whose business it was to "deal with all matters arising under the National Insurance Act that are dealt with by the National Insurance Commissioners, Insurance Committees and Local Medical Committees; to watch the interests of the profession, in relation to the National Insurance Act; and report to the Council."

Beginning as an ordinary Committee of the Association whose members, like members of other committees, were elected partly by the Representative Body and partly by the Council, it has gradually been changed into a body whose composition and mode of election accurately reflect its history, its relations with the Association and its connection with the statutory machinery of the National Health Insurance system. It now consists of 37 members of whom 23 are directly elected by the Local Medical and Panel Committees of the country. Those elected need not be members of the B.M.A. nor need their constituents. Five members are elected by the Representative Body of the Association. Five are *ex officio*, namely, the President, Chairman of Representative Body, Chairman of Council and Treasurer of the Association, and Chairman of Conferences of Representatives of Local

Medical and Panel Committees. The remainder are—1 nominated by the Poor Law Medical Officers' Association, 1 nominated by the Society of Medical Officers of Health, 1 nominated by the Medical Women's Federation, and 1 appointed by the Hospitals Committee of the Association to represent the staffs of Voluntary Hospitals.

In 1914 the Association called a Conference of Representatives of Local Medical and Panel Committees. This has met every year since and is now a firmly established part of the machinery which the profession has devised to meet the new problems arising out of the National Health Insurance Act. The Conference meets annually, or oftener if required; it contains representatives, elected by every Local Medical and Panel Committee, who together with their constituents, may or may not be members of the British Medical Association; it elects its own Chairman, and it has formally and repeatedly recognised the Insurance Acts Committee of the Association as its official mouthpiece in negotiations with the Government. It uses the staff and machinery of the Association for its own purposes, and the Association has for some years been content to leave to the Conference the decision of all questions of details, regulations, and negotiations as regards remuneration.

## PART II.

### A SCHEME OF NATIONAL HEALTH INSURANCE.

(The following sections of this Statement are not self-contained, and must be read in connection with each other.)

1. The subject of this part of the Statement is the organisation of a national scheme of Health Insurance so far as medical services are concerned and the relationship of such a scheme to other services concerned with public health.

#### GENERAL.

2. At the outset it is desired to emphasise two general considerations. The first is that the organisation of a National Health Insurance scheme is not necessarily, or even probably, the best means of utilising limited resources for the promotion of national health. It is more than likely that there are a number of other directions in which, severally or collectively, a corresponding expenditure would produce an even more satisfactory return. Such are (1) proper housing, (2) town-planning with the proper provision of open spaces and recreation facilities, (3) smoke abatement, (4) a pure milk supply, (5) public-house reform and the regulation of the sale of alcoholic beverages, (6) the destruction of vermin, (7) education, (8) the aiding of medical research.

3. If, however, resources are sufficient, or if for other reasons it is deemed desirable to organise a National Health Insurance scheme, a second general consideration becomes of paramount importance, *viz.* that regard should be had primarily and constantly to the maintenance of health and the prevention of disease and not merely to provision for the alleviation or cure of morbid conditions when once they have arisen. To this end it is essential not only that the attention of all practitioners should be directed continually to the preventive aspects of their work, but that the existing machinery and medical officers of the public health service should be brought into close and organic connection with the insurance scheme.

4. A National Health Insurance system is understood to be one through which, in return for premiums paid or contributions made, participants are entitled to medical attendance and treatment, together with certain services ancillary thereto, and also to cash payments under certain conditions during ill-health or disablement. The medical profession, as such, is concerned only with the former class of these benefits, and with the giving of such certificates and reports as may be required in connection with the latter class.

5. The system established under the National Health Insurance Acts is on those lines. The medical profession has now had experience of it since January, 1913. At the beginning the success of the system was jeopardised by the facts that a large proportion of professional opinion was antagonistic to the system

or to some of its important details, that sections of the insured population shared this antagonism, and that a lack of experience, combined with the overwhelming amount of work involved, led on the one hand to unsatisfactory practice arrangements, and on the other to very imperfect administrative machinery and methods. A little later the immense disturbance of the War and then of demobilisation prevented acquired experience from having its full practical effect, and it is during the last three years only that the system can be said to have been working in a really smooth and normal fashion. Indeed, some essential improvements came into force only at the beginning of 1924. Nevertheless, in the year 1922 both the Representative Body of the Association and the Conference of Representatives of Local Medical and Panel Committees declared "that the measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Act system has been sufficient to justify the profession in uniting to ensure the continuance and improvement of an insurance system."

6. A comparison of the conditions of practice among the classes to which insured persons belong, before and since 1913, leaves no doubt in the mind of the profession (a) that large numbers, indeed whole classes, of persons are now receiving a real medical attention which they formally did not receive at all; (b) that the number of practitioners in proportion to the population in densely populated areas has increased; (c) that the amount and character of the medical attention given is superior to that formerly given even in the best of the old clubs, and immensely superior to that given in the great majority of the clubs which were far from the best; (d) that illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case; (e) that, speaking generally, the work of practitioners has been given a bias towards prevention which was formerly not so marked; (f) that clinical records have been or are being provided which may be made of great service in relation to medical research and public health; (g) that co-operation among practitioners is being encouraged to an increasing degree; and (h) that there is now a more marked recognition than formerly of the collective responsibility of the profession to the community in respect of all health matters. All these are immense gains and, though it is possible that some of them may not be wholly due to the establishment of the National Health Insurance scheme, they have certainly been hastened and intensified by that system.

7. On the other hand it has to be said that this very success had led, at certain seasons, and in times of widespread epidemic disease, to a strain upon its powers and resources which the profession has scarcely been able to bear; and the new conditions have resulted in a volume of regulations which must be observed, rules which must be obeyed, forms which must be filled up, and quasi-judicial machinery which it is desirable to avoid, to an extent which is regarded by insurance practitioners as oppressive, or even menacing, and which actually by itself deters some other practitioners from taking part in the service at all. The doctor is still an individual dealing with an individual patient and having his prime duty in this relationship; and in so far as his mind is seriously diverted from this by concern for other duties and relationships, and by fear of transgressing unwittingly rules and regulations made for other purposes, this is detrimental to his work and to the interests of those whom he is primarily serving. It is, of course, true that all citizens live and work under the restraining influence of law and social custom, and that members of the medical profession have also in mind the disciplinary powers of the General Medical Council and the ethical and other traditions of their profession; but in the world, even in the medical world, these are not so onerous, so omnipresent, so imminent, as to be a constant source of worry or distraction. Experience of the National Health Insurance system as at present established, has led the profession to realise very vividly that its work may be made not more efficient but less efficient by a

multiplicity of departmental requirements. Its aim is so to improve the system as to enable the profession to supply what the public needs under conditions which will make its services most easily and suitably available to the community.

8. It is the belief of the Association that in any National Health Insurance scheme certain broad principles with regard to medical benefit must be regarded as fundamental. These are:—

- (a) The medical provision should be available for those persons, and only for those persons, who would be unable to obtain it without the help of the Insurance scheme;
- (b) The medical provision made for such persons should be, as far as possible, complete;
- (c) The conditions under which the medical attention is given to the individual should approximate as nearly as possible to those of private practice;
- (d) Medical representatives should be closely associated with the administration of the scheme, and as far as questions of purely professional conduct and treatment are concerned, judgment should be in the hands of purely professional bodies;
- (e) Remuneration should be on such a basis as (i) would produce an income not less than that which corresponding responsibility and work should produce in comparable private practice, regard being had to all relevant considerations, and (ii) would not prejudice the continuous supply of the best type of practitioner.

9. If these conditions are not secured there will be grave danger (1) that the volume of work imposed upon the medical profession will be much greater than it can properly perform, at any rate for some time to come; (2) that much of the advantage of present professional feeling and tradition will be lost and the present relationship of doctor and patient be changed for the worse, to the prejudice of the patient; (3) that work under the Insurance scheme will be regarded as of only secondary importance when compared with other branches of medical practice.

#### SECTION A. PERSONS TO BE PROVIDED FOR.

10. The first of the above principles raises at once the question as to the extent of the National Health Insurance service as regards the persons for whom provision should be made. Within the present scheme are included all persons under a contract of service, namely, (a) all manual workers, without any income limit, and (b) non-manual workers with an income limit of £250 a year. Any such employed person who has a private income or pension of not less than 10s. per week, or is ordinarily and mainly dependent for his livelihood on some other person, may claim exemption and is then required to make his own arrangements for medical attendance if his total income is above £160 a year (i.e., if his earned income is more than £184 a year or even less than this). Such persons are exempt from insurance in general but entitled to medical benefit. Further, certain whole classes of persons are excluded because, though under a contract of service, they serve under conditions which provide, by means of a superannuation scheme or otherwise, benefits considered to be at least equivalent to those of the national insurance scheme. On the other hand, certain persons who have been compulsorily insured for at least two years may continue their insurance voluntarily, even though they have ceased to be under a contract of service. These, however, are a relatively small number.

11. Questions which arise are (1) whether it is necessary to include within a National Health Insurance scheme all such persons as are at present included; (2) whether it is not at least equally necessary, from a national point of view, to include other workers who, though not under a contract of service, are in a like economic position; (3) whether

those economically dependent upon such persons, should be included; (4) whether it is desirable to include within the same system of medical benefit those who are actually destitute, in this case of course with appropriate modifications as to contributions.

12. With regard to the first question, the Association, as will be seen in paragraph 15 of this Statement, is of opinion that certain classes of persons now included in the scheme should be excluded therefrom. It is impossible to resist the conclusion that provision for medical advice and treatment for certain of those referred to in the second and third questions is necessary in some form, and the Association is of opinion that the best way of making such provision is by help towards securing a family doctor or general practitioner, as can be done by an Insurance scheme with a wide freedom of choice and conditions, rather than by state-paid or rate-paid medical officers or by the establishment of treatment clinics which must necessarily be restricted in their activities and their staffing. The Association also has no doubt that it is desirable to make provision for those referred to in the fourth question by means of the same general system.

13. It is recognised that the problems, even the medical problems, raised by these suggestions are by no means simple. While agreeing that, as a matter of national health, proper provision for medical advice and treatment should be made for the dependants of poorly paid earners (though not for the dependants of all insured persons as at present defined), as well as for such earners themselves, and that the alternative methods mentioned in the previous paragraph are not to be recommended as the best methods of making this provision, a considerable body of opinion within the profession fears that the difficulties may be so great as to make the suggestion of including even these persons in an Insurance scheme impracticable. There is, however, a body of opinion in the profession which regards the provision of medical attendance on this class of dependants as being a most urgent need. On the financial side numbers would be formidable and there is no reason to suppose that the new entrants into an Insurance scheme would be less costly than their predecessors. On the medical side the main difficulties would be found in (a) the amount of additional work imposed on the profession, and (b) consequential alterations in the conditions of practice in many areas.

14. There does not appear to be any exact estimate of the number of dependants, but assuming for the moment that the number of insured persons (say 15,500,000) remains the same as at present, and that to these be added persons in a like economic position and the dependants of both these classes, the additional number is possibly something like one and a half times as great—that is to say the total number would probably amount to 38,750,000 in all. It must be remembered that the demands on the profession under an Insurance scheme would necessarily and properly be considerably heavier than those at present made by the same persons. This fact emerged during the early years of the operation of the National Insurance Scheme. The Association holds very strongly (1) that an extension on the scale indicated by the above figures is wholly unnecessary and would in practice be found almost impossible, and (2) that to cope properly with the new work which would be involved in any extension whatever of the insured population, to make it tolerable by the profession and to reduce the difficulties and liabilities in order to bring the whole problem within more measurable compass, it is imperative:

- (a) to apply the first principle enunciated in paragraph 8 (namely the provision of medical service only for those persons who are unable to obtain it without the help of such a scheme) as strictly as is administratively possible;
- (b) to make, concurrently with any such extension, certain arrangements tending to lighten the work.

#### 15. The Association is of opinion:—

- (a) That the classes of persons exempt from the scheme by reason of their contract of service including provisions giving benefits equal to those of the national scheme, should be extended to include others (e.g., bank and insurance clerks) not at present exempt;
- (b) That persons with an unearned income of an amount per week not less than that prescribed for sickness benefit should be excluded;
- (c) That any income limit (whether £250 a year or a lower amount) should be applied alike to the non-manual worker, the manual worker, and the voluntarily insured person;
- (d) That unless a lower income limit than the present one is applied generally to insured persons, a still lower income limit than that which is applied generally should be necessary with regard to inclusion of dependants.

16. It is not suggested that these income limits are exact criteria of economic need, but, in view of the considerable increase in the total of medical advice and treatment which would be entailed by the inclusion of dependants and others in like economic position, it seems necessary to draw the line of inclusion in the scheme as low as is reasonably possible, rather than as high as in other circumstances might be found desirable. The question of whether a contribution from the employer should be required for every one of his employees regardless of all, or any of, the suggested exemptions, is not a medical question and is not prejudiced by the above suggestions.

17. The Association is further of opinion that essential conditions accompanying any extension of a National Health Insurance scheme to include any dependants and others of a like economic status must be (a) a sufficiently adequate service of nurses available for home nursing; (b) the reduction to a minimum of all records and reports required from practitioners with regard to the new entrants, and a lightening of those required with regard to existing insured persons; (c) a revision of the matters which may be made the subject of complaint and of the methods of dealing with them on the lines of the suggestions made in a subsequent section of this Statement. In suitable populous areas it would be desirable also to establish or continue infant welfare centres strictly confined to the instruction of mothers and the routine examination of infants and young children as to weight, etc., provided that these centres were kept in proper relationship to practitioners who should have reasonable access to the records of all cases under their individual care.

18. From the medical side only, the problem of the provision of advice and treatment for the poor person *not* under any contract of service, or for the necessitous person, is not specially difficult. The difficulties here are the details of finance and administration. If these can be overcome the profession is prepared to undertake the work in general accordance with the National Health Insurance scheme here outlined. It is, however, essential that provision should in that case be made to preserve the interests, as to superannuation and otherwise, of all existing medical officers affected by the change.

#### SECTION B. EXTENT OF PROVISION TO BE MADE.

19. The second of the main points is that the medical provision made for all persons included in the scheme should be, as far as possible, complete. Under the present scheme the medical advice and treatment provided is, broadly, such as can reasonably be expected from general practitioners as a class. Other services publicly provided under the auspices of local authorities are also available—certain pathological facilities, treatment for tuberculosis and venereal disease, and for certain infective fevers, the treatment of certain conditions of children of

school age, and provision in connection with maternity and infant welfare. Moreover, some Approved Societies make contributions to some of their members toward the cost of a few other treatments, e.g., dental, ophthalmic, or institutional. These benefits are, however, available for only a small proportion of insured persons, although all pay the same premiums. A further small provision for possible consultative advice by or through the regional medical officers, is, so far, scarcely at all developed.

20. It is desired to make all such services and benefits an integral part of the Insurance scheme or to bring them into proper relationship thereto, so that they may be available for all persons included; and to extend the provision so as to include complete consultant and specialist advice and treatment, full laboratory facilities for clinical purposes, residential institutional treatment so far as possible with limited accommodation, dental advice and treatment, such ancillary help as can be given by nurses and masseurs, and an ambulance service—in addition to the general practitioner advice and treatment and the provision of necessary drugs and appliances which is at present the main provision made. The Association is of opinion that all these benefits should be equally available to all insured persons alike, regardless of their membership of any particular society.

21. It seems necessary here to emphasise that when "general practitioner advice and treatment" is spoken of, the phrase does not indicate anything of an inferior character. In their own way and for their own purposes, such services "as can reasonably be expected from general practitioners as a class" are fully as important, as scientific, as highly skilled, as those which are provided by other practitioners in more special and restricted lines of practice. Practitioners, whatever their sphere of practice, may be relied upon to devote to their work all the knowledge, care and skill which they have; the distinction is mainly one of range. Experience and skill in certain directions can only be acquired by those (some general practitioners included) who are able to direct special attention to a particular branch of practice or class of case, or to the performance of certain surgical operations or manipulations. It is desirable to secure all these different kinds of skill for the participants in an Insurance scheme, without implying that one kind is superior in itself to another.

22. It is obvious, as is the case at present in connection with the provision of drugs and appliances, that persons who under the scheme would be eligible for all the additional services could not be put into a position to claim them whenever they wished. Otherwise demands might be made which would be disadvantageous medically and ruinous financially. With slight modification in one or two instances these services should be available only on the recommendation of the general practitioner responsible for the patient. This rule, however, might require safeguarding in two directions. On the one hand it is conceivable that a practitioner might make unreasonable or excessive use of these facilities, and accordingly practitioners might be (a) required to notify the administrative authority on recommending a patient for these extra services, and (b) liable to explain to a professional committee the reason for any apparently excessive use. On the other hand there might be cases, as in private practice, in which there might be a difference of opinion between practitioner and patient as to the need for the extra service, or cases in which a society or other body responsible for cash payments during sickness might make a request for further special advice, and accordingly provision might be made for an official referee to decide the matter in such cases where necessary.

23. The cases calling for a modification of the general rule that services should be available only on the recommendation of the general practitioner responsible are (a) the prescribing of any necessary drugs or appliances, or the using of other extra ser-

vices by the consultant or specialist to whom the patient has been referred not for consultation only but for the carrying out of some special investigation or treatment; and (b) the direct application by the patient to a dental surgeon or dentist for dental treatment. In the latter case some safeguards would be required for dental services of specified kinds or for any procedure estimated to involve expenditure beyond a stated amount.

24. The medical personnel of the consultant or specialist service should consist of those registered medical practitioners who satisfy certain criteria as to status and who express their willingness to accept service within each area. These criteria should be those at present laid down in the Medical Benefit Regulations and elsewhere for a similar purpose. These are:

- (a) That he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character; or
- (b) That he has had special academic or post-graduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid; or
- (c) That he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

The decision as to whether any individual practitioner desiring to serve in a consulting or specialist capacity does in fact satisfy these criteria should be in the hands of a local professional committee. Any practitioner excluded by the decision of such a committee should have the right of appeal to a small *ad hoc* professional committee representing a wider geographical area. From a list of consultants and specialists so compiled a practitioner, in agreement with his patient, might choose any individual considered most suitable for the particular case.

25. In normal circumstances, or whenever possible, such consultations would take place or such specialist services would be given, either at the consultant's rooms, or at the practitioner's house or surgery, or at the patient's house. The conditions in some localities, however, might make desirable the establishment of special premises for this purpose, and such premises might in some cases even be the out-patient department of a hospital. Wherever such consultative or specialist clinics were established attendance would have to be given by the medical officers at fixed times, the clinic should be available for the purposes of medical education, particularly post-graduate, and general practitioners not on the specialist list should be eligible for service as clinical assistants.

26. Among the detailed arrangements that must be made for the conduct of such a service is the important one for exchange of opinion and co-operation in treatment between the general practitioner responsible for the case and the consultant or specialist to whom the patient has been referred for advice or treatment. It is desirable that a system should be adopted whereby the practitioner referring a case would furnish the consultant by some method with information of the previous history and points on which advice is specially desired, and the consultant would furnish the practitioner with information as to the results of his examination and any treatment given or future treatment advised. Provision might be made for insisting upon actual personal consultation between practitioner and consultant where either of them considered this necessary. The primary responsibility of the general practitioner in charge should be preserved in all cases.

27. The relation of certain existing clinics or treatment centres, provided by local authorities under statutory powers, to the suggested arrangements must

be considered. Obviously in so far as persons provided for by these clinics come under a Health Insurance scheme, and so far as the treatment provided thereat is either general practitioner treatment or such as can normally be given by a consultant or specialist elsewhere, they would no longer be required. If they remained—as in many cases no doubt they would—their functions would be somewhat as follows: (a) they would be centres for education in health matters; (b) they would be places at which practitioners might make appointments with their patients when necessary for special purposes; (c) they would be specialist clinics for persons under the Insurance scheme where consultations elsewhere were not possible; (d) they would be available for public provision for such persons as did not come under the Insurance scheme when such provision was still held to be necessary for certain purposes.

28. It is likely that for some time to come it would still be necessary to continue the appointment of whole-time officers dealing with tuberculosis and with venereal diseases.

29. The relationship of maternity work to the Health Insurance scheme requires special mention. At present, attendance in connection with confinement is expressly excluded from medical benefit, and such public provision as insured women and the wives of insured men can avail themselves of is under other auspices and is not complete in character. The Association is of opinion that attendance in connection with confinement should be brought into close and proper relationship with medical benefit in general, and that, in addition to a cash payment, provision should be made under the insurance scheme whereby insured women and the wives of insured men should be entitled both to suitable ante-natal supervision and to attendance at confinement and during the puerperal period. It would no doubt be preferable, if possible, that this attendance should be given throughout by a registered medical practitioner. A large proportion of normal births are however at present attended by midwives only, and as this appears generally to be satisfactory an Insurance scheme can scarcely be expected to provide more than this in such normal cases. Nevertheless, it is clearly desirable that any abnormality that could be discovered before the actual confinement should have been noted, that any practitioner consenting to be called in by the midwife in any abnormal condition should have had previous knowledge of the case, and that there should be proper means for dealing with any abnormality that may arise. Within these limits, therefore, every maternity case should be in relationship with a responsible medical practitioner, though if the mother arranged for the actual attendance of such practitioner in respect of a normal confinement this would be an arrangement outside the Insurance provision. Provision for a woman within the Insurance scheme as set forth in this Statement would thus be (a) ante-natal medical examination (if requested by her) and supervision, (b) attendance by a registered midwife during normal labour and the puerperal period, (c) attendance by the practitioner of her choice during labour and the puerperal period when his attendance is requested by the midwife under defined conditions or when as the result of his ante-natal examination he has declared his personal attendance to be necessary. Professional services under these headings would be remunerated as in the case of the other extra services, by a special scale of fees.

30. Certain conditions are absolutely essential if any arrangement of this kind is to be effective. Such conditions are: (1) any insurance practitioner should be at complete liberty to undertake or to decline this work without any administrative detriment to his interests otherwise; (2) any complaint as to treatment in connection with this work must be referred to a solely professional committee on which the local administrative authority should be represented by its medical officer; (3) there must be everywhere an efficient service of registered midwives; (4) the consultant and specialist service should be available; (5) there should be provision for institutional treatment, for serious cases of ante-natal complications, for cases

requiring major obstetrical operations, for cases where isolation and treatment of septic infection is specially indicated, and for cases where the home conditions are very unsuitable or dangerous for confinements; (6) any registered practitioner should be at liberty to place his or her name upon the list for maternity purposes only. The procedure would thus be for the insured woman, at an early stage of pregnancy, to consult the insurance practitioner who, in the great majority of cases, would accept the responsibility for maternity attendance. If the insurance practitioner did not accept this responsibility it would be his duty to arrange for consultation with (and, if desired, ante-natal examination by) another practitioner chosen by the woman, who was prepared to accept this responsibility in accordance with the scheme. If during pregnancy, at confinement, or during the puerperium, conditions arose which in the opinion of the practitioner necessitated consultation with a specialist or institutional treatment, such consultation or treatment would be available under the ordinary conditions of the service as set out in other paragraphs of this Statement.

31. The provision for a clinical laboratory service stands on a somewhat different footing. There are advantages in such a service being associated with research work; and suitable laboratories are as a rule connected with universities or hospitals, sometimes the larger voluntary hospitals, sometimes hospitals for infectious disease established by local authorities. When, however routine investigations are undertaken by a university laboratory, such routine work should not be allowed to interfere unduly with teaching and research which are the proper work of a university department. It is desirable that the necessary laboratory work should be divided between a relatively small number of large central laboratories and a larger number of small laboratories. At the former investigations requiring special facilities or apparatus or those which can be carried out with greater accuracy, uniformity and economy when large numbers of specimens are dealt with, would be made. At the latter, tests not involving the use of elaborate or exceptional apparatus would be carried out. Highly trained pathologists would be required for most of this work, and in practice it would be impossible and undesirable to restrict their activities to work required by the National Health Insurance scheme alone. Under these circumstances it seems desirable that laboratories should be established and maintained under other auspices, and that a suitable financial contribution should be made to them from the National Health Insurance Fund in respect of the work which they do for persons included within the scheme. Some approved clinical laboratories under private management might be recognised for the same purpose. There is a number of cases, moreover, in which satisfactory results can be expected only if it is possible to provide pathologists to visit patients in their own homes and take the specimens required for examination. It is advisable to arrange for this, as well as for exchange of opinion between clinicians and laboratory workers.

32. For residential institutional treatment arrangements on much the same plan would probably be found most suitable, at any rate for a considerable period of time. There would be available the voluntary hospitals of various types, the hospitals for infectious disease, and the tuberculosis sanatoriums established by local authorities, and the present poor law hospitals. In use none of them could be restricted to persons under the Insurance scheme alone, and the total accommodation in them would be insufficient in many areas. The right of insured persons to admission would thus be limited in accordance with arrangements made with the authorities governing particular hospitals or institutions. A copy of the hospital policy of the British Medical Association is attached hereto (Appendix D), with those provisions marked which have special applicability to any such arrangement made on behalf of participants in an Insurance scheme. This makes it clear that when use is made of voluntary hospitals or other charitable institutions for the treatment of insured persons, either as in-patients or out-patients, the cost



of such treatment should not be a charge on the ordinary funds of the institution but should be defrayed in full out of special funds provided for the purpose in connection with the Insurance Acts, taking into consideration that the charge should include a percentage for the remuneration of the visiting staffs of the hospital in accordance with paragraph 31 of the British Medical Association Hospital Policy. The position of convalescent or rest-homes requires special consideration in this connection.

33. Before leaving this section it may be as well to point out that even within the scope of general practitioner treatment at present the provision for the needs of insured persons is not complete. Although there is complete provision for the supply of any drug or medicine which the practitioner in charge of a case may consider necessary (with due provision against sheer extravagance) there is considerable restriction as to the appliances which may be ordered. No doubt the reason for this is financial, but it would be a great advantage to allow all appliances necessary for the sick person to be supplied. In the case of some such appliances it might be possible to arrange for their loan to the insured person where they are required only temporarily.

34. One other contingent suggestion may perhaps be made. If it should be found desirable to continue to require payments from employers in respect of certain of their employees who were not included in the Insurance scheme as a whole (i.e., exempt persons but for whom a card has to be stamped by the employer), it might be found possible and advisable to give such employees the benefit of some or all of these extra services by reason of such contributions.

#### SECTION C. REGULATIONS AND TERMS OF SERVICE.

35. A third main principle is that the conditions under which medical advice and treatment is given, whether by general practitioners or consultants, should approximate as nearly as possible to those of private practice, and should preserve within wide limits professional customs and traditions. These traditions and conditions must, of course, to some extent be modified by the facts that the scheme is based upon an Insurance plan, and that under the scheme the practitioner undertakes certain responsibilities not to his patient alone but to the State and to societies or bodies administering cash payments during sickness or disablement; but no unnecessary requirements should be imposed either upon the insured person or the practitioner.

36. An essential point is that, as is the case at present, any registered medical practitioner shall be able to participate in the service as a right if he is willing to accept the conditions, and until his continuance in the service has been properly adjudged to be detrimental to it. Unless this be so, a large part of their possible field of work would be automatically cut off from practitioners who have complied with those tests which have been recognised by the General Medical Council, in this respect the statutory governing body of the profession, as permitting entry to the profession. It seems to follow as a corollary from this that the conditions laid down for acceptance should be as little complicated and onerous as possible, so that as large a number as possible shall be willing to engage in work under a National Health Insurance scheme. This would be an advantage to the profession, to insured persons and to the public health alike. It is believed that the suggestions in this and the following section would tend, if adopted, to increase the number of practitioners willing to take part in this work.

37. The main fact of daily professional work is the intimate and confidential relationship which must necessarily arise between patient and doctor and without which, in a large number of instances, results must be far less satisfactory than would otherwise be the case. A very important factor in preserving this relationship is the right of a patient at any moment to seek the services of another practitioner

and the right of a practitioner to intimate that he wishes no longer to be responsible for a particular case. All questions of supposed neglect or lack of success or improper behaviour on the part of a doctor, and of unreasonable conduct on the part of a patient may be solved very simply by the exercise of these rights, and there is no reason why, speaking generally, in reference to such matters, specific rules accompanied by penalties should be imposed on insured persons or special provision be made for complaints against practitioners, if a similar freedom of choice can be exercised. This freedom has been secured absolutely for insured persons under the regulations which came into force in 1924, but the corresponding freedom of the practitioner is still unnecessarily restricted. It should be equally absolute, except that he should not abandon his responsibility for an actually ill person until other attendance has been secured. In the circumstances indicated it is obvious that the desirable thing to do is not to keep doctor and patient tied together as long as possible, but to make other arrangements as rapidly as may be, and to do this with as little unpleasantness or recrimination as possible. There can be no objection, of course, to a statement in general terms as to what constitutes reasonable conduct in certain respects on the part of a patient, or what are in general the duties which the doctor undertakes to perform.

38. The conditions of an Insurance scheme also make certain requirements or provisions necessary which are not needed in the conditions of private practice. These, however, though important, should be few. An insured person should be required (1) to seek acceptance by a doctor before occasion for medical treatment arises; (2) to claim treatment as an insured person, by the production of a medical card or otherwise, on at least the first consultation of each series. Failure in either of these respects should render the insured person liable to a penalty or to the payment of a fee, for otherwise an essential principle of Insurance is violated or the doctor is placed in a serious difficulty as to his duty. An insurance practitioner should be liable to a penalty for (1) wilfully charging a fee for any service which he had undertaken to render as part of the Insurance service; (2) such general conduct as is held to be detrimental to the interests of the service.

39. An insured person, moreover, has an obvious grievance if he experiences undue difficulty in securing acceptance by any practitioner in his district at all unless he has brought this about by placing himself in charge of an unqualified person and whilst he continues in such charge; and the arrangement made with the practitioners of an area must provide against an insured person being placed in this position.

40. Beyond his relationship to his patient as medical attendant the practitioner undertakes to keep certain records and make certain reports and also to furnish certain certificates. Statements made in such records, reports, or certificates about a patient's condition are matters of professional judgment, and, if honestly made, should not render the practitioner liable to any complaint beyond that to which all practitioners are liable in all their professional work, but wilful failure to keep records, make reports, or furnish certificates on the occasions on which the practitioner has undertaken this duty, or the making of wilfully false statements in such documents, may well be the subject of serious official action.

41. If official complaints against an insured person were restricted to his failure to take action in the two ways indicated in paragraph 38; and if official complaints against practitioners were restricted to the cases indicated above, it is probable that such complaints would not be numerous and liability to them would be recognised as on the whole just. It is probable, too, that the machinery at present provided for dealing with such complaints would, with some minor adjustments, be considered to be not inappropriate in the majority of cases. The Association is of opinion (1) that all complaints against a practitioner should in the first instance be sent to the Chairman of the Local Medical Committee and the chief administrative medical officer of the local

authority (mentioned in paragraph 46); (2) that only such as could not be settled by them with the acquiescence of both parties should proceed further; (3) that questions of general conduct, detrimental to the service, or of giving false certificates should be reported upon in the first instance by the Local Medical Committee; (4) that an appeal to the Courts should be possible not only on the ground of improper procedure as at present, but also on the ground that the penalty inflicted was out of proportion to the offence; (5) that in the case of proposed removal from the service the practitioner should have the right of appeal to a duly constituted central professional committee, and that the Minister of Health, in cases where this right was exercised, should not be able to remove the practitioner from the service unless the central professional committee advised this course.

42. There have recently been a number of cases in which the action of the Ministry of Health in imposing penalties on practitioners has appeared to the Association to be of an inexplicable character, and has given rise in the minds of many practitioners to a feeling of injustice or even a suspicion of vindictiveness. The Association recognises the administrative duties of the Ministry in this connection and is very anxious to foster in the profession a feeling of confidence in the exercise by the Ministry of its judicial or quasi-judicial functions associated therewith. When, however, agreements with the profession have been reached with regard to the machinery and procedure by which decisions shall be arrived at, it is exceedingly disquieting to find that, though the machinery is used and the procedure followed, there are cases in which there seems little or no relationship between the decisions of the Ministry and the reports or recommendations of the bodies on which action is supposed to depend. The Association desires to emphasise its view (1) that when a complaint has been dealt with by the bodies set up by the Regulations for this purpose there should not be a liability to have the whole matter re-opened by separate Departmental action either by the Ministry itself or by those bodies at the instigation of the Ministry; (2) that when the complaint has been made in one prescribed form penalties should not be inflicted in respect of offences not formally alleged or of offences which, if alleged, should have been formulated in a different prescribed way and might have required a different line of defence; (3) that full consideration should be paid to the findings or recommendations of a committee (whether Medical Service Sub-Committee or Inquiry Committee) which has itself investigated the details of the case in mitigation of the heinousness of the misconduct even when proved; (4) that it is essential to draw a strict distinction between professional conduct in the attention given to a patient and the nature of the exact professional treatment given to the patient, and that the propriety or otherwise of any particular method or line of treatment should not be made the subject of investigation in connection with the Insurance service.

43. The circumstances of medical practice are so diverse in different parts of the country that any absolute uniform regulations or terms of service are very difficult of application in some respects and in some areas. Particularly do the conditions in sparsely populated districts need special consideration. It is, on the other hand, undesirable that similar conditions in different geographical areas should be differently dealt with, and, indeed, that there should be any unnecessary variety in the conditions or terms under which practitioners serve. It is suggested, therefore, that in the official regulations and terms of service there should be in some sections alternative provisions which might be adopted in certain districts or even in individual cases. Evidence as to special conditions in (a) sparsely populated rural areas, and (b) certain colliery areas, will be found in Appendices A and B.

44. There is one anomaly in the arrangements for the provision of medical benefit created by section 15 (1) of the 1911 Act (section 24 (4) of the 1924 Act) which the Association is of opinion should now be rectified. The section in question of the 1911 Act

recognised certain medical aid institutes existing at the passing of the Act as agents for the administration of medical benefit (including the provision of any necessary drugs and appliances) for their members. The term "Medical Aid Institute" is a generic title which covered Friendly Society Institutes, Workmen's Medical Aid Associations, Workmen's Medical Funds and certain Provident Dispensaries—all now known under the style of "Approved (15 (4)) Institutes." It is believed that all these institutions employ whole-time medical officers paid by a salary, whose appointment and control is entirely in the hands of the governing body of the institute—a purely lay committee. The Association is of opinion that the standard of treatment given by these institutions is not equal to that given by the Insurance service as a whole; it is certain that the great majority of medical men decline to take service under the conditions laid down by these institutions, and it is difficult to argue that they supply any such need of the community as justifies their being placed outside the general scheme of administration of medical benefit.

#### SECTION D. ADMINISTRATION.

45. Two of the main principles to be satisfied in the administration of a National Health Insurance scheme seem to the Association to be these: (1) that the medical benefits in the widest sense (including the "treatment benefits" at present provided and administered by some Approved Societies) should be regarded as a health service and administered along with other health services, distinct from the administration of any cash benefits, which should themselves be administered either separately or along with other cash benefits available from other schemes of National Insurance, and (2) that in the administration of the health services provision should be made for participation of the medical profession to an adequate extent. In Appendix C will be found a statement as to points in connection with one of the "additional benefits," namely, ophthalmic benefit.

46. The central administration of all health services should be under the control of the Ministry of Health, and the local administration of all these services should be in the hands of a local authority established *ad hoc*, or acting through a statutory committee constituted in accordance with schemes—all of which should provide for a proportion of membership of persons of experience in health matters, including representatives of the medical profession. Such committees would be analogous to the existing statutory Education Committees of local authorities. It is recognised that existing Local Government areas are in many cases not ideally the best for purposes of health administration, and that altogether new areas centred in each case round a considerable town, would be more satisfactory for purposes both of health and of education. Of existing authorities, however, it is probable that County Councils and County Borough Councils would be found the least unsuitable, though in a few cases it might be preferable to group a few Borough or Urban District areas.

47. In any case such unification of medical services as those contemplated in this Statement would in such an administrative system involve the disappearance as such of Insurance Committees and the transfer of the health functions of the Poor Law Guardians. It is certain, however, that many of the members and officers of these bodies would be indispensable for the work of the unified authority.

48. Each such Authority would have a Chief Administrative Medical Officer, who would no doubt in most cases be the existing Medical Officer of Health. In each area there would be also a Statutory Local Medical Committee elected or appointed under a scheme which would ensure that it was representative of all kinds of medical practice in the area. Such a medical committee would take the place of both the existing Panel Committee and the existing Local Medical Committee, and like the former of these but unlike the latter, would have funds provided for administrative purposes. The duties of this Committee

would be to appoint the representatives of the medical profession on the Local Health Committee and on any other local committees containing such representatives, to conduct any negotiations with the local health authority on behalf of the profession, to advise that authority on purely professional matters and to perform any other statutory duties imposed upon such a medical committee. The Medical Committee should have the right to present its view not only to the Local Health Committee but also to the Ministry of Health and to the public. A separate Dental Committee would probably be required.

49. The administration of the cash benefits (sickness disablement, maternity) does not primarily concern the medical profession as such. Practitioners are, however, brought into close and important relationship thereto by reason of the facts: (1) that they have to give medical certificates on which to a large extent the payment of these cash benefits depends; (2) that they often find their patients in doubt, difficulty or even distress with reference to these payments; (3) that they, through the Insurance Committees, are largely dependent on the bodies which administer these benefits for the correctness or otherwise of the lists of insured persons for whom they are responsible.

50. Evidence of serious imperfections in the administration of Approved Societies both in notifying Insurance Committees of the enrolment of insured persons and of the suspension of their members from medical benefit, and in the payment of sickness benefit to their members, is continually coming to the notice of practitioners in their daily work; but except as to one matter on which there are official statistics of great importance, the Association does not wish to stress this. Doubtless, as in the corresponding matter of the imperfections of medical attendance and treatment, a considerable proportion of the complaints are vague and incapable of being substantiated, or are really due to faulty action on the part of the insured persons themselves. Doubtless, too, there are a considerable number of agents of large societies and a number of part-time officials of small societies who are unable to understand, or do not take the trouble to understand, the regulations under which they work or the instructions of their superior officers, just as there are some practitioners who will not read or consider memoranda or communications addressed to them. Doubtless, again, as in the case of medical attendances, the proportion of cases in which there is cause for complaint is quite small in relation to the total number of occasions on which complaint might possibly have arisen. Nevertheless it is distressing to doctor as well as to patient to witness cases in which actual want arises and delay in recovery ensues owing to the non-payment or the delay in payment of benefits to which the insured person appears entitled; and there is much loss of valuable time in explaining to such persons what they should do in order to secure what they believe to be their rights or to what quarter their complaints should be addressed.

51. The matter of the delay of Approved Societies to notify promptly the fact that members have passed out of medical benefit or to issue orange slips notifying suspensions from medical benefit is, however, serious. The following extract is from the official Memorandum (C.I.C.I.) issued to Approved Societies by the Central Index Committee in March, 1923:—

"21. *Delay in issue of Orange Slips.*—The suspension from medical benefit which requires to be notified by the issue of an orange slip arises out of circumstances which should be known to the Society some considerable time before the suspension is due to take effect, and in the case of employed contributors usually about six months before that date. The instructions require that the Society should issue the orange slip as early as possible in the half-year at the close of which the member is due to be suspended. This, again, is no mere formality; it is necessary in order that the orange slip may be forwarded to the In-

urance Committee before the suspension actually takes effect so that the member may be removed from the doctor's list immediately he ceases to be entitled to benefit. Doctors are credited on the numbers upon their lists at the beginning of each quarter; and it follows that if the Insurance Committee is unable to remove a suspended member from his doctor's list by the first day of the ensuing half-year, the doctor is credited, for a further quarter at least in respect of that member, while the member himself may enjoy a period of medical benefit beyond that to which he is entitled.

"22. Notwithstanding, however, the practical importance of the prompt despatch of orange slips, much delay is experienced by the Central Index in receiving them from Societies. The orange slips received notifying suspension on 30th June, 1921, for example, numbered 275,000, of which no more than 100,000 were received in time to permit of their being dealt with before the date of suspension, the balance of 63 per cent. of the persons concerned being still credited to doctors after ceasing to be entitled. In the case of suspensions taking effect on 31st December, 1921, 474,000 orange slips were received, of which 250,000 only were in time to be dealt with by the date of suspension; while of the suspensions taking effect on 30th June, 1922, 326,000 were received, of which 223,000 alone could be dealt with before the date of suspension."

"23. It will thus be seen that in practice a large proportion of the orange slips issued are despatched too late to be made effective by the date of the suspension which they are intended to notify; and the consequence of this delay is, as already indicated, that hundreds of thousands of insured persons are in a position to obtain benefit beyond the period for which they are entitled to receive it, while credit for them is unavoidably given to the doctors concerned for a full quarter at least beyond the date of suspension, irrespective of the date when the numbers are actually taken off the doctors' lists. Some substantial improvements can reasonably be expected in the connection; and apart from the consequences just indicated, the Central Index Committee think it necessary to point out that delay of this kind is bound to increase the administration expenses of the Index. If all orange slips were forwarded promptly by each Society in the early part of the half-year at the end of which suspension is due, or in the case of large societies issued in equal instalments at regular intervals throughout that half-year, the heavy work of handling them and passing them on to Insurance Committees could be overtaken with an even load of work. If, however, receipts of orange slips are, as at present, congested towards the end of that half-year, extra expense is incurred through the dislocation of the current work or the employment of extra staff to cope with the congestion."

This shows that in a period of eighteen months as the direct result of imperfect administration on the part of Approved Societies there were 503,000 persons whom doctors were liable to attend in respect of whom no contribution was forthcoming, and there are figures showing that in Manchester alone there were such persons actually receiving treatment as follows:—During the last two quarters of 1921, 252; first three quarters of 1922, 758; whole of 1923, 1,180; and during the first three quarters of 1924, 796.

52. The profession regards the question of false certification as of the highest importance, and looks upon the issue of a false medical certificate as one of the gravest offences of which a practitioner can be guilty. There has, no doubt, from time to time, been a certain amount of lax, as distinguished from wilfully false, certification on the part of some practitioners, and some disregard the certification rules which, since they were in force, should have been strictly obeyed. In practice, however, it is difficult

\* The figures in this paragraph relate to England.

sometimes to obey all these rules strictly without doing injustice to the insured person, and many of the conclusions which have sometimes been drawn by the officials of Approved Societies from an examination of large numbers of medical certificates or from the results of reference to Regional Medical Officers are erroneous, due often to very natural misinterpretation or misunderstanding. It is recognised that bodies responsible for the administration of cash benefits have a right to be consulted with regard to the arrangements for certification and to criticise the working of such arrangements, and the Association is prepared, should the Royal Commission wish it, to go more fully into the question of certification and to reply to any allegations which may possibly be made with regard thereto; but it appears that, in the main, medical certification in relation to sickness benefit is remarkably well done, and certainly an immense amount of trouble is taken to do it conscientiously and accurately, in spite of some failures.

53. Some alterations in the forms of certificate and of the Certification Rules and arrangements would conduce to the easier and more harmonious working of the system, and would be for the convenience alike of doctor and patient, without seriously interfering with the rights of the bodies administering cash benefits. For example, the phrase "incapable of work" used in the Acts and therefore necessarily repeated in all certificate forms is misleading and inaccurate if the words are given their ordinary signification; and certificates containing this phrase can be signed honestly only because the words are now understood to have a technical meaning, which, however, needs a pamphlet to set forth accurately. It is desirable that this phrase should be altered. With this exception the form of the first and of the final certificates might remain as at present, and it is probable that a first intermediate certificate may properly be required under the same conditions as now; but with regard to other intermediate certificates it is suggested (a) that they should simply state that the practitioner has seen the patient on a particular day and that the patient remains unfit for work; (b) that the interval between the issue of such certificates should be at the discretion of the practitioner provided that such interval was not greater than 14 days in the case of sickness benefit more than 42 days (or in rural areas three months) in the case of disablement benefit; (c) that the practitioner should be able in the former case to apply for permission to make the interval longer than 14 days, and that the body administering disablement benefit should be able in the latter case to ask that the interval should be made shorter than 42 days or three months, as the case may be; (d) that the arrangements for special intermediate certificates dealing with absence from home should be more elastic both as to the period of illness at which such certificates may be issued and as to the length of time for which they should be available.

54. In the event of the complete separation of the administration of medical benefit from that of cash benefits which is suggested, the method by which these cash benefits shall continue to be administered is not the concern of the profession. Many practitioners, however, hold the belief, based on experience, that this administration is likely to be more satisfactory and sympathetic in the hands of certain classes of Approved Societies than in the hands of a large State organisation or committee of a local Government Authority. If it is determined that Approved Societies shall continue with this administration as one of their functions it is suggested that there should be certain requirements which all such Societies should meet. They should (1) be of such a size as would constitute a properly insurable group; (2) be of such a character (or have such financial arrangements made for them by consent) as will not vitiate a uniform Insurance scheme; (3) be of sufficiently uncomplicated constitution so as not to put their members at a disadvantage; (4) be obliged to classify all their members on a territorial basis; (5) be as uniform as possible in their rules for the conduct of insured persons.

55. The profession is completely convinced, in consequence of intercourse with insured persons over a period of twelve years, that Approved Societies, as at present constituted, do not as a whole in any sense represent insured persons, their wishes or opinions. For the most part insured persons take not the slightest interest in the work of their Societies, and very often do not know the name of the Society to which they belong. This indifference is probably inevitable in the case of the larger Societies, and of the great majority of insured persons, and does not necessarily indicate any lack of interest or ability or zeal on the part of the principal officials of such Societies.

#### SECTION E. REMUNERATION.

56. The remuneration of members of the medical profession working under the National Health Insurance scheme should be determined on its merits by negotiation between the Ministry of Health on the one hand and a central body representing the profession on the other. Such central body might most properly be the Council of the British Medical Association, representing, as it does, all branches of the profession through its Divisions and Branches, and the Local Medical Committees of the country through its Insurance Acts Committee. The Association is strongly of opinion that the remuneration of the general practitioner service should be by a capitation system, though local option might be allowed as now in the distribution of the amount allotted in each area. The remuneration of consultation and specialist work, on the other hand, must necessarily be by tariff fees according to the variety of service rendered, or in some cases by sessional fees according to the time given and character of the work done. The two funds for the general practitioner service and for the extra services, would be distinct, and completely independent of one another.

57. The amount of the Central Practitioners Fund must necessarily be arrived at by a somewhat elaborate actuarial calculation since it is impossible accurately to count the insured population day by day. The distribution of this pool to the different areas, too, must be made by a small expert committee who will take account of all relevant facts. In the past there have been great difficulties in both these calculations, and it is desirable that the profession should be completely assured that any margin of error is reduced to a minimum.

58. The principle on which the amount of the remuneration should be established is that it should in total compare not unfavourably with that which should be forthcoming from similar responsibility and work in private practice of a like nature among the same class of persons, allowance being made for security on the one hand, and on the other hand for work done not primarily for the individual patient but for the State or public body.

59. The actual amount of the capitation fee on which remuneration for the general practitioner service should be based has been so recently and so fully argued, before the Court of Enquiry in January, 1924, that the profession has no wish to re-open the matter at the moment. They are, however, convinced (1) that the capitation fee of 9s. is still too low to be a proper remuneration for the responsibilities undertaken and work done under the Insurance scheme; (2) that the extra amount allowed for rural conditions requires reconsideration. The exact determination of this matter, however, and the appropriate tariff of fees for consultant and specialist services must depend largely upon the nature of the Insurance scheme recommended by the Royal Commission and enacted by Parliament. It is, therefore, not possible with advantage to carry it much further at the present time.

## APPENDIX A.

SPECIAL CONDITIONS OF INSURANCE PRACTICE IN RURAL  
AREAS AND THE EXTRA REMUNERATION CALLED FOR  
TO MEET THEM.

1. Any consideration of the special conditions of rural practice was specifically excluded from the Reference to the Court of Enquiry into Remuneration in January of last year. It therefore becomes necessary to go somewhat fully into this aspect of the question before the Royal Commission. The importance of the matter to the profession is evidenced by the fact that in 1923 of 12,711 insurance practitioners there were 5,649 (40 per cent.) who claimed mileage, and therefore to some extent were practising under rural conditions.

2. There are certain undeniable peculiarities in these conditions to which the attention of the Ministry has already been drawn, and which have been acknowledged by them as worthy of consideration. They may be summarised as follows:—

- (i) The list of a practitioner in a sparsely populated district must necessarily be smaller on the average than that of one in a town;
- (ii) The cost of travelling and the time occupied in travelling is much more in the country than in a town;
- (iii) The facilities for lightening the work of the practitioner (*e.g.*, nursing and hospital facilities) are less in the country than in the town;
- (iv) The proportion of visits to attendances at the surgery is higher in the country than in the town, and the time occupied in rendering service is longer;
- (v) The necessity to engage a *locum tenens*, even for a short absence from home, whether for holiday, study, or professional business, presses hard on the country doctor, since deputising arrangements such as are the custom in the towns, are impracticable;
- (vi) The absence of day schools and of practically any higher education facilities in the more rural districts adds very materially to the country doctor's domestic expenses.

3. With regard to (i.), the average number of insured persons on the lists of the doctors who claim mileage is 697, that on the lists of all other doctors is 1,200. The doctors claiming mileage include many town practitioners who have a few patients in the country, and if these were excluded it is probable that the genuine country practitioner would be found to have an average of between four and five hundred, and that this list is incapable of increase. It may fairly be contended that a list of 500 people in a sparsely populated district takes at least as much time to work as one of a thousand in a town.

4. With regard to (ii.), since 1920 a mileage grant has been established purporting to cover the cost in money and time of travelling beyond two miles from the practitioner's residence, and a comparatively small addition was made in 1924 to meet the other conditions enumerated.

5. There is no doubt that at present owing to the unattractive financial conditions, rural practices are being abandoned in certain parts of the country. The difficulty is not confined to Great Britain and is perhaps inevitable, but if it is desired to retain efficient doctors in the country, it is absolutely necessary that their emoluments should be such as will enable them to maintain in all essentials a suitable standard of life.

6. The best solution would seem to be the retention of the present system of a general capitation fee for the whole profession with augmentations to meet the special requirements of the rural practitioner.

7. Remuneration as expressed by the capitation fee has been approached in the past chiefly from two directions: (1) the value of work done for insured persons as measured by the time occupied in the services rendered—a certain net income for an average practitioner in full work being assumed—and

(ii) the value of services rendered as estimated by the fees commonly charged by general practitioners. Both these lines of approach would seem to point to the need for a supplementary fund for practitioners in rural districts, for (i) the time occupied in the same services is definitely greater under country conditions for the same number of patients, and (ii) the fees charged both for visits and attendances at the surgery in country practices have always been of necessity higher than those in towns—a fact apparently left out of consideration in 1911, when the matter was investigated chiefly on urban data.

## APPENDIX B.

SPECIAL CONDITIONS IN COLLIERY AREAS OF SOUTH  
WALES.

1. Section 16 (3) of the 1911 National Health Insurance Act (24 (3) in the Act of 1924) authorises the Insurance Committee to *require* any person whose income exceeds a limit to be fixed by the Committee and to "*allow* any other persons in lieu of receiving medical benefit under such arrangements as aforesaid, to make their own arrangements for receiving medical treatment and attendance . . . and in such cases the Committee shall . . . out of the funds out of which medical benefit is payable contribute . . . sums not exceeding in the aggregate the amounts which the Committee would otherwise have expended in providing medical benefit for them."

2. In practically every area with the exception of South Wales this section of the Act has been taken to apply to *individuals*, but the Insurance Committees of Monmouthshire and Glamorgan have taken advantage of it to hand over the capitation fees to bodies of workmen who have set up "Schemes" for the purpose of giving medical attendance by salaried doctors to the workmen and their families. The money for the families is obtained by deductions from the men's wages supplemented by the money provided from Insurance funds under the above-mentioned section of the Insurance Act. The medical profession has always protested strongly against what it believes to be an abuse of the section, on the ground that the Schemes are an evasion of the intentions of the Act which contemplate that the normal system will be the panel system, whereas these Schemes are worked on a whole-time salaried system.

3. The Schemes are invariably introduced and from time to time stimulated by a system of canvassing which is very unfair to competing doctors; they are controlled by Workmen's Committees, which are not responsible bodies like the Insurance Committee: they are subject to little or no central control, they allow no direct representatives of the medical profession on them, nor are they guided, as the Insurance Committee largely is in medical matters, by a purely medical committee—the Panel Committee. Experience has shown that the service provided is on the whole unsatisfactory as compared with that given by doctors under the normal system; most of these Schemes have disappeared after a comparatively short but unsatisfactory existence; and it is hoped that the Royal Commission will recommend such changes as will make it impossible to finance such Schemes out of National Health Insurance Funds.

## APPENDIX C.

## OPHTHALMIC BENEFIT.

1. Among present "additional benefits" dental and ophthalmic are easily first in demand and in value to insured persons.

2. Ophthalmic benefit appeals greatly to the insured person, for the symptoms of eye strain are most disturbing and are more frequent with the increasing complexity of modern life.

3. This benefit should be dealt with administratively in the way suggested in the main body of the Statement with regard to the "treatment benefits" in general by being removed from the administration of Approved Societies. Under the present

system, however, a few Approved Societies have made arrangements with specially qualified practitioners on behalf of their members and these arrangements are not open to the objection which is set out in the following paragraphs.

4. Other Approved Societies have entered into arrangements which are open to serious criticism and are certain to lead to grave danger to the insured persons.

5. These Societies have arranged for the provision of spectacles by opticians and without the necessary preliminary examination by a competent medical practitioner. The arrangement, it is alleged, is cheap. But cheap methods in dealing with human beings usually prove costly in the long run. It is sure to prove so in this regard, both immediately and in the future. An ophthalmic benefit secured through a competent medical practitioner is a full consultation covering external or internal diseases of the eye, refraction work, and vascular and neural examinations. The results of these examinations should be communicated to the insurance practitioner and would afford him information regarding his patients which he cannot get otherwise, and which will be a material guide to his work. The bare provision of spectacles by a "sight-testing" optician cannot secure those benefits, for he is not trained in the diseases of the eye and of the body which are concerned therewith. Apart from the risks inevitable in the employment of untrained or part-trained men for the examination of the most delicate sense organ and one closely connected with the brain, examinations by sight-testing opticians are inadequate and therefore unprofitable.

6. The utilisation of medical practitioners for this purpose will make it certain that within a very few years there will be a full supply of well-trained and competent ophthalmologists ready and able to do this work to the best advantage. If the employment of sight-testing opticians be continued or extended there will be a diminution of the supply of doctors willing to do this work, to the ultimate disadvantage of the community.

7. Further, as examination of the refraction of the eye for the purpose of fitting spectacles is regarded as a form of medical treatment, medical practitioners, with due regard to the disciplinary disabilities that would follow, or with proper regard for the welfare of their patients, cannot send their patients or be party to sending their patients to persons not on the Medical Register.

British Medical Association,  
429, Strand, London, W.C.2  
April, 1925.

#### APPENDIX D.

##### THE HOSPITAL POLICY OF THE BRITISH MEDICAL ASSOCIATION.

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###### (A) INTRODUCTORY NOTE.

Among the social changes of recent years none is more remarkable than that which is taking place in

our hospitals. From charitable institutions for the treatment of the very poor they are becoming centres to which many who are by no means poor turn for help in sickness, and where the community as a whole claims as a right, services which can only be rendered by a great organisation or by its dependent branches. There can be few medical men who will not welcome such a change, with the great opportunities which it offers for the development of their work and for the protection of the health of the nation. But these changes necessarily involve a modification in the relationship of the doctor and his patient, and a change in the basis of hospital service. To the very complex questions which arise the British Medical Association has devoted a great deal of attention, and it has evolved a definite, co-ordinated and considered policy.

The policy of the British Medical Association is the result of the slow and steady growth of opinion within the medical profession. It is the work of the members of the Association acting through its deliberating bodies, it has been discussed and voted upon by the members of the Association through the Divisions of the Associations, and it has been submitted to the vote of conferences of medical staffs of the hospitals called for that purpose. The policy of the British Medical Association is based upon the direct experience of men engaged in the practice of medicine in the widest sense, and in particular of those engaged in hospital work. It is a practical policy, not an academic scheme. It is believed that the application of the British Medical Association policy to present-day conditions would secure a steady improvement in hospital work and thus contribute to the wellbeing of the nation.

###### (B) INTER-RELATION AND CO-ORDINATION OF HOSPITAL PROVISION.

(1) There are in this country three types of hospitals in which provision is made for the treatment and nursing of the sick, viz., voluntary hospitals, poor-law hospitals and municipal hospitals.

(2) The Association has during many years formulated lines of policy regarding the various types of hospital. It has now proceeded to outline means whereby these several hospitals should be co-ordinated.

(3) Tentative efforts have been made to connect the poor-law hospitals in certain areas with the existing voluntary hospitals for the double purpose of benefiting the poor-law hospital by an enlargement of its staff from the voluntary hospital staff, and by relieving the stress on the accommodation of the voluntary hospitals by opening up the larger accommodation of the poor-law hospitals.

(4) It is inevitable that the anomalies of the existing hospital provision must be amended; overcrowding of the voluntary hospitals is a danger to them; under-staffing and the isolation of the poor-law hospitals is a loss both to the public and the profession. The desire for correction of such anomalies may lead to measures of reform being forced upon the hospital authorities from without. It is better therefore that the Association should endeavour to foster suitable methods by which these reforms may be secured.

The Association recommends:—

1. That the principle of the Local Voluntary Hospitals Committees (as set up under the action taken on the report of the Voluntary Hospitals Committee presided over by Viscount Cave, and now in existence in many parts of the country) should be approved, and that the scope of these Committees should be extended so as to make them the co-ordinating bodies for all the hospital accommodation required within their areas, including voluntary, municipal and poor-law, provided:—

(a) That the areas covered by the Committees should be large enough to cover effective hospital districts and not necessarily confined to Local Government areas; and

- (b) That the personnel of these Committees should include representatives of all the hospitals or hospital authorities concerned, voluntary, municipal and poor-law, and of the medical practitioners of the area.

2. That the terms of reference to these Committees should include:—

- (a) The survey of all the hospital accommodation of the area of such Committee;
- (b) The determination of adequate hospital accommodation in that area;
- (c) The co-ordination of all existing accommodation in the area, both special and general voluntary hospitals, municipal and poor-law hospitals;
- (d) The recommendation of the provision of any necessary additional accommodation and the type of such provision, both as regards general and special hospitals, primary centres in rural districts, and convalescent homes; and
- (e) The Committees should not interfere with the domestic autonomy of the several hospitals of whatever type within their areas, but act only in an advisory capacity; each type of hospital should be encouraged to work upon those lines of local initiative which have proved so vital in hospital work.

3. That the scope of the existing Voluntary Hospitals Commission should be extended similarly so as to make it a Standing Consultative Hospitals Committee for England and Wales which should represent all the Local Hospitals Committees of the several areas, and should act as between the Ministry of Health and the Local Committees in all matters concerning the hospital policy of the Ministry, and the allocation of any grants which may be allotted to hospitals not directly supported by the State in its various functions.

#### (C) UTILISATION OF MUNICIPAL HOSPITALS FOR CIVIL NEEDS.

In any contemplated application by a local sanitary authority under the Public Health Act, 1875 (section 131), enabling such authority to establish or maintain a public hospital:—

1. Any such additional hospital accommodation should be related to existing hospital accommodation whether in voluntary hospitals or poor-law infirmaries, so as to ensure that there shall be no duplication of accommodation or competition with or between the institutions provided.

2. Representatives of the medical practitioners chosen by the practitioners of the area for which additional hospital accommodation is proposed should be invited to consult with and advise the representatives of the local sanitary authority in the formulation of its scheme. For the selection of these representatives use should be made of the local organisation of the British Medical Association.

3. In municipal hospitals established by the local sanitary authority certain beds should be set aside for private patients paying a fee to be settled by the authority; where a general practitioner is desired by the patient to continue treatment, he should be allowed to do so under the general administrative supervision of the medical superintendent, and any of these patients should be allowed to call in a consultant from outside, the patient bearing the cost thereof.

4. For private patients submitted to municipal hospitals there should be an inclusive charge to cover the cost of medical supervision, maintenance, nursing, food and medicines, within the ordinary tariff and pharmacopœia of the hospital, the patient paying his medical attendant independently.

5. Any extra nursing and any food or medicine ordered over and above those allowed under the ordinary tariff and pharmacopœia of the hospital, should be charged as extras to the patient.

6. All medical attendance by private practitioners on "paying" patients in hospitals should be under the administrative supervision of the medical superintendent.

7. Municipal hospitals so far as practicable should be utilised for medical education.

8. In any hospital maintained by a local authority for general cases, provision should be made for wards on the lines of the suggested primary health centre as outlined in the Consultative Council's Report, for the reception of private patients admitted on the recommendation of their own practitioner, who should be allowed to attend these patients in such wards.

9. Municipal hospitals should be controlled by an *ad hoc* committee, on which there should be a small but definite representation of the medical profession, nominated by members of the local profession.

10. The normal method of admission to a municipal hospital should be on the recommendation of a general practitioner.

11. Except for the treatment of private patients, the normal medical staff of any municipal hospital should be a combination of the whole-time resident staff, or a part-time selected staff, with part-time specialists, the last being called in by the medical superintendent as and when necessary.

#### (D) UTILISATION OF POOR-LAW HOSPITALS FOR CIVIL NEEDS.

1. In those poor-law infirmaries where there is spare accommodation and when the needs of the poor-law patients have been met, it would be desirable that certain beds should be set aside for private patients paying a fee to be settled by the Guardians: that where a general practitioner wishes to continue to treat therein patients of his own, he should be allowed to do so under the general administrative supervision of the medical superintendent; and that any of these patients should be allowed to call in a consultant from outside, the patient bearing the cost thereof.

2. For "paying" patients admitted to infirmaries there should be an inclusive charge to cover the cost of medical supervision, maintenance, nursing, food and medicines, within the ordinary tariff and pharmacopœia of the infirmary, the patient paying his medical attendant independently.

3. Any extra nursing and any food or medicine ordered over and above those allowed under the ordinary tariff and pharmacopœia of the infirmaries should be charged as extras to the patient.

4. All medical attendance by private practitioners on "paying" patients in infirmaries should be under the administrative supervision of the medical superintendent of the infirmary.

5. Infirmaries, so far as practicable, should be utilised for medical education.

6. In any hospital maintained by a local authority (including Boards of Guardians) for general cases, provision should be made for wards for the reception, on the lines of the suggested primary health centre as outlined in the Consultative Council's Report, of private patients admitted on the recommendation of their own practitioner, who should be able to attend these patients in such wards.

7. Municipal hospitals should be controlled by an *ad hoc* committee on which there should be a small but definite representation of the medical profession, nominated by members of the local profession.

8. It is desirable in the interests of the patient that the medical superintendent should have power in special cases (including cases of urgency) to admit or retain patients from other parishes, the Guardians being empowered to recover the cost of maintenance

thereof from the parish or borough in which the patient resides.

9. To meet the need of accommodation for senile and chronic cases, a part of the poor-law institution should be separated from it whenever possible, which should be formed into an infirmary dependence under the control of the medical superintendent of the infirmary.

10. Certain classes of cases, *e.g.*, tuberculosis and certain infectious fevers not already provided for, should not be accommodated in general infirmaries, but in special hospitals arranged for this purpose.

11. The normal method of admission to an infirmary should be on the recommendation of a general practitioner.

12. District medical officers should be selected from the private practitioners of the neighbourhood.

13. Except for the treatment of private patients, the normal medical staff of an infirmary should be a combination of the whole-time resident staff, or a part-time selected staff, with part-time specialists, the last being called in by the medical superintendent as and when necessary.

#### (E) VOLUNTARY HOSPITAL POLICY (UNITED KINGDOM)

##### I.—Introduction.

1. The requirements of the voluntary hospitals as affected by present day conditions of finance, and the consequential demand made by many of the hospitals for payment from patients for hospital services, have been carefully considered by the Association.

Also numerous contributory schemes for the provision of hospital benefit for certain sections of the community, submitted to the Association for its approval, have been subjected to examination.

Throughout this document the term "Medical Treatment" includes any and all of those services which can be and are rendered by a registered medical practitioner, *e.g.*, examination, whether clinical or laboratory, advice, consultation, and the application of remedies, whether medical, physical or operative.

2. The voluntary hospitals have grown up upon a general understanding between the subscribers, the Board of Management and the members of the honorary medical staff that both funds and services were placed gratuitously at the disposal of those members of the community unable to pay for adequate medical treatment. This understanding for gratuitous service was mutual and reciprocal, and the general tendency now existing for the exaction of payment, however small, from the patient, necessarily modifies the original understanding and fundamentally alters the basis of the relationship between the honorary medical staffs and the subscribers.

3. The Association recognises a dual policy as regards the voluntary hospitals: (a) that the purely charitable side should be continued wherein the whole cost of the maintenance of indigent patients is met by the gratuitous contributions received by the hospital and on whose behalf the services of the honorary medical staffs are given gratuitously; (b) that other patients who are not indigent may be received for treatment at voluntary hospitals when they cannot pay for or cannot obtain adequate treatment elsewhere, and that for them payment should be received by the hospital either from the patients themselves or, on their behalf, from the authority or body referring them to the hospital, and that on account of their treatment some method of remuneration of the honorary medical staff should be arranged.

4. In view the tendency of the State through local and central authorities to require services of the voluntary hospitals, it should be provided that in any arrangements for such services the State should pay the full cost to the hospital for such services, so that no portion thereof shall be charged to the charitable funds of the hospital, and that the payment so made shall include an amount for the remuneration of the honorary medical staff of the

hospital. It is neither just nor expedient for the community to throw upon one section thereof the onus of undertaking, gratuitously, professional work of a responsible character. Services rendered to the State should be remunerated by the State, not only on the grounds of justice to those concerned but also on the grounds of public advantage. Such work could only be requested gratuitously either as an act of charity or as a demand on the services of the citizen. Charity can only be requested on behalf of those who are themselves unable to pay, and the State does not come within this category. Further, there can be no just claim by the State on the gratuitous services of a particular class of citizens which can be rendered only by that particular section, and are not and cannot be demanded from the general body of citizens.

##### II.—The Voluntary Hospital.

5. The Association records its belief that the voluntary method of administration of the voluntary hospitals of the country is to the advantage of the public, medical science, and the medical profession, and that it should be maintained.

6. The Association maintains that the essence of the voluntary hospital system is the independent and voluntary management, and that this is not necessarily related to the conditions of service of the medical staff.

##### III.—Sources from which Funds are Received by Voluntary Hospitals.

7. Funds may be received by Hospital Authorities from two sources: (a) gratuitous contributions (*i.e.*, contributions from whatever source to which no such conditions are attached as would involve the obligations of service on the part of the hospital but are charitable contributions to be expended at the discretion of those to whom the management of the hospital is entrusted); and (b) contributions for services rendered or to be rendered (*i.e.*, contributions made either by patients themselves or on their behalf, for hospital benefit).

8. It is undesirable that the voluntary hospitals should be subsidised by the local rating authorities, except in so far as *pro rata* payment is made for the maintenance and medical treatment of patients for whom these authorities are responsible.

9. Contributions to hospitals by employers of labour or massed or periodical contributions by employees should be considered as contributions for services rendered or to be rendered.

[As paragraph 9 was not adopted by the A.R.M., 1924, by a two-thirds majority, it must be confirmed by the A.R.M., 1925, if it is to become the "policy" of the Association.]

10. Every patient of a voluntary hospital who is able should make a contribution towards the cost of maintenance and medical treatment, unless the contributory method of subscription is adopted as essential in industrial areas.

11. Greatly extended support for voluntary hospitals should be sought from employers and insurance companies, seeing that they benefit largely both directly and indirectly by the services of the voluntary hospitals.

##### IV.—Contributory Schemes.

(A contributory scheme in this document means a scheme to which contributions are made for which there is to be a stated or implied return.)

12. It is undesirable that the Association should approve specific contributory schemes for the provision of hospital benefit as such. To do so would imply that the Association had considered and provided against all the possibilities that may arise out of any scheme approved, such as financial stability, sufficiency of hospital accommodation for the area involved, and a number of other and related conditions which can only be determined during the actual working of several of these schemes for an



extended period. But it is desirable that certain principles should be approved by the Association as applicable to any contributory scheme.

13. In any schemes for providing hospital benefit by voluntary hospitals, it is undesirable that the hospitals concerned should undertake any insurance risk, i.e., undertake to provide hospital benefit, when required, in return for a periodic payment by an individual or a group of individuals; so that where schemes are set up to provide payment for hospital benefit for specified individuals or groups of individuals, such schemes should be organised not by the hospital, but by some independent body.

14. The acceptance by voluntary hospitals of an insurance risk under any scheme for the provision of hospital benefits would (a) prejudice the primary consideration in the admission of a patient to hospital, namely, the suitability of the case for admission on medical grounds; and (b) in the event of the actuarial estimates upon which the scale of premiums and benefits are based proving faulty, render the hospitals liable to meet outlays for which there was no financial provision and consequently endanger the purely charitable funds of the hospitals.

15. In any contributory scheme the presence, limitations, or absence of a contractual obligation for the provision of hospital and additional benefits should be plainly stated to the contributors. Failure to provide such statement is likely to reflect upon the good faith of the hospitals and of the promoters of the scheme.

#### V.—Suitability of Patients for Hospital Treatment.

16. The primary consideration in the admission of a patient to hospital should be the suitability of the case on medical grounds.

17. Some means of investigation into the circumstances of the applicants for relief, by means of an almoner or other agent, should be employed in all medical charities.

#### VI.—Categories of Patients for In-Patient Treatment.

18. Patients admitted to voluntary hospitals should be classed under the following groups: "Free" (Indigent), "Tariff," and "Private":—

- (a) *Free (Indigent) Patients.*—Those certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and treatment.
- (b) *Tariff Patients.*—Those paying, or for whom is paid, in part or in whole, the tariff cost of maintenance and treatment; this group includes all those for whom any payment has been made by (i) Public Authorities; (ii) Approved Societies, Employers of Labour, Insurance Companies, or other bodies; or (iii) under any contributory scheme; and
- (c) *Private Patients.*—Those who pay for special accommodation and who arrange for medical treatment fees independently of the hospital.

#### VII.—Free (Indigent) In-Patients.

19. These are persons certified by the almoner or other officer of the hospital as unable to contribute in any way towards their maintenance and medical treatment; and for whom hospital benefit is provided by the gratuitous contributions placed at the discretion of the hospital managers and by the gratuitous services of the honorary medical staffs.

20. Cases of obvious destitution or cases already in receipt of poor-law relief should, after they have been seen once in the casualty or out-patient depart-

ment, be referred to the poor-law relieving officer, unless they should be retained by the hospital for treatment. But in case of patients referred by poor-law medical officers to hospital for consultation or treatment, payment should be required from the poor-law guardians both for advice, treatment and maintenance.

#### VIII.—Tariff In-Patients.

21. When the Board of Management of a voluntary hospital enters into a financial arrangement with an employer of labour, a public authority, Approved Society, insurance company or any other body, or under a contributory scheme for the reception of patients, such arrangements should be taken to cover the full cost of maintenance and medical treatment, and should provide as follows:—

- (a) Payments made for tariff in-patients should be for work done, based upon a tariff of fees agreed upon from time to time between the contracting parties; such tariff of fees making full allowance for provision of hospital accommodation, maintenance and payment of medical staff.
- (b) The accounts of the hospitals should be kept so as to show the cost of this hospital benefit.
- (c) Inability to pay for adequate treatment as a private patient whether in the hospital or outside should be the consideration for the admission of all tariff patients for hospital treatment.
- (d) All persons, whether insured under the National Health Insurance Acts or not, whose income from all sources does not exceed the limits of a specified scale, should be eligible for hospital benefit on tariff rates. The hospital should reserve its right to challenge admissions.

[The following maximum scale is suggested, subject to economic and local variations, and to periodic revision:—

##### CLASS 1.—Limit of Income £200.

- (a) Single persons over 16 years of age.
- (b) Widow or widower without children under 16 years of age.

##### CLASS 2.—Limit of Income £250.

- (a) Married couples without children under 16 years of age.
- (b) Persons with one dependant under 16 years of age.

##### CLASS 3.—Limit of Income £300.

- (a) Married couples with a child or children under 16 years of age.
- (b) Persons with more than one dependant under 16 years of age.]

- (e) For those persons whose income places them beyond the agreed specified scale for tariff patients, arrangements may be made to receive them as private patients; for the conditions governing which see paragraphs 22 and 23 below.
- (f) The ordinary hospital routine of admission, transference and discharge of patients should not be modified for tariff patients, nor should any preferential treatment be given to them.
- (g) No tariff patient should be admitted without the recommendation of the attending practitioner, except in the case of emergency.

#### IX.—(a) Private Patients in Nursing Homes attached to Hospitals.

22. Where it is desirable that special accommodation in the nature of a nursing home should be provided in connection with voluntary hospitals for the

reception of private patients there should be provided as follows:—

- (a) Private patients should be admitted to such special accommodation only on the recommendation of a private practitioner, except in cases of emergency. In the latter circumstances the patient's own medical attendant should be informed.
- (b) It shall be open to a private patient to select any registered medical practitioner as his attendant.
- (c) The scale of charges for the private patient for maintenance shall be such as fully to cover every cost to the hospital.
- (d) No fixed rate of payment for professional services rendered to such patients should be established; the fees so payable to remain, as at present, a matter of arrangement between patient, family physician and consultant.

(n) *Private In-Patients in Hospitals.*

23. Where private patients are admitted under special arrangements into the public wards of a voluntary hospital:—

- (a) Private patients should be admitted to such wards only on the recommendation of a private practitioner, except in cases of emergency.
- (b) The scale of charges for the private patient for maintenance shall be such as fully to cover every cost to the hospital.
- (c) No fixed rate of payment for professional services rendered to such patients should be established; the fees so payable to remain, as at present, a matter of arrangement between the patient and the member of the staff of the hospital.
- (d) The accounts of the hospitals should be kept so as to show the cost of this hospital benefit.
- (e) The ordinary hospital routine of admission, transference and discharge of patients should not be modified for these private patients, nor should any preferential treatment be given to them.

X.—*Out-Patients.*

24. The primary object of the Out-Patient Department should be for consultation.

25. Only such treatment should be given as cannot consistently with the best interests of the patients be properly undertaken by a general practitioner of ordinary professional competence and skill.

26. All cases not suitable for hospital treatment should be referred in general terms to a medical practitioner, to a public medical service, an approved provident dispensary or to the relieving officer under the Poor Law.

27. Where arrangements for consultations or specialists services for tariff patients are made under some contributory scheme or otherwise, such arrangements should provide that these services shall be given so far as is possible and consistent with the best interests of the patients by the private practitioner at his consulting rooms or at the patient's own home and not at the Out-patient Department of the voluntary hospital.

28. Private patients should not be seen or treated at the Out-patient Department of a voluntary hospital except where no other arrangement is practicable, or in case of emergency; and in such cases preceding para. 22 (c) and (d) should govern arrangements.

29. In cases where consultations or treatment are given at an Out-patient Department, the ordinary hospital routine should not be modified nor should any preferential treatment be given to tariff or private patients.

XI.—*Medical Staffs of Voluntary Hospitals.*

30. Full opportunity should be given to private practitioners who possess the necessary qualifications and experience to participate in the work of voluntary hospitals, and for that purpose:—

- (a) The age limit or tenure of office of members of the honorary medical staffs of voluntary hospitals should, where necessary, be so modified as to allow more and younger practitioners to obtain responsible hospital experience.
- (b) Greatly increased facilities should be provided for the appointment of clinical and chief clinical assistants to the various departments of the larger hospitals.
- (c) When the number of patients of voluntary hospitals increases the medical staff of all grades should be increased.
- (d) In considering the eligibility of a practitioner for one of these appointments, the points which would afford indications to which due regard should be given are one or more of the following:—
  - (i) Special academic or post-graduate study, if combined with some evidence of actual practice of the speciality.
  - (ii) Tenure of hospital and other appointments affording special opportunities for acquiring experience; and
  - (iii) Local professional recognition of competence in a consultative or expert capacity.

XII.—*Methods of Recognition of Services of Visiting Medical Staffs.*

31. When the Board of Management of a voluntary hospital enters into a financial arrangement with a public authority, an employer of labour, Approved Society, insurance company, or under a contributory scheme or otherwise, for the reception of patients, such arrangements should be taken to cover the cost of maintenance and medical treatment, and a percentage of all such receipts should be passed into a fund which is at the disposal of the visiting medical staff of that hospital.

32. Where the Board of Management of a voluntary hospital accepts contributions for patients from an Approved Society, insurance company, contributory scheme, employer of labour and/or by massed or periodical payments by employees, the members of the visiting medical staff should receive recognition of their services either in the form of an agreed honorarium, or by means of a percentage of all such payments being passed into a special fund. Such honorarium or fund can be allocated in any manner which the visiting medical staff may determine.

33. Where the Board of a voluntary hospital receives contributions from individuals in return for, or in anticipation of, treatment [other than paying patients referred to in Sections IX. (a) and IX. (b)], the members of the visiting medical staffs should receive recognition of their services either in the form of an agreed honorarium, or by means of a percentage of all such payments being passed into a special fund. Such honorarium or fund can be allocated in any manner which the visiting medical staff may determine.

34. The honorary medical staffs may find the following suggestions valuable in connection with the disposal of the moneys in the special fund, and accordingly the Association suggests to the hospital staffs concerned that one or more of the following methods of distribution of any moneys in the special fund may be found suitable:—

- (a) To the members of the honorary medical staffs for their own personal disposal;
- (b) For the assistance of members of the medical staff in connection with research work;

- (c) For the purchase of instruments, books, etc., for the use of the medical staff, or for lending to other members of the profession;
- (d) For the initiation or development of post-graduate teaching in the institution;
- (e) The institution of a local medical benevolent fund, administered by the members of the honorary medical staff, for dealing with necessitous cases (*e.g.*, widows and children of former colleagues);
- (f) Grants to any recognised medical benevolent fund or institution; or
- (g) Otherwise as the medical staff may decide.

35. In cases where members of the staffs of voluntary hospitals attend tariff patients at stated hours under arrangement, they should receive adequate payment upon a time basis.

36. Any concession of a nominal recognition of the services of the visiting medical staff by a percentage or honorarium should be accepted without prejudice and on account of the existing general economic conditions.

#### XIII.—*Recognition of Local Advisory Medical Committee.*

37. In every hospital area (*e.g.*, the area of a Voluntary Hospitals Committee) the Association, through its local organisation, should form and maintain a representative local advisory medical committee which should be recognised by the authorities concerned, and from which representation should be given upon the Voluntary Hospitals Committee.

#### XIV.—*Representation on Boards of Management.*

##### (A) *Medical Representation.*

38. The association of officially recognised representatives of the local medical profession in the promotion and general management of hospitals and other medical charities is desirable in the interests of those institutions as well as of the profession, and for the appointment of such representatives use should be made of the machinery afforded by a Division of the British Medical Association.

##### (B) *Lay Representation.*

39. Where representation of benefactors, subscribers or contributors to the funds of a voluntary hospital is given on the Board of Management of Governors of the hospital, representation should be distributed so as to secure the representation of each interest in the hospital, and so that no single interest should be in a majority. Contributions given with an implicit or explicit obligation of hospital service shall not rank for representation with other benefactors.

#### XV.—*Contributory Schemes and Additional Services.*

40. No contributory scheme for hospital benefit should be considered satisfactory unless there are arrangements for an adequate home nursing and ambulance service, and for dental, laboratory, and X-ray facilities.

#### XVI.—*Cottage Hospitals.*

41. As far as possible, every patient in a cottage hospital should have the right to be attended by his usual medical attendant.

42. The previous provisions contained in this Report are also applicable to cottage hospitals.

#### XVII.—*Admission of Cases in Receipt of Maternity Benefit.*

43. As it is necessary for the training in midwifery of medical students and pupil midwives that there should be an adequate supply of clinical material available for that purpose, no parturient woman should be refused treatment in the obstetric department of a voluntary hospital or similar institution

on the ground that she is eligible for a maternity benefit.

44. All women receiving treatment through the obstetric department of a voluntary hospital, or similar institution, who are entitled to a maternity benefit, should be required to pay such sum to the hospital or institution as shall be determined upon by the governing body.

45. From each sum an amount, to be agreed upon between the governing body and medical staff, should be placed to a special fund, which shall belong to the medical staff.

#### (F) *CONTRIBUTORY SCHEMES.*

1. The requirements of the voluntary hospitals as affected by present-day conditions of finance, and the consequential demand made by many of the hospitals for payment from patients for hospital services, have been carefully considered by the Association.

Also numerous contributory schemes for the provision of hospital benefit for certain sections of the community, submitted to the Association for its approval, have been subjected to examination.

2. A contributory scheme in this document means a scheme to which contributions are made for which there is to be a stated or implied return.

3. In any schemes for providing hospital benefit by voluntary hospitals, it is undesirable that the hospitals concerned should undertake any insurance risk, *i.e.*, undertake to provide hospital benefit, when required, in return for a periodic payment by an individual or group of individuals; so that where schemes are set up to provide payment for hospital benefit for specified individuals or groups of individuals, such schemes should be organised not by the hospital, but by some independent body.

4. The acceptance by voluntary hospitals of an insurance risk under any scheme for the provision of hospital benefits would (a) prejudice the primary consideration in the admission of a patient to hospital, namely, the suitability of the case for admission on medical grounds; and (b) in the event of the actuarial estimates upon which the scale of premiums and benefits are based proving faulty, render the hospitals liable to meet outlays for which there was no financial provision and consequently endanger the purely charitable funds of the hospitals.

5. In any contributory scheme the presence, limitations, or absence of a contractual obligation for the provision of hospital and additional benefits should be plainly stated to the contributors. Failure to provide such treatment is likely to reflect upon the good faith of the hospitals and of the promoters of the scheme.

6. The primary consideration in the admission of a patient to hospital should be the suitability of the case on medical grounds.

7. When the Board of Management of a voluntary hospital enters into a financial arrangement under a contributory scheme for the reception of patients, such arrangement should be taken to cover the cost of maintenance (*i.e.*, every cost to the hospital) and medical treatment, and should provide as follows:—

- (a) Payments made should be for work done based upon a tariff of fees agreed upon from time to time between the contracting parties; such tariff of fees making full allowance for provision of hospital accommodation, maintenance and payment of medical staff.
- (b) The accounts of the hospitals should be kept so as to show the cost of this hospital benefit.
- (c) Inability to pay for adequate treatment as a private patient whether in the hospital or outside, should be the consideration for the admission of all tariff patients for hospital treatment.

- (d) All persons, whether insured under the National Health Insurance Acts or not, whose income from all sources does not exceed the limit of a specified scale, should be eligible for hospital benefit on tariff rates. The hospital should reserve its right to challenge admissions.

[The following maximum scale is suggested, subject to economic and local variations and to periodic revision:—

**CLASS 1.—Limit of Income £200.**

- (a) Single persons over 16 years of age.  
(b) Widow or widower without children under 16 years of age.

**CLASS 2.—Limit of Income £250.**

- (a) Married couples without children under 16 years of age.  
(b) Persons with one dependant under 16 years of age.

**CLASS 3.—Limit of Income £300.**

- (a) Married couples with a child or children under 16 years of age.  
(b) Persons with more than one dependant under 16 years of age.]

- (e) The ordinary hospital routine of admission, transference and discharge of patients should not be modified for tariff patients, nor should any preferential treatment be given to them.  
(f) No tariff patient should be admitted without the recommendation of the attending practitioner, except in case of emergency.

8. Where arrangements for consultations or specialist services for tariff patients are made under some contributory scheme or otherwise, such arrangements should provide that these services shall be given so far as is possible and consistent with the best interests of the patients by a private practitioner at his consulting rooms or at the patient's own home and not at the Out-Patient Department of the voluntary hospital.

9. When the Board of Management of a voluntary hospital enters into a financial arrangement under a contributory scheme or otherwise for the reception of patients, such arrangement should be taken to cover the cost of maintenance and medical treatment and a percentage of all such receipts should be passed into a fund which is at the disposal of the honorary medical staff of that hospital.

**(G) CONTRIBUTORY SCHEMES FOR "PRIVATE" PATIENTS.**

In the event of proposals being made to establish contributory schemes to provide in-patient treatment for those referred to in the Hospital Policy of the Association as private patients and yet who are unable to pay individually at the time of illness for these benefits, such schemes shall provide as follows:—

- (a) An income limit scale such as is approved by the majority of the medical profession resident and practising within the area of the scheme  
(b) The accommodation provided for in-patient treatment to be at recognised nursing homes, paying hospitals, or in accommodation of the nature of a nursing home in connection with a voluntary hospital.  
(c) Patients should be admitted to the benefits of the scheme only on the recommendation of a private practitioner, except in cases of emergency.  
(d) Free choice of doctor (attendant and specialist) by the patient, subject to the consent of the doctor to act.

- (e) The scheme to be administered by a general committee representative of all the interests concerned—medical, hospital and lay—and not by any voluntary hospital or other co-operating institution.

- (f) The method of remuneration of medical specialists to be payment for work done on the terms customary for such patients in each area.

- (g) Any provision made under such schemes for consultation and specialists' services apart from in-patient treatment shall be arranged for at the consulting rooms of the chosen consultant or at the home of the patient on terms customary for such patients in the area of the scheme, and not in any out-patient department of any institution.

**(H) STANDARDS FOR HOSPITALS (ENGLAND AND WALES) WITH 100 OR MORE BEDS.**

The following are the standards which the Association considers should exist in hospitals in England and Wales with 100 or more beds:—

- (a) In every such hospital the visiting staff should be of recognised competency and should be proportionate to the number of beds in the hospital; a suitable ratio is about 1 to every 25 beds, or where out-patient departments exist the ratio of staff should be greater.  
(b) In every such hospital recognised arrangements should exist for obtaining the services of registered practitioners experienced in (a) anaesthesia; (b) dental surgery; (c) dermatology; (d) diseases of the ear, nose, and throat; (e) electrology; (f) gynaecology; and (g) ophthalmology  
(c) In every such hospital there should be recognised departments for radiology, medical electricity, and massage.  
(d) In every such hospital there should be provision, wherever useful and possible, for the services of clinical assistants.  
(e) In every such hospital there should be at least 1 resident officer to every 50 beds.  
(f) In every such hospital there should be staff meetings for discussion of clinical work at least once a month, and an analysis of the hospital work should be presented at each meeting.  
(g) Every such hospital should have an efficient clinical laboratory with a recognised pathologist in charge.  
(h) In every such hospital, case records should be kept in respect of every patient, and these should be signed by the member of the staff responsible for the case; these records should be filed and indexed by a competent clerk; every effort should be made to obtain the subsequent medical history of each patient.  
(i) There should be exchanges of information between the patient's medical attendant and the hospital medical staff.

[NOTE.—To all letters issued by medical members of hospital staffs the following note should be appended:

"The information contained in this letter is strictly private and confidential to the person to whom it is addressed, and must not be divulged without the consent of the writer."

- (j) Every such hospital should employ a registered pharmacist.  
(k) Every such hospital should be a recognised training school for nurses, and should have, or be associated with, a preliminary training school.

**(I) SCHEME FOR FORMATION OF LOCAL HOSPITALS COMMITTEES.**

The following scheme for the formation of Local Hospitals Committees for the purpose of organising local professional opinion as to hospital medical service has been approved by the Association:

- (i) That the Hospitals Committee of the B.M.A. be the central advisory and, where necessary, executive body;
- (ii) That Hospitals Committees be formed by the Branch (and in some instances the Division) most particularly concerned, or even, in some instances, by combinations of Branches where this is necessary;
- (iii) That the Branch Councils (or Division Executives) concerned be asked to convene a meeting of the hospital staffs in the areas concerned, in order that the scheme may be explained to them and in order that the basis of representation and the size of the Committee may be determined;
- (iv) That the terms of reference to these Committees should be on the following lines:  
To consider and report to the Council of the Branch (or Executive Committee of the Division) upon questions concerning hospitals and other medical charities;
- (v) That the members of these Committees shall be elected to hold office for a period of one year and shall be eligible for re-election;

- (vi) That the Committees shall be Committees of the Branch Councils (or Division Executives) and shall be composed of equal numbers elected by the members of hospital staffs of the area, and elected by the Branch Council (or Division Executive Committee), the members elected by the members of the hospital staffs of the area being elected either by postal vote of those concerned or in such manner as may be decided by those concerned as a body;
- (vii) That the expenses of the Committee should be borne by the Branch concerned;
- (viii) That all arrangements and disputes in connection with hospital conditions should be referred to the Local Hospitals Committee and all local arrangements entered into shall be reported to the Hospitals Committee of the B.M.A.

**(J) SUBSCRIBERS' LETTERS.**

That the production of subscribers' letters shall cease to be compulsory, and that, where possible, the system shall be abolished.

*Note.*—Some hospitals consider the abolition of subscribers' letters impracticable, having regard to local conditions. Where this is so, the Association recommends that such letters should be so worded as to preclude their use by unsuitable persons.

British Medical Association,  
429, Strand, London, W.C.2.  
November, 1924.

**APPENDIX XLVIII.**

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE MEDICAL PRACTITIONERS' UNION BY DR. E. A. GREGG, L.R.C.P., L.R.C.S., PRESIDENT, DR. GORDON WARD, M.D., VICE-PRESIDENT, MR. S. G. DAVIS, AND MR. CHARLES DAVIS, SOLICITORS, AND DR. A. WELPLY, M.D., GENERAL SECRETARY OF THE UNION. See Minutes of Evidence of the Twenty-Seventh Day, Questions 15,337 to 15,744.

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#### THE ORIGIN AND AUTHORITY OF THIS STATEMENT.

The Medical Practitioners' Union is a medical organisation with between three and four thousand members and was founded so recently as the year 1915. It represents the more progressive opinion of all sections of the Profession, and in particular perhaps of those who have watched with no little anxiety the increasing complexity of the relations between the State and medical practitioners.

It was therefore only natural that the Union should have decided at an early date that any evidence given before this Commission must draw its inspiration from the widest possible survey of the subject of National Health Insurance. It was felt to be neither possible nor desirable to separate administrative and financial problems from those of a purely professional character. The task of drawing up a Statement was accordingly deputed to a Committee of medical men (mostly insurance practitioners) whose experience on Insurance and Panel Committees and in the offices of the Union had brought them into close contact with the problems involved. The Statement prepared by this Committee was submitted to the Council of the Union which considered it paragraph by paragraph and, although endorsing the main lines, introduced several modifications and a few new sections. The Statement as amended was circulated to all members of the profession with a covering letter which summarised the chief recommendations and asked that opinions, whether favourable or otherwise, should be sent to the Union. Of the communications received in answer to this request the great majority were favourable, while some were critical on one or more points. None were opposed to the Statement in more than a minority of points.

These communications were considered by the Council of the Union. The Council decided that no important change in the Statement was called for with the exception of some amplification of the views of the Union on maternity benefit. This amplification will be found in Appendix D.

The Union now claims that the opinions expressed are such as can be translated into legislative action within a reasonable period. It also makes the claim that the resulting legislation would meet with the approval and goodwill of the great majority of practitioners provided that the views of the Union on society control, discipline and remuneration were given due weight. It bases this claim not so much on the favourable reception of this Statement by the profession as on its knowledge of professional ways of thought and of the past relationships between the State and medical men.

By Order of the Council,

A. WELPLY,

General Secretary,  
Medical Practitioners' Union.

March, 1925.

#### PART I.—THE FUTURE OF NATIONAL HEALTH INSURANCE—GENERAL CONSIDERATIONS.

##### INTRODUCTORY.

1. National Health Insurance is but one part of the machinery which deals with public health. Nevertheless, it has its own officers and organisation and is scarcely at all (except in the case of tuberculosis) co-ordinated with other Departments. From many points of view this is to be regretted. The future of National Health Insurance cannot be considered alone. Some regard must be had to developments which may reasonably be expected in other health services as well as to the form which these services take to-day. It is, for example, impossible to disregard the Poor Law medical service or to consider the inclusion of "dependants" in National Health Insurance without reference to the scope of the Schools Medical Service.

A further reason for taking the broadest possible view is afforded by the fact that what is done to-day

in National Health Insurance may be extremely difficult to undo to-morrow, however undesirable it may prove in practice. The unequal benefits now given to insured persons are a striking example of this. Nor is it unimportant to remember that the education of the public in health matters ought to be allowed to proceed as smoothly as possible and ought not to be interrupted by such continual re-arrangements as might result from too narrow a point of view.

2. It is of course recognised that the terms of reference to this Commission involve restrictions on the subjects to be discussed and the Union will not attempt so wide a discussion as the preceding paragraph might suggest. But it is desired to make it quite plain that the Medical Practitioners' Union considers the public and sociological aspect of the question of paramount importance. It will indeed be necessary to submit evidence on various matters of direct interest to the Profession and of relatively little interest to other people. But, in so far as this evidence involves recommendations, they are to be understood as made from the standpoint already set forth and not as expressions of merely selfish interests.

##### THE FUTURE SCOPE OF PUBLIC MEDICAL SERVICES.

3. It is difficult or impossible to view National Health Insurance in proper perspective without being prepared to answer the question, "To what point is the provision of medical services by the State desirable?" There are those who consider that it already extends too far and who would appear to be of the opinion that private enterprise can do all that is required. The most noteworthy efforts of private enterprise are: (a) the voluntary hospitals; and (b) private practice. The inadequacy of the former is evident from the fact that there are many State hospitals and that the voluntary hospitals are increasingly dependent on one or other form of State assistance. That private practice did not in the past provide what was required is witnessed by the fact that National Health Insurance has, by general consent, brought the services of the medical practitioner within the reach of many who previously were unable to obtain them. It is impossible, therefore, to agree with those who consider that State enterprise has already gone too far. The Union is in fact of the opposite opinion, and to the question which commences this paragraph would offer the answer: "Until the widest possible benefits of preventive and curative medicine are made available for those persons who without State assistance would be unable to obtain them."

4. Increased scope of services under some form of State assistance is accordingly recognised by the Union as necessary and inevitable and no objection in principle is taken to it.

But this statement of policy must not be read as if it stood alone. It is to a considerable extent contingent on the precise nature of future developments which might be of such a character as to merge theoretical acceptance of a principle in the most strenuous opposition to the way in which that principle was proposed to be applied. The Union wishes to make its attitude absolutely clear in this matter. Medical men cannot fail to perceive in the present National Health Insurance system the persistence of regulations and the development of tendencies which gravely affect their prestige and authority with patients. The therapeutic value of this prestige is very great indeed, but this fact is hidden from many of those who have been allowed to shape the regulations and tendencies referred to. For these reasons a large body of medical opinion would much prefer to diminish the numbers of those entitled to benefit under the National Health Insurance Acts and to this extent to revert to the old "independent" private practice. With this opinion the Union has no little sympathy. But there remain the other considerations set out above, and the Union cannot escape the conclusion that the State will presently be obliged to extend medical assistance to a much larger section of the community than at present. The Union does not think that medical men would

in fact desire to make any resistance to this extension. In all these circumstances it seems to the Union that it will best serve its members and most assist the State if this Statement concerns itself with setting out the lines on which extension can most usefully and smoothly proceed. Such, accordingly, is the scope of the Union's evidence.

#### THE QUESTION OF A STATE MEDICAL SERVICE.

5. The exact form which State assistance should take is a matter of great interest to all practitioners and to all persons likely to benefit by health schemes. Amongst political parties there is a considerable body of opinion in favour of what is known as a "State Medical Service." Particulars may be found in "The Labour Movement and Preventive and Curative Medical Services," published by the Trade Union Congress and the Labour Party. Such a service is usually understood as involving whole-time salaried practitioners and has always aroused the most strenuous objection from the Medical Profession. The Union accordingly addresses itself to this subject before considering questions of more circumscribed importance.

6. The expression "State Medical Service" holds so many different meanings that its use is an impediment to discussion. As already stated in paragraph 4, the Union has no objection in principle to any such service. It is only in matters of detail that objection might arise. The Union would certainly object to a whole-time salaried service, but it sees no reason why a State system should take this form. The advantages of private practice in the form that it now takes are:—

- (1) That the patient has free choice of doctor where more than one is available.
- (2) Individual practitioners are in economic competition with each other with the result that fees keep a reasonable level and the average service is of high quality.
- (3) The doctor is likely to reside for a long period, usually throughout his professional life, in one town or village so that he is able to become thoroughly conversant with all aspects of his patients' lives and histories.
- (4) The interests of the patient run little or no risk of being subordinated to administrative requirements such as the filling up of forms.

It is not usually contemplated by the opponents of State Medical Service that these advantages, or any of them, might be preserved even under a State system. It is commonly said that all would necessarily be sacrificed. Yet the National Health Insurance Medical Service stands as a ready witness to the contrary, for it is undoubtedly controlled by the State and it has preserved the first three of these almost intact. Moreover, the fourth may easily be preserved if the will to preserve it be present. Nor is it questioned by competent authority that the panel service is at least as valuable and efficient as that form of private practice which it displaced. Many indeed are firmly of the opinion that the balance of advantage is quite distinctly with the State service.

7. The Medical Practitioners' Union therefore recommends very strongly to the Commission the importance of maintaining, in the present or any extended service, the above-set-out advantages of private practice.

#### EXTENSION OF THE SERVICE TO DEPENDANTS.

8. The increased Scope of Service foreseen in paragraph 4 may involve extension of the National Health Insurance medical service in the direction of increasing (a) the services to be given and/or (b) the range of persons to be benefited. The former is dealt with in paragraphs 30 to 39; the latter must be considered forthwith.

9. Before one can discuss the desirability or otherwise of including the dependants of those already insured, it is necessary to enquire as to whether the present beneficiaries are really those

most in need of assistance. Alternatively it may be desirable to seek some new definition of this class. Although it will not be disputed that the great bulk of those insured are wisely included within the scope of National Health Insurance, it is equally clear that the exceptions are many and important.

There is included a group of manual labourers who earn wages in advance of those of many middle-class families. There is another large group composed of the sons and daughters of the comparatively wealthy, who live at home and enjoy allowances in cash or kind which bring their actual income up to a much higher figure than that of many who are excluded.

On the other hand, the existing Scheme fails to include certain casual workers, classes of workers, and individuals to whom the State is under no less obligation than it is to the insured class and to whom the State might with advantage to itself extend the benefits of National Health Insurance.

It is difficult to see how any important rectification of these anomalies could be based on the present system of deciding who shall and who shall not be insured. The existing test of employment (involving contributions by the employer) is insufficiently elastic.

The Union does not wish to offer formal evidence on these anomalies of which the Commission will already be well aware. They are recited in support of the contention that the present basis of Insurance is not so satisfactory that it can provide a proper groundwork for the inclusion of "dependants" which is so often discussed. In the opinion of the Union the line between insured and uninsured is not the line which divides those who require assistance through a State system from those who are in a position to provide for themselves. The Union would accordingly welcome any method of differentiation which promised more success.

10. But, altogether apart from the above, the idea of "dependants" introduces difficulties of no mean order. Wives and children are evidently included, but the degrees of dependency are many and varied, so many that it seems useless to seek for a definition which would be equitable and yet would involve some factor which (like wages) could be assessed by the State. Not only is there difficulty in defining a dependant, but even more perhaps in evolving machinery which could keep count of such persons and see that contributions on their behalf were duly paid.

The Union accordingly ventures to recommend to the Commission that the ideas connoted by the phrase "inclusion of dependants" should be relegated to a remote mental horizon and that some simpler and clearer conception should occupy the foreground.

11. The idea of dependants as such being abandoned, we may proceed to consider those whom it is proposed to include from another point of view. The very large number of persons concerned immediately assumes importance. It is calculated that any extension which had the effect of including the wives and families of the present insured class would add so many to those already insured that not less than 88 per cent. of the whole population would come under the Acts. There can be little doubt that a very large proportion of these is in need of the advantages which those now insured enjoy.

12. The administrative problem accordingly demands attention. It is indeed very insistent since the suggestion that so large a number of persons might well be included has very little value unless the actual possibility of their inclusion can also be demonstrated. The Union notes the expression of opinion by Sir Walter Kinnear on page 3 of the First Day's Minutes of Evidence:

"One of the biggest problems we have to face is the proper collection of contributions and to ensure success in the collection of contributions it is necessary to fasten the responsibility for stamping the cards when wages are paid on somebody. I think the test of contract of service is the best means for achieving that end."

It does not appear that any other test has been seriously proposed. Nevertheless, to employ this would be to do that which the Union has already deprecated, namely, to extend the service on the present unsatisfactory basis. Nor does it appear that the incidence of the extra contributions required would be equitably distributed supposing the weekly payment to remain constant for each employed person. There would always be an extra burden resting on many thousands of persons who could never expect to enjoy the benefits it was designed to provide. The spinster of 50 years of age could not properly be called upon to pay extra contributions in order that the children of her more fortunate sisters should secure medical assistance. If, on the other hand, the incidence of the extra burden is to be variable and to bear some relation to the number of children, etc., it must give rise to administrative problems which appear to the Union to be almost insoluble.

The Union is forced to the conclusion that if dependants are to be included it may be necessary to finance the service without contributions and from the National Exchequer. It might be argued that this method would, in fact, spread the incidence of contribution (through the various sources from which revenue is drawn) as equitably as any other system which could be devised.

That any such method would remove the element of insurance from the scheme does not seem to the Union to be a matter of any great moment if it be allowed that the method is the best possible for the purposes in view and that those purposes are in themselves beneficial and right. The Union is sceptical as to the alleged educative and moral value of the insurance elements in the existing scheme.

13. The Union summarises its conclusions up to this point as follows:

- (a) It is right and proper that the provision of medical services by the State should extend until the widest possible benefits of preventive and curative medicine are available for those persons who without State assistance would be unable to obtain them.
- (b) It is as impossible to recede from the position now gained with regard to the provision of such services as it is to stand still there. Advance is the only course open to the State.
- (c) The existing basis of National Health Insurance is not in itself satisfactory and the inclusion of dependants on this basis would only accentuate its defects.
- (d) Even if it were possible to define and include dependants there would still be excluded from benefits many to whom they ought to be available.
- (e) Those to whom benefits might usefully be extended comprise a very large proportion of the community.
- (f) The most economical and satisfactory way of financing such an extended service might be by abandoning individual contributions in favour of direct provision from the National Exchequer.
- (g) Provided a national service is set up on the lines and with the provisions suggested neither the Union nor any considerable number of the Profession will refuse co-operation.

#### FINANCIAL CONSIDERATIONS.

14. The Union would have wished to pass directly from the conception of a wider scheme to a consideration of the steps by which the existing system might be developed in that direction. But it is perhaps desirable that it should first state with more precision the nature of the arrangements under which an extended scheme might be managed, although these are not matters in which it has any purely professional concern. The following brief survey of some of the most difficult problems is intended to serve this purpose.

15. As already noted, the key to the present financial position is really the employer, the man charged with the duty of seeing that contributions are paid. For the purposes of National Health Insurance he is the tax collector of the State levying the sums decreed both upon himself and upon the insured person. With the inclusion of persons who are not employed it might be necessary either to abandon contributions towards medical benefit or to discover some other method of collecting them.

The Union has considered certain suggested methods, for example, through the heads of families, by means of local rate-collectors, or by means of special officials, or by means of stamped cards which should alone entitle to medical benefit. But all of these are so expensive and so little likely to prove successful in actual operation that, as already noted, it might prove better to abandon direct individual contributions in favour of a "free" service for dependants.

This service would in such case be provided out of the Exchequer which in turn derives its funds from the taxpayer. The provision of a curative medical service in this way is no more opposed to public policy than is the existing provision of preventive services at the cost of the tax and ratepayer.

16. It would remain necessary to devise some method of assessing the payments due to medical practitioners and the existing medical card could well be adapted to this purpose. Payment would remain on a capitation basis.

The potential patient would draw a medical card from the appropriate local authority. He would present it to the doctor who would sign it and return it to the same authority, receiving a record envelope in return. The doctor would be paid on the number on his list as determined in this way.

17. With regard to sickness benefit the test of employment would still be required and the Union is not concerned to offer any suggestion as to the way in which this should be administered. But it is obvious that unemployment, whether due to sickness, old age or mere scarcity of work might be dealt with under a single scheme and that the complete separation of medical and sickness benefits would facilitate this.

#### THE FUTURE OF APPROVED SOCIETIES.

18. The Approved Societies have been associated with Health Insurance since the State first assumed responsibility for it. There has thus been ample time to judge of their fitness for the position of subordinate partners of the State. This position they now hold in virtue of the fact that they have secured a large measure of control over funds collected under compulsion of the law. The Union feels that this position is one which justifies and, indeed, compels the application of the strictest standards to the operations of these Societies.

In the opinion of the Union these standards have not been attained as the following facts bear witness:

- (a) The Societies provide a system of unequal benefits which is plainly repugnant to justice and equity, and advocate the continuance of that system.
- (b) The Societies have continued to countenance and employ a system of local agents which, by reason of overlapping in some districts and absence of agents from others, is wasteful of time and money. The Commission has already had striking evidence of the state of affairs in Glasgow and elsewhere. This system has no doubt been perpetuated by the competition between Societies which has thus militated against the claims of economy and good management.
- (c) The Societies have, through their recognised spokesmen, frequently sought to bring the medical service into disrespect and contempt, having even gone so far as to circulate leaflets plainly calculated to disturb that confidence between doctor and



patient which is essential to the best treatment.

The following statement by Sir Thomas Neill is a fair sample of the irresponsible accusations from which insurance practitioners have suffered at the hands of Approved Society officials. It is taken from a letter addressed to the Ministry of Health in connection with the Court of Enquiry into the Capitation Fee, which letter was circulated as part of the proceedings of that Enquiry. It was signed by Sir Thomas Neill as Chairman of the Provisional General Council of Approved Societies.

The words italicised in the following sentence are those to which objection is taken:

"It was for these reasons that we asked for and hope to get at an early date a Royal Commission to enquire into the whole subject, so that the original scheme of National Health Insurance and the schemes which many of the administrators have long had in mind may be considered and something may emerge which will tend to remove the present discontent which prevents so many hundreds of thousands of compulsorily insured persons from availing themselves of the medical service for which they pay under the panel system."

This letter was dated January 18th, 1924, and a copy is at the disposal of the Commission. It will be noted that Sir Thomas Neill has had his opportunity of appearing before the Royal Commission, but has produced no evidence of the existence of hundreds, far less of thousands of thousands, of such discontented persons.

- (d) The Societies have proved very indifferent keepers of accounts (*see* Table 20, page 70, Appendix to Minutes of Evidence) and have, under section 26, removed from the purview of the Audit Department extensive items of expenditure (paras. 245-249, page 56, Appendix to Minutes of Evidence).
- (e) The difficulties which patients experience in obtaining the benefits due are often very great, and it does not appear to the Union that there has been any improvement in this respect since the number of complaints on this score which doctors are asked by their patients to consider shows no signs of decreasing.
- (f) The Societies have not provided for the effectual representation of the views or desires of insured persons (*vide* Table 3 on page 58 of the Appendix to the Minutes of Evidence) and their claim to represent insured persons is no less and no more valid than would be a claim by the Postmaster-General to represent old-age pensioners.
- (g) The Societies have elaborated rules which must be quite beyond the comprehension of the average insured person and have not scrupled to enforce such rules to the detriment of the insured person. The Union would be glad to give detailed evidence of a case which shows very well the expense and trouble to which an insured person must go if his rights are to be maintained.
- (h) The following quotation is evidence of another direction in which Approved Society administration has proved defective. It is taken from the Evidence of the Scottish Association of Insurance Committees given before the Court of Enquiry into the Capitation Fee.

"It has unfortunately been the experience of many Committees that the complaints of Societies are mainly confined to petty breaches of the Certifica-

tion Rules, troublesome no doubt, but seldom involving any real loss to the Society concerned."

- (i) The Societies have sought to gain a position in relation to public health which plainly conflicts with the maxim that taxation and representation should go hand in hand. To a large extent this position has actually been attained and the Societies now seek to consolidate and extend it, *e.g.*, by control of hospitals (Minutes of Evidence, Eleventh Day, Question 5,445).
- (j) The Societies are accustomed to plead in their own favour the virtues of competition which, they assert, obliges them to give particular care and attention to economical management in order that they may attract new members. The reports of the Auditor seem to the Union to show very little evidence of such care. If by economical management is meant the exclusion by medical examination of those likely to be a charge upon Societies and a very strict insistence on the observance of complicated rules, then the Union sees little virtue in it. Nor is it apparent to the Union that the enormous surpluses which have accrued have been due to anything but the efficiency of the medical service together with a miscalculation as to the incidence of sickness, a miscalculation which was possibly unavoidable, but for the results of which the Societies are certainly not entitled to claim any credit.

Moreover, the Union views with considerable apprehension the growth of competition between Societies with its consequent procuration fees, advertisement for members and transfers to and from societies in the search for larger and larger benefits. No such grotesque conception of a National Scheme of Insurance can possibly have been in the minds of the originators of the Acts, and the Union hopes that the Commission will unhesitatingly affirm the principle of "Equal rights for equal payments."

19. Since these things are true after more than ten years' experience and since there is still very much room for improvement (only 52 per cent. of accounts being certified without reservations), the Union is of the opinion that any part taken by existing officials of Approved Societies in future arrangements must be much more strictly controlled. Since collectors and distributors will still be necessary (*e.g.*, for sickness benefit) there is no reason why those now employed in this work should not continue to do it. But it would seem convenient and equitable that they should be directly responsible to the State or to Local Authorities and that they should operate on a strictly territorial basis. They would probably enjoy very much the status and emoluments of Post Office employees or of municipal servants.

20. The Union considers that the way in which Societies have made use of section 26 is in itself ample proof of their essential unfitness to bear the responsibilities now placed upon them. The effect of perusing the statement issued by the Ministry on the subject of Approved Society finance is to impress upon the reader the fact that the standard reached falls very far short of that which should be obligatory where public money is concerned.

The Union therefore records its opinion that the system of Approved Society administration has proved unsatisfactory and that the Approved Societies as such should no longer be continued.

#### A SERVICE BASED ON EXISTING AUTHORITIES.

21. It is not unreasonable to apply to Insurance Committees the same standards as those by which Approved Societies have been judged. Nor have Insurance Committees anything to fear from the comparison. Their standard of administration is that of Local Authorities and this in turn is at least

as high as that in any other country. With certain exceptions the Committees, through their responsible spokesmen, have maintained the unbiassed and judicial attitude which their position makes desirable and which is a primary condition of general confidence and good work. The Union, therefore, hopes that these Committees will be maintained, although perhaps in a modified form and with increased medical representation, and considers that they should have a definite status as parts of the county administrative machine with powers and responsibilities broadly approximating to those of county education authorities.

22. There should be in all Local Authority areas subordinate bodies responsible to the county committees. The Union ventures to express a hope that the powers of Poor Law and district authorities will very soon be vested in single bodies comprising in their jurisdiction as a rule one existing urban and its associated rural district area or a single borough or county borough. These subordinate bodies can then be formed for what are now Poor Law areas. The functions of these bodies would be largely the same as those of Approved Society branches operating only in restricted areas (if there are any such).

#### THE STEPS BY WHICH DEVELOPMENT MIGHT PROCEED.

23. The question is sometimes asked: "Is the time ripe for the inclusion of dependants?" To this the Union would return an emphatic negative, holding, as it does, that the present machine is ill-adapted to the strain of any such extension and must first be greatly altered and amended.

The Union suggests that the existing machinery might be adapted to wider uses by the following steps. It is considered that both surpluses already accrued and those about to be divulged should, as far as it is legal, be utilised to finance these administrative re-arrangements.

24. The first step proposed is that all extra cash benefits should be abolished as from a certain date and all surpluses should from that date be held by the State on behalf of contributors. The Union expresses no opinion on the desirability or otherwise of increasing the amount of the statutory sickness benefit. All additional medical benefits should be suspended, except dental benefit which should become a statutory benefit. It is anticipated that at least one year would be required for this process, which would equalise benefits.

25. The second step would be the transfer of insured persons from Societies to county committees. This would import the necessary territorial basis into the scheme. Deposit contributors would be similarly transferred and their anomalous position thus rectified. The majority of existing Approved Society agents would probably find work under these committees. The completion of this step would witness the elimination of Approved Societies as such.

26. The third step would be in the direction of amalgamating the existing machinery dealing with Old Age Pensions and Unemployment Benefit with that part of the county committees' work which dealt with sickness benefit. At the same time the regulations governing the provision of medical benefit by the doctors should be so altered that a smooth transition to the larger scheme would be assured.

27. The fourth step would be the abolition of such portion of contributions as is calculated to be required for medical benefit and the extension of this benefit to a larger community. The Union is of the opinion that this step might be initiated in five years from the present time.

28. The fifth step would be the gradual restoration on the wider basis of the suspended additional medical benefits. The conclusion of this step would witness that full service which is generally desired, but which cannot be inaugurated without careful preparation.

29. The Union is well aware that the above paragraphs afford no more than a very indefinite outline of what might eventually be found necessary or advisable. It is difficult to foresee and guide the

processes of evolution in the sphere of government as in other spheres.

These suggestions have been made because the Union was under an obligation to set forth in some detail the standpoint from which it viewed such matters as are set forth in subsequent parts of its evidence. These matters are of great importance to medical men and lack of attention to such relatively small matters has sometimes wrecked larger designs than National Health Insurance. It is at the same time necessary for medical men as citizens with specialised knowledge to see in their true proportion things to which the world will attach less importance than they do themselves.

The conclusions of the Union up to this point may be summarised as follows:

- (a) The extension of medical services by the State is desirable until the greatest possible benefits of preventive and curative medicine are made available for those persons who without State assistance would be unable to obtain them.
- (b) In so far as general practitioner services are concerned it is essential that the factors of free choice and competition between doctors should be maintained, and that doctors should be as little as possible subject to change of residence and that administrative and clerical work should be kept at a minimum.
- (c) The suggested extension of medical benefit may not be possible on a contributory basis.
- (d) This service might then be "free," but contributions would still be collected for sickness benefit and these might well be calculated to provide also unemployment benefit and old-age pensions.
- (e) Approved Society administration has proved unsatisfactory and should no longer be continued.
- (f) The service should be territorial and under the control of local authorities.
- (g) The transition from the old to the wider service might occupy at least five years.

## PART II—THE FUTURE OF NATIONAL HEALTH INSURANCE—SOME MORE DETAILED CONSIDERATIONS.

### ADDITIONAL SERVICES.

30. Services additional to general practitioner service cannot be excluded from discussion, although it appears very doubtful whether the State will be able to afford the expense of providing all of them, at least, for several years.

Such services may be provided in various ways, of which the following are the chief:—

- (a) By including them as part of the general practitioner service, *e.g.*, the administration of anaesthetics.
- (b) By the setting up of parallel services, *e.g.*, a dental service.
- (c) By cash grants sufficient to allow the insured person to procure the service for himself.
- (d) By provision of public services quite outside the scope of the Insurance Acts, *e.g.*, V.D. clinics.
- (e) By some combination of these methods.

These various methods differ in their effect, some are more, some less suitable to the end in view. The Union offers the following comments on this aspect of the question.

### ADMINISTRATION OF ANAESTHETICS.

31. There are certain services which are commonly recognised to be within the competence of the average practitioner, *e.g.*, the giving of ordinary anaesthetics and attendance at maternity cases. In actual practice the giving of anaesthetics is tending to become the speciality of certain practitioners and is less in favour with others, who may perhaps prefer to excel in some other direction. It will probably be allowed that the tendency referred to above is to the advantage of the patient who secures a degree of skill

which he might otherwise fail to obtain. The scheme now in operation is noteworthy for its failure to recognise this tendency.

No exception is taken to the fees forming a charge on the medical pool (except that the pool is too small), but it is sufficiently evident that a fee should be payable in all cases or in none at all.

#### TREATMENT OF VENEREAL DISEASE.

32. The treatment of venereal disease is at least as much within the competence of the average practitioner as is the giving of anaesthetics. Nevertheless, it calls for entirely different provision. The primary interest of the State is that it shall be thoroughly treated, but it is well known that the patient frequently prefers to consult another practitioner rather than his usual medical attendant. Moreover, the treatment calls for special appliances. There is thus a case for a "clinic" service, i.e., a service given by a specialist (who may, of course, be an insurance practitioner) in a building specially equipped for dealing with this disease.

Nor is it necessary or desirable that this clinic should form any part of the Health Insurance scheme, for it cannot usefully be confined to the treatment of insured persons. Nor could it be financed by grants from Health Insurance funds without considerable risk of disclosure of the names of patients, a disclosure which would effectually destroy the usefulness of the clinic.

Facilities for the treatment of venereal disease should therefore be provided, as they now are, in clinics which are entirely apart from any Health Insurance scheme.

#### MATERNITY SERVICES.

33. The provision of maternity services is again a problem presenting special difficulties. The claim that a maternity service should be included under National Health Insurance is made in various forms, some wishing for the services of midwives, some for those of the practitioner and others still for both. The claim usually or always assumes two things: (a) that these services are required and (b) that they are best provided under the National Health Insurance Acts. The Union does not feel able to support these assumptions without very considerable modification. A brief review of the services already available will, it is felt, convince the Commission that any demand remaining to be met and which might be supplied by the practitioner is relatively unimportant.

The following services are now available:

- (a) Clinics at which pre-natal advice can be obtained.
- (b) A district service of maternity nurses is available in most localities and when any such nurse reports a case as abnormal she can procure assistance from a practitioner at the expense of the county rates.
- (c) There is a limited supply of beds in institutions (but the normal case has little chance of admission).
- (d) There are in most urban localities child welfare clinics which assist with advice.
- (e) Destitute cases are admitted to Poor Law institutions.
- (f) A very large number of mothers receive a cash grant of forty shillings to eighty shillings from National Health Insurance funds and are so able to obtain nursing assistance at no cost to themselves.

34. The provision of facilities is thus reasonably complete. Moreover, it is obvious to those who have studied the subject, that the greatest need in connection with maternity cases is not for a general practitioner service, but for institutional treatment for those with unsuitable home surroundings; or in need of specialist services.

The basis on which these things can be provided already exists outside the ambit of National Health Insurance, and there is no apparent reason why it should not serve for any further developments required. In any case, the Union would not presume to bring the subject of maternity services before the Commission without making it quite clear that the

inclusion of such services within the duties of the practitioner must entail a far more extensive disorganisation of existing agencies for helping the mother than has been hinted at by those who demand this inclusion.

35. It is also relevant to enquire what purpose would actually be served by giving all insured women the right to the services of a practitioner during confinement.

That right would no doubt be exercised in most cases. The suggestion that the nurse in attendance should decide when the right was to be exercised is illusory. No nurse could assume the responsibility of preventing a patient from exercising her right, nor is it to be forgotten that the presence of the doctor relieves the nurse herself of responsibility and is therefore likely to be asked for with little hesitation.

In the opinion of the Union the extension of service contemplated would bring the doctor to the bedside of the great majority of maternity cases, whether normal or abnormal. To the abnormal he is already summoned, so that the gain would consist solely in his presence at a very large number of normal cases.

36. It has further to be asked whether there are sufficient doctors to undertake the duties contemplated. These are certain to occupy a very large amount of time, each individual case demanding more time than at present, as well as large numbers of new cases being added to those which practitioners normally attend. It is admitted that the number of doctors in industrial districts is already too small to cope with the work. They must be much less able to cope with the increased work which will be most apparent in these very districts. The extra burden must be justified by very cogent reasons, and these should outweigh the fact that it cannot possibly be adequately borne in present circumstances. The Union cannot discover any such reasons amongst the arguments of those who desire the inclusion of maternity services in the contract of the practitioner.

#### DENTAL SERVICES.

37. It has already been suggested that dental benefit should become a statutory benefit. This suggestion was prompted by the fact that dental treatment is so often essential to restoration to health. It is also a preventive measure of the greatest value. There is already so much provision of specialist services through voluntary agencies that few insured persons are, in fact, deprived of expert advice when urgently required. But this is not the case with dental services, since dental hospitals are very few in number. The Union therefore would press for the inclusion of dental benefit forthwith.

The cost of this benefit is difficult to estimate, and will have to be decided by experience (as was the case with medical benefit). It is better that this experience should be obtained from the restricted field of those now insured. This is an additional reason for its inclusion at once and before the "dependants" are included. It is obvious that the taking over of surpluses by the State suggested in paragraph 24 will not alter the fact that these surpluses were collected for definite purposes and cannot be used for any others. Nor can they be used to benefit those not hitherto insured. It would appear very appropriate that these surpluses should be used to defray the cost of dental benefit. It is assumed that they would suffice for a full service during the period of most intense need, i.e., the first three to five years after the benefit became available. This would prevent the difficulty likely to be occasioned by any suggestion that the Exchequer should give a blank cheque to the Ministry in respect of these services. It would also obviate the need to ask for further contributions from insured persons while large surpluses remained in hand.

The exact form which such services should take will doubtless be discussed with representatives of dental practitioners.

#### OTHER SPECIAL SERVICES.

38. With regard to other specialist services the Union does not wish to offer any evidence unless the

sired, since it anticipates that it will be some years before they can be brought into force, and that the experience of intervening years might modify views expressed to-day. From the instances chosen it will be evident that each particular service will be likely to present its own problems, and that no single method of provision will be best for all. But a broad principle emerges which the Union considers should be stated now, and which is discussed in the following paragraph.

39. These additional medical services are likely to tend towards the creation of a very large body of specialists. There is a danger that these specialists will be modelled on those of to-day, and a proportion may lack knowledge outside their own speciality. Reference is made particulars to Private Specialists, the Tuberculosis Officers, School Medical Officers, and similar officers of Local Authorities.

The whole-time officers of asylums, fever hospitals and Poor Law infirmaries are to some extent in the same class. They all withdraw from the purview of the general practitioner much that would be of interest and value in his work. At the same time each of them is less efficient than he might otherwise be by reason of his lack of opportunity for studying mankind in bulk and disease as a departure from the normal. A population (for example, that of an asylum) in which disease is the rule and health an exception is a very bad training-ground for the young doctor.

The need for certain specialists of such an eminence as those attached to London hospitals and large provincial hospitals is not disputed, but the creation of so many whole-time specialists in the employ of county, etc., authorities has not been attended by the success which might have been ensured. These "specialists" are recruited young, are expected to possess certain academic qualifications and have never, as a rule, been in general practice. It would be of great advantage if every general practitioner were obliged to have had at least two years' experience of one or two specialities. But it would be of even more advantage if every specialist had actual experience of the circumstances in which his advice would have to be applied. To ensure this all such "specialists" should be recruited from the ranks of general practitioners. In most cases they should be part-time officers only. Doctors often seek whole-time posts because they offer advantages which practitioners cannot obtain and because they involve less worrying responsibility. The interests of the public health have not had consideration from any broad point of view and a tendency has been allowed to develop which should be checked before it does further damage.

The Union therefore wishes to enunciate as a vital principle that where it is better that a particular class of case should be treated at one centre or by one individual and the creation of a specialist is accordingly required, that specialist should be chosen from the ranks of general practitioners and should, whenever possible, be a part-time officer.

#### SOME OF THE ESSENTIALS OF A WIDER SERVICE.

40. The extension of State-provided general practitioner services to at least the whole of the industrial population is a contingency which seems extremely likely to arise. One effect of this will be that medical practitioners in industrial areas will have no other source of income than the State. This income will be limited by the number of patients available to them in their own districts, for they cannot extend their operations over a wider area as might be possible to commercial concerns. Practice in such areas carries the additional disadvantages of unpleasant surroundings and minimal opportunities for social intercourse, and therefore will not be congenial to the best type of practitioner.

The inference is plain. If private practice is to be abolished, any system which supplants it must provide those attractions which have hitherto ensured a supply of high quality, or, alternatively, must supply attractions fully as potent. No concern, professional or commercial, State-owned or otherwise,

will attract men of high character and ability unless their character and ability can find opportunity of earning the due reward.

#### FAULTS OF THE EXISTING SERVICE.

41. It is a valid criticism of the present National Health Insurance system that it has not succeeded in attracting many practitioners who could afford to stay outside and that several have stayed outside at considerable financial cost to themselves. There are abundant reasons for this, some of which are inherent in the system and are hinted at above, while others are of the nature of attacks by ignorant persons, attacks to which any service would be exposed. The Union is here concerned with faults inherent in the system. The faults already menace the future of the existing restricted service; they are faults plainly foreseen by those who opposed the scheme at its inception; and there has been little or no attempt to remedy them.

Their evil influence will be magnified by any extension of the service. The chief faults are:—

- (a) Complete lack of confidence between different sections of the service.
- (b) A disciplinary system generally regarded as unjust.
- (c) Absence of pension.
- (d) Lack of facilities for post-graduate study.
- (e) Lack of arrangements for holiday leave.

It will be appreciated that certain of these are not so much faults of the present system (which might be regarded as too small to justify their remedying) as arrangements which will constitute grave faults if allowed to continue under a wider system.

#### LACK OF CONFIDENCE.

42. The existing lack of confidence between different sections of the service is a matter deserving of the closest attention.

One of the chief causes is no doubt the intrusion of lay persons, i.e., officials of Approved Societies, into matters of purely professional concern such as remuneration. At the recent Court of Inquiry representatives of Approved Societies were allowed to appear and give evidence of the efficiency of the service. Their evidence has never been printed, but those who heard it are well aware that the knowledge of such purely professional matters as diagnosis assumed by some of these representatives was ludicrous. The practitioner does not understand these things. He feels that he is being required to serve two masters: the Ministry and the Approved Societies.

Another cause is the lack of sympathetic understanding of professional ways of thought and ideals manifested by the Ministry itself. This was very prominently evidenced by the placing upon the backs of medical certificates of advertisements of proprietary articles. This might indeed have been due to some oversight capable of correction so soon as attention was drawn to it, but, as a matter of fact, the Ministry of Health supported the issue of these certificates and refused to withdraw them until the fact that no one would use them made withdrawal necessary.

The attitude of the Ministry in connection with negotiations has also given great offence and insurance practitioners feel that they have often been asked to discuss the price of their services in a way which is repugnant to those with a professional training.

#### PROCEDURE FOR DEALING WITH COMPLAINTS.

43. This is outlined on pages 81 and 82 of the Statement of Evidence submitted by the Ministry. Insurance practitioners and many who are not in Insurance practice regard it as involving such manifest and gross injustices that it is difficult to deal with the matter in a temperate spirit. Objection is taken not only to the procedure as laid down, but even more to the way in which this procedure is allowed to operate. It is the deliberate and considered opinion of the Union that a great State Department, the Ministry of Health, has shown itself

to be incapable of appreciating or unwilling to act upon those elementary principles of justice which have made our courts of justice the pride of all English-speaking peoples. So grave a charge can only be justified by very definite evidence, and this is set out in the following paragraphs. *Where the citation of illustrative cases is required the Union is willing to give such full references as cannot conveniently be embodied in this Statement.* In these paragraphs details of procedure, etc., are discussed in the order in which they would ordinarily arise during the hearing of a complaint against a practitioner:—

(a) *First, as to the Medical Service Sub-committee:*

(i) Complaints come before Insurance Committees in various forms and are either (a) questions arising between a doctor and an insured person; (b) questions of certification raised by an Approved Society; or (c) questions dealt with under section 28 (2) of the Medical Benefit Regulations, 1924 (*see para. xi below*). Such questions as fall under (a) and (b) above are automatically referred to the Medical Service Sub-committee, and should be raised within six weeks of the event to be investigated. In the case of (c) there is no time limit.

(ii) Complaints commonly arise in the form of a letter from an insured person and such letters are often so vague in form that it is difficult to determine what, if any, complaint is really being made. There is accordingly a procedure specified for the clarification of the issue. The Clerk to the Insurance Committee passes the letter to the Chairman of the Medical Service Sub-committee, who may, be it noted, be quite without any legal knowledge or judicial experience. If in the opinion of the Chairman the complaint is frivolous or vexatious or discloses no *prima facie* ground of complaint, the complainant is so informed. But the matter is not then disposed of, for the complainant is actually invited to submit a further statement (Rules of Procedure 6, 1 (b)). If he fail to do this the matter is nevertheless brought before the Sub-committee, which may dispose of it without a hearing, and presumably would do so in most cases. But it is obvious that the doctor may be put to much trouble and expense in connection with even a vexatious complaint if the Sub-committee elect to hear it, as they must if they wish to penalise the insured person.

If the complaint is in the form of a letter and is of such a nature that it must obviously stand referred to the Medical Service Sub-committee, the Clerk sends a copy (in some cases extracts only) to the doctor concerned and invites his comments. If the doctor makes a reply, a copy thereof is forthwith sent to the complainant and various letters which have originated in this matter are later brought before the Sub-committee. The Union takes the greatest possible exception to a copy of the doctor's reply being sent to the complainant, as such reply should be regarded as confidential to the Sub-committee and not as a considered answer to the charge.

(iii) The Sub-committee having thus received, at least three days before its meeting, documents which may, and frequently do, contain irrelevant and prejudicial matter, proceeds to hear the case. The suggestions contained in these documents are not necessarily supported by oral evidence at the hearing, and the doctor may be called upon to rebut charges which he had not even perceived to arise. The Union con-

tends that a reasonably precise charge should be defined in all cases and that nothing not strictly relevant to that charge should be circulated to the members of the Sub-committee or be allowed to emerge in evidence.

(iv) It must be noted that certain Societies by their agents make a practice of asking insured persons whether they are satisfied with the attention which they are receiving. It is obvious that unjustifiable and vexatious complaints might easily originate in this way and that such questions ought not to be permitted. The Union has no evidence as to whether or no they are countenanced by the head offices of Societies, but wishes to register an objection to a practice which, even if actuated by the most innocent motives, is certainly objectionable.

(v) We have now to consider the constitution of these Medical Service Sub-committees before which complaints are heard. They are composed of three to five doctors and a similar number (mostly Approved Society officials) who are considered to represent the insured (Medical Benefit Regulations, 1924, 27, 2 (1)). There is a "neutral" Chairman. It is difficult to understand how a judicial consideration of any dispute can be obtained from a tribunal directly representative of the two parties involved. It is significant that the Ministry goes no further than to describe the proceedings as "quasi-judicial" (para. 40, page 81 of the Ministry's Statement of Evidence). Since the "facts" elicited and inferred by this Committee have the importance presently to be described, the Union feels that it is anomalous, to say no more, that only a "quasi-judicial" hearing is secured.

(vi) Nor has the provision whereby a Chairman is elected from amongst the "neutral" members of the Insurance Committee worked at all satisfactorily. It has left practically no choice in most areas and is in no way a guarantee of impartiality. Nor does it necessarily provide the Committee with a Chairman who has any legal knowledge. In one very important Medical Service Sub-committee the Chairman was so far unacceptable to the medical members, who asserted that he was not impartial, that these members refused to take any further part in proceedings over which he presided. Nevertheless, no other person could be found amongst the "neutral" members who was willing to take his place, with the result that the business came to a complete standstill, the Ministry having at present no power to intervene in such cases.

(vii) It is eloquent of what can happen on these Committees that the Union is prepared to call witnesses who will vouch for the spectacle of the "neutral" Chairman shaking his fist at the defendant doctor.

(viii) It is a noteworthy defect of these Sub-committees that there is a complete absence of any provision for securing that there shall be present anyone with a knowledge of those safeguards for the accused which are incorporated in the Rules of Evidence and are inherent in the procedure of all judicial bodies. Complainant and defendant are expressly forbidden to present their cases through counsel or solicitor, although they may, in special circumstances and by permission, have assistance of a non-legal order.

(ix) The procedure of these Sub-committees requires further consideration. It appears to vary in some details and in general "the procedure at the hearing" is "such

as the Sub-committee may determine" (Rules of Procedure, 6, 1 (f)). In some cases all witnesses, complainant and accused are present together and are questioned one by one. It is to be remembered that, except in Scotland, no one is on oath. This procedure offers every facility for corroboration of evidence and tends to prevent the detection of inconsistencies which might otherwise be apparent. Questioning is conducted by the Chairman with or without the participation of other members of the Committee. No bar is placed on leading questions calculated to suggest their own answers and the field of enquiry is apt to be widened indefinitely. This mockery of judicial procedure is allowed although the events under consideration may have taken place six months or more previously. All the Rules of Evidence are in general completely disregarded.

- (x) It is true that there is a Regulation (Medical Benefit Regulations, 1924, 28 (1)) intended to prevent the hearing of complaints delayed later than six weeks from the date of the events which gave rise to them. But a discretion is vested in the Sub-committee by which "illness or other reasonable cause" may be considered good reason for delay. That such reasonable causes may be of the flimsiest nature may be judged from the following extract from the Forty-sixth Report of the Medical Service Sub-committee for Kent:

"The alleged failure to attend occurred between the 1st and 2nd September, 1922, and the matter was not, in fact, brought to the notice of the Committee until the 16th January, 1923. The complainant, however, represented to us that he was unaware of the existence of the Regulation requiring notice of a matter complained of to be given within six weeks, and also that he thought it best to await the receipt of the private doctor's account before writing to the Insurance Committee. In these circumstances we deemed it desirable to investigate the matter."

It will be observed that in this case ignorance of the law was held to be reasonable cause for failing to comply with it and that the interests of the defendant doctor on whose behalf the law was presumably framed had no consideration whatever. Such interpretation of the Regulations inflicts a real hardship upon a busy practitioner, who, after a lapse of six weeks, may well be quite unable to recollect the circumstances and details of the matter complained of. It may be noted, by way of contrast, that societies do not allow ignorance of the Rules to be pleaded successfully when notice of illness has been delayed and so as to entitle to sickness benefits. The Ministry permits them to withhold sickness benefit where notice of sickness has been delayed and ignorance of the Rules is pleaded in excuse. (Ministry of Health Statement, page 16, paragraph 61.)

- (xi) There is moreover another way in which the six weeks Regulation may be evaded. This is by investigating the matter under the provisions of Medical Benefit Regulation 28 (2). This Regulation permits the Medical Service Sub-committee to investigate "any matter relating to . . . the discharge by any practitioner of his duties" and there is no time limit of any sort. The Union is at a loss to understand why the safeguard provided by the previous paragraph of the Medical Benefit Regulations should be deliberately taken away by that now in question. It is a minor but not unimportant illustration of

the extent to which the practitioner is placed at a disadvantage throughout the investigation of a complaint.

- (xii) It is the duty of the Medical Service Sub-committee to arrive at findings of fact and to draw inferences therefrom. These "facts" and inferences are held to be established and cannot be reviewed except on appeal to the Minister. Whether or no appeal is made, the "facts" remain on record and are perused by the Minister in any subsequent case involving the same defendant. It does not follow, however, that the "facts" found have emerged from the hearing. In a quite recent London case prescriptions alleged to have been given by the practitioner were subsequently and without notice to the practitioner submitted to the Medical Service Sub-committee, and reference thereto incorporated in the report in support of the alleged "facts" found by the Sub-committee as if they had been produced in the presence of the doctor. At a subsequent hearing under Regulation 36 it was contended that such procedure was correct and was based on the action taken by the Minister himself.

- (xiii) The proceedings of Medical Service Sub-committees are reported to Insurance Committees and thereafter the findings in such reports may come before the Minister in one of three ways. These must be specified, since the procedure is different in each case. They are as follows:

A direct appeal to the Minister from the decision of an Insurance Committee based on the report of the Medical Service Sub-committee.

In default of enquiry or appeal, the hearing of any representations which a practitioner may wish to make before a penalty is decided upon by the Minister.

The hearing of representations made by an Insurance Committee to the effect that the continuance of a practitioner on the panel would be prejudicial to the service.

- (b) Secondly, as to appeals to the Minister:

- (xiv) The Union first calls attention to certain features of the hearing of an appeal. Frequently the Minister hears an appeal by means of a Court consisting of two officials of the Ministry, one often being the Senior Regional Medical Officer of the area in which the practitioner concerned practises and the other a member of the Legal Department. Each side is properly represented and witnesses are put on oath. But these facts are not so reassuring as they sound. This tribunal has no power to decide anything. It can only report upon the case to the Minister. The appeal having been heard, the matter then goes to a Committee of Officials at the Ministry who decide the recommendation to be made to the Minister.

Apart from the very real hardship of having to appeal to a Court who have no power to decide anything, it is a greater hardship still that the persons who make the recommendation to the Minister are never seen by the appellant. It is an extraordinary thing that in coming to a decision the Minister acts not only upon the report of the particular case, but upon Departmental reports from the officers of the Ministry and upon other statements of which the appellant has no knowledge. It is admitted that the Minister takes into consideration documents and evidence which have reached him after the Court of Appeal or Inquiry has reported and

which have never been disclosed to the parties to the Appeal or Inquiry.

- (xv) The appeal has to be lodged within one month after the receipt by the doctor of the decision of the Insurance Committee. For this purpose the day of receipt is deemed to be the day on which a letter would be delivered in the ordinary course of post. No leniency is granted in this respect, and a day late has been held to make the appeal out of time. In one case, a doctor alleged that he lodged the appeal within the month, but because he could not prove that there was delay in posting or in the post, his appeal was held to be out of time. This severity where a doctor is concerned compares most unfavourably with the latitude permitted to an insured person (*see* para. x above) and the discrimination exercised by the Ministry in this matter seems to the Union to be most unfortunate.
- (xvi) From a financial point of view the doctor who appeals or is involved in a case which goes to appeal is heavily handicapped. Technically the appeal is against the Insurance Committee which thus steps into the place of the insured person complainant and employs its funds in support of him. The doctor, on the other hand, must pay his own expenses and must even pay for a transcript of the shorthand notes, if any are available, of the hearing before the Medical Service Sub-committee. Even if the doctor be successful he is rarely given costs, and when any are awarded they are often insufficient to reimburse him so much as the cost of the shorthand notes and leave him heavily out of pocket if he has engaged legal assistance. If he should fail on appeal he may have to pay the costs of the Insurance Committee—a handicap which should at least rest equally on the Insurance Committee where the doctor is successful.
- (xvii) If it be as wrong to delay justice as it is to deny it, the record of the Ministry is open to serious criticism. The decision of the Minister is invariably delayed for several weeks so that the doctor continues in doubt as to the result. If a decision is adverse a pecuniary fine is frequently imposed under the powers vested in the Ministry which will be discussed later. In a recent case, a decision was in part adverse to the doctor, but no mention of a fine was made in the notification which he received. In the notification to the Insurance Committee, however, it was stated that the consideration of a fine was deferred and the practitioner is still in doubt. In the opinion of the Union these delays are unjust and indefensible.

The Union contends that appeals ought not to be heard by officials of the Ministry, as in the opinion of the Union their very positions at the Ministry disqualify them. The members of the Appeal Court should not be chiefly engaged in administering the Act from the Government point of view. If their daily duty is to ensure the working of the Acts, this fact, it is submitted, must tend to deprive them of the ability to judge fairly between the insured person and the practitioner and may give rise to the impression that the case opens with a bias against the doctor. Moreover, although the procedure on appeal is by way of rehearing, nevertheless the Tribunal start by having before them the "facts" and "findings" from which an appeal is being made.

The Union considers that the Minister should appoint an independent Court to hear appeals.

(c) *Thirdly, as to procedure in default of appeal:*

- (xviii) This procedure affords the practitioner an opportunity, when there has been no appeal, of making representations in mitigation of sentence on the findings of the Medical Service Sub-committee, and such representations are heard by one or two of the officials of the Ministry, one of them being a Medical Officer. To this extent the Union is willing to recognise that the interests of the practitioner are not so systematically neglected as would otherwise appear to be the case. But it must be pointed out that this right to make representations was conferred on the practitioner for the excellent reason that the same Regulation confers upon the Minister the right to impose fines whenever he shall satisfy himself in any manner whatsoever that a fine would be desirable. There is no limit to the fine which the Minister may inflict and there is no right of appeal against his decision.

(d) *Fourthly, as to representations to remove a practitioner from the panel:*

- (xix) Inquiries are held by the Minister when he receives from (*e.g.*) an Insurance Committee representations to the effect that the continuance on the panel of a particular practitioner would be prejudicial to the service. When such representations are pending the doctor cannot resign, cannot appeal and cannot dispose of his practice. He is, however, permitted to continue in practice pending enquiry and, after the enquiry, pending the Minister's decision. This decision may be many weeks after the hearing, and the Union protests most strongly against the scandalous delay of justice involved, a delay which is equally a denial, since the veriest criminal is entitled to immediate judgment when his case has been heard. In two recent cases the enquiries were held respectively on the 19th and 22nd December, 1924, and the decisions were not given until the middle of March, 1925.

The practitioner is limited before the Inquiry Committee to the exact plea stated in the representations, and although the contention is that it is prejudicial to the service that he continues on the panel, he is not permitted to give evidence of how he conducts his practice, and this notwithstanding that, as frequently happens, the representations are based on treatment rendered to one patient.

It is also anomalous and contrary to all ideas of justice that when a doctor has been acquitted of the charge made against him he should be fined.

In two recent London cases this has actually happened. In both cases charges of gross negligence were made and the Tribunal held that the charges wholly failed. In one case, they stated that the doctor had committed an error of judgment as to his knowledge of the case and that therefore the doctor should pay his own costs. In the other case, they held that the Insurance Committee were not justified in setting the Inquiry machinery in motion and therefore they should pay the doctor's costs. Yet in the first case the doctor was fined £10, and in the second, £20. The Union urge most strongly that the power to fine capriciously ought not to remain.

- (xx) The penalties inflicted by the Minister have on various occasions caused considerable apprehension amongst medical men, but in one particular case the penalty was so excessive as to make it certain that profound distrust of the Minister's judicial

capacity will long remain amongst the profession. This case has assumed such importance that the Union wishes to bring to the notice of the Commission the findings of the Court of Inquiry set up by the Minister and the penalty awarded. The findings were as follows and may be read on pages 65 to 68 of Volume III of "Reports of Inquiries and Appeals, etc.," issued by the Ministry of Health:—

"We submit the following inferences of fact:

- (i) The respondent, Dr. A. B., in taking over the practice in 1916, probably did not realise the absolute nature of the obligations of an insurance doctor not to accept payment for medicine supplied to insured persons or to supply medicine to them, which obligations were in 1920 specifically defined in clauses 9 (1) and 8 (10) of the terms of service scheduled to the Regulations. A similar observation may be made as to the respondent, Dr. C. D., as at the time when he became a partner. Both he and the other respondent must have been aware of the existence of the impression mentioned in paragraph (5) (ii) above, and soon must have become aware of a custom prevalent in the county, amongst other districts, whereby the ordinary patient seems to regard the supply of medicine and payment for the same as a matter of greater importance in his cure than the services rendered by the doctor by way of attendance.
- (ii) It was not seriously contended on behalf of either respondent that the actual rendering of accounts and acceptance of payment did not constitute a plain breach of their terms of service. Stress was laid by their respective advocates on the fact that neither had properly grasped the meaning of those terms and that the acts complained of in this respect were done rather in ignorance of the law than with an intent to evade their obligations with a view to private profit. If the case for the complainants had rested merely on the facts of supply and acceptance of payment we think that the explanation put forward by the respondents would have carried more weight, although we are far from suggesting that any carelessness in appreciating the nature of contractual obligations is excusable.
- (iii) In view, however, of our findings of fact set out in paragraph 5 (v) above, we must come to the conclusion that in some instances the respondents were guilty of more than the carelessness mentioned above. We do not think that they systematically exploited their insured patients with a view to profit, but that they acquiesced in the patient's impression as to the superiority of "private" medicine, and were not sufficiently careful to combat that impression.

Our general view of the evidence was that the insured persons did not require much persuasion in being, as it were, parties to these infractions of the terms of service rather than that the respondents exercised undue pressure upon them to this end. But we must observe that an obvious responsibility lies upon an Insurance doctor to see that the Acts and Regulations are obeyed and his knowledge of the actual obligations contained therein must,

generally speaking, be superior to that of his patient.

- (iv) It is a notable feature of this case in relation to either of the heads of the charges brought forward that the respondents were guilty of no concealment, and that evidence in support of the first two of these heads was easily obtainable from their own books and accounts. We have already observed upon the assistance given by them in frankly disclosing all of their documents to the complainants.
- (v) We think the two instances mentioned in paragraph 5 (iv) above, in which vaccines were supplied and charged for, can reasonably be regarded as matters not calling for censure, but due to an excusable mistake on the part of the respondent, Dr. A. B.
- (vi) In so far as our observations have been favourable or unfavourable to the respondents we find no grounds for differentiating between them.

General evidence of good repute was tendered, and we felt no doubt as to the efficiency of the respondents in relation to their insured patients apart from the questions which formed the subject of our inquiry."

Taking these findings as they stand the Union feels that they are evidence indeed of wrong-doing, but not of deliberate intention to exploit insured persons. It appears also that the breaches of Regulations complained of were committed rather by inadvertence than from any evil intention and that no harm ensued to their patients which the respondents were not willing and able to compensate. Nevertheless the Ministry decreed the following financial penalties:

That £1,000 should be deducted from the remuneration of these practitioners.

That they should pay their own and complainants' costs.

That a full refund should be made of all the fees charged.

The Union does not hesitate to designate this penalty as improper, extravagant and altogether out of proportion to the seriousness of the offence committed.

We note in contrast thereto such cases as that reported on pages 197 to 202 of the volume already quoted. In this case it was held to be proved that a practitioner had failed to make a proper examination of his patient and to provide treatment of the standard required. He was fined £30 only, although possible detriment to the health of a patient was here in question.

- (xxi) The Reports relating to enquiries into representations of the sort mentioned in para. xix are sent by the Minister to the General Medical Council which is the statutory body entrusted with the disciplinary control of the medical profession. In general this Council does not enquire into any question raised with regard to a particular practitioner unless some individual will assume the role of prosecutor. But in the case of questions originating with the Ministry enquiry is held without a prosecutor other than the Minister and the unfortunate practitioner has once more to involve himself in expenditure of time and money lest he incur a further penalty for that for which he once already has been tried and punished. The Union holds that this system of double trial is quite indefensible and that the Minister should either surrender his jurisdiction in such



cases to the General Medical Council or should, if he holds an enquiry himself, refrain from forwarding the papers to any other authority.

- (xxii) Another vagary of the Minister to which the gravest exception is taken is his claim to exact a higher standard of treatment than is called for in the ordinary Courts. This claim is enforced by fines. The way in which this claim is made is perhaps best understood by considering an hypothetical case.

Dr. A. is called to attend Mr. X., an insured person. He uses every care and shows such skill as is proper, but he arrives at a diagnosis which is not in fact correct and thereon bases his treatment. All this he does in good faith and neither his care nor the standard of his skill are shown (or sought to be shown) to be otherwise than well up to the average. Before the ordinary Courts no action will succeed against Dr. A., even although Mr. X. has suffered some detriment from a mistake in diagnosis; for it is well understood that Dr. A. did not offer nor Mr. X. expect to receive any more care and skill than the average practitioner of repute could provide. It is equally understood that the art of diagnosis is not yet so advanced that a correct opinion is possible in every case.

This view of the limitations to a medical man's responsibility does not commend itself to the Ministry which seeks to exact a standard of service in which no allowance is made for failures of the diagnostic art. In the eyes of the Ministry an erroneous diagnosis is in itself evidence of failure to reach the standard required and the practitioner is accordingly mulcted in damages. The Ministry has actually inflicted a penalty where the care and skill of the practitioner have been shown to be rather above than below the average.

It is not to be supposed that the Ministry has considered the complexion which its actions wear when viewed in this way; and the Union does not impute deliberate illegality so much as unfitness for the exercise of judicial functions—unless, perhaps, under such control as would be provided by the knowledge that its decisions might be reviewed by the Courts.

The Union feels that the facts cited in the foregoing paragraphs are ample evidence of the essential injustice of the procedure relating to complaints. This injustice is apparent at every stage of the procedure. The doctor is debarred from the ordinary Courts although his livelihood may be in jeopardy. The Minister may be accuser, jury and judge. His penalties may be and have been grotesquely excessive; they are governed by no rule or reason which the most observant can descry. In any case, they represent the judgments of a layman on professional matters with which he has no acquaintance.

The Union claims that the delay and denial of justice is so gross and deliberate and that the elementary rights and liberties of the individual are held in such low esteem that insurance practitioners are justified in demanding, as they do demand, that the whole system shall be swept utterly away. The doctor claims no more favour than strict justice, but he cannot rest content with less and the Union will at all times and in every possible way seek for him that elementary right of citizenship.

#### PENSIONS.

44. It is recognised in all public services and also under the Old Age Pensions Act that those who have given their whole lives to the State are justified in expecting that they shall receive a competence when their working days are passed. It is also recognised that the individual cannot be asked to provide this competence out of his own savings. The advantage of savings effected by deductions from wages

(whether actually expressed as such or not) are so manifest that pensions are a normal part of the machinery of employment by the State.

It is evident then that pensions are calculated to meet a need which is universally felt, and that their absence from a scheme of National Health Insurance would be a serious blemish.

The cost of pensions is uncertain, since it depends on many factors which cannot be clearly foreseen. It is suggested that they should be payable on the retirement of the doctor from the service, and should be based on length and amount of service.

#### POST-GRADUATE STUDY.

45. The lack of facilities for post-graduate study is one difficult to discuss before the Commission, since it is intimately bound up with subjects clearly outside the terms of reference, *e.g.*, the future of the hospitals. It has been enquired into by a Departmental Committee within the last few years, and the Union will not offer evidence unless requested.

#### HOLIDAY LEAVE.

46. The question of holiday leave is most urgent in the country. If a country practitioner wishes to be absent from his practice he must employ someone to do his work. He cannot ask his neighbours to look after his patients because he has no medical neighbours. He must procure a locum tenens at an average cost of £8 8s. to £10 10s. per week salary, plus food and lodging, locomotion, etc. This is in any case a heavy drain on his resources, but it is aggravated by the fact that a trustworthy locum tenens is difficult to obtain, and one who is trustworthy may nevertheless be unaccustomed or unsuited to the particular type of practice. It is often the case that the activities of a locum tenens do more harm than good to his principal's practice. This is, of course, even more true of those urban practices in which a locum tenens is employed since the patient may promptly seek other advice in a way which is impossible in the country.

In all public services the replacement of those absent by reason of sickness or on holiday is automatically arranged and similar provision is essential in any public medical service.

### PART III.—ALTERATIONS DESIRABLE IN THE CONDITIONS OF THE EXISTING SERVICE.

#### COMPLAINTS TRIBUNAL.

47. The objections felt by the profession to the existing Medical Service Sub-committees have already been detailed in paragraph 43, but no alternative procedure was suggested. There are two classes of complaint to be considered, namely, complaints which are trivial, but for which some outlet must be found, and complaints which are sufficiently serious to warrant a formal hearing. It is one of the mistakes of the present system that an organisation which might have sufficed for the first class has been used for the second also. The Union's suggestions are as follows:

- (a) Any complaint from any quarter shall first stand referred to a tribunal composed of three persons of standing, one of whom shall be the Chairman of the Panel Committee. It should be the duty of this tribunal to deal with complaints based on misunderstanding and provided always that its decision is satisfactory to the complainant no further action should be taken in respect of such complaint.
- (b) The complaints suited for informal investigation having thus been sorted out, there will remain certain cases in which either the complainant is not satisfied or the tribunal of three is of opinion that more formal action is required. The tribunal of three should then define the charge made and should remit the case, if a doctor is accused, to the Judicial Sub-committee of the Panel Committee, or, if the accused is not a doctor, to the Pharmaceutical or other appropriate Committee. This Committee should be charged with the duty of

ascertaining all relevant facts, should sit under the presidency of a barrister, take evidence on oath, and should state whether in its opinion the charge is proven or not proven. It should in general have the powers, duties and responsibilities of a court-martial, including the awarding of punishment. There should be no right of appeal from the findings of Judicial Sub-committees as such.

- (c) The findings of the Judicial Sub-committee should go forward to the Minister of Health for confirmation. On his confirmation any penalty should become operative, but an appeal should lie to the Courts and the accused should be allowed adequate time for coming to a decision on the question of appeal.
- (d) The accused should not be subjected to any further disciplinary proceedings through the agency of the Ministry, and the papers should not be forwarded or the case notified to any other body whatsoever.
- (e) This procedure should apply to doctors, chemists and insured persons, an appropriate judicial committee being formed in each case.

The above is suggested as the outline of a scheme which would give satisfaction to the medical profession by (1) avoiding the prolonged hearing of trivial charges; (2) ensuring due observance of legal safeguards to both parties; and (3) abolishing the despotic power of the Minister.

RECORDS.

48. The keeping of medical records, i.e., clinical records of the disabilities and treatment of patients, is not objected to by any section of the profession, and its importance is part of the routine teaching of medical schools. But grave objection is taken to the present record cards in that they call for the entering of particulars which are of no value to the patient and which often oblige the doctor to provide clerical assistance which he can ill afford or alternatively make grave inroads on his scanty leisure.

The particulars are the date of every consultation afforded, visit made or certificate given. All these are recorded on the back of the record "envelope." On the front of the card the doctor is asked to fill in:

- (a) Changes of the patient's address.
- (b) Occupation and changes of occupation.
- (c) Whether patient is married, single or widowed.
- (d) Date of patient's first attendance.
- (e) Patient's age on first attendance.
- (f) The date on which the patient died or ceased to be insured.
- (g) In case of death, the cause of death.
- (h) The doctor's name "and date." (It is not clear what date is desired.)

Changes of address may well be inserted by the doctor for his own convenience, and it is not apparent that they are intended to serve any other purpose. The patient's occupation, whether married (in the case of a woman), age and cause of death are all in the nature of clinical details, and space should be provided if required on the clinical side of the card. The other details demanded appear superfluous, in particular it is difficult to understand the demand for the "doctor's signature and date" on a card on which his name has already been stamped by the Insurance Committee.

It is the contention of the Union that no good purpose is served by pretending that these cards are likely to be of scientific value except in relation to the individual patient. When scientific information of a statistical nature is required, it should be obtained from selected practitioners, who should be paid and who would keep such special and more detailed cards as might be deemed useful.

In the same way, when statistics are required of attendances, etc., these should be obtained by a process of sampling and not from every practitioner. Statistics of certificates should be obtained from Approved Society records.

The actual form of the cards is open to the objection that they are difficult to withdraw from the file, each having a double edge at the top. It would be better that they should open at the side, and have a single edge at the top, as is now the case in Scotland.

The Union re-affirms its opinion that clinical records ought to be kept for the benefit of the individual patient, but that nothing of value can be obtained by the imposition on every practitioner of the duty to keep statistical records. Such records should be obtained by sampling. It will be within the knowledge of the Commission that when such records have been required during the last 12 years this method has always been resorted to.

Further, very complicated records are required from practitioners in relation to cases of tuberculosis. These are intended to convey to Tuberculosis Officers information acquired by the practitioner during his domiciliary treatment of cases of tuberculosis. Similar records are sometimes kept in sanatoria, but they are far more detailed than any it is usually possible to keep in general practice. Most of the information asked for could better be procured by the Tuberculosis Officer during his own examination of the patient. In any case, it is desirable to point out that if such detailed information is required by the Tuberculosis Officer from the practitioner, no less information ought to be given by the Tuberculosis Officer to the practitioner who has referred a case to him. In fact, the practitioner receives no more than a personal letter giving an opinion in general terms. The Union is of the opinion that this satisfactorily meets the case, and that there is no sufficient reason for requiring anything more than a short progress report from the practitioner.

CERTIFICATION.

49. Certification is even more burdensome than record keeping as at present required, and both are a menace to the therapeutic success of the system. The need of the Approved Societies is for evidence of incapacity sufficient to justify payments of cash benefits. This need would be met by a certificate in the following form:—

<p>To.....</p> <p>I hereby certify that after due examination I am of the opinion that you <sup>are</sup> suffering from .....  <sub>were</sub> .....(state nature of disease). I am further of the opinion that you</p> <ol style="list-style-type: none"> <li>1. Are incapable of work.</li> <li>2. Have continued incapable of work until to-day.</li> <li>3. Are now fit to resume work.</li> <li>4. Will be fit to resume work on .....                      (not more than three days after date below).</li> <li>5. Will remain incapable of work during the next.....weeks (not more than four).</li> <li>6. May properly be absent from home for the purpose of convalescent treatment for.....weeks (not more than four).</li> <li>7. Were capable of work from.....to.....</li> </ol> <p>Doctor's signature..... Date of signing.....</p>	<p>Cross out numbers which do not apply.</p>
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It will be observed that this certificate proposes to rely upon the integrity of the doctor and supposes that a doctor will not certify as to fact without making the enquiries and examinations required.

The existing certificates do not exhibit such reliance, but ask for the exact date on which the patient was examined. In order to meet the requirements of his Society the patient will often ask for a certificate showing that he was examined on a day on which he was not in fact seen. (See Appendix A.) The doctor must then give a certificate which is false although not fraudulent, or he must stand in the way of his patient's chances of obtaining the benefit due. Often he has taken the former course, and this has given rise to disciplinary action. In either case the doctor is bound to suffer, either from a complaint lodged by the Society or from the disfavour

of a patient who will usually fail to understand why he should not cheerfully give a false certificate. The mentality of the patient may be understood from the fact that it is quite usual for the wife of a pensioner to bring up a form of claim already signed by her husband with the request that the doctor will witness the signature.

The Union admits that some doctors might be so careless in signing certificates as to allow of fraudulent claims on the funds of Societies. It would be foolish affectation to pretend that no wrong-doer ever finds his way into the Profession. But the Union claims that medical men as a whole are remarkable rather for their rectitude than for a propensity to petty crimes. To this claim the Union adheres, and protests against the implication in the present certificates that the word of a doctor cannot be trusted without corroborative evidence. If Societies would refrain from requiring certificates on particular days the present form of certificate would still remain offensive, but it would at least be possible to use it without detriment to the patient. But while this requirement persists, and it is evident that it must persist unless Society procedure is to be revolutionised, the certificate is both gratuitously offensive and impossible to use without detriment to a proportion of patients.

The multiplication of certificates for different purposes shows no sign of abatement. The Profession has repeatedly asked for an "all in" certificate, but the request has always been disregarded. It is probable that the issue of many certificates of different colours may in some way reduce the work required in Approved Society offices, but the Union is not aware of any other or any more valid reason for this particular imposition upon medical men. The certificate suggested above would take the place of five and possibly of six of the existing certificates.

50. On the subject of Certification the Union would like to register an objection to the inferences commonly drawn from statistics of cases referred to Regional Medical Officers or Referees. Many of these cases are reported fit for work, and witnesses before the Commission have usually assumed that such reports are sufficient evidence of lack of care or skill on the part of panel practitioners. This inference is not a fair or proper deduction from the premises. It would be equally fair for panel practitioners to claim that the difference of opinion argued lack of skill or care on the part of the Referee.

The number of cases in which a difference of opinion has occurred is partly to be explained by doubt as to the meaning of the expression "incapable of work" and partly by the fact that medicine is not yet so exact a science that there remains no room for *bona-fide* differences of opinion on individual cases. In such cases it is well to remember that the insurance practitioner has usually the greater knowledge of the patient and his capabilities. It may also be mentioned that the Referee is not a specialist in the particular disease from which the patient suffers, but merely a general practitioner of average experience.

The Union can quote in support of its explanation of these statistics the experience of the Scottish Miners' Federation Approved Society, which appears to refer cases of dispute between insurance practitioner and official referees to its own referee. Question 6704 (see Minutes of Evidence, Fourteenth Day) states that this independent referee has in most cases decided in favour of the insurance practitioner.

The value of these statistics is further modified by the fact that some cases declared fit for work are found by the test of experience to be unfit, although it may well have been that no other test could have given decisive evidence. Nor is it fair to assume that those who declined examination and returned to work were necessarily fit. In many cases the insured person would rather do his best to carry on than appear for examination by a doctor with whom he is not acquainted.

The type of inference to which the Union takes exception is well exemplified in the evidence of the Rational Association Friendly Society heard on the Thirteenth Day of the Commission's proceedings.

#### CONVALESCENT AND MONTHLY CERTIFICATES.

51. A considerable reduction of clerical work would be effected by making longer the period during which patients might have convalescent leave from home. This is now two weeks and, at the end of this time, the patient must either come home or must choose a doctor, submit his card for signature and despatch to the Insurance Committee and—generally—impose the maximum of work upon everyone else in order to obtain a single weekly certificate for himself. The regulation which prohibits the issuing of convalescent certificates earlier than 28 days from the commencement of the illness frequently operates to the disadvantage of the patient, and may entail the payment of sickness benefit for an unduly long period.

The obligation to issue weekly certificates in cases, e.g., fractures, in which four to six weeks' disability can be plainly foreseen, is a source of more exasperation than any other clerical requirement.

#### POSTAGES.

52. The postage on cards, etc., returned to the Insurance Committee is at present paid by practitioners, although the amount expended is reckoned up and credited to the individual or to the medical pool. It is difficult to imagine a more futile method of achieving an end which would be much more surely obtained by the issue of envelopes already stamped (or bearing a frank if the Post Office can be persuaded to adopt a less obdurate attitude). Such envelopes would then be issued, stamped and addressed, with each communication sent to a practitioner. The quick return of record cards would probably be much facilitated and the clerical work of the practitioner appreciably reduced by this means.

#### A NATIONAL FORMULARY.

53. There is another reform which is overdue and which would diminish the work of both doctor and chemist and that is the issue of a National Formulary containing numbered prescriptions, each carrying with it the appropriate directions as to use.

There are many drugs of which the value has been determined by their use for many years, and which are practically universally employed in the treatment of certain diseases. Often these are drugs or combinations of drugs used for particular purposes, for example, to lessen fever, to stimulate the heart, to allay pain, etc. It is convenient that these drugs should be embodied in appropriate doses in standard prescriptions. The chemist can then often keep them in bulk and dispense them more readily and for a less fee. The doctor can order them by number and need not write the prescription in full every time. This convenience is so generally recognised and approved that all large hospitals and many Panel Committees have issued formularies of their own. But there is no standard formulary, and the entry of the number of a prescription on a clinical record in one county will convey no impression (or even a wrong impression) to practitioners in any other county to which the patient removed. It is difficult to understand why this very necessary reform has been delayed so long, and it should certainly be put in hand forthwith.

54. The Union considers that the increase of clerical work is insidious and so menacing to the efficiency of the clinical side of the service that it is in the highest public interest that it should be carefully controlled. The following measures are suggested as being possible at once or, at least, within a short period:—

- (a) The deletion of columns for recording each visit, consultation and certificate on the record card.
- (b) Alterations on the front of the envelope as noted in para. 48.
- (c) A revised form of card opening at the side.
- (d) The abolition of tuberculosis case sheets in favour of simple progress reports.
- (e) An "all-in" certificate as suggested in para. 49.

- (f) Use of stamped or franked and addressed envelopes for return of record cards.
- (g) The issue of a National Formulary of prescriptions.

#### REPRESENTATION OF PRACTITIONERS.

55. The Union feels that the methods by which the views of insurance practitioners are ascertained and presented, whether to the Ministry of Health or before this Commission, are in many respects unsatisfactory and call for reform.

This is largely due to a peculiar defect in the Insurance Acts. These Acts have set up and maintained certain local committees of medical men, known as the Local Medical Committees (representative of the whole profession) and Panel Committees (representing insurance practitioners). The former class of Committee has practically become obsolete and in many cases the Panel Committees have been allowed by the Ministry to act for both. But the Acts provided no central committee to which these local committees might send representatives. There is thus no statutory body from which the views of insurance practitioners may be obtained.

The Medical Practitioners' Union therefore urges upon the Commission that some machinery less unwieldy than the present ought to be set up by means of which the views of those engaged in National Health Insurance can be ascertained. It is suggested that this should take the form of three statutory National Panel Committees respectively for England, Scotland and Wales, and a statutory Central Medical Committee formed of representatives from the National Committees, which would in turn be directly elected from the existing Panel Committees.

#### CHARGES FOR SPECIAL SERVICES.

56. A recent development of National Health Insurance has been the attempt to control fees charged for services which are not provided by the Acts, e.g., major operations. The particular control objected to is in the form of a requirement to produce evidence of ability to perform the particular services. Although there seems no authority for any such regulation in any of the principal Acts, the position now is that a practitioner may not charge a panel patient for a service to which he is clearly and admittedly not entitled without proving that he satisfies one of the following criteria, namely:—

- (a) That he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character; or
- (b) That he has had special academic or post-graduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid; or
- (c) That he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

It will be noted that the young doctor newly entered into practice and not having been able to afford to hold hospital appointments is necessarily unable to fulfil any of these requirements. His practice will almost certainly lie for the first few years largely among insured persons. If the service is extended it may always lie among insured persons. It is to the interest of the public that he should develop special skill in any line which attracts him, but skill can only come by practice, and if he may not charge there is little inducement to acquire skill. Suppose that he desires to specialise in X-ray work. He is required by the regulation quoted to take photographs at no small cost to himself and without remuneration, or, alternatively, to restrict his practice to those who are not insured. The regulation is plainly contrary to the interests of the public. Where surgery is in question greater difficulties arise since some amount of surgical practice is a part of

the ordinary education of the medical student and it is extremely difficult to say where "special proficiency and experience" begin. The third of the conditions quoted above seems to be designed to prevent the possibility of "special experience" being obtained, although the greatest surgical reputations of the day began in inexperience. Nor would it suffice for the doctor to take a post-graduate course of instruction, for the second condition calls for both post-graduate instruction and "actual recent practice."

In the opinion of the Union the whole of these three conditions forms an unwarrantable interference with the liberty of the doctor to earn a livelihood by the exercise of his profession.

It will perhaps be argued that some restrictions must be imposed lest the enthusiasm of some newly-qualified practitioner should lead him to attempt operations which he lacked the skill to carry through. It is not the experience of the Union that the newly-qualified practitioner is so ignorant of his limitations or so careless of human life as to fall into this error. It must be remembered that he has had a liberal education followed by at least five years' technical training and so is better fitted to view things in their proper proportion than are most persons newly entered to their life's career. There is an additional safeguard in the fact that such operations would necessarily be performed in a hospital and in the presence of at least two colleagues, an assistant and an anaesthetist. The presence of these and of the nursing staff provides a very real check to unbalanced enthusiasm for surgery, a check which far outweighs in importance the irritating and clumsy restraints imposed under the Insurance Regulations.

It is, in fact, usual for a newly-qualified practitioner anxious to become proficient as a surgeon, to take a House Surgeon's appointment for some time, and, even then, when he comes to operate in his own practice, to secure the presence of a senior colleague when there is any possibility that the operation may prove to be beyond his powers. In this way he slowly acquires the self-reliance and technical skill which will enable him in due course to give like assistance to others.

It seems probable that if the apprehensions mentioned above could be traced to their source, they would be found to originate with the sensational novelist rather than in any well-attested instances. But, even if these things were not so, to forbid the charge would scarcely prevent the enthusiast from operating or greatly assist his patients. The appropriate remedy would surely be to forbid the operation.

The Union recommends that practitioners should be at liberty to charge for any service admittedly outside those provided by the State under the National Health Insurance Acts and repudiates the suggestion that there is any authority under the Acts to make regulations interfering with such charges.

#### ALTERATION OF ANÆSTHETIC REGULATIONS.

57. It is suggested that these regulations should be altered to allow of a fee being paid in all cases in which a general anæsthetic is required and in which a fee is properly claimed (on his own behalf or otherwise) by the insurance practitioner.

#### APPROVED INSTITUTIONS.

58. These Institutes were approved under the original Act in order to avoid too sudden an interference with subsisting arrangements and vested interests. It is not to be supposed that this approval implied any particular moral sanction.

These Institutes provide a service which seems to nullify the intentions of the Acts in three ways:—

- (a) There is no free choice of doctor except by leaving the Institute, and this is only allowed at certain times.
- (b) The doctor is controlled by a lay committee.
- (c) Owing to professional objections to this type of service, there is commonly great difficulty in securing a doctor of the character and standard of skill which obtain in the rest of the Insurance service.

The Union recommends that all such Institutes should be given two years in which to bring to an end their National Health Insurance work, and that approval should then be finally withdrawn.

#### PHARMACEUTICAL SERVICES.

59. There is still room for considerable improvement in the direction of ensuring a more prompt supply of medicines. The complaints which most frequently reach doctors are (1) that when chemists' shops are open there is often an hour or more to wait before prescriptions are dispensed; (2) that it is often difficult to get medicines after 8 o'clock; and (3) that the Sunday service is far too restricted.

The Union is not unaware of the fact that the Shop Acts are in part responsible for these complaints, but feels that much more might be done to satisfy them than is in fact attempted. The doctor is required to be on duty night and day, year in and year out. This requirement is imposed because the need for his services may arise at any time. The need for the chemist's services may be less urgent, but that cannot excuse the very indifferent preparation which is made to meet it. Where there are three or four chemists' shops within a short distance of each other it should be possible to obtain medicine at any hour of the night or day and on Sundays.

The Union suggests to the Commission that this procedure by which it can be made could no doubt obtain in all urban areas of appropriate size. The procedure by which it can be made could no doubt be suggested by those responsible for providing pharmaceutical services.

#### PART IV.—REMUNERATION.

##### PREVIOUS NEGOTIATIONS UNSATISFACTORY.

60. There has hitherto been no agreement as to the basis on which medical remuneration should be calculated. The actual amount of payment in each period has been reached by a process of bargaining. To this process there have in fact been three parties, namely, the Ministry, the doctors and the Approved Societies. The main contentions of these parties have scarcely varied and are as follows:

The Ministry at the recent Court of Enquiry alleged that, whilst the service was good, the then current rate of remuneration was too high. In support of this view it adduced such irrelevant considerations as (1) that there was no money available in certain funds from which medical remuneration might otherwise be drawn; and (2) that extra services imposed did not entitle doctors to claim increased remuneration.

The doctors have usually alleged that the service was good, but the pay too small, resting their claim on cost of living and other statistics.

The Societies have frequently asserted that the service was bad and could only be improved by lessening the remuneration, but have never cited any case in which such a measure has produced the result desired.

The resulting triangular debates have been followed by the Press with close attention and much additional evidence of a dubious character. It is not clear that political considerations have always been absent and the general result of this method of bargaining has been profoundly unsatisfactory to all parties concerned, and very damaging to the prestige of the service. Damaged prestige must lead to increasing lack of confidence and, where there is no confidence, little good can be expected from the most skilled advice.

In the opinion of the Union the negotiations concerning remuneration, since the first cheap jibe of a "quarrel in a sick room," have been so uniformly deplorable in effect that it is imperative that a way be found to render them more dignified and useful in future. The observations and suggestion of the Union are primarily directed to this end.

61. It is recognised that there must be negotiations, but there is no apparent reason why these should be influenced by Approved Societies. The doctor's employer is the State and it is for the State to agree with the doctor his terms of service. It is

axiomatic that no man can serve two masters, but for the past twelve years the Ministry has imposed such service on the Medical Profession. One of the first steps towards an era of better understanding must be the complete elimination of the Approved Society influence from future negotiations.

##### THE PROPER BASIS OF REMUNERATION.

62. Of no less importance is some definite agreement as to the basis on which remuneration is to be fixed. It is assumed that the Commission will have before it copies of at least the various Memoranda of Evidence presented to the Court of Inquiry into the capitation fee which sat early in 1924. From these it will be seen that the Ministry has adopted several different bases of which two examples may suffice.

In one argument it is assumed that the doctor is entitled to a remuneration similar in amount to that of the civil servant. The fact that the civil servant has limited hours, guaranteed holidays, pension, etc., is conveniently left out of the calculation and by an extraordinary confusion between net and gross income it is shown that the doctor will get the proper rate of remuneration if the capitation fee be so much per head.

In another argument it is assumed (quite without evidence) that the average doctor has 2,000 panel patients (which is not the case) and spends half his time dealing with them. It is further assumed (again without any adequate evidence) that the average professional income is so many pounds per annum. The payment for 2,000 panel patients should then provide half this sum. This it will do if the capitation rate be so much per head.

Deductions drawn from arguments in which almost every factor is an "unknown" are easily made to support preconceived notions, but they bring no lasting satisfaction to anyone. The Union suggests that all such deductions are as useless as the premises from which they are drawn are inapplicable.

There can be only one proper basis for calculations as to the value of any service or commodity and that is the actual current price in the open market of that service or commodity.

In order that this basis may be employed for the calculation of medical remuneration, it is necessary for the State to know exactly what service it desires to provide for. When that has been determined it will be necessary to discover who gives that service and what he is paid for it in the open market. The two problems are by no means free from complexity, but the Union believes that they must sooner or later be faced.

##### THE SERVICE REQUIRED.

63. The service required is stated in the Regulations as follows:

"All proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess."

The words "proper and necessary medical services" are of course capable of many different definitions and their precise import is still doubtful. But their general sense is not in question and there is machinery by which particular cases of doubt can be decided. It has, however, to be noted that maternity and dental services *are not* included, while clerical services, other than those required for any medical purpose, *are* included.

It will be observed that the above-quoted definition says nothing as to the degree of skill which must be employed in the "proper and necessary medical services" and for some inkling of what is intended we must look to the earlier definition (*see* page 80 of "Evidence" offered by the Ministry). This incorporates the phrase "a general practitioner of ordinary professional competence and skill." The Union attaches great importance to this because the existing rate of remuneration is avowedly based on the attendance provided in the most densely populated industrial areas.

It would appear therefore that it is the usual service of the *average* practitioner which is intended to be obtained and it is on the current charge for this that remuneration ought to be based.

64. There is, however, a further modifying factor to be considered. It is well known that the doctor's fee varies according to his patient's ability to pay. The well-to-do pay not only for their own treatment, but such additional sum as makes it possible for the doctor to attend his poorer patients at very reduced or nominal charges.

The charges made to the latter are accordingly not, in an average mixed practice, a true measure of the remuneration received by the doctor for the services rendered to them. The average charge cannot be deduced from that made to the families of insured persons. Hitherto the State has been content to take advantage of this peculiarity of the economics of medical practice. The attitude of the profession would be distinctly hostile if at any time the income limit were raised or abolished so that those who now pay higher fees became entitled to attention at the basic rate, that rate having been decided solely in relation to the employed classes.

The Union in the meantime defines the service for which the due remuneration has to be calculated as:

The usual service of the average practitioner to the average person of the insured class.

65. It might somewhat pertinently be asked whether this "average person" is likely to be male or female, since the amount of attendance required differs in the two cases. On this point the Union would remark that the inclusion of women and children, if decided upon, will certainly increase the number of attendances actually given per person insured. This, of course, must be one factor in any such deliberate calculation of the capitation fee as is here advocated. The exact value of this factor can only be determined after experience and in the meantime the profession will necessarily profit or suffer, as the case may be, under such approximation to it as may be agreed for the first few years.

66. No mention has yet been made of the varying nature of the services for which the doctor actually charges and of which the market value can therefore be ascertained. For most purposes covered by the definition of service already quoted, these are three in number:

- (a) A consultation at the doctor's surgery.
- (b) A visit at the patient's house.
- (c) The dispensing of a bottle of medicine.

With regard to (a) and (b) together there is already agreement that from 3.5 to 3.7 services of these sorts are rendered to the average insured person per year. These figures have been obtained by the process of sampling or taking test records referred to in paragraph 48. Since the average number of attendances is certainly rising as the insured person becomes more alive to his privileges and since the numbers quoted refer to "healthy" years, it is desirable that they should be checked annually. The exact proportion which visits bear to attendances is not known and varies in town and country. These figures could be obtained and the years intervening between 1925 and the date of any extension of the Service ought to be utilised for the procuring of such figures. In the meantime calculations must necessarily be based on the "average" service where visits and attendances are in question.

In the case of (c) the market value can be obtained from the average price paid per prescription to chemists.

#### THE CALCULATION OF THE CAPITATION FEE.

67. It is the opinion of the Union that the capitation fee should in future be based on the following calculation:—

- (a) Take first the number of insured persons and the number of attendances, etc., paid to each. Multiply. Deduce the total number of services to be provided.

- (b) Divide the total of services into visits and consultations and multiply each by the current market value (determined as in paragraph 68).

- (c) Add the last two cash totals and divide by the number of insured persons. Deduce the capitation fee.

68. The market value of the average service is not difficult to obtain. The general rate of charge is a matter of common knowledge in most districts. The returns of the Union from more than 1,100 practitioners are summarised in Appendix C. If exception is taken to the fact that they are obtained from interested persons, the Union is quite prepared to abide by return collected in some other way which is agreed to be equitable.

It has often been suggested that the actual charge and the fee which is eventually paid are very different things. The Union admits that the figures arrived at in Appendix C may be corrected in various ways. They may be regarded as too high in view of the following facts:

- (a) That there is a proportion of bad debts.
- (b) That a certain amount of "scaling-down" from these fees is made for multiple attendances in some cases and where two or more persons are seen in one house.

They may, on the other hand, be regarded as far too low in that:

- (c) They provide for no clerical work or certificates.
- (d) They do not provide for the administration of anaesthetics or for extras, or, in general, for nearly so complete a service as is provided under the National Health Insurance Acts.

By the exercise of sufficient ingenuity it is possible to modify these figures in any direction, but the Union would point out that the cost of clerical services has long been placed at two shillings and sixpence per head and that this alone would render acceptance of the figures as they stand rather unfavourable than otherwise to the practitioner. It is suggested that the value of all such modifying factors must be determined or agreed between the Ministry and insurance practitioners as a part of the procedure for calculating the capitation fee.

69. The Union is not unaware that some of the calculations referred to above are not quite so simple as appears (for example, the total number of insured persons) and does not wish to bind itself to a hard and fast scheme so much as to remove the calculation of remuneration from the sphere of newspaper controversy. The method suggested is at least an indication of a better way than has been followed in the past, of a new direction well worth following. The Union claims no more and wishes to call the attention of the Commission to the fact that the first rough draft of this plan was made on 31st January, 1925, at which date the Union was still collecting the data on which Appendices B and C are based. The plan is thus cleared of the implication of having been made to fit in with some preconceived capitation fee. The actual fee is probably a matter with which the Commission will not feel that it need concern itself, but the Union wishes to press very strongly for consideration of the methods employed to arrive at that fee and to express its complete condemnation of such burlesques of argument as were placed before the Court of Inquiry of 1924.

70. The present fee as calculated from Appendix C should be 13s. per head.

#### ADMINISTRATION ALLOWANCE.

71. No administration allowance is made in respect of the many duties of Panel Committees. This arrangement had formerly the approval of the Profession, since it was apprehended that a separate administration allowance would be held to justify undue interference with the work of Panel Committees. Owing to the increase of the duties of Panel Committees which has occurred since the inception of National Health Insurance, the Union

suggests that an administration allowance should now be made and the existing statutory levy on the moneys of practitioners abolished.

#### APPENDIX A.—DEMANDS FOR IRREGULAR CERTIFICATES.

Since the suggestion that Societies frequently demand irregular certificates is sometimes disputed by the Societies, the Union desires to put in evidence two letters illustrating the form in which these demands appear. As a rule the request is oral, but at times a written communication is produced. The following letters were received by the same doctor directly or from patients during December, 1924, and January, 1925. The original letters are at the disposal of the Commission:

The first letter is as follows:

PRUDENTIAL ASSURANCE COMPANY, LIMITED.  
(Name and Address of Agent.)

18th December, 1924.

DEAR SIR,

With reference to certificates required in the case of Miss P., the last certificate received from you is an intermediate one, dated 6/11/24, with the remarks that the member is now out of hospital.

Hence, further certificates are required, since that date, either intermediate ones or final, according to your jurisdiction, if you will oblige.

Yours faithfully,  
A. B. C.

Dr. X. Y. Z.

In this case certificates are demanded covering a period of twelve days prior to the date on which they are asked for.

The second letter is as follows and was signed by a gentleman who has already appeared before the Commission:

HEARTS OF OAK BENEFIT SOCIETY.

Benefits:  
D/S. PT/MG.  
F.4316018.

10th January, 1925.

MADAM,

With reference to your sickness claim, the certificate dated the 20th December was for a period of fourteen days only. A further certificate on Form Med. 40 B became due on January 3rd, but same is not yet to hand.

Will you please obtain and forward the required certificate without delay.

Yours faithfully,  
A. B. C.,  
Secretary.

Miss X. Y. Z.

In this case a particular insurance certificate dated for seven days before the letter was written is demanded by the chief secretary of a Society of over 400,000 members. It is apparent that this example is likely to spread to agents of lower rank.

#### APPENDIX B.—AVERAGE INCOME AND PRACTICE EXPENSES.

There are two figures, those of (a) average income, and (b) practice expenses, which have frequently assumed importance in connection with negotiations as to the remuneration of insurance practitioners. The Union has accordingly endeavoured to obtain reliable data on these two points. It has met with the difficulty that medical men are very unwilling to fill up forms of any sort even in their own interests. Although the particular form employed, drawn up by the Union, was distributed to the whole of the Profession, only 305 effective replies were received. Twenty-five forms were excluded as insufficiently detailed. These 305 were distributed as follows:

62 from urban residential practices.  
117 from urban industrial practices.  
56 from semi-rural (country town) practices.  
70 from rural practices.

The average gross income was £1,394 per annum. The urban practices showed a slightly higher average (£1,403) than the rural (£1,380). This is due to the fact that the country town practices averaged £100 less than the average.

The average practice expenses were £561 or just over 40 per cent. of the average income, the rural practices averaging 5 per cent. more than the urban.

These expenses were divided as follows:

	£	Per cent.
Rent, rates, taxes, etc. ... ..	109	7.86
Branch surgeries ... ..	12	0.88
Wages (including chauffeur) ... ..	180	12.94
Car and transport* ... ..	142	10.21
Drugs, instruments and dressings	115	8.29
Other charges ... ..	1	0.09

The complexity of the form circulated makes it probable that it was in general returned only by practitioners of some years' standing. The average income is thus likely to be somewhat too high, but the proportion of expenses is no doubt accurate.

#### APPENDIX C.—FEES.

The Union circulated a questionnaire on fees to the whole of the profession and received 1,077 returns; 923 were from panel practitioners with total lists of 966,941 insured persons, while 154 were from non-panel practitioners.

All types of practice were included and were in the following proportions:—

	Panel.	Non-Panel.
Urban and mainly residential practices	136	73
Urban and mainly industrial practices	359	40
Semi-rural (country town) practices	175	24
Rural practices ... ..	219	9
Type of practice not stated ... ..	34	8

The fee for a surgery attendance without medicine was on an average of the whole 3s. 3½d. The fee for a visit without medicine was 4s. 4½d. These are the two figures required by para. 67 for the calculation of a basic capitation fee. The calculation according to that paragraph would be as follows:

- 15,500,000 insured persons each asking 3.7 services per annum require a total of 57,350,000 services.
- If visits are to consultations as 1 is to 4 (which the Union believes to be the correct average proportion) there are required 11,470,000 visits at 4s. 4½d. each and 45,880,000 surgery attendances at 3s. 3½d. each. The two cash totals are £2,509,050 and £7,503,250.
- These add up to £10,012,300 which distributed over 15,500,000 persons would produce a capitation fee of 13s.

The Union contends that this fee represents the type of service which the State should seek to procure and should accordingly stand as the basic fee to which corrections should be applied as suggested in para. 68.

The Union feels that these corrections could and should be agreed between the Ministry and the Statutory Committee mentioned in para. 55 and that in this way alone can a settlement fair and agreeable to all parties be ensured.

#### APPENDIX D.—SOME FURTHER SUGGESTIONS AS TO MATERNITY SERVICES.

Since this Statement was circulated to the profession it has become apparent to the Council of the Union that its attitude on the subject of maternity services has been rather widely regarded as unsympathetic. It has been felt to take too little account of those earnest persons who have accepted the very sweeping conclusions of Dr. Janet Campbell's Report to the Ministry of Health and who have been shocked and amazed in consequence. Although the Union is very far from accepting those conclusions, it is well

\* The actual cost per car used was £169; the average above is reduced by the failure of some doctors to complete returns under this head.

† Reports on Public Health and Medical Subjects, No. 25, Maternal Mortality.

aware that in this as in other countries the death and morbidity rates for childbirth have not shown that downward tendency which the spread of antiseptic methods might have been expected to bring about. There is undoubtedly room for improvement in the maternity services of the country and it is possible that assistance from National Health Insurance funds might promote this improvement. It might have this effect in the following ways:

- (a) By providing for proper care where home conditions are very imperfect. The Union refrains from describing in print the appalling surroundings amongst which some unfortunates are born. Such care may take the form of no more than decent and clean housing and is not to be interpreted as meaning hospital accommodation. If payment was forthcoming in such cases it is probable that a demand would be created which would speedily be met by voluntary agencies.
- (b) By providing adequate payment for cases needing hospital care. Here again, the prospect of payment would probably encourage hospitals to set apart beds for this purpose.
- (c) By providing for consultation services. In view of the limited number of recognised specialists available many districts would be unable to procure their services. It is fortunate that the experienced general practitioner is usually a specialist of no mean ability in this particular matter and a consultation with and assistance from a brother practitioner would often be at least as useful as the services of a recognised specialist. Such consultations could be provided with no great difficulty and at relatively small expense.
- (d) By providing contributions towards the funds of District Nursing Associations employing qualified midwives to attend insured persons. These Associations are a very im-

portant part of the Health Services of all districts and the Union wishes to see them encouraged in every possible way.

- (c) By the provision of nourishment, etc., by means of a cash grant to the mother (the existing maternity benefit) or to such agencies as already provide assistance before or after childbirth.
- (f) By the provision of doctors' fees on an agreed scale.

It is probable that there are other ways in which National Health Insurance funds might be made available for the improvement of maternity services and it is in particular very desirable that some of the grants made in aid of research should be augmented and definitely ear-marked for this purpose. The origin and nature of puerperal fever are still matters as to which there is no agreement and the need for properly planned research is extremely urgent.

The Union feels that almost every factor is wanting which would make it possible to offer a complete maternity service to insured persons forthwith. The service must be built up deliberately, although with as much speed as possible. The foundations exist and not to utilise them would be the grossest folly. But they are foundations involving many different bodies, the County Councils, the Poor Law Authorities, the Voluntary Hospitals and District Nursing Associations and individual practitioners. None of these can easily be coerced or suddenly forced into some new scheme under the control of the National Health Insurance Authorities. But each can be assisted and encouraged upon lines with which they are already familiar, i.e., by grants conditional on efficiency. It is in this way that, in the opinion of the Union, National Health Insurance funds can most profitably be employed for the improvement of maternity services.

The Union hopes that it has cleared itself of the charge of lack of sympathy with those who are so genuinely anxious to improve maternity services. It has in fact given prolonged consideration to the subject and has not arrived at its conclusions on any unsubstantial grounds.

## APPENDIX XLIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL MEDICAL UNION BY DR. VIVIAN T. GREENYER, F.R.C.S., CHAIRMAN OF THE COUNCIL, AND DR. CHARLES T. T. COMBER, O.B.E., M.D., MEMBER OF THE COUNCIL OF THE UNION. See Minutes of Evidence of the Twenty-Eighth Day, Questions 15,745 to 15,989.

### PREAMBLE.

1. The salient point which emerges from the history of the growth and development of Medicine is the proof afforded of the discovery, by the personal and unaided initiative of the student of Nature in all ages, of those facts, interpretations and laws of life in health and disease, which have, in the fulness of time, brought into being that body of organised Medicine to which humanity owes so much and to which it will, unless individual energy be checked by bureaucratic control, owe still more.

2. The history of Medicine shows the unceasing and unrelenting cultivation and discovery of the nature and treatment of disease with which the profession is familiar and of some of the more striking results of which even the "man in the street" is not altogether ignorant. Public Health Officers were in existence, factories and mines were under supervision, Poor Law officials were fully employed, voluntary hospitals, general and special and many excellent dispensaries for the treatment of the needy, were well supported by the charitable public; private practice was pursued by a well-instructed and progressive profession.

3. Such was the situation when a fresh departure was instituted in the mode of medical practice which

seriously involved both the interests of the public in its relation to the profession and the economic interests of the profession itself.

4. The depreciation of the state of Medicine at that time, urged to justify the bureaucratic invasion of the profession, is both uncalled for and false.

5. This change was largely brought about by the action of the then Chancellor of the Exchequer taking his inspiration from the health legislation of the German Empire.

6. At that time he determined to harness to the car of State that profession which had, without State aid, become a health-giving and disease-preventing power, with a recognised status and economic interests. To his surprise, according to his latest biographer, he found that, however beneficent the influence of that body, it did not see eye to eye with him on many points, ethical and economic. Their opposition, indeed, jeopardised the prospects of his Bill becoming law, and rather than lose it or have its consideration postponed, it is a matter of history, that it was forced through the Commons by the most unscrupulous application of the closure.

7. How the Royal Colleges and a powerful professional organisation the British Medical Association



missed the greatest opportunity in their history of securing the independence of Medicine need not be retold.

#### THE HOSTILITY OF THE PROFESSION TO THE NATIONAL HEALTH INSURANCE SCHEME.

8. At a special Representative Meeting of the British Medical Association held in London on December 21st, 1912, to consider the final offer of the Government as to service under the National Health Insurance Act, a motion was carried with only one or two dissentients, the terms of which were as follows:—

"That this Representative Body, having carefully considered the replies of the Chancellor of the Exchequer to the deputation appointed at the recent Representative Meeting to confer with him, is of opinion, that they do not remove the strong objections to the regulations and conditions of service determined on by the last Representative Meeting, but confirm the then expressed opinion that such are, in the best interests of the public and Profession, unworkable and derogatory."

9. It is well known that it was only by raising the capitation grant to an unexpected height and the timidity of a certain number of the profession under the threat of an expropriation of their practices by the appointment of a whole-time State Medical Service that, at the last moment, the adhesion of a sufficient number of members of the Profession was secured to work the Act.

10. Whatever beneficial results are now claimed from the working of the Acts it is also now indisputable that it is still only the maintenance of the capitation grant at a certain figure which retains the services of those at present on the panel.

11. The National Medical Union representing that considerable portion of the Profession who refused service under the Acts and founded at the commencement of the National Health Insurance controversy, has maintained objections to the scheme once shared by the profession generally, down to the present time. It considers that its attitude has been justified by the situation from time to time revealed in the working of the Acts.

12. Measures taken by the Union from time to time have shown that many both of the Profession and of the insured laity entertain the strongest objections to the service both given and received under the Acts by the panel system as at present constituted. Details of such objections we are prepared to give the Commission during the inquiry.

#### PERSONS INCLUDED IN THE SCHEME OF NATIONAL HEALTH INSURANCE AS AT PRESENT CONSTITUTED.

13. It is the view of the National Medical Union that there should be a State Medical Service for necessitous persons, and that the Poor Law as it at present exists should be modified on lines which they are prepared to submit to the Commission. The insured person as he exists under the National Health Insurance Acts, being in no sense a necessitous or destitute person, but, in a large proportion, well able to pay for medical attendance, the National Medical Union considers, should be voluntarily insured under one or other of the Insurance Societies under the supervision of the Registrar of Friendly Societies, which well served the purposes of medical benefit before the present National Health Insurance Scheme became enacted.

#### THE CONTENT OF MEDICAL BENEFIT AND OTHER MEDICAL BENEFITS.

14. Outside the State Medical Service for necessitous persons to which reference has been made, the National Medical Union considers that the scope of medical work in the stratum of insured persons, should be as wide as that undertaken by the general practitioner in voluntary private practices. The

specialisation of various spheres and diseases under the National Health Insurance Acts has deteriorated the efficiency of the general practitioner of medicine, who, under the prolonged curricula of instruction necessary prior to qualification, is sufficiently equipped to undertake the charge of the categories withdrawn from his care by the specialisations indicated.

#### THE ADMINISTRATION OF MEDICAL BENEFIT.

15. The medical and lay committees and mixed professional and lay assessors of the National Health Insurance Acts with above all the absolute and grotesque power placed in the hands of the Minister of Health, have degraded a liberal profession to the level of a supervised trade and deprived all accepting it of that responsible sense of self-respect once the essential feature of a free Profession.

16. There are many who accept and groan under this system compelled by stress of circumstances to do so, but there are few even of those engaged in panel practice who would not gladly see all lay control eliminated from any scheme of medical benefit.

17. The National Medical Union advocates the censorship of the General Medical Council alone and in necessary cases submission like all other citizens to the common law of the country, but the removal root and branch of other censorship and most especially the grotesque autocracy of the Minister of Health over a liberal profession.

18. Can any sane person imagine a similar position occupied by a Minister of Justice or of Worship towards either the Legal Professions or the Church? Is the Medical Profession less developed or independent than these?

19. The following circular letter which contains a statement of the policy of the Union has received the assent of a large section of the Medical Profession:—

#### THE NATIONAL MEDICAL UNION.

11, Chandos Street,  
Cavendish Square,  
London, W.1.

DEAR SIR,

The National Medical Union is making an effort to collect evidence of medical opinion throughout the Country in support of its policy, for presentation to the forthcoming Royal Commission on National Health Insurance.

The essence of the Union's policy is:—

That a State Medical Service is necessary only for genuinely necessitous persons, otherwise defined as destitute persons or as persons temporarily or permanently unable to provide for themselves.

That the matter of Insurance against the financial risks of sickness, of which, in principle, the Union approves, should have separate treatment. The Union proposes that this should be effected by a genuine system of Insurance against doctors' bills, cost of drugs, institutional treatment, &c., and that the Profession of Medicine should be left absolutely free from State interference, to develop on the traditional lines of private practice.

The National Deposit Friendly Society system and also that of the Scottish Clerks' Association were, before the present Act came into force, examples of the type of Insurance indicated.

If this policy appeals to you the Union requests that you will kindly signify your approval by signing

below and returning this at once to the Hon. Sec. of the National Medical Union.

Yours faithfully,

A. BLACKHALL-MORISON, M.D., F.R.C.P.  
W. RUSSELL, M.D., LL.D., F.R.C.P.Ed.  
J. HOWSON RAY, M.B., F.R.C.S.

E. H. WORTH, M.R.C.S.,  
Hon. Sec.

I cordially support the policy of the National Medical Union as indicated above.

Name \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

20. Our objections to the National Health Insurance Act may be summarised as follows:—

#### GENERALLY.

- (1) No public demand for such legislation.
- (2) Not National, not Insurance, of no value to Public Health.
- (3) Opposed to voluntary thrift.
- (4) Rests upon the theory of compulsion.
- (5) Establishes a permanent social stratification, pauperising independent and self-respecting labour.
- (6) Increase of industrial burden (cost of production, diminution of output).
- (7) Cost of administration an unknown factor.
- (8) Increasing cost to the State.
- (9) Increased cost of administration of Poor Law ever since inception.
- (10) Public dissatisfied with the working of the Act.

#### AS APPLIED TO THE MEDICAL PROFESSION.

- (11) Panel system virtually a qualified system of State Medicine of a most inefficient type.
- (12) Depreciation of public faith in Medical Profession.
- (13) Increased resort of public to harmful and unsuitable patent medicines.
- (14) Many insured prefer to consult their private doctor and so pay twice.
- (15) Inadequate in cases of serious or prolonged illness.
- (16) Great increase in malingering since inception of the Act.
- (17) Definition of range of service in regulations unintelligible.
- (18) Regulations burdensome and complicated.
- (19) Prosecutions under regulations degrading to Profession.
- (20) Patients' confidences open to abuse.
- (21) Remuneration not in relation to service rendered.
- (22) Competition amongst Panel Doctors for obtaining patients degrading and offensive.
- (23) Income limit open to abuse.
- (24) Failure to carry out the Act.
- (25) Serious illness treated by non-panel doctors or in voluntary hospitals.
- (26) Minor ailments still flocking to the voluntary hospitals.
- (27) Insured patients dissatisfied with treatment received.
- (28) Tubercular disease sent to hospitals for infectious diseases.

21. On all the points stated the representatives of the National Medical Union desire to submit themselves to the interrogatory of the Commission and to give evidence in support of their position.

## APPENDIX L.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SCOTTISH MEDICAL GUILD BY PROFESSOR WILLIAM RUSSELL, M.D., LL.D., VICE-PRESIDENT, AND DR. FREDERICK PORTER, M.B., HON. SECRETARY. See Minutes of Evidence of the Twenty-Eighth Day, Questions 15,990 to 16,092.

#### PERSONS INCLUDED IN THE PRESENT NATIONAL HEALTH INSURANCE SCHEME.

1. We classify the manual workers thus:—

- (1) Those whose employment is precarious or whose wages are low and who cannot afford to pay for medical attendance for their wives and dependants.
- (2) Workers in coal mines and in certain public works where, before the passing of the Acts, there was established a system of weekly capitation payments which covered not only the worker but also his dependants. This was a system of collective arrangement which has been found satisfactory.
- (3) Those in good and regular employment who, along with their families were, before the passing of the Acts, attended as private patients. Many of these being opposed to the panel system of medical attendance, have not adopted it, but have continued to be attended as formerly, thus sacrificing their medical benefit under the Act.

2. Our recommendations for manual workers are:—

- (1) State provision ought to be made for medical attendance as explained in the Memorandum appended. This service should be available for all who apply on the ground of inability to make provision for themselves.

(2) For this class there is no necessity to alter the present conditions of service if the workers and doctors are satisfied with them.

(3) All persons in this class ought to be free to make their own medical arrangements individually or as members of the non-State section of such organisations as the National Deposit Friendly Society and the Scottish Clerks' Association, in which attendance is on the basis of private practice. This would allow complete freedom of choice of doctor. Choice at present is confined to an official panel list.

3. Non-manual workers originally included clerks, typists and others with incomes up to £150 per annum and who were entitled to medical attendance under the panel system. The income limit was raised recently to £250 per annum. This latter group is not eligible for medical attendance under the panel system. They are required to make their own medical arrangements as in private practice. This has failed to be effective, as the medical man selected is required to sign a Government contract, and in our experience the non-panel doctor will not do so. This restriction ought to be removed.

4. Form I.C. 215 B makes the provision we recommend (see especially page 3, paragraph 6), but its efficacy has been destroyed (1) by the doctor being required to sign an agreement with an Insurance

Committee, to which he is opposed for the same reasons as he is to putting his name on the panel list; (2) By the doctor being brought under the regulations of the Acts.

#### SPECIAL PROVISIONS FOR PARTICULAR CLASSES OF INSURED PERSONS.

5. "Particular classes" have been dealt with under the recommendation in paragraph 2 (1), and arrangements suitable for each have been submitted.

#### CONTENT OF MEDICAL BENEFIT.

6. The panel system is disliked and distrusted by a large, and, we believe, an increasing number, of insured persons. The reason for this is that the panel system disturbs that personal relationship between doctor and patient which exists in private practice. This is confirmed by the fact that many, where they have the opportunity, sacrifice their medical benefit and employ a private medical practitioner.

#### ATTITUDE OF NON-PANEL PRACTITIONERS.

7. The content of medical benefit with its rules and regulations made the non-panel practitioner at the outset see that his work would be hampered and that he would be prevented from giving his best service to his patients. This is exemplified by reference to the limited expenditure allowed on drugs which encourages the manufacture and sale of inferior qualities, while the list of drugs which may be prescribed is limited. Many important drugs of a physiological standard of potency were freely prescribed before the Act came into existence, but some of these are not available for insured persons. Drugs ought to be beyond the category of mere commercial products, and no official drug ought to be allowed on the market which is inert.

#### OTHER TREATMENT BENEFITS.

8. Under this we understand the provision of consultants and experts in various departments, also of institutional and other special treatment. With regard to those who are unable to provide such benefits for themselves, this has been dealt with under the recommendation in paragraph 2 (1).

9. With regard to all others, expert and consultant assistance ought to be left to the free choice of doctor and patient, and could be arranged on the same lines as general medical attendance (see recommendation in paragraph 2 (3).)

10. Were the Poor Law Hospitals made into State or Municipal Hospitals, as suggested in the Memorandum appended, the problems (1) of adequate provision for institutional treatment and (2) of the position of the existing voluntary hospitals would be largely settled.

#### MEMORANDUM.

#### THE NATIONAL MEDICAL UNION AND THE SCOTTISH MEDICAL GUILD.

#### *A State Medical Service as a Basis of Wise Legislation.*

11. Dissatisfaction with the working of the medical benefit section of the National Health Insurance Act has lately been voiced so widely that an inquiry has been accepted by all parties as not only desirable, but necessary. This at once suggests the question, "Why and where has the Act failed?" At the same time there has been talk in some quarters of the transformation of the present system into a "State Medical Service." The public do not appear to realise that only about half the doctors on the Medical Register have accepted service under the Act in question. The other half has no collective voice, but is in part represented by two Societies, namely, the National Medical Union, with its headquarters in London and a strong section in Manchester; and the

Scottish Medical Guild in Edinburgh. These Societies were formed when the Act came into force. Their policy from the outset consisted of two parts:—

- (1) Opposition to the panel system of medical practice;
- (2) The basis on which a State Medical Service ought to be established.

For the consideration of the latter, a historical retrospect may be helpful as a guide to future action in relation to amendment of the Act as it stands.

12. When the Government of the day sanctioned the introduction of a Bill to enforce a system of Insurance that would provide medical attendance and drugs for the sick amongst millions of manual workers of all grades, of all kinds, and of both sexes, it may be assumed that they were stirred by benevolent and altruistic sentiment towards the millions who would be swept into the scheme. If this were really the motive, the question naturally arises, why did they sweep into the State scheme millions of workers who already, individually, or through organisations and associations of many kinds, had made provision for themselves, and on more liberal terms than the State proposed? Even amongst these, there were many who, instead of exercising their right of obtaining medical service from their club or society doctor, engaged another doctor to attend themselves and their families during illness. The community is entitled to expect that its legislators are acquainted with the existing conditions which they contemplate altering or interfering with. When the Government adopted the Bill referred to, has it to be assumed that their decision was reached after a thorough survey of the mixed social and economic conditions prevailing amongst the mass of people for whom it was proposed to legislate? The conditions which existed were as follows:—

- (1) There was a Poor Law system intended for destitute persons, destitute from a great variety of causes, while their generic appellation was paupers. Doctors were appointed to districts to give medical attendance to them.
- (2) There was a great mass of wage-earners, many of whom had irregular and precarious employment; but many of whom had steady employment, sufficient wage to live comfortably, and, when thrift was exercised, to save some money. Many, if not all, of the latter were members of clubs or associations which provided sickness benefit, medical attendance, and even allowances for permanent disability.
- (3) There was a large body of people who did not fall into either of these categories.

13. From the humanitarian point of view, the people who required to be considered were certainly not those grouped in No. (3); nor those in No. (2), who were in a position to take care of themselves, and of their wives, and children, and were already doing so.

14. The people whose circumstances definitely called for a generous scheme of medical help were the labourers, the little-skilled and the untrained workers, often with wives and children dependent upon them. These merged into and often drifted into No. (1) category.

15. When the position is thus analysed, it is evident that enlightened humanitarianism should have begun here and it could certainly have evolved a scheme of medical benefit on the lines of the Poor Law, taking from it the stigma of pauperism, and including in its scope not only No. (1), but the section of No. (2) nearest to it. Unfortunately, this plain and reasonable line of advance in social amelioration was not adopted.

16. The fact however remains that both the National Medical Union and the Scottish Medical Guild incorporated, in the earliest expression of their policy, the doctrine that a State Medical Service should take the place of the Poor Law Service; and that the stigma of

pauperism should be eliminated. Experience of the working of the medical benefit section of the National Health Insurance Act has only deepened conviction of the wisdom of the doctrine then enunciated, and we hold that the application of this doctrine now is the only line along which true and pure social reform can efficiently move.

17. Had it been realised that there was in No. (1) category and in the lower section of No. (2) a great body of persons and families not in a position to pay for medical attendance on their dependants, it would have become apparent that our voluntary-maintained hospitals and dispensaries could not possibly provide all that the social and economic conditions required. Before the passing of the Act, the conditions were met, so far as they were met, not only by Dispensaries and by Out-patient Departments of Hospital, but by the unpaid services of sympathetic medical men, and in some large centres of population by the "sixpenny doctor." At the best, medical attendance on this section of the community was highly precarious, and the present Act made no provision whatever for the wives and children of the class of worker referred to.

18. Our contention was, and is, that true State philanthropy ought to have begun here. The class referred to is so large in populous districts, that it would require a whole-time service,—a State Medical Service in fact. Many medical men and women would deliberately, adopt such a service as their life-work. In it salaries would be paid, and no fees exacted. Some would enter the service from the highest of motives, and on the whole the work would be conscientiously done, while the men and women in it would hold an honourable place in public and professional confidence and esteem. The State Service would, of course, be graded, and at the head of it would suitably be placed a well-organised, equipped, and staffed State Hospital—replacing the present Poor Law Hospital.

19. Such is the State Medical Service which the National Medical Union and the Medical Guild hold ought to have been established.

20. Were this given effect to now, the present system of Medical Insurance adhered to, the large section of No. (2) category who are in a position to select medical attendance for themselves, their wives, and families, ought to have absolutely free choice of doctor, with the question of fee left to be settled between them, individually or collectively, and the doctors of their choice. In this large section of the community, the voluntarily-supported hospital would have abundant scope for its beneficence, and its funds could be helped by a maintenance charge on the Insurance funds available for Institutional treatment.

21. With regard to the question of method of payment for medical attendance, no rigid system is applicable, and no attempt ought to be made to make one. As stated above, the question of fee or of remuneration ought to be settled between the insured person, *individually or collectively*, and the doctor.

22. Individual selection existed prior to the present dispensation, as is shown in the admirable working of the National Deposit Friendly Society and the Scottish Clerks' Association, where individual choice of doctor and payment for work done were highly satisfactory and economically sound. Collective individuality existed long before the present Act was enforced, and it worked admirably in colliery districts and in many public works. In the former, at least, wives and families were included.

23. True reform of present conditions can only be effected by the creation of a State Service available for persons and families permanently or temporarily unable to provide medical attendance for themselves and for those dependent on them. All others ought to be given complete freedom of choice of doctor, with no State interference, and no officious bureaucracy intervening between sick person and medical attendant.

## APPENDIX LI.

STATEMENT OF EVIDENCE SUBMITTED BY DR. HARRY ROBERTS, L.M.S.S.A. See Minutes of Evidence of the Twenty-Eighth Day, Questions 16,093 to 16,193.

### MY STATUS IN RELATION TO HEALTH INSURANCE.

1. I practise as a general practitioner in East London in the Borough of Stepney; and I so practised there at my present address for several years before the passing of the Insurance Act—at first single-handed, later with the help of an assistant. My practice was a very large one, and, for several years, I conducted over 500 midwifery cases every year, in addition to ordinary medical work. At the present time I, in conjunction with three partners, with the help of an assistant, and with the supplemental help of dentist, masseur, nurses, etc., am responsible for medical attendance on nearly ten thousand insured persons.

2. I am, therefore, in a position to speak of the conditions of medical practice in a poor industrial area in both pre-insurance and post-insurance times.

3. On what may be termed the doctor's personal relation to the Insurance Act—considered purely as a doctor—I do not wish to offer individual evidence. That has been or is being adequately presented by the appointed delegates of the British Medical Association, the Medical Practitioners' Union and other bodies. I am, and have been, specially interested in the working of the Act as it affects the insured person and the public interest generally.

4. The insured person himself has little opportunity of getting his case publicly presented, and his point

of view publicly expressed; for no one with the slightest practical experience of the working of the Act, who comes into contact with a large number of insured persons on friendly and semi-confidential terms, can possibly regard as other than farcical the claim of the Approved Society officials to represent, either as appointed delegates or as personal familiars, the individuals who make up the membership of their Societies. In fact, the insured person as such takes no part in electing either the ruling bodies of the Approved Society that handles his contributions, or the Insurance Committee of his County.

### COMPARISON OF MEDICAL SERVICE TO INSURED PERSONS WITH THE MEDICAL SERVICE TO SIMILARLY PLACED PERSONS IN PRE-INSURANCE ACT DAYS.

5. Before the passing of the Insurance Act I attended very much the same people as after its passing. In a district such as mine it was clearly impossible for the majority of patients to pay an adequate fee for medical attendance. Consequently it was necessary, in order to obtain a reasonable professional income, to attend an enormous number of individuals, and to work fairly continuously seven days and seven nights a week. Only a man of exceptional health and energy, and with democratic sympathies, would be likely to practise under such conditions for any length of time if other spheres

of practice were open to him. The financial limitations of the situation made it impossible to obtain the amount of assistance that one knew to be necessary in the interests both of the patients and of one's health. Moreover one was almost hourly confronted with the impracticability of seeing patients, suffering from acute disease, with that frequency which their condition demanded, merely because they could not possibly afford it. Accordingly the better type of slum practice was largely dependent for such efficiency as it had on the philanthropic zeal and abnormal energy of the doctor. It is probably not unfair to say that the majority of slum practices were conducted by men who, for one reason or another, had failed or could not reasonably hope to succeed elsewhere. With the passing of the Insurance Act and the consequent bringing up of the rate of payment per attendance somewhat nearer to the rate customary in what we may call artisan or prosperous working-class districts, an entirely new situation was created in districts like mine. I at once realised that it would now be practicable—if the bulk of my private patients remained with me as insured patients—so to reorganise my work as not only to gain greater leisure for myself, but to provide an altogether fuller medical service for my patients.

Of course, the same holds good of other practitioners, but I am speaking only of my own experience. I took three other men into partnership; engaged a dental surgeon, nurses, and others; and so organised matters that all of us were able to work on a timetable, with definite hours on and off duty; and also to provide our patients with various special services previously impossible. So far as insured persons were concerned, the old difficulty of giving inadequate attendance through fear of unduly encroaching on the patient's last few shillings was removed. We were free to give just as much attendance as we thought desirable from a purely medical point of view. Looking back, the old days seem to me like a nightmare, although at the time I certainly found them full of interest though exhausting. Briefly, in my experience, there can be no question as to the enormous advantage to insured persons resulting from the medical provisions of the Insurance Act.

#### RELATIONS BETWEEN INSURED PERSONS AND DOCTORS.

6. In my own personal experience there is no change in the personal relations between myself and my patients now from the years before 1912. Nor do I think from observation in my own district, and from the remarks of patients who have had relations with other doctors, that there is any considerable general alteration in relations. Of course, one hears a good deal about the unpopular minority; but these men or their prototypes existed in just about the same proportion before the Insurance Act as they do to-day. But insured persons nowadays see very much more of their doctors than they used to do; and until the recent facilities for change of doctor were granted, persons insured under the Act had a half-conscious feeling of being more or less tied for life to the doctor of their first choice. Whereas, in pre-insurance days, they would probably not have visited a man they disliked or distrusted more than once or twice. With the present free change of doctor this small source of friction will almost certainly become less and less. In my own experience, and in that of most other doctors with whose practices I am closely familiar, the relation between doctor and insured patient is a ninety-nine per cent. cordial one, with much mutual consideration, a large degree of real personal friendliness, genuine sense of responsibility on the part of the doctor, and genuine confidence on the part of the patient. The chief source of open or veiled clash of sympathies is in certification. It is regrettable, though no doubt necessary, that the functions of physician and detective should have to be exercised by one and the same individual.

#### RELATION BETWEEN INSURED PERSONS AND THE APPROVED SOCIETIES.

7. In my experience, so slight is the personal relation between insured persons and their Approved

Societies that upwards of fifty per cent. of them have not the slightest idea to what Society they belong. Their efforts to find out are often pathetically amusing. Of the rules, regulations, penalties and privileges which, by their membership they are liable to suffer or are entitled to enjoy, they have no notion. No one tells them; no book of rules is even supplied to them—not that most of them could make much of it if it were. Even the names of the officials who claim to speak on their behalf are unknown to them. Since 1913 the letters which I alone have written to Approved Societies on behalf of patients who clearly—though unknown to themselves—were not receiving their due, either through fault of an agent, some unknown technical omission of their own, or other cause, have averaged at least twenty a week. I have never heard an insured person speak of his Approved Society in a filial spirit. When he has any picture of it at all it is generally as a kind of blend of Scotland Yard and the Board of Guardians.

#### RELATION BETWEEN INSURED PERSONS AND INSURANCE COMMITTEES.

8. Here, also, is an entire absence of personal relation. In my experience the insured person has nothing to say against the Insurance Committee. He has no knowledge either of its functions or its personnel. When he is aware of its existence at all, he generally ranks it with the Foreign Office and Socrates, as a world-phenomenon, remote and, to him, irrelevant and meaningless.

#### SOME GENERAL DEFECTS IN THE WORKING OF THE INSURANCE ACT.

9. The first and most striking defect, in my experience, is one arising out of the relations between the insured persons, the Approved Societies and the Insurance Committees, which I have described. It is the complete ignorance of nearly all insured persons, not only of the general principles of Insurance and of the Health Insurance Act, but of the regulations of the Societies, and consequently of the rights and benefits to which they are entitled, and of the penalties to which they are subject, and how those penalties may be avoided. They do not know when they are entitled to medical benefit—for many of them do not receive medical cards until they make individual application for them—nor under what conditions they will cease to be entitled. When their entitlement ceases they are rarely informed until they present themselves to their doctor for treatment, on whom, therefore, falls the unpleasant task. When they have reason to believe that they are not receiving the sickness benefit to which they are entitled, they have no notion to what tribunal they may appeal; nor, when it is established that they have been the victims of fraud or negligence, is there any tribunal before which they can hale the offending Society or official, as they are able to do with their doctor if he be thought to have failed in his duty. They read in the papers of penalties imposed on panel doctors, but never of a penalty imposed on their Society, which they therefore assume to be above the law.

10. A grave defect from the point of view of the insured person, as well as that of the conscientious doctor, and also that of the public health, is the dis-entitlement to medical benefit consequent on persistent unemployment. It seems absurd that a certain measure of poverty should be necessary to entitle a man to medical benefit under the Insurance Act, whilst a still further measure of poverty, entailing even greater need, should disentitle him. Many patients drop in and out of entitlement to medical benefit in the most disconcerting way, involving elaborate explanations on the part of the doctor and general disgruntlement on the part of the patient, and a lamentable discontinuity of treatment.

#### SOME DEFECTS FROM THE POINT OF VIEW OF EFFICIENCY OF MEDICAL SERVICE.

11. The general standard of medical competence is, of course, what it is, Insurance Act or no Insurance

Act. That different degrees of competence exist among doctors is as true now as in all times. The re-labelling of a general practitioner as "panel doctor" clearly has no effect on his technical skill or general ability, though it may on the spirit in which he does his work. I have not found that the removal of the commercial element—or at any rate its minimisation—through the financial system of the Insurance Act, has had any but a good effect on the spirit in which medical work is done. The technical aspect becomes almost the only one, and this can but be all to the good. It is doubtful if a man concerned only with his fees, rendered much more real service in the old private practice days than he does to his panel patients to-day. He may have been more oily in manner and more assiduous in paying visits, necessary and unnecessary; but these, probably, did just as much harm as good to his victims.

12. The work of certification certainly, as I have said, diverts a certain part of the doctor's attention from what should be his main problem. Also, it often introduces an element of suspicion as to the motive which led the patient to the consulting room. This, though I see no escape from it, seems to me the only inherent medical defect of the panel system.

13. Of the unnecessary and remediable defects I consider the most irritating to be the regulation which compels the useless recording of every attendance on every patient, no matter how trifling or even universal his ailment. To waste minutes in hunting up a Record Card and writing thereon such words as "acne," "cut finger," "dental caries," and the like, seems to me the merest robbing of the insured person of the time which rightly belongs to him. The only kind of detailed notes which could have the slightest value can clearly not be recorded for every patient. Such notes as it is practicable to make in the inevitable circumstances of a busy practice can

never serve any useful purpose whatever; nor does anyone imagine that they ever will. Few things are so constantly exasperating to the doctor anxious to do his best for his patients as the present system of compulsory medical records.

14. The principal limitations of utility of the present medical service under the Act seem to me to be these:

- (1) The falling out of benefit of insured persons through unemployment.
- (2) The limitation of medical benefit to certain members of a family only, so that, for the same ailment, one member of a family may receive adequate medical treatment, whilst other members can only afford very inadequate treatment.
- (3) The limitation of provided medical treatment to such as is assumed to be within the range of an average general practitioner. In my own case, thanks to the proximity of a large general hospital and the invariable courtesy and helpfulness of its specialist staff, this limitation does not press very hardly. But most men are not so well placed.
- (4) The general neglect of Insurance Committees to make use of their powers to organise public education of the people in the laws and principles of health.

In every district where local men exist with competence to express and experience in expressing in a popular way, to people who know them and respect them, the fundamental facts relevant to the personal care of health, the possibility of useful work exists. There would not be much point in sending official lecturers with standardised lectures into districts where they are not known. But if local material were used the value would be enormous.

## APPENDIX LII.

STATEMENT OF EVIDENCE SUBMITTED BY LT.-COL. W. BICKERTON-EDWARDS, C.B.E., M.B.,  
(late) R.A.M.C. See Minutes of Evidence of the Twenty-Eighth Day, Questions 16,194 to 16,345.

1. An opinion as to whether National Health Insurance has been a success or otherwise must be influenced by the original intention of those responsible for bringing it into being. If intended to be an integral part of a National Health policy I venture to suggest that the Act has not up to the present fully realised these anticipations. If on the other hand its functions were intended to include certification and general practitioner treatment of the sick, together with certain assured monetary benefits to the insured person during sickness, we may assume that it has been at least a partial success.

2. Before proceeding to a closer criticism of the working of the Act, the question which naturally presents itself is the following: Is a National Health Service or campaign embodying in it all branches of the medical service necessary?

3. The appalling condition of the people of the country has for long demanded that such a service is not only necessary but essential to our national existence. The conditions of living, of housing, of feeding, of clothing, and of employment are unspeakable, and were in some small degree exposed by our recruiting returns during the Great War. It is not possible here to enter into the appalling conditions that do exist amongst the masses, but that they do exist and should be remedied there can be no question.

4. If it is conceded that a Health campaign is essential it must naturally be asked does such a service with a clear cut plan of campaign under one directing body exist? If the answer to this question is in the affirmative, can it be explained why the

general practitioner is excluded from being a part of the machinery? Again, if a National Health campaign does exist under one directing body, how can the machine be effective unless there is complete control. Is there such control?

5. The branches of the medical profession concerned in the health of the nation are:—

- (1) The General Practitioner,
- (2) The Medical Officers of Health (including County and Local Medical Officers of Health), School Medical Officers, Tuberculosis Officers, &c.,
- (3) Specialists and Consultants,
- (4) Civil and other Hospital Staffs,
- (5) Ministry of Health.

Are these services so organised as to co-ordinate their efforts on one definite objective, or are they watertight and overlapping.

6. That you may possibly find on one day in a single small village:—

- (1) The County Medical Officer of Health,
- (2) The Local Medical Officer of Health,
- (3) The School Medical Officer,
- (4) The Tuberculosis Officer,
- (5) The Compensation Doctor,
- (6) The Factory Surgeon,
- (7) The Insurance Doctor,
- (8) The General Practitioner, and
- (9) probably his Assistant.

would lead one to think that overlapping in medical service and expenditure is rather the rule than the exception.

7. The only foundation upon which any Health Service can be built is the general practitioner. He constitutes the Front Line, and unless the Front Line be properly organised and supported the whole fabric of such a service, whatever it may be, must inevitably fail.

8. Let us take into consideration the actual life and conditions of service of the ordinary general or panel practitioner in any of the populous industrial districts. The working life of a general practitioner in an industrial area is short (probably not more than an average of 15 to 20 years), and during this period he has to live and maintain his family, and make provision for a period when he will be unable to carry on active work. He is on this account, therefore, forced to take on as much work as he can possibly obtain. The result is we find that, in addition to large panels, the general practitioner takes on the wives and children under contract, together with any public appointment such as vaccinator or parish doctor that he can obtain.

9. The almost invariable result is that:—

- (1) He is overworked and unable to do justice to himself or his patients, who consequently suffer.
- (2) He has no time for a careful and necessary study of his cases.
- (3) He has no leisure for reading or post graduate courses.
- (4) He has to strive for popularity which is not synonymous with efficiency.
- (5) His work is a hopeless routine of the hardest physical labour and mental anxiety, and is a continual fight against the forces of circumstances for which he is not responsible and which often prove too strong for him.
- (6) He is usually isolated literally or by opposition.
- (7) He has no train of institutions (as exist in London and other large towns) behind him to support, relieve and advise him. Whatever cases occur, however serious, however complex, he has to deal with them in their homes whether he is capable of doing so or not, he has to take them on as there is no other alternative. He either treats his cases or loses his patients.
- (8) As a panel practitioner he is not responsible for specialist treatment, yet if a specialist is called in he becomes responsible for the fees as only too frequently his patients cannot afford payment. The result is that the panel practitioner has to do specialist work. This means that the panel patient does not obtain specialist treatment. Frequently general practitioners are called upon to carry out operations which would tax the skill of a consulting surgeon. However sound a man may be as a general practitioner, it cannot be maintained for a single instant that a patient has the same chance under his hands, e.g., an abdominal operation in poor surroundings as under a skilled surgeon in a well-equipped hospital. The general public is not yet educated to understand the ramifications of medicine and surgery. To the ordinary man a doctor is a doctor, and as such, in their opinion, qualified in all branches of his profession. The panel practitioner does not, except perhaps in our large cities, obtain the services of specialists as frequently as should be the case.
- (9) Frequently in large areas of 50,000 to 60,000 inhabitants there is no isolation hospital, and infectious cases have to be treated in their homes, with the result that epidemics, heavier than they should be, throw an undue strain upon the general practitioner.
- (10) In the whole of Wales I think I am safe in saying that there is not one institution wholly devoted to the treatment of diseases of women and children.

(11) With rare exceptions general and panel practitioners constitute a splendid body of men, who under the most difficult conditions of service unselfishly endeavour to carry out an impossible task.

10. The National Health Insurance Scheme appears to me to be defective on its medical side in the following respects:—

- (1) Instead of, as was hoped, breaking down it has created monopolies, and has often placed those monopolies in wrong hands.
- (2) Popularity, not synonymous with efficiency, has produced large panels. Panels are not proportionate to merit.
- (3) Being an underpaid service, it induces medical men to take on more work than they can efficiently carry through. A visiting list of 50-100 for the day over a scattered area, and 50-60 patients twice a day in the doctor's consulting rooms worked out in minutes speaks for itself. The possibility or otherwise of doing justice to cases is obvious.
- (4) It may be maintained that it is a better paid service than that under the old Friendly Society system. This may be so, but the fact remains that a service which compels medical men to take on more work than they can efficiently perform in order to make a living wage is an underpaid service.
- (5) The lack of provision of specialist service is bad for both the panel practitioner and patient. Neither the patient nor the practitioner can afford a specialist, and he is therefore not called in.
- (6) There is no definite facility for institutional treatment for panel patients. The civil hospital, with a long waiting list, even when available, is not very helpful.
- (7) The panel practitioner is too isolated. He takes no part in his work as one of a team. No one recognises the work done by the good man, and no one condemns that done by the inefficient. The result is that there is no incentive to the sound practitioner and no deterrent to the incompetent.
- (8) The clerical work imposed on the panel practitioner is heavy and in some respects unnecessary. Of what possible value can records be as at present often compiled.
- (9) The panel practitioner, if an able man, has nothing to look forward to and must remain a panel practitioner. There is no incentive to outstanding work, he becomes a machine, he unknowingly enters a groove of least resistance with all that that implies. He has been called upon to carry out the impossible and he loses his self respect.

11. If the conditions of National Health Insurance and panel practitioners are to be improved, the scheme should be readjusted and remodelled in such a way as to:

- (1) Include the wives and families;
- (2) Allow increased sick allowances;
- (3) Prevent the necessity of overwork on the part of the medical practitioner;
- (4) Pay consultants;
- (5) Ensure proper and efficient institutional treatment;
- (6) Pay compensation in the case of death from disease, as in accidents, of the wage earner;
- (7) Organise the body of general practitioners in such a way as to give such service as will co-ordinate with and be the foundation of any scheme of National Health;
- (8) Retain the principle of free choice of doctor.

12. The following scheme is suggested:—

- (1) The whole country should be divided into areas.
- (2) Each area should have within it an area hospital with a resident medical officer, nursing staff, and ambulance car.
- (3) Each general practitioner in the area should be connected with his hospital by telephone.

- (4) Each hospital should have an X-ray apparatus.
  - (5) Convenient groups of hospitals should be served by bacteriological laboratories.
  - (6) Groups of hospitals should be linked up with base hospitals, and base hospitals should be extended to include orthopaedics, diseases of women and children, etc.
  - (7) Groups of hospitals should have staffs of whole or part-time consultants, preferably the former.
  - (8) A general practitioner, upon finding a case in his practice that he thinks unlikely to recover under home surroundings, either on account of bad hygienic conditions, lack of efficient nursing, or otherwise, should ring up the hospital and have the patient removed there by ambulance.
  - (9) Having the patient in hospital, and under good conditions, he could, if necessary, call upon the particular specialist required. He and the specialist in consultation would decide the course of treatment to be adopted. Should the case be one of severe operation, or likely to be a prolonged one, they might decide upon his removal to the base hospital. On the other hand, if of opinion that the patient would be likely to recover within a reasonable period, they might decide that he should remain at the area hospital under the care of the general practitioner. This would ensure as free a choice of doctor as is at present possible with an infinitely better service for the patients. It may be said that the above procedure is open to abuse in that certain practitioners would be prone to relieve themselves of responsibility by placing patients unnecessarily in the hospitals. Instances of this may occur, but no more frequently than at present in our larger towns. It can with safety be said that the patients of medical men of the type likely to shirk responsibility would be infinitely better out of their hands.
  - (10) Panels should be limited in size.
  - (11) The panel doctor should be better paid. He should feel that he is taking an important part in the National scheme of health. He should have opportunities for post-graduate study, bacteriological and other work at hospitals. He should feel that his good work will lead to something beyond the drab drudgery of a general practitioner. He should know and feel that he is an important member of the team and should be consulted in medical matters affecting the area in which he serves.
  - (12) His work should be subject to inspection. This suggestion will probably meet with opposition. Still, I consider it to be essential. A good man has nothing to conceal, and will not object. Though it would be impossible to find a finer or more conscientious body of men than the general practitioners of this country, yet it is no good concealing from ourselves the fact that there are unfortunately in the ranks of the medical profession a number of men whose work calls for close scrutiny and inspection.
13. Ignorance of their professional work, laxity in ethics, work, and certification does and will occur. Members of the public from lack of knowledge as to

the quality of the work are not in a position to safeguard themselves, and should be protected by strict periodical inspection by medical men capable of judging the type of work being carried on. The people have a right to demand that this should be done. Medical men paid from public funds have no sound reason to object.

14. My suggestions will, I fear, seem far fetched, yet I cannot see the alternative unless it is intended to perpetuate the present condition of things.

15. The general practitioner must be the foundation of any National Scheme of Health, and must be brought into line in that scheme of general re-organisation of the profession which must sooner or later take place.

16. I have ventured to put forward very imperfectly a scheme whereby this may be brought about, while still retaining free choice of doctor.

17. The question which naturally arises is: Where are the necessary funds to be found? At first sight this seems an insurmountable difficulty. Is it, however, not such a difficulty as first appears.

18. I venture to propose that a body of experts be appointed to investigate and report upon:—

- (1) Any possible overlapping in the medical services, and upon any economies that might be brought about by a re-organisation of those services.
- (2) The possibility of pooling of the existing funds concerned in the medical services of the country, either by counties or over the country as a whole.
- (3) The possibility of the creation of a Public Health Fund by an alteration in the Workmen's Compensation Act. As at present the Compensation Act demands that every employer shall insure against compensation. The uncertainty, litigation, necessary employment of special medical officers has made the working of this Act objectionable to both employer and employee. Masters and men consider it unjust in operation, and both sides are concerned at the enormous costs annually involved in the Law Courts. The Act, as it now stands, should be amended, and be replaced by what might be termed a Health Tax.

The form and amount of that tax is a matter for actuarial calculation and expert advice.

19. It is conceivable that by the pooling of all available funds and by a modification of the Compensation Act sufficient funds would be forthcoming within a reasonable period, available:—

- (1) To pay sickness benefit at a considerably higher scale than at present.
- (2) To include the families of the insured.
- (3) To pay compensation for loss of the wage earner by death, whether from accident or sickness.
- (4) For gradually enabling a National Health Scheme on the lines indicated to be evolved.

20. It would not be a matter of insurmountable difficulty to organise a system acceptable to all concerned whereby abuses and litigation might be reduced to a minimum.



## APPENDIX LIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE COUNCIL OF THE FRIENDLY SOCIETIES' MEDICAL ALLIANCE BY MR. S. A. SYDDALL, PRESIDENT, AND MR. SAMUEL PRIDE, SECRETARY OF THE COUNCIL. See Minutes of Evidence of the Twenty-Ninth Day, Questions 16,346 to 16,513.

## FRIENDLY SOCIETIES' MEDICAL INSTITUTIONS.

1. These Institutions were originally formed in various towns and industrial districts throughout the country by amalgamation of Friendly and Trade societies and their branches for the purpose of providing an efficient medical service for the members of such societies, their wives and dependants in lieu of the old and somewhat discredited system of "club-doctoring," under contract, by part-time practitioners who were also engaged in private practice.

2. Under the old contract system of "club-doctoring" there were many complaints as to the quality and efficacy of the medicines and treatment afforded to members and also regarding the disproportionate amount of attention given by the club doctor to his private patients compared with the service rendered to members of the Societies.

3. The lack or unsuitability of waiting-room accommodation, and the long periods of standing about in draughty passages or outside the doctor's residence, exposed to the inclemency of the prevailing weather, were also much objected to.

4. Friendly Societies' Medical Institutions provide efficient general domiciliary attendance and treatment. Drugs, surgical dressings, and appliances of high standard quality are also supplied to the members freely, as required.

5. The waiting rooms, dispensaries and consulting rooms provided by these Institutions are properly furnished and adapted for the purpose. There is no differentiation or invidious distinction in the treatment of patients.

6. In the year 1911 there were upwards of 100 Friendly Societies' Medical Institutions established in the provinces, 30 or more of them having buildings of their own, with a membership of about 350,000.

7. Many of these Medical Institutions have now, unfortunately, ceased to exist, owing to financial losses sustained and the difficulties which have arisen and hindered their operations under the Medical Benefit Regulations and administration of the provisions of the National Health Insurance Act.

## SECTION 15 (4)—NOW 24 (4)—OF THE INSURANCE ACT.

8. This sub-section was introduced by Mr. Cecil B. Harmsworth (Member of Parliament for the Luton Division) during the debate on the Second Reading of the National Insurance Bill in the House of Commons, primarily to protect the interests of Friendly Societies' Medical Institutions, and was prepared by the Government draughtsman especially for that purpose.

9. An assurance was given that the words thus inserted in the Bill were sufficient to safeguard the continuance of Institutions, and the Government Officers declared the amendment adopted by Parliament to be "water-tight" in all respects.

10. This sub-section became known as the "Harmsworth Amendment," and was greatly objected to at the time by the British Medical Association. The words "existing at the time of the passing of this Act," were specially inserted at the instigation of that organisation, and were, doubtless, intended to prevent the establishment or recognition

of newly-formed Medical Institutions, but the word "system" which is used in this sub-section is capable of a wide and generic meaning.

11. It is contended by the Council of the Friendly Societies' Medical Alliance that although no new "system" could be recognised for the purposes of the Act, the Minister of Health and the Insurance Committees have power to approve of new Medical Institutions established under the existing "system."

12. The Minister of Health and his official advisers have, however, decreed otherwise, and no newly-formed institutions have, since the passing of the Insurance Act been approved, or existing institutions permitted to extend the radius of their operations.

13. It is contended that when the Insurance Acts and the regulations thereunder made governing the administration of medical benefit are amended, facilities should be provided for the recognition of newly-formed Institutions and the extension of the radius of existing Institutions throughout our industrial districts, by the opening of branch surgeries.

## PAYMENTS TO INSTITUTIONS.

14. Approved Institutions are required to render service to insured persons not inferior to that of insurance practitioners, and it is a condition of their continued approval that Institutions shall be conducted in such manner as to comply with the terms of service of insurance practitioners, and with such other conditions as the Minister of Health may from time to time impose.

15. Payments by Insurance Committees to Medical Institutions for the service provided to insured persons are, however, in the aggregate, and in every area considerably less per capita than the amounts paid for similar service to insurance practitioners. This is most unfair and detrimental to institutions and their insured members. There should be equal payment for similar service under the Insurance Scheme.

## CHANGE OF DOCTOR OR INSTITUTION.

16. An insured person may, at any time, change from one doctor to another by simply presenting his medical card, completed in part B, to the doctor of his choice.

17. In cases of change, otherwise than by consent, between an Approved Institution and an insurance practitioner, or vice versa, notice must, however, be given in writing to the Insurance Committee before the 1st June or 1st of December, to take effect as from the 1st of July or 1st January following.

18. This invidious distinction and differentiation in procedure is not in the interest of insured persons. It is contended that one system of change should prevail, applicable to all insured persons, whether on the medical list of an Approved Institution or panel practitioner.

## REPRESENTATION OF APPROVED INSTITUTIONS.

19. Approved Institutions are not entitled to representation on Insurance Committees, although all other interests and bodies concerned or taking part in the administration of the benefits and provisions of National Health Insurance are directly represented thereon.

20. This disfranchisement should be remedied, either by regulation or an amendment of the Act, if such is necessary to enable Institutions to be represented.

#### THE FRIENDLY SOCIETIES' MEDICAL ALLIANCE.

21. This Alliance is a Federation of Friendly Societies' Medical Institutions registered under the Friendly Societies' Act, 1896, and approved by the Minister of Health and the local Insurance Committees for the purposes of section 15 (4)—now 24 (4)—of the National Health Insurance Act.

22. The objects of the Alliance are for mutual protection and the promotion of the interests and development of Friendly Societies' Medical and Approved Institutions.

23. In pursuance of these objects the Council of the Friendly Societies' Medical Alliance make the following recommendations:—

- (1) That newly-formed Institutions or Associations of Approved Societies or their branches and extensions of the radius of existing institutions be recognised and approved by the Minister of Health and Insurance Committees for the administration of medical benefit to insured persons and their dependants by an amendment of section 24, sub-section 4, of the National Health Insurance Act, omitting the words "existing on the sixteenth day of December, nineteen hundred and eleven."
- (2) That in constituting the Institutions Fund the aggregate amount credited to the Fund shall be determined by the number of insured persons found in each year to be entitled to medical benefit (including drugs and appliances) through Approved Institutions multiplied by the capitation fee payable for the period, and that any balance remaining after the discharge of the claims found to be due on the certificates of expenditure shall remain in the Institutions Fund.
- (3) That provision be made for credit to the Institutions Fund of a due proportion of the capitation fees allowed for the treatment of insured persons who have failed or neglected to make choice of a panel doctor or Approved Institution.
- (4) That the regulations be so amended to provide for uniformity of procedure by insured persons in regard to change of panel doctor or Approved Institution.
- (5) That cases which may be referred to the Regional Medical Officers for consultation and a further opinion shall not be confined to those cases only where the patient has been certified as incapable of work for a period of at least four weeks, but that it shall be open to any panel practitioner or Approved Institution to refer any case of an insured patient to such officer for a second opinion.
- (6) That provision be made for the direct representation of Approved Institutions upon local Insurance Committees acting for the area wherein such Institutions are established.

(7) That in the event of an extension of medical benefit to the wives and/or dependants of insured persons, Approved Institutions should be recognised for the provision of these additional benefits under any such scheme.

GEO. WISTOW WALKER,  
President.

SAMUEL PRIDE,  
Secretary.

8th November, 1924.

"The Woodlands,"  
Cromwell Hill, Luton.

#### APPENDIX.

##### LUTON FRIENDLY SOCIETIES' MEDICAL INSTITUTE.

The following figures illustrate the growing popularity and continuous increase in the insured membership of the Institute, notwithstanding the serious extent of unemployment in Luton and the district during the last three years:—

Just before the outbreak of War in August, 1914, there were on the register of the Institute 5,251 insured members.

During the War, owing to enlistments in H.M. Forces and other causes, the numbers fell to 4,654 insured members on 1st October, 1918.

After the War ended the numbers on the register rose continuously, without a break, until they reached:

5,659 insured members on 1st January, 1922.  
and 5,673 " " " 1st April, 1922.

The register was then thoroughly overhauled and purged of errors and duplications. Notwithstanding considerable additions, the numbers were reduced to 5,643 insured members on 1st July, 1922.

but quickly rose again to

5,672 insured members on 1st October, 1922.  
and 5,693 " " " 1st January, 1923.  
" 5,713 " " " 1st April, 1923.  
" 5,740 " " " 1st July, 1923.  
" 5,764 " " " 1st October, 1923.  
" 5,820 " " " 1st January, 1924.  
" 5,874 " " " 1st April, 1924.  
" 5,913 " " " 1st July, 1924.  
" 5,957 " " " 1st October, 1924.

The increase in the insured membership of the Institute during the last six years is 1,303.

The uninsured wives and dependants of members voluntarily contributing and entitled to treatment, medicine and appliances through the Institute number 3,873.

The total membership of the Institute is 9,530.

Three whole-time medical officers are in the service of the Institute, who, by their agreements, are strictly debarred from engaging in private practice.

Two up-to-date covered-in motor cars and two whole-time chauffeurs are also employed by the Committee of the Institute and are at the disposal of the Medical Staff for domiciliary visitation of patients in Luton and the surrounding villages, at any time during the day or night.

There are 20 doctors in Luton engaged in private practice, who are also on the List of panel doctors for National Health Insurance service.

The population of Luton, according to the Census of 1921, was 57,077 and is now estimated at 58,530.

## APPENDIX LIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE FRIENDLY SOCIETIES MEDICAL OFFICERS' UNION BY Dr. D. HOLMES, M.B., M.C., L.R.C.S., PRESIDENT, Dr. JOHN H. ROBERTS, M.R.C.S., L.R.C.P., SECRETARY, AND Dr. A. HAMILTON, M.B., C.M., MEMBER. See Minutes of Evidence of the Twenty-Ninth Day, Questions 16,514 to 16,706.

1. "Approved Institutions" were established under the terms of sec. 15 (4) of the National Health Insurance Act, 1911, known as the Harmsworth Amendment and accepted by Mr. Lloyd George, who stated that "Their interests should be safeguarded on account of their valuable pioneer work."

2. Approval was limited to Friendly Societies' Medical Associations in existence at the passing of the Act.

3. Having regard to the fact that over 250,000 insured persons have exercised their right to obtain medical benefit through these Institutions, the time is opportune to examine the record of the past 12 years' experience, and to determine if their continuance is necessary or what modifications in constitution or powers are called for.

4. The effect of repressive regulations immediately enforced was that a considerable proportion of these Institutions were soon starved to death; a portion of the remainder more slowly succumbed.

5. The survivors, among them The Coventry Provident Dispensary, are still struggling against misrepresentations and injustices which clog their activities and threaten their existence; a considerable number are in serious difficulties.

6. All representations by the Friendly Societies' Medical Alliance for redress have been ineffective.

7. Until the advent of Dr. Addison as Minister of Health, Medical Officers of Institutions were ignored, being considered apparently merely as fractions of "The Institution"—"its of an it."

8. Medical Officers are exasperated by the prolonged injustices which react upon them; they are too numerous to detail in full but chief among them are:—

- (1) Denial of representation to Institutions, which are an important factor in the general scheme of National Health Insurance.
- (2) Absolute refusal to consider the problems created for these Institutions by the Great War; the price of essential drugs advanced by from 200 to 300 per cent., and are still about 100 per cent. above pre-war prices, but *not one penny would the Commissioners grant on this account.*
- (3) The interpretation given to regulations, which have been held to apply to Institutions when injurious to them and their Medical Officers, but not to apply when advantageous to them; in furthering this procedure dialectic arguments are employed against us, and when these wax thin, the final resort is to invoke the "Provisions of the Act," as in the following instance quoted from a letter from the Ministry of Health, dated 30th December, 1921, which discloses one of the most glaring injustices:—"It follows that the payments to an Approved Institution being contributions towards the expenses of the treatment of insured persons . . ."

The supreme injustice of this is evident when it is pointed out that the essential condition of approval and its continuance, is, that:—"The treatment by an Institution shall not be inferior to that of the Panel Service generally."

9. The expenses of a well-equipped Institution are necessarily much heavier than those of a panel practitioner, but the *per capita* payments to the former

for the treatment of their panel members have always been much below those of the latter.

10. The Government insists on the best service and pays only part of the cost thereof; the balance has to be provided by exploitation of the resources of the Institution, and the Medical Officers have to submit to underpayment.

The injustices are of threefold character:—

- (1) To the Institution and its own provident members.
- (2) To the Medical Officers of the Institution who are vicariously sweated.
- (3) To the insured members themselves, who have exercised the right conferred on them by Act of Parliament, to receive their medical benefit through an "Approved Institution," who number not less than 250,000 throughout the Kingdom, and should not be subjected to sweated service.

11. Some few of these Approved Institutions endeavour to deal fairly with their Medical Officers, but their position is anomalous and in some cases ignominious. They are not on the panel, nor, with one notable exception, will the executive of these Institutions allow them any representation on their committees or any voice in the disbursement of funds which they alone earn for the Institutions.

12. Their duty to their patients demands the prescription of certain remedies, but the finances of the Institution will not permit it.

13. The committees who nominally control these Institutions and their Medical Officers are usually paid for all committee meetings, but in most instances control rests with a clique, and in many cases one individual—in some instances the secretary—dominates the position. In one noted Institution, it was a current saying "It is fatal to offend . . . the secretary."

14. Friendly Societies' Medical Associations, prior to the Insurance Act, obtained the services of a Medical Officer on the very lowest terms that one could be obtained. Two hundred pounds or less per annum, with a house, was common as a start. The work was simply prodigious, and he was considered and spoken of as the servant of the Institution, both by committee men and members: a phrase frequently used by a large Association, formerly employing two medical men, was, "We pays you—we keeps you—you're our servant."

15. There is a body called the "Friendly Societies' Medical Alliance"—somewhat mis-named—formed from representatives of Associations. This body has always ignored any representation, help, or advice, from their Medical Officers on any matters represented to the Commissioners or Minister of Health.

16. Its dominant policy is a sinister one to the medical profession; the enslavement of medical men under whole time contracts with penal clauses against any attempt to start in practice in the neighbourhood.

17. The doctor is their employee, liable to dismissal for no complaint or reason other than the will of the employer.

18. As at present constituted "Approved Institutions" violate the fundamental principles and intentions of the National Health Insurance Acts. They are a state within a state.

## RECOMMENDATIONS.

19. If these Institutions are continued, we make the following recommendations:—

- (1) That Medical Officers of Institutions shall be liable to answer personally to any complaint to the duly constituted tribunals for panel practitioners.
- (2) That no agreement shall be valid which in any way infringes the right of insured persons to free choice of doctor in the event of a Medical Officer leaving an Institution.
- (3) That *per capita* payments to Institutions shall be of the same amount and at the same times as payments to panel practitioners for a similar number of patients.

- (4) That in the dispensing department, scripts shall be furnished, and costing be adopted, similar to ordinary panel scripts, and payments thereon made on a similar basis.
- (5) That a separate banking account must be kept referring to the panel side of Institutions, which shall be duly and independently audited.
- (6) That the amount of remuneration paid to Medical Officers for the panel side work shall be subject to approval by the Ministry of Health

D. HOLMES, M.B., M.C., L.R.C.S.,  
President.  
JOHN H. ROBERTS, M.R.C.S.Eng.,  
L.R.C.P.LOND.,  
Secretary, F.S.M.O.U.

## APPENDIX LV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SOUTH WALES AND MONMOUTHSHIRE ALLIANCE OF MEDICAL AID SOCIETIES BY MR. WALTER CONWAY AND MR. EVAN PUGH, Secretary of the Alliance. See Minutes of Evidence of the Twenty-Ninth Day, Questions 16,707 to 16,926.

1. The South Wales and Monmouthshire Alliance of Medical Aid Societies begs to submit evidence before the Royal Commission with a view of amending the several Acts and Regulations, so that Medical Institutions may be treated in the same manner as medical practitioners who are on the panel. In the areas of Glamorgan and Monmouthshire Insurance Committees there are sixteen Medical Institutions approved under section 15 (3) or 15 (4) of the National Health Insurance Act, 1911, and attached to six of these Institutions there is a cottage hospital, where practically all operations are performed. The Alliance has on several occasions made efforts to have the disadvantages under which Medical Institutions labour as compared with medical practitioners on the panel, removed, but we find that it has not been possible, and on the last occasion the Alliance submitted their grievance to the Ministry of Health, it was suggested to them to submit the matters to the Royal Commission on National Health Insurance.

2. The matters that the Alliance wish to respectfully bring to the notice of the Royal Commission

relate chiefly to the unfair treatment and disabilities that the Medical Institutions labour under in connection with the National Health Insurance Acts in force at present, as compared with panel practitioners who may be or who are desirous of giving their services under the Act. A perusal of the appended statement containing the statistical and other evidence required by the Commission will we believe reveal the fact that the medical treatment meted out to the insured persons by Medical Institutions is at least equal to that rendered by the panel practitioner, and these Institutions therefore claim that the same facilities should be afforded them for participating in the provision of medical treatment for insured persons, and also to enjoy the same advantages as those afforded to the panel practitioners.

3. With a view to enabling the Royal Commission to appreciate the disadvantages under which the Medical Institutions labour at present as compared with panel practitioners, we submit the following comparative statement of the conditions of the panel practitioner and the Medical Institution respectively.

*Comparative Statement.**Conditions relating to Panel Practitioners.*

(1) If a medical practitioner is desirous of entering Insurance practice, he may do so by sending his application to the Insurance Committee for the area in which he is resident, and can only be refused on the ground that he has been previously removed from the Medical List.

(2) The Medical Benefit Regulations do not interfere with the expenditure of the State Grants received by the panel practitioner, but are solely designed to ensure adequate medical treatment for the insured person.

(3) Insured persons on the list of panel practitioners are governed by the rules on their medical vouchers.

(4) Panel practitioners have at least four direct representatives on Insurance Committees, also on Medical Committees which are consulted in respect to the general terms of service relating to panel practitioners, with further representation on the Medical Services Sub-Committees which deal with complaints between insured persons and panel practitioners.

(5) Insured persons on the list of panel practitioners can transfer to the list of another panel practitioner at any time, but can transfer to a Medical Institution only by giving notice to the Insurance Committees before 1st June or 1st December.

(6) The medical capital grants of insured persons who have not elected a doctor on the panel, or Institution for their attendance and treatment, are divided between the panel practitioners.

*Conditions relating to the Medical Institutions.*

(1) Application for Medical Institutions to become approved under section 15 (3) or 15 (4) of the 1911 Act generally meets with strenuous opposition from the Insurance Committees and it is only on rare occasions that any application has been approved in recent years.

(2) Regulations are in operation which not only govern medical attendance and treatment but also interfere with the expenditure of the State Grants, and attempts have been made by Insurance Committees to interfere with the funds obtained from other sources.

(3) The insured persons have the same rules on their medical vouchers but the Medical Institutions have to print at their own expense rules of a more expensive character which also interfere with their internal administration.

(4) No representation on either of these bodies.

(5) Insured persons on list of Medical Institutions cannot transfer except at the stated periods, 1st June and 1st December.

(6) Medical Institutions do not participate in the allocation of these un-allocated funds.

4. In conclusion, we would respectfully urge upon the Royal Commission the urgent necessity of removing these anomalies and disabilities which are in our opinion positively unjust in their operation towards our Medical Institutions, many of which have been highly commended for the scope and character of the services which they are rendering in the areas they are operating, by many authorities, amongst which we are proud to state is our Welsh Board of Health.

For and on behalf of the Alliance,

EVAN PUGH,  
Secretary.

#### APPENDIX.

(1) Persons included in the Scheme:—

Insured persons ...	40,000	
Un-insured persons ...	5,000	45,000
Dependants of above		60,000
		105,000
Total ...		

(2) (a) Sources of revenue:—

Contributions of workmen (colliery and iron-works).  
Contribution of other workmen.  
Capitation for insured persons.

(b) Collection of contributions:—

By deduction of an agreed sum per £ of wages earned, made at the works offices by arrangement between employers and workmen at a commission ranging from 2 to 5 per cent.  
Monthly contributions of other workmen, paid to the secretary.

(3) Content of medical benefit.

Medical attendance and treatment of members and dependants at their homes.  
Consultations with other doctors (specialists).  
Surgical operations.  
District nurses attending at their homes.  
Ophthalmic and dental treatment.  
Drugs, dressings and appliances supplied.

Other treatment benefit:—

Surgical appliances.  
Artificial limbs and eyes.  
Surgical boots.  
Dentures.  
Spectacles.  
Trusses, elastic belts and stockings.  
Cost of travelling to general hospitals and also convalescent treatment.

(4) Administration of medical benefits:—

In accordance with rules, registered under the Friendly Societies Act or approved by the Welsh Board of Health. A Committee appointed annually by the members, together with a representative of the medical officers.

(5) Finance:—

Receipts, contribution of workmen ... by cheque	} All paid into bank
Other workmen monthly ... by cash	
Capitation of insured persons ... by cheque	

Expenditure:—All payments authorised by Committee duly recorded in minute book and paid by cheque.

(6) Audit annually by chartered accountant, or public auditor approved by the Welsh Board of Health, and the accounts duly audited, submitted to the Welsh Board of Health previous to being published and a copy forwarded to the Insurance Committee in whose area the Society is situated.

## APPENDIX LVI.

### STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SOCIETY OF MEDICAL OFFICERS OF HEALTH BY DR. R. A. LYSTER, M.D., Ch.B., B.Sc., D.P.H., PRESIDENT, AND DR. J. J. BUCHAN, M.D., D.P.H. See Minutes of Evidence of the Twenty-Ninth Day, Questions 16,927 to 17,126.

#### GENERAL.

1. The Society of Medical Officers of Health represents a large majority of members of the medical profession engaged in the health service of the country. This service, primarily concerned in the preservation of health generally, has from the beginning recognised the impossibility of adequately discharging its function in disassociation from measures for the restoration of health to individuals. The health service is, therefore, not only engaged in all those broader aspects of public health such as are comprised in the improvement of housing, environment, education and food supplies of the people, the prevention of disease and the like, but is also deeply engaged in more intimate matters relating to the health of individuals in the community. A large variety of health workers are included in the service, among which may be mentioned, medical officers of health; pathologists and bacteriologists; school medical officers; maternity and child welfare medical officers; tuberculosis medical officers; venereal medical officers; hospital medical officers; dental officers; medical specialists and others officially connected with the work, all of whom the Society of Medical Officers of Health represent.

2. Medical Officers of Health and other medical officers of Local Authorities, have been associated with the National Health Insurance Scheme since its inauguration and they have followed closely and sympathetically its development and changes, more

especially in its effects on the health of the Nation. From the commencement their concern has been solely that of the improvement of the general and individual health of the people, and they feel themselves in a good position to express a fair and unprejudiced opinion of the results obtained under the Scheme.

3. While the Society of Medical Officers of Health fully recognise that much of the improvement in the social and economic and health conditions of the people is the outcome more or less indirect of the National Health Insurance Scheme, it can be stated at once that no real attempt has been made so far to attain many of the most important objects from a health point of view of the original scheme. Making every allowance for the exceptional circumstances and times under, and during which, the scheme has been in operation, it has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health, and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it.

#### ADMINISTRATION.

4. The National Health Insurance Scheme provides certain forms of assistance to a large portion of the population when physical disablement arises. It is not a pure mutual insurance scheme in which the funds are wholly subscribed by the insured persons; but it is essentially an aided insurance scheme, in which

the largest portion of the funds are contributed by the State and by employers through the operation of the statutes. In greater part the scheme is one for social and health improvement maintained and enforced by the State, yet it is to a great extent isolated from the other schemes of the State in operation and doing essentially similar work. On the one hand, the relationship of such work to that done by local authorities should be of a most intimate nature because (a) the work of local authorities in preventing sickness and physical incapacity and ameliorating disease reduces the demands on National Health Insurance and (b) the material assistance and medical treatment provided promotes the general health of the community. On the other hand a relationship of such insurance work exists with that done by the Poor Law authorities in so far as both are schemes of material assistance, the former preventing or lessening the demands on the latter. It is neither practicable nor advisable to attempt to set up at the present time any co-ordination with Poor Law authorities as at present constituted, except as will so far subsequently appear. It is more urgently necessary in the revision of the insurance scheme closely to co-ordinate the work done under it with that of the local health authorities, so that each community should secure the maximum benefit from a joint effort. Centrally it is true that the administrations are amalgamated in one Government Department, but such an amalgamation is of comparatively little value if the practical and detailed working of each in local areas is ill-co-ordinated or impossible.

5. Every attempt at co-ordination, either central or local, must have regard to points of difference as well as to points of similarity, and the chief point of difference between National Insurance work and that of local authorities, has relation to the source of funds financing each. In National Insurance the funds are subscribed by the insured person and his employer, while the funds of local authorities are raised by rates; in both cases contributions are made from the National Exchequer. The funds in National Insurance are not ear-marked for each benefit, but the contribution by the National Exchequer is nearly sufficient to meet the benefit in kind at present provided (medical benefit) while the money payments (the sickness disablement and maternity benefits) are more than sufficiently covered by the other contributions. It is reasonable that the administration of such funds as accrue from the whole contributions by insured persons and part of the contributions by employers should rest largely in the hands of the insured persons themselves, subject only to such general control as is required to protect public and individual interests.

6. The voluntary groupings of insured persons in Approved Societies for the purpose of controlling these funds as at present existing in this country, is defective and requires regulation and amendment. The Approved Societies are usually formed on national lines and without any regard to the health subdivision of the country, so that although their liabilities for sickness and disablement are largely affected by local health activity, relationships with the authorities responsible for the latter are practically non-existent. While this formation, no doubt, has advantages in averaging the liabilities of Approved Societies, it has the disadvantage, that it obscures the very intimate association that exists between the efficiency of local health work, and the work of the societies, and the support which each should give the other, is lost. The organisation of Approved Societies mainly on a national basis has not fostered the development of an interest in their work on the part of the insured persons themselves. Approved Societies are of many kinds and show considerable differences in this respect, but in general it can be said that the great mass of insured persons take little, or no interest in their societies, and in the case of the societies formed at the instigation of Insurance Companies which cover more than half of the insured persons in this country, such an interest does not exist, and has never existed. Approved Societies as at present existing, can have little, or no, part or function in the Health Insurance Scheme unless they can so arrange

their operations that they secure a genuine local interest in their work and a local management of their funds. This is a change of a drastic nature for the Approved Societies, involving many financial and other considerations; but in the interests of the public, the insured persons and the societies alike, it is one which can now be regarded as essential, if the aims of the original scheme are not to be abandoned. The Approved Societies in each area should be required to form themselves into a council for the area for purposes of negotiation and consultation with the local authority.

7. Representatives of the Approved Societies form the majority of the members of Insurance Committees which administer medical benefit and the benefits for deposit contributors, the remaining members being appointed by the County or the County Borough Council, the medical profession and the Minister of Health. This is not a committee of any other body, but is itself a body corporate. The great bulk of its funds represent the national contribution to the Insurance Scheme.

Insurance Committees have certain general public duties, but they have failed to be efficient instruments in the promotion of better health conditions on account of (a) the very indefinite character of their duties (b) their very peculiar constitution which results in their being composed, to a considerable extent, of men and women without a sense of responsibility to the public at large and (c) the disregard of a public for a body which has never been representative of them. Insurance Committees are as separate bodies corporate no longer required. Their duties would be more efficiently carried out by the local health authority, and any advantage that may be thought to accrue from a committee for this matter could as easily be secured by requiring the local authority to appoint such a committee with representation added for the interests involved. On such a new committee the local authority, and not the Approved Societies, should have a majority representation. Such a new Insurance Committee should, in addition to having to discharge the duties of the present Insurance Committees, have imposed upon it the duty of investigating the incidence of sickness among insured persons in the area as revealed in the records of medical sickness and disablement benefits, and advising the local authority thereon. For this latter purpose, Approved Societies and panel medical practitioners should be required to make such returns and reports to this Committee as the Minister of Health approves.

#### SICKNESS AND DISABLEMENT BENEFITS.

8. The Society of Medical Officers of Health regard sickness and disablement benefits as most important provisions in the restoration to health of the insured person, and the maintenance of health of his dependants. These benefits frequently form the chief source of income in families at a time of increased expenditure. The lengthened experience now of medical officers of health, particularly in tuberculosis, maternity and child welfare, and the health of the school child, has convinced them of the great part nutritional considerations play both in the preservation of health and the cure of disease, and local authorities in each of the departments of the work mentioned have regarded it as necessary, after consideration of special medical and other circumstances, in many cases, to make arrangements for additional nourishment to be supplied. Sickness and disablement benefits should not, therefore, be divorced in their administration from the general health work of the area, but they should, nevertheless, continue to be managed and controlled by Approved Societies. These benefits should not be uniform, but they should be fixed in amount within certain limits. The societies should have power to extend the amount beyond the minimum according to the needs of the individual and the nature of the illness, or condition, necessitating the benefit. Societies should not be permitted to increase a sickness or disablement benefit on account of the nature of the illness or similar condition without a proper medical certificate of its necessity. The initial step in this matter should be able to be taken by

either the society or the medical practitioner attending the case. No increase should operate without the consent of the local authority's Insurance Committee. Insured persons applying for an increased benefit should also have a right of appeal to the Insurance Committee. Societies should have power to call upon local authorities to supplement, or contribute, towards the continuance of the benefits in all cases where, but for the existence of increased sickness or disablement benefit, the insured person would require to be relieved by the poor or other rate. Further, the Society of Medical Officers of Health feel that sickness and disablement benefit should be capable of being administered so as to form an augmentation of income for sick or disabled persons actually employed. In many diseases, notably tuberculosis, a commencement of work is to be regarded as actually part of the treatment of the case, and the abrupt termination of sickness and disablement benefits where anything of the kind is attempted, leads to a delay in recovery in many cases and in some to the ultimate failure of the treatment altogether. The Society realise the difficult administrative procedure which such a system of payment of partial sickness or disablement benefit during attempted work would entail, but they feel that if the whole matter were gone into carefully in each disease, some arrangements, as for example tuberculosis workshops, could be made which would help to solve the difficulties involved.

#### MATERNITY BENEFIT.

9. This at present is said to be the mother's benefit in confinement administered by Approved Societies in the interests of the mother and child in cash or otherwise. In actual practice, in the great majority of cases, it is nothing of the kind, it is merely a cash payment made in confinement which is used by the recipient in any manner which she, or her husband, sees fit. It is clearly impossible for Approved Societies to administer this benefit properly in any other form than money payments, as apart from the fact that these societies do not possess the knowledge of the essential needs of maternity to enable them to administer the benefit in kind, they have no local relationships, and arrangements for its administration in kind in Penzance would not necessarily be feasible in Berwick. Local authorities have for many years now paid special attention to the health needs of their communities so far as maternity and child welfare are concerned. Since 1915, Maternity and Child Welfare Committees have been set up in each district of England and Wales, and there has been developed a large and important public service which has brought about an enormous improvement in the conditions affecting motherhood and infancy. Local authorities feel fully justified by their results to advance still further on the lines already laid down, and many, apart from any question of insurance, will undoubtedly do so. Maternity benefit, so long as it is administered in money payments, has aided, rather than impeded, the development of the work, but if any attempt were made by Approved Societies to administer it in kind, a chaotic condition of affairs would result and the whole work would be jeopardised. The Maternity and Child Welfare Schemes have involved local authorities in large expenditure frequently greatly exceeding the total amount of maternity benefit paid in their district. In one area, for example, the cost of this work for motherhood and infancy exceeds £5 per birth per annum over all the births in that locality. These schemes are of the same essential nature as maternity benefit, and the only practical method by which this latter benefit can be administered in the interests of the mother and child is by requiring local authorities to administer it through their statutory Maternity and Child Welfare Committees. Many local authorities are at present maintaining a maternity hospital, or beds in a maternity hospital; they are running consultation centres for expectant women; and they are paying medical fees when necessary in cases of midwifery. In order to administer this benefit satisfactorily, provision must be made for (a) medical supervision and examination

during pregnancy, (b) attendance by a doctor or certified midwife during the ante-natal period, the normal labour and the puerperium, (c) the attendance by a registered medical practitioner when required during these periods and requested by the midwife, and (d) institutional accommodation when necessary. Medical supervision in maternity must not be considered as a part of ordinary medical treatment; and ante-natal medical supervision of the mother should be regarded as an essential requisite to obtaining maternity benefit. In no case should double maternity benefit be given, even when the wife of an insured person is herself an insured person, and maternity benefit, even in money value, should vary according to the necessities of the mother and the medical character of the case both before and after confinement. Arrangements should be made to bring in the whole medical profession to co-operate in a fuller fashion in the health work of Maternity and Child Welfare Committees, but the present Maternity and Child Welfare Centres of local authorities must be maintained.

Local authorities should be required to prepare and maintain a list of all medical practitioners in their area who are willing to undertake duties in connection with maternity benefit, and copies of this list should be supplied to all mid-wives practising in the area.

#### MEDICAL BENEFIT.

10. So far medical benefit in the National Health Insurance Scheme has been curtailed to mean such domiciliary medical treatment and attendance as can reasonably be expected from general medical practitioners. The Society of Medical Officers of Health desire to record their opinion that the maintenance of a high standard of work in general medical practice is of the first importance in public health, but they are bound to recognise that the whole needs of insured persons in the preservation of, and restoration to, health cannot be met in this fashion. Medical science and treatment have become increasingly complex, and while this makes ever more exacting demands on the general practitioner, it opens up new lines of treatment which cannot be followed with advantage under the present curtailed arrangements for administering medical benefit. Financial considerations have in the past led to a restricted meaning of the words "medical benefit," with the result that local authorities and voluntary hospitals have felt themselves compelled to make provision of various forms of medical benefits, both of which have become increasingly popular with the public. The fact is not to be lost sight of that insurance funds other than the State contribution have up to the present done exceedingly little to provide such medical benefit as exists for insured persons, and it is safe to predict that whatever sums may become available in the future, these will be insufficient to provide for an adequate medical benefit for insured persons and their dependants. The Insurance Acts contain provisions for contributions by local authorities towards medical benefit, but it is easy to understand why this has not been acted upon.

On the other hand local authorities themselves have spent large sums on services which are covered by a wider reading of the term "medical benefit." Thus one local authority is already paying for general hospital treatment alone more than the total amount paid to all panel practitioners in their own area for medical benefit. Medical benefit should be administered by the local authority through its insurance committee, and a commencement should be made to give medical benefits its true meaning by including (a) facilities to the medical profession for laboratory diagnosis (b) specialist advice and treatment (c) dental treatment (d) treatment in general hospitals and other like institutions (e) further accommodation for the treatment of tuberculosis, especially surgical tuberculosis (f) treatment in convalescent homes (g) home nursing when required (h) all other necessary medical advice and treatment (including the provision of such nursing, dressings and equipment as may be necessary). This is an extensive and costly programme which has already been begun by many local authorities but which will take many years to

carry out fully. It is unlikely to be attempted under the Scheme of National Health Insurance as it at present exists.

11. The need for some genuine co-ordination of all the medical agencies in every area has long been severely felt, and the intricate and costly nature of the provision necessary for the people constitutes an additional reason for a full co-operation of all the institutions and personnel taking part in this work. The medical profession as a whole have been too exclusively concerned in the curative aspect of their work, and it is essential in the general health interest of the country that they should be encouraged, by every reasonable means, to take a more active part in the prevention of illness. Medical benefit should, therefore, be regarded as not merely a means of restoration to health, but also as a means of preservation of health, and it should include a health supervision of persons not already ill. Health authorities and Medical Officers of Health earnestly desire a closer co-operation and an increasing interest of the medical profession in preventive work. While it is true that this in a general way has been attained under the present arrangements of the National Health Insurance Scheme, it is believed that medical practitioners should in the future have a direct interest in maintaining the patients' health. Varying payments should, therefore, be made to medical practitioners for work in this capacity, the funds for such payments being drawn from any saving resulting from decreased sickness or disablement payments. The Society of Medical Officers of Health does not desire to discuss methods of payments for medical benefit except to point out that up to the present there has been no special inducement, or reward, for good work, and there has been no inducement for preventive work. They would like to add that in many cases coming under their notice, a uniform flat rate payment is unsuitable, as for example, in tuberculosis when a patient for the preservation of his health requires, it may be for many years, constant medical supervision.

Further, in order to promote a full co-operation of the medical profession with the local health authority, there should be established in each area, a local medical committee for consultation with the authority on the medical work of the area and for taking over the work now done by the existing Local Panel Committee and the existing Local Medical Committee, both of which should be abolished. The new Local Medical Committee should be representative of all registered medical practitioners practising in the area and its approved administrative costs should be borne by the local authority.

#### EXTENSION OF BENEFITS.

12. Reference has already been made to the changes necessary in existing benefits which, under the Insurance Scheme, are treated as additional benefits. The extension of benefits to persons not already insured, is, however, a different matter. Two classes of these persons call for attention—(a) dependants of insured persons and (b) poor persons without earned income. In the first of these classes, the need for medical treatment of the wives and children of insured persons is, from a national and health point of view, even greater than that for the medical treatment of the insured person himself. Reference has already been made to the costly nature of the provision necessary for adequately dealing with this subject and to the fact that a start has already been made by most local authorities to meet the more important needs of their populations in this respect. These authorities are already deeply interested in the health of the children up to five years of age, in the health of the school child up to the time he commences work, and they would be able to link up the various agencies required in each locality in a way which no other bodies could do. For the supervision of the health, and the restoration to health, of dependants of insured persons, arrangements are required somewhat similar to those for the insured person himself, but in the case of young life, the preventive aspects of medicine and the detection of defect or disease in its earliest stage are of even

greater importance than in the adult. The health and school medical services during the past 18 years have been developing organisations and institutions for this latter work especially, which now cover the country and have reached large dimensions. The results of this work have been so encouraging that the authorities concerned feel justified in its fuller development and with the experience they have gained, this would not be a difficult matter. Here again, the general medical practitioner would be required to play an important part, not merely in the cure of disease but also in its prevention. Much greater benefit would be derived by the community by the further development of the work done by local authorities, than by any extension of medical benefit to dependants, as medical benefit is understood in the present Insurance Scheme. It is to be clearly understood that all the work done for these dependants of insured persons by local authorities is equally available to dependants similarly situated who have no relationship to an insured person, and it would be unwise for any community to make a distinction in the matter.

For the poor a medical service at present exists under the Poor Law comparable with that under the present medical benefit arrangements. The service is handicapped by the fact that it is controlled by an authority usually disliked by the respectable poor. This causes delay in many instances in seeking medical aid, and there is no reason why the sick poor should be dealt with as a separate class of sick. The Society of Medical Officers of Health is strongly of opinion that whatever arrangements are made for the insured sick should be made available for the poor sick, and that the poor law medical service, at least so far as its out-door work is concerned, should be abolished. Such a change would be readily and inexpensively made by transferring the administration of medical benefit, as extended, to the local authorities.

#### MISCELLANEOUS.

13. The present duties of Insurance Committees in relation to propaganda and education in matters affecting health, have been very fitfully carried out, and with advantage these duties could be placed on local authorities.

The Approved Societies should be encouraged to take an interest in all questions of health and excessive sickness and should be free to make such representations to the local authorities as they see fit, and ultimately to the Minister of Health.

The administration of all the benefits in all their details should be subject to the Minister of Health, who should form an ultimate Court of Appeal, and who should retain in his hands the right of collective bargaining on behalf of local authorities, if he sees fit. With respect, however, to any matters dealing with professional ethics, involving in any degree by implication conduct infamous in a professional respect, the Court of Appeal should be the General Medical Council.

#### SUMMARY.

14. (1) The main function of the National Health Insurance Scheme is to promote the health and social welfare of the people by the distribution of money payments under certain conditions, and by the institution, or furtherance, of measures for the preservation of, and restoration to, health. The Scheme is at present so isolated from kindred branches of public work that it suffers great limitations in its power of carrying out its function.

(2) The need for a closer relationship between the National Health Insurance Scheme and public activities of a like kind is felt, both centrally and locally, and there is in local and detailed administration an absence of any effective system of co-ordination and mutual co-operation in endeavouring to attain the same ends.

(3) For the purpose of distributing payments in money, groupings of insured persons in Approved Societies form a not unsatisfactory instrument.

(4) The distribution of money payments in sickness and disablement has a definite and close relationship



to health conditions. Great advantages would, therefore, follow the grouping of insured persons in Approved Societies on the lines of the areas of local health administration in the country. Approved Societies should be empowered and required to carry out their function of distributing money payments so as to secure the maximum benefits both from a health and a social point of view.

(5) The present Insurance Committees have failed to make full use of their opportunities to help materially the health progress of the nation. Their constitution is faulty: they do not command sufficient local respect and their health functions are very indefinite.

(6) Insurance Committees should cease to be bodies corporate and committees of local authorities should be substituted in their place.

(7) In order to promote a full measure of co-ordination and co-operation, in each area there should be established:—

- (a) Where more than one Approved Society is operating in the area, a Council of Approved Societies for purposes of negotiation and consultation with the local authority.
- (b) A local medical committee representative of all registered medical practitioners practising in the area, for purposes of consultation with the local authority on medical matters and for undertaking the duties of existing panel committee and the existing local medical committee, both of which should be abolished.

(8) Sickness and disablement benefits should not be administered at a uniform rate, but within prescribed limits in accordance with the needs of the insured.

(9) Sickness and disablement benefits should in certain circumstances be able to be paid in part even when the insured person is partly employed.

(10) Maternity benefit, whether in its present, or in an extended form, should cease to be administered by Approved Societies and be administered both in money and kind by local authorities; which, in their turn, should be made definitely responsible for providing medical attention. The attendance upon maternity cases should not be an obligation upon a panel practitioner.

(11) Maternity benefit should provide for all necessary medical attendance in pregnancy and maternity, and medical benefit should be understood to be exclusive of such medical attendance.

(12) Medical benefit should be administered by local authorities through their committees, with, or without, outside members.

(13) Medical benefit should be extended so as to provide insured persons with all necessary treatment and nursing in illness.

(14) Medical benefit should be so administered that good work done by medical practitioners in the preservation of health should be rewarded.

(15) The advantages of medical benefit as extended should, as far as possible, be made available to the dependants of insured persons.

(16) The advantages of medical benefit, as extended, should be made available to the poor and the Poor Law Medical System abolished.

## APPENDIX LVII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE BRITISH HOSPITALS ASSOCIATION BY MR. H. WADE DEACON, C.B.E., CHAIRMAN OF THE COUNCIL, THE RT. HON. VISCOUNT HAMBLEDEN, HON. TREASURER, AND MR. J. COURTNEY BUCHANAN, C.B.E., HON. SECRETARY. *See Minutes of Evidence of the Thirtieth Day, Questions 17,127 to 17,285.*

The points on which the Representatives would desire to give evidence are as follows:—

1. It is found in practice, as originally anticipated by Hospital Authorities throughout the country when the Insurance Bill was before the House of Commons in 1911, that the treatment of insured persons by panel practitioners is incomplete because no satisfactory provision for hospital treatment was made in the Bill.

2. Since the inception of the National Health Insurance Act hospitals have always examined and, where necessary, treated, without discrimination between persons insured and persons uninsured, cases coming to the hospitals either on reference from their medical attendants or upon their own initiative.

3. All sick persons attending the Voluntary Hospitals must necessarily be examined by a medical officer before being allowed to depart, the greatest care being taken that no person be sent away in a serious or dying condition.

4. The Voluntary Hospitals have felt very severely the general financial stress since the War, the expenses of most hospitals having increased at least 75 per cent., and many over 100 per cent., beyond the expense of completing a similar number of cases in the year 1914. It has become necessary to ask for contributions from patients when they can afford to contribute something in order to help to meet the increased cost of upkeep, and the collection of such contributions and the receipt of contributions in respect of patients have been important factors in keeping open many hospital beds.

5. The hospitals acknowledge very warmly the attitude taken up by those of the Approved Societies which have arranged with the representatives of The British Hospitals Association to make contributions for the maintenance of in-patients entitled to extra benefits out of the accumulated funds after the last quinquennial valuation; but, inasmuch as these funds cannot be used in any form for the benefit of patients who are not entitled to the benefits at the period of the last quinquennial valuation, a heavy percentage of insured persons are being treated for whom no extra benefit is available.

6. The sum contributed voluntarily by the Approved Societies on behalf of the members entitled to such help varies considerably; but in no instance does this help amount to more than a proportion of the average cost per occupied bed per week.

7. While the value of the in-patient accommodation provided at the Voluntary Hospitals has been recognised by some Approved Societies, the admission of patients as in-patients represents only one side of the Voluntary Hospitals work and no contributions are made by Approved Societies to the general out-patient work, which also is of great economic value not only to the State as a whole but also to Approved Societies in particular by enabling members to return to their work more quickly after illness or accident.

8. The out-patient special departments of the Voluntary Hospitals, i.e., the dental, throat, nose and ear, massage, electro-therapy departments and special clinics, are utilised for special cases, not only in the general diagnosis of the patients' complaints,

but also in their subsequent treatment and relief. All of these special departments are extremely expensive to the hospitals.

9. Since the Inception of the National Health Insurance Act the necessity for medical treatment has become more apparent to the population; and, whereas in the past, patients attended at the out-patient department of their own volition, the number attending is found to be increased by direct reference of patients from and by their panel doctors.

10. The tendency is for the out-patient department to become more and more consultative and patients appreciate the value and the benefit of treatment by the consulting staff at the hospital. It has been ascertained that approximately 50 per cent. of those attending at the hospital come directly on the advice of their medical attendants.

11. Financial help should be given towards the provision of clerical assistance in communicating diagnoses or written reports to the panel practitioners for the assistance of insured persons in their general medical treatment and by consultations, in order that

serious diseases and conditions may be diagnosed and dealt with in as early a stage as may be possible.

12. The proportion of insured persons to the total number of cases admitted, and also the proportion of such insured persons for whom contributions are at the present time received from Approved Societies are indicated by the figures furnished to the Royal Commission.

13. In any provision made for the treatment of insured persons it should be clearly recognised that the Voluntary Hospitals are anxious to preserve their voluntary status.

14. There should be no contract to treat; but inasmuch as insured persons and their employers are alike contributing towards the cost of medical necessities in order to secure the adequate treatment of insured sick persons, the important rôle filled by the Voluntary Hospitals in supplementing the work of the panel practitioners and in furnishing the additional services unfortunately required in so many cases, should be recognised by practical assistance from Insurance Funds.

TABLE  
The British Hospital Association Insurance Return, 1924.

Hospital.	(a) No. of In-Patients admitted.			(b) No. of Insured Persons included in (a).			(c) No. of Persons for whom contributions have been received or claimed.		
	1st Quarter	2nd Quarter	3rd Quarter.	1st Quarter.	2nd Quarter.	3rd Quarter.	1st Quarter.	2nd Quarter.	3rd Quarter.
University College ... ..	1,205	1,185	1,112	271	308	293	148	128	168
General Hospital, Birmingham...	1,675	1,766	1,670	524	510	545	124	147	160
Derbyshire Royal Infirmary ...	1,197	1,216	1,193	464	427	385	180	169	161
Royal Infirmary, Bradford ...	830	832	811	335	360	331	141	129	135
General Hospital, Nottingham...	1,234	1,125	1,270	743	620	760	148	146	166
Guy's Hospital ... ..	2,316	2,336	2,452	714	643	719	284	209	248
Royal Victoria Infirmary, New- castle-on-Tyne.	3,254	3,188	3,287	1,298	1,259	1,251	369	363	370
Metropolitan Hospital ... ..	477	434	439	129	114	99	66	71	62
Wolverhampton and Staffs ...	828	885	917	343	362	384	127	132	128
Liverpool Royal Infirmary ...	1,247	1,191	1,257	352	324	365	115	106	144
Manchester Royal Infirmary ...	2,796	2,597	2,774	1,055	1,070	1,156	413	367	369
E. Suffolk and Ipswich... ..	594	677	566	165	201	288	29	41	42
Dundee Royal Infirmary ... ..	1,467	1,446	1,530	651	628	669	200	167	136
Middlesex Hospital ... ..	1,441	1,394	1,454	556	504	564	277	279	311
Radcliffe Infirmary ... ..	1,389	1,390	1,343	511	470	443	257	164	215
West London Hospital... ..	632	609	626	137	135	156	84	86	66
St. Thomas's Hospital ... ..	2,559	2,405	2,602	653	706	786	260	266	330
Cardiff Royal Infirmary ... ..	1,159	1,051	1,220	408	418	464	—	82	—
London Hospital ... ..	3,178	3,047	3,090	757	754	767	279	266	229
St. Bartholomew's Hospital ...	2,183	2,226	1,988	758	699	629	313	324	272
	31,661	31,000	31,601	10,824	10,452	11,064	3,814	3,642	3,712

## APPENDIX LVIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SHEFFIELD JOINT HOSPITALS' COUNCIL BY SIR HENRY HADOW, C.B.E., CHAIRMAN OF THE COUNCIL, AND MR. S. R. LAMB, M.B.E., SECRETARY. See Minutes of Evidence of the Thirtieth Day, Questions 17,286 to 17,383.

THE JOINT HOSPITALS' COUNCIL REPRESENTS THE FOLLOWING INSTITUTIONS:—

SHEFFIELD ROYAL INFIRMARY.  
SHEFFIELD ROYAL HOSPITAL.  
JESSOP HOSPITAL FOR WOMEN.  
CHILDREN'S HOSPITAL.  
EDGAR ALLEN (ORTHOPEDIC) INSTITUTE.  
CONISBORO' RECOVERY HOME FOR WOMEN AND CHILDREN.  
FULWOOD RECOVERY HOME FOR MEN.

1. The principal object of National Health Insurance is to promote a satisfactory National Health Service.

2. Under existing conditions a National Health Service is not complete without the co-operation of the Voluntary Hospitals.

3. The Voluntary Hospitals, especially in University cities, attract some of the very best brains in the medical profession.

4. The equipment, especially in a Teaching Hospital, is becoming increasingly elaborate and expensive. (Light treatment, electro-therapy, X-ray, team work of medical research, scientists in pathology, bio-chemistry, bacteriology, physiology, etc.)

5. This pooling of specialists in a Voluntary Hospital which is available to panel doctors is of considerable value to National Health.

6. We are encouraging the view that a Voluntary Hospital should be used largely for consultative and operative work, and a consistent effort is maintained to discourage treatment being given in the out-patient department of our Hospitals which could equally effectively be given by a panel doctor.

7. During 1923, however, 3,247 casualties per month were received into our Sheffield Hospitals, and patients, thinking probably that the family doctor may be away from home, are of the opinion that they will secure prompt service by attending a Voluntary Hospital.

8. The tendency of modern medicine and surgery is that observation, diagnosis and treatment can best be carried out in an institution rather than in the patient's home or the doctor's own surgery.

9. Hospital out-patient facilities such as X-ray, massage, electro-therapy, etc., are becoming of increasing value to the employer, the wage earner and the State in restoring a patient to health and employment.

10. Whilst consultants continue to give their services gratuitously to Voluntary Hospitals, should not our hospitals receive payment from National Health Insurance Funds towards administrative costs (clerical assistance, etc.) in the provision of consultative service given by hospital specialists for insured persons at the request of the panel doctor?

11. We gratefully recognise the readiness of a certain number of Approved Societies who are reimbursing the Voluntary Hospitals a sum towards the

maintenance cost, in hospital, of their members who were in membership with the Approved Society concerned at December 31st, 1918.

12. It is considered that the out-of-pocket expense of maintaining insured in-patients and out-patients in a Voluntary Hospital should fall on National Health Insurance Funds.

13. In any case, such expenditure by the Voluntary Hospitals on insured persons should, in future, be the first claim on the Quinquennial Surplus declared by the Government Auditor.

14. In connection with any payments received from National Health Insurance Funds, it is of importance that such financial grants shall in no sense impair the voluntary character of the hospitals receiving grants from National Health Insurance Funds.

NATIONAL HEALTH INSURANCE FUNDS AT  
DECEMBER 31st, 1918.

	England and Wales. £	Proportionate figures for Sheffield City. £
Approximate accumulated reserve for future liabilities ... ..	92,781,000	1,250,000
Surplus after every liability had been allowed for by the Government Auditors ...	15,000,000	200,000
Annual value of above Surplus distributable during the Quinquennium ended Dec. 31st, 1923 ... ..	3,000,000	40,000

Statement of Costs of Insured Persons (National Health Insurance) receiving Voluntary Hospital Treatment.

Name of Sheffield Hospital.	No. of N.H.I. in-patients admitted during 1923.	Total and average cost of N.H.I. in-patients.	Proportion of total cost of all in-patient service.	No. of N.H.I. out-patients treated during 1923.	Total and average cost of N.H.I. out-patients.	Proportion of total cost of all out-patient service.	Total cost of providing service to N.H.I. patients.	Total amount of voluntary contributions received from Approved and Friendly Societies.	Grants towards patients' maintenance from last Quinquennial Surplus.	Total and average amount received from N.H.I. Funds.
Royal Infirmary	1,735	£ 13,012 10 0 (£7 10s)	33	4,847*	£ 1,817 12 6 (7s. 6d.)	19	14,830 2 6	£ 18 0 0	£ 2,092 0 0	£ 2,110 0 0 (†£1 4 4)
Royal Hospital	1,170	9,550 2 6 (£8 3s. 3d.)	31.4	10,200	1,445 0 0 (2s. 10d.)	21.2	10,995 2 6	26 0 0	1,822 0 0	1,848 0 0 (†£1 11 7)
Jessop Hospital for Women	316	2,923 0 0 (£9 5s.)	16.1	222	122 11 3 (11s. 0½d.)	8.5	3,045 11 3	11 17 0	331 0 3	342 17 3 (†£1 1 6)
<b>Total for 1923</b>	<b>3,221</b>	<b>25,485 12 6</b>	<b>—</b>	<b>15,269</b>	<b>3,385 3 9</b>	<b>—</b>	<b>28,870 16 3</b>	<b>55 17 0</b>	<b>4,245 0 3</b>	<b>4,300 17 3</b>
Joint Hospital Council's Convalescent service 1924	787	3,928 10 6 (£4 19s. 10d.)	60	—	—	—	3,935 0 0	Nil	807 4 4	807 4 4 (†£1 0 6)
<b>TOTALS ...</b>	<b>4,008</b>	<b>29,414 3 0</b>	<b>—</b>	<b>15,269</b>	<b>3,385 3 9</b>	<b>—</b>	<b>32,805 16 3</b>	<b>55 17 0</b>	<b>5,052 4 7</b>	<b>5,108 1 7</b>

\* Not including casualties.

† Per in-patient.

## APPENDIX LIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE MIDDLESEX HOSPITAL BY MR. A. E. WEBB-JOHNSON, C.B.E., D.S.O., F.R.C.S., DEAN OF THE MEDICAL SCHOOL, AND MR. WALTER KEWLEY, SECRETARY SUPERINTENDENT. See Minutes of Evidence of the Thirtieth Day, Questions 17,384 to 17,482.

### SPECIALIST REQUIREMENTS.

1. The present medical service obtained by the insured patient is such as is only within the competence of the average general practitioner. Experience in the out-patient department of a large General Hospital reveals the undoubted fact that a

considerable number of patients included in the Insurance Scheme require treatment by a specialist.

2. It is certain that in these days of well-defined specialism the patient secures the best advice obtainable by transferring his case to the care of a hospital.

3. In large towns a workable scheme of close co-operation with the Voluntary Hospitals to cover

the above class of patient should be well within the bounds of possibility, and in more scattered districts the deficiency could be met by establishing specialist clinics at convenient centres to which the patient could be referred by his medical attendant.

#### INSTITUTIONAL TREATMENT BENEFITS.

4. The absence of any organised provision for general institutional treatment is unquestionably a serious matter.

5. To carry out an Insurance Scheme to its logical conclusion provision should be made for the insured person whatever the nature of his malady. At present the more serious cases have to come into a Voluntary Hospital, and, except in the instance of members of Approved Societies, which are in a position to make grants on their behalf as additional benefits from accumulated funds, the cost of this treatment falls upon the hospital.

6. The conditions should be so amended that the Voluntary Hospitals should be placed in a position to deal with these cases even if capital expenditure became necessary to furnish them with adequate accommodation for this purpose.

7. Full use should be made of the advantages which the Voluntary Hospitals afford for dealing with certain classes of diseases. The large Hospitals are the necessary homes of medical education and research work in close connection with their clinical work and teaching. Public health and the interests of the patients themselves would be best served if the efforts of the State were made in close co-operation with existing Institutions instead of independently, as is too often the case.

8. This lack of combination inevitably limits the success of a new movement and withholds from the old-established organisations additional facilities for the advancement of medical education and research, whilst it also deprives the patients themselves of the most efficient treatment.

#### TREATMENT OF INCURABLE CASES.

9. A further defect of the Insurance Acts is that no satisfactory provision is made for incurable cases which may require treatment over a lengthy period, e.g., cancer. An insured person under present conditions may have paid his combined contributions for many years without requiring any benefits under his insurance; yet if he is then stricken down with some incurable malady his disablement benefit is totally inadequate to provide the necessary attention, and is a poor return for all the insurance money paid on his behalf. The treatment benefits should surely include a way of securing efficient care for this class of patient.

#### PREVENTIVE TREATMENT BENEFITS.

10. The value of preventive treatment is not sufficiently recognised under the Acts. Practical preventive medical treatment for systematic detection of disease is far better than waiting to attempt the cure of developed conditions.

11. For this purpose facilities for, and encouragement of, a system of an annual overhaul of insured persons should be effected. Power to give a certificate of temporary unfitness to work—carrying with it a period of treatment at a convalescent home with a view to prevention of serious illness and a complete breakdown would prove of great benefit. This and many other additional benefits, which are now provided from surplus funds, could, with advantage, be included in the principal scheme.

12. The present efforts towards prevention as exemplified in co-operation between Public Health Authorities and the Hospitals in their existing Maternity and Infant Welfare Centres should be more general and might well be extended to cover other phases with the greatest advantage to the whole community and the improvement of the standard of the life of the nation. This way lies true economy in insuring its health and eventually diminishing the demands upon Hospitals and Institutional accommodation.

## APPENDIX LX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INSTITUTE OF OPHTHALMIC OPTICIANS BY MR. OWEN AVES, F.B.O.A. (HONS.) CHAIRMAN, MR. FRANCIS T. GREGG, M.A. (DUBLIN), SECRETARY, AND MR. JAS. FORREST, M.B., Ch.B., F.R.C.S. See Minutes of Evidence of the Thirtieth Day, Questions 17,483 to 17,617.

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#### APPENDICES.

- A. Summary of Towns showing approximately the Number of Ophthalmic Surgeons and Qualified Opticians.
- B. Comparative Tables showing the Contrast between Medical Refractive Service in Industrial Towns and Health Resorts.
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#### WITNESSES.

MR. OWEN AVES, F.B.O.A. (HONS.), Chairman of the Institute of Ophthalmic Opticians; Member of the Executive Committee and of the Council of the British Optical Association; Minute Secretary of the Joint Council of Qualified Opticians; Member of the Optical Standards Committee.

MR. FRANCIS THORNTON GREGG, M.A. (Dublin), Incorporated Secretary; Secretary of the Institute of Ophthalmic Opticians; Secretary of the Refraction Hospital.

MR. JAMES FORREST, M.B., Ch.B., F.R.C.S. Ophthalmic Surgeon, Vice-President of the Institute of Ophthalmic Opticians.

#### THE INSTITUTE OF OPHTHALMIC OPTICIANS.

1. The Institute of Ophthalmic Opticians was founded 20 years ago (1904) for the education and for the improvement of the status of opticians; it was incorporated 27th July, 1905.

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Its members number over thirteen hundred qualified persons, and they are limited to those who hold.

- (1) The qualification by examination for sight-testing of the Worshipful Company of Spectacle Makers;
- (2) The qualifications of the British Optical Association; or
- (3) The qualifications of the State Boards of Registration for Qualified Opticians in those parts of the British Empire which have already adopted legislation for the regulation of sight-testing opticians.

#### NATURE OF THE EVIDENCE.

2. "Taking the results as a whole, no student of social conditions can fail to be impressed by the financial strength of the system of National Health Insurance and by the capacity of the system to minister to some of the most urgent needs of the industrial population." (Government Actuary. Cmd. 1882, par. 76.)

It is in a spirit of full appreciation of the truth of this statement, and a desire to render it equally true with regard to the additional benefits, that the Institute of Ophthalmic Opticians offers the following evidence, with special reference to the administration of optical treatment to insured persons under the Act. One of the additional benefits under the National Health Insurance Act is "Payment of the whole or any part of the cost of optical treatment and appliances."

3. Briefly, such treatment consists of the testing of sight and the supply of the necessary spectacles to persons entitled to this benefit. Ever since the use of spectacles for the correction of visual defects became a practice, the major portion of this work has been in the hands of the optician, who has, by individual effort and by collective organisation, used every effort to attain a high standard of efficiency in this work.

4. The question of the training and qualifications of ophthalmic opticians having been raised in the recent Report of the Departmental Committee on the Causes and Prevention of Blindness the Council has thought it proper to submit specific evidence on this point, which evidence will be found at a later stage in this Statement.

5. At the present time qualified opticians in this country are not registered by the State, but for the purpose of rendering the fullest assistance to Approved Societies in the administration of optical benefits, a register was formed by the Joint Council of Qualified Opticians. This body was founded in 1921, and consists of representatives nominated by the Councils of the British Optical Association and the Institute of Ophthalmic Opticians, together with members elected by the persons on the register.

#### THE INSTITUTE AND OPTICAL BENEFIT PROPOSALS.

6. In the summer of 1921 a charitable association, formed for the purpose of administering the additional benefits, approached the Council of the Institute of Ophthalmic Opticians with suggestions for a scheme whereby the Institute members should work under the said charitable association for the provision of optical treatment and the supply of spectacles, the reason given by the secretaries of the association being as follows:

That the Ministry of Health had approved and issued tentatively a Model Schedule for the various Approved Societies who desired to administer optical benefits. This Schedule provided that spectacles should only be paid for by the Approved Society if made up to the prescription of a medical man. . . . That the Approved Societies were not bound to accept the Model Schedule, but had power to alter or amend the same, as the outstanding feature of the system of administration set up by the Act was the placing of the control very largely in the hands of the insured persons themselves. They further informed the Institute Council that they had advised many Approved Societies in their own

Association to amend this clause so as to enable the prescribing of spectacles to be undertaken by qualified opticians, as they were of opinion that the work would be much more efficiently and economically carried out by those who had been specially trained for this work, than by medical men, the majority of whom had absolutely no knowledge of refractive work.

7. Negotiations between the said charitable association and the Council of the Institute of Ophthalmic Opticians continued for some time, but eventually broke down.

#### THE JOINT COUNCIL OF QUALIFIED OPTICIANS.

8. Negotiations with the said charitable association having failed, the Councils of the Institute of Ophthalmic Opticians and the British Optical Association co-operated to form a special association legally empowered to administer optical treatment by opticians who possessed recognised qualifications for sight-testing, and the Joint Council of Qualified Opticians was the outcome of these negotiations. In drafting regulations for the administration of optical treatment, the Joint Council of Qualified Opticians made very exhaustive inquiries to ensure that the insured persons should receive the fullest possible benefits under the Act.

9. The result has been that, whatever the means of the insured person—and it is to be remembered that the income of the great majority of these is less than £150 a year—he or she is guaranteed:—

- (1) That wherever he may reside he is able to take full advantage of the facilities for optical treatment without unnecessary expenditure of time and money, as the 2,500 registered opticians are widely distributed and accessible to insured persons in practically every town and in many villages throughout the country.
- (2) That whilst retaining his right to consult a medical practitioner—should he so desire—the insured person is given, within the wide limits of the register of the Joint Council of Qualified Opticians, absolute freedom of choice as to the selection of the optician he may prefer to consult. The last provision is highly desirable, as it must be remembered that an overwhelming majority of those who need optical treatment are long established clients of practising opticians, or are members of the families of such clients.

10. That the regulations laid down by the Joint Council of Qualified Opticians were right in principle and have worked with remarkable success, will be shown by the evidence which that body is submitting to the Commission.

#### OPPOSITION TO QUALIFIED OPTICIANS.

11. A certain, though small, section of medical practitioners interested in refraction work appears to have been disturbed by the fact that the large majority of insured persons obviously prefer to consult a qualified optician when requiring optical treatment. Representations were therefore made to the Council of the British Medical Association with a view to bringing pressure to bear upon the Ministry of Health to make certain alterations in the method of administering optical benefit.

12. These alterations appear to have been definitely drafted with the object of precluding the insured person from visiting a qualified optician for optical treatment, and compelling those having visual defects to visit first their panel doctor and then to proceed to an ophthalmic surgeon for a prescription before glasses can be supplied.

13. The following particulars taken from the official organ of the British Medical Association support the above views:—

"Subsequently to interviewing the Ministry of Health a conference was arranged between representatives of that body and of the British Medical Association.

"The British Medical Association consulted with the Council of British Ophthalmologists on this question, and Dr. Wallace Henry raised the matter of State recognition of opticians. But the opinion of the Council of British Ophthalmologists was that as the conference was called for the specific purpose of considering optical benefit—or, to use the expression they preferred, ophthalmic benefit—under the Insurance Act, they could take no action in the matter. It was, however, resolved to appoint a committee to consider the question of State recognition of opticians, and to invite the Council of British Ophthalmologists to co-operate with the Association and send five representatives.

#### ALTERNATIVE SCHEME PROPOSED BY OPHTHALMOLOGISTS.

14. "A joint Sub-Committee appointed to take conjoined action arrived at the following decisions with regard to which an interview with the Minister of Health was sought:—

(a) That the so-called 'Optical Benefit' shall be designated 'Ophthalmic Benefit.'

*Ophthalmic Benefit would include examination and prescription for spectacles, if required, and such operative treatment and advice as can be given at a single consultation at the consulting room. A report, when necessary, shall be given for the guidance of the medical practitioner.*

(b) That in order to ensure the satisfactory working of the proposed scheme, it is essential that the insured members of every Approved Society should, in any case of ocular disorder or visual defect, apply to their insurance practitioner.

(c) If the insurance practitioner considers the case one requiring special advice or treatment, he should give the applicant a certificate which would enable him to consult a specialist at a reduced fee and, at the same time, a list of the ophthalmic medical practitioners in the district in which he resides who are willing to see him for such a fee.

(d) A list of ophthalmic medical practitioners qualified and willing to see insured members of Approved Societies at a consultation fee of £1 1s. should be prepared in accordance with the following principles:—

(i) that he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character, or

(ii) that he has had academic or post-graduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid, or

(iii) that he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

(e) That a list be prepared of opticians who are willing to supply optical appliances prescribed by medical practitioners for insured members of Approved Societies in accordance with an agreed schedule of charges.

(f) *In the event of the surplus funds of an Approved Society being insufficient to allow of its paying the specialist's reduced fee of £1 1s. for consultation, the patient himself will be required to furnish any amount additional to that which the Approved Society is able to grant for this purpose."*

#### RELATIVE SCOPE OF "OPTICAL" AND "OPHTHALMIC" TREATMENT.

15. The Council would desire to draw special attention to those parts of the above extract which they have emphasised, as they clearly show that every insured person, as well as every Approved Society, would be adversely affected by these drastic and retrograde proposals were they adopted.

16. In reference to paragraph (a), whilst the Council would heartily approve the inclusion of ophthalmic benefit as an additional benefit to insured persons, and would agree that the suggested reduced fee of one guinea is very reasonable to cover medical and surgical treatment for such cases, it would respectfully point out that the correction of refractive errors, and the giving of prescriptions for spectacles, does not come under the above category. In addition, the Council would point out that as the very great majority of ocular defects are cases requiring optical treatment solely, and not medical or surgical attention, the proposal to include these at such a fee in the case of the insured person would be extremely unwise as well as uneconomic.

17. Reference to the Appendix to the Minutes of Evidence, Section B, paragraph 212, of the present Commission, which deals with the subject of optical treatment and appliances, shows that

"This benefit appears to be most in demand next to dental treatment. . . . It is not a benefit which ordinarily costs a great deal. The average cost may be taken at about 15s. or less."

Now the 15s. here mentioned covers the opticians' fee of 6s. for sight-testing, together with glasses in utility steel frames.

18. It is obvious, therefore, that the suggested alterations put forward by the Ophthalmic Benefits Committee would act in such a manner as to cause unreasonable and, in the majority of cases, intolerable hardship to the insured person, inasmuch as the average amount of 15s. grant per case, which the Approved Societies have hitherto allowed toward the cost of treatment and glasses, would be more than absorbed by the fee for the ophthalmic surgeon's prescription alone. So that the insured person would not only have to pay the balance of the fee, but, in addition, the total cost of the necessary spectacles.

19. Every patient would also be required to expend additional time—and in many cases money—to consult an ophthalmic surgeon for further examination and prescription at a "reduced fee" of £1 1s. As will be seen by reference to Appendix A of this Statement the mere cost of travelling to an ophthalmic surgeon, apart from fees, is in many cases a very serious item.

20. The argument that the Societies might make a grant for optical treatment which would be sufficient to prevent the insured person being burdened with this heavy and unnecessary additional expense is not founded on any firm basis of practical experience, as such munificent Societies would be few and their membership small in comparison with the large Centralised Societies for which the Joint Council of Qualified Opticians' scheme especially caters.

21. The Council of the Institute would further point out that the suggestions made to the Minister of Health, as quoted above, are not only fraught with serious financial difficulties to the insured persons and Approved Societies concerned, but are totally unworkable for other reasons.

#### EXTENT OF REFRACTIVE DEFECTS.

22. In the first place, refractive defects are so widespread that it would be a physical impossibility for the comparatively few medical men who have any real knowledge of refraction to cope with a tenth of the cases which require optical treatment. The incidence of refractive errors is difficult to estimate with exactitude, but various authorities have given it as ranging between 25 per cent. and 60 per cent. of the total population. Taking the mean of these ratios gives something over 15,000,000 persons

who require optical treatment. Assuming that re-examination is necessary on an average once in two or three years, this requires the services of at least 3,000 refractionists to do the work efficiently. This refers only to those cases requiring refractive treatment; there remain to be considered those cases of defective sight due to accident or disease. Here again statistics vary, but putting the incidence as low as 10 per cent. of eye cases, there remains a number of over a million persons who need, and should have, first claim to the attention of competent ophthalmic practitioners.

#### INSURANCE PRACTITIONERS' OBJECTIONS TO THE ALTERNATIVE SCHEME.

23. In the second place, the suggestions require that the already overworked insurance medical practitioner should make a preliminary examination of every patient requiring glasses, to find out whether special advice or treatment is necessary. Such a preliminary examination calls for both time and skill if the certificate required is to represent the conscientious opinion of the medical practitioner.

24. This considerable and additional work of examination and certificate writing to the oculist is apparently to be imposed on general medical practitioners as a further part of their panel duties, without fee or reward, regardless of the fact that the overwhelming majority of them freely admit that they do not understand refraction defects sufficiently to enable them to give an opinion, and that for this very reason they prefer to send their patients to the qualified optician or to the hospital.

#### GEOGRAPHICAL DISTRIBUTION OF EXISTING REFRACTION SERVICES.

25. It is not generally realised how small is the number of ophthalmic surgeons, nor how totally inadequate is their relative distribution throughout the country. In this connection the Council of the Institute of Ophthalmic Opticians, knowing the difficulties which many private patients experience in procuring skilled ophthalmic service locally, in cases where ocular disease is present, recently caused a full enquiry to be made in order to ascertain the actual situation in this respect. The evidence obtained was of such a startling character that the Council ordered the results of the investigation to be tabulated.

26. It will be seen upon reference to the tables annexed (Appendix A) that over 500 reports were received from 358 centres, covering practically every important city and town in the United Kingdom.

The returns in many cases have been checked against a number of independent reports from the same town, and the results may therefore be considered as adequately showing the numerical strength of the respective types of refraction service. These tabulated results show, amongst other pertinent facts, the respective numbers of:—

- (1) Qualified Ophthalmic Opticians.
- (2) Ophthalmic Surgeons.

27. The number of Qualified Opticians is definitely and easily ascertained.

The number of Ophthalmic Surgeons devoting themselves entirely to ophthalmic work, appears to be generally well known, and little difficulty was experienced in obtaining correct records so far as they were concerned.

28. The number of practitioners "doing a certain amount of sight-testing" is, however, extremely difficult to compute, owing to the uncertainty where the line should be drawn. The results sent in indicate that only some of these (viz., a few of the 490 names sent in) might rightly be called ophthalmic practitioners, as there were submitted many names of doctors who test very occasionally, and with so little knowledge of the subject that even cases of simple astigmatism, etc., are referred by them to the local qualified optician or hospital.

Even if these doubtful names were included, the list would still be so small as to be absurdly inadequate for a public refractive service.

#### THE FAILURE OF THE MODEL SCHEDULE.

29. Referring again to the Model Schedule in connection with the administration of optical benefits in the Appendix prepared by Government Departments for this Commission (Section B., Ch. V., paragraph 212), the following passage appears:—

" . . . it is estimated that 3,750,000 members may have the right to apply for it. In one very large Society the claims have numbered 500 a week. There are, however, in connection with it, somewhat similar difficulties to those which have been indicated in the case of dental treatment. The model schedule provides that 'payment in respect of the cost of an optical appliance shall only be made on the production of a prescription from a qualified practitioner or a hospital,' practitioners meaning, of course, a medical practitioner. In some instances, and in particular in rural districts, it has been found that to insist on this condition precedent to obtaining the benefit, might cause, in some cases, hardship, or be tantamount to a denial of the benefit, or would involve a considerable and possibly unnecessary, expense. In a few schemes, therefore, the strict enforcement of this condition has been relaxed."

30. The exact nature and wide extent of the difficulties thus briefly mentioned by the Ministry of Health will be better understood by a close scrutiny of the tables given in Appendix A. herewith. From this it will be clearly seen that, without the full co-operation which qualified ophthalmic opticians have rendered by means of the scheme of the Joint Council of Qualified Opticians, the efficient administration of optical benefit would have been quite impossible except in a very few areas. The large majority of towns have no resident ophthalmic surgeon at all, and the table shows the very considerable distances insured persons would have to travel to avail themselves of the services of the whole time ophthalmic surgeon. A great many towns have not even a general medical practitioner who does occasional sight-testing, and in those great cities where the number of ophthalmic practitioners is apparently large, it is in reality small, and out of all proportion to the population of the city area and its environs which these practitioners are called upon to serve.

31. Indeed, the only towns which have a number of ophthalmic practitioners which might be considered as being in any way commensurate with the refractive needs of the population, are those negligibly few health resorts tabulated in the lower section of Appendix B., which are chiefly inhabited by well-to-do residents who are able, of course, to meet the fees of the ophthalmic surgeon. On the other hand, the first group of towns mentioned in Appendix B., namely, the industrial towns, are extremely badly served in this respect, the proportion of medical practitioners and ophthalmic surgeons combined, to qualified opticians being only seventeen to fifty-five.

32. The perusal of the hundreds of original reports makes it quite obvious that in industrial areas—where insurance benefits are most needed—the number of ophthalmic practitioners is hopelessly inadequate, the medical practitioners in such districts being far too overworked to undertake sight-testing.

#### OPHTHALMIC SERVICES AVAILABLE.

33. The main duties for which an ophthalmic surgeon receives his specific training are the diagnosis and treatment of ocular disease, and due consideration should be given to the fact that many of these gentlemen hold a number of public appointments as consulting ophthalmic surgeons to hospitals, institutions, asylums, education committees and so forth, a considerable proportion holding as many as four or five appointments each. It will thus be readily understood that they are not left with much leisure time to undertake the further responsibilities of adequately attending to the refractive needs of insured persons.

34. When we consider the number of general medical practitioners "doing a certain amount of

refraction work," the case for the testing of the insured person by such medical refractionists is still worse. As already indicated, the number small as it is, compared with that of the qualified ophthalmic optician, would be further depleted were any attempt made to eliminate those medical men who are not competent as refractionists.

35. The perfunctory testing by the few general medical practitioners attempting this work, with in many cases, incomplete equipment, is totally inadequate to meet the needs of the insured person. The fact that such a small proportion of persons have hitherto gone to medical refractionists for testing when given the opportunity of freedom of choice is the best proof of these statements.

#### MEDICAL PRACTITIONERS AND OPHTHALMOLOGISTS.

36. A critical examination of the "principles," which are suggested for the preparation of the "list" of ophthalmic practitioners qualified and willing to see members of Approved Societies, reveals the difficulty of forming a panel of really qualified ophthalmic practitioners sufficiently large in numbers and universal in local distribution, to serve the needs of the insured person.

37. To those inexperienced in appraising professional qualifications at their true value the principles marked (i) and (iii) in paragraph 14 appear to have a validity which they do not in reality possess. Members of the Commission who have had experience of the training of students in hospitals and other institutions which afford "special opportunities for acquiring special skill and experience" will fully appreciate the comment of the Council that students benefit but little by such "special opportunities" unless spurred to greater effort by the necessity of having to pass a practical examination in the subjects there taught.

38. The Council of the Institute has personal experience of this specific matter, but as such evidence might be considered *ex parte*, we submit the following extract, taken from a report dealing with the training of medical students, presented to the General Medical Council by the ophthalmologists themselves, which condemns in no uncertain terms the practice of considering hospital attendance as being in itself evidence of the possession of special skill.

" . . . Moreover, at other institutions the interpretation of what is meant by three months course varies widely and should be more accurately defined. . . . In Great Britain only a small minority of the licensing bodies apply regularly a test of ophthalmic knowledge."

39. " . . . It is the opinion of the Council of British Ophthalmologists that the knowledge of ophthalmology possessed by the majority of medical students at the time of their qualification is inadequate to enable them to diagnose and treat efficiently cases of ordinary eye disease met with in general practice.

" . . . Teachers in the medical schools are well aware that, without the stimulus of an examination, many students give the least possible attention to ophthalmology and may, and often do, finish their training without gaining even a rudimentary knowledge of the subject."

40. If the above statements of the Council of British Ophthalmologists as regards the insufficiency of general ophthalmological knowledge amongst medical practitioners are correct—and the Council of the Institute has every reason to think, and much evidence to show, that it is so—how much more true is it of the medical man's knowledge of that still more highly specialised and highly technical subject of practical refraction, to which the qualified ophthalmic optician devotes the whole of his training.

#### OPHTHALMIC OPTICIANS AS COMPETENT REFRACTIONISTS.

41. The Council considers that it cannot be stated too definitely or emphasised too clearly that refraction is highly specialised work, requiring considerable theoretical training and practical technical ability,

and, above all, patient and painstaking investigation of each case presented for examination.

42. Despite the Report of the Departmental Committee of the Ministry of Health on the Causes and Prevention of Blindness, the Council submits that the qualified ophthalmic optician is as fully equipped for the efficient practice of refraction work and for the detection of ocular disease, as the qualified ophthalmic surgeon is for the treatment of ocular disease. On this point the following evidence is submitted.

43. The training of the qualified optician is not only intensive with respect to the theory and practice of refraction but is also extensive concerning matters cognate to, and arising out of such practice. Beginning with a basis of mathematics the optical student proceeds to the specific study of geometric optics and the properties of lenses. His further studies include ocular anatomy and physiological optics, on which foundation he is then taught the principles of sight-testing and the correction of refractive errors. Lastly he is taught to detect abnormal cases which require medical or surgical attention, in order that he may fulfil his ethical obligation to the public to pass on for medical advice those cases which require other than optical treatment.

44. The examinations of the British Optical Association, and of the Worshipful Company of Spectacle Makers are conducted by eminent ophthalmic surgeons, refractionists, and physicists, and are admittedly searching in character and comprehensive in scope.

45. As evidence that the Council is justified in maintaining that the training and examinations fully protect the public, and will bear the strictest investigation, the fact is mentioned that the Institute and other optical organisations have repeatedly requested the Ministry of Health to make thorough and searching inquiry into the facilities for training and the methods of conducting the examinations for optical qualifications for diplomas in refraction.

#### OPTICAL TRAINING AND QUALIFICATIONS.

46. The Council being conscious of the difficulty of advocating the claims of qualified opticians in a sufficiently just and adequate manner, while maintaining a modest and correct demeanour, submits the following evidence in the form of outside opinions and reports of ophthalmic practitioners, and other persons of recognised standing.

##### *An Eminent Ophthalmologist.*

47. Over twenty years ago an eminent ophthalmologist wrote of the organisation and training of sight-testing opticians as follows:—

"An organisation, though regarded by medical men as a step backwards, is, in my opinion, a considerable progress. . . . Schools and colleges have come into existence where opticians are given instruction in every branch of their daily work, and especially in the determination of refraction.

"In the interests of the public at large it seems to me desirable that this work of a very special character should be taken from the medical practitioner, who necessarily has to charge high fees on account of his social status and his years of previous medical study, a great part of which is of no importance in the case under consideration."

##### *The Spectacle Makers' Company.*

48. In 1903 the Worshipful Company of Spectacle Makers received a memorial signed by the late Lord Kelvin and other scientific men and Members of Parliament, praying for an inquiry into the desirability or otherwise of sight-testing by non-medical practitioners. A committee of investigation was appointed, consisting of the Right Hon. Lord Aldenham, M.A., Sir Marcus Samuel (now Lord Bearsted), the Right Hon. Sir Wm. Hart Dyke, Bart., M.A., Lieut.-Col. Sir Horatio Davies and others.

49. The conclusions of this Committee, "based on elaborate expert evidence, were to the effect that:



fitting spectacles and adapting lenses to correct mechanical defects of vision is an art or profession wholly distinct from those of medicine and surgery," and that it was eminently desirable that the optician should test vision, and that a theoretical and practical examination affecting this part of his practice should be added to the Company's examination scheme. This verdict was endorsed by Sir William Crookes, Sir William Abney, Lord Rosse, Sir Robert Ball and other eminent scientific men. It was decided accordingly that a theoretical and practical examination in sight-testing should be instituted.

#### *The British Optical Association.*

50. The British Optical Association, formed in the year 1896, issues after examination, two qualifications: the Fellowship (F.B.O.A.) and a Final (F.B.O.A. Hons.). It fosters the production of the skilled sight-testing optician, and the far-reaching scope of its examinations has earned the warm commendation of many ophthalmic surgeons. The late Sydney Stephenson, Esq., F.R.C.S., wrote in the "Ophthalmoscope" as follows:—

51. "Those conversant with the facts will be the last to deny that some of these skilled opticians do their refraction work remarkably well. They are well trained, and, for that matter, their methods are much the same as our own. They often take wonderful pains with their clients. The equipment of their testing-rooms would in many instances put the modest outfit of some ophthalmic surgeons to the blush. . . ."

"The rules and practice of the Association have been modelled on those which prevail in the Medical and Dental Professions. It aims at raising its diplomates to a professional grade; inculcates ethical principles; and sets its face strongly against anything approaching blatant advertisement on the part of its members. It enforces discipline by withdrawing its diplomas from holders, and its power to do so has been upheld by a recent legal decision. The aim of the British Optical Association, in short, is to render opticians better qualified for their work, and to enforce a code of ethics upon its members."

52. Its examinations are conducted by eminent physicists and ophthalmic surgeons and cover the whole field of subjective and objective sight-testing. They include papers on anatomy, physiological optics and the detection of abnormal or diseased conditions of the eye.

#### *Opticians and the Detection of Disease.*

53. As further evidence that the optician is fully capable of detecting diseases and abnormalities, to which such frequent reference is made in the Departmental Report, the following passage is quoted from the letter of a well-known ophthalmic surgeon.

"The dangers which attend the ordering of glasses by qualified opticians are, in my opinion, exaggerated, and the fact that many persons with defective vision complicated by eye disease have been advised to seek medical treatment by the optician from whom they sought advice, has been overlooked in a most ungenerous way.

"In my private practice during the year 1922 (up to date) I have seen 236 patients who were refused treatment by qualified opticians and advised to consult an oculist, on account of errors of refraction complicated by disease of the eye which comprised:—

- (1) Cataract.
- (2) Glaucoma.
- (3) Detachment of the retina.
- (4) Choroiditis.
- (5) Macular changes accompanying myopia.
- (6) Optic neuritis.
- (7) Blepharitis.
- (8) Strabismus.
- (9) Congenital defects.
- (10) Errors complicated with heterophoria.

"This must be the experience of many oculists . . . ."

"That the general public has confidence in the optician who knows his work is indisputable, and that the trained optician has abused this confidence has never been proved.

"The present state of affairs with regard to the treatment of defective eyesight is highly unsatisfactory; anyone, without the least knowledge of ophthalmic work, can practise as an unqualified oculist, and legislation makes no attempt to protect the public . . . ."

"It is a gross injustice to class the trained optician with the 'quack,' and I therefore consider that it would be in the interest of the community to have an official register of opticians, as in the case of midwives who are allowed to conduct normal cases of labour irrespective of the fact that serious complications may arise in the process of their work, when they may demand the services of a medical practitioner."

54. As to the relative efficiency of the training of the qualified optician in refraction work, as compared with the training of the medical students and ophthalmic practitioners, the Council would refer the members of the Commission to the letter of Freeland Fergus, Esq., M.D., F.R.F.P.S.G., in Appendix C.

#### *EXAMINATION THE PUBLIC CRITERION OF ABILITY.*

55. The Council respectfully submits, that the passing of an approved examination in sight-testing is the only practical test of ability, and that in the administration of a public service affecting millions of His Majesty's subjects, qualification by actual examination in the work specifically involved is the only reliable criterion.

56. It was for this reason (amongst others) that the Council definitely requested the Ministry of Health to make searching enquiry into the various examinations which are held for the purpose of issuing diplomas for refraction work, a request which it regrets to state—as appears from a letter received from the Ministry of Health, dated November, 1924, the Department is reluctant to grant at present.

#### *GOVERNMENT DEPARTMENTS AND OPTICAL ORGANISATIONS.*

57. There is another point on which the Council considers it desirable that evidence should be submitted, that is the apparent lack of cognizance of, or recognition of, optical organisations by the Government Departments in considering problems affecting the eyesight of the public.

58. The model schedule referring to optical benefits appears to have been drafted by the Ministry of Health without consultation with any of the representatives of the organisations representing qualified opticians. So far as the Council of the Institute is aware, neither the British Optical Association, nor the Spectacle Makers' Company were approached by the Ministry prior to the issuance of the model schedule referred to. Certainly the Council of the Institute of Ophthalmic Opticians was not consulted in the matter.

59. With all due deference, the Council would point out, that in the public interest it is desirable that in the administration of a national scheme dealing with optical treatment and the supply of spectacles to millions of insured persons, the fullest information should be obtained from official optical organisations, such as those above referred to, and the most serious consideration given to suggestions emanating therefrom.

60. It has been the traditional policy of the Institute of Ophthalmic Opticians since its foundation, while supporting the interests of the qualified optician, to attach prime importance to the safeguarding of public interests both in relation to efficiency and economy, and had the Council been so approached by the Ministry of Health, it would have maintained this ideal of public service in any suggestions it conveyed to the Department.

61. The question of accessibility to various Government Departments is admittedly a difficult one, but it has always been a tradition of British rule that all sides should be heard, and in a matter which vitally

affects the status of a considerable number of highly-skilled practitioners, the Council would strongly urge that in any re-drafting or amendment of regulations pertaining to optical treatment and the supply of spectacles the Institute and other similar organisations of qualified ophthalmic opticians should always be consulted.

62. The moderate language in which the above request is couched by no means adequately expresses the very strong feeling of the Council concerning this matter of official omission. As evidence that such feeling is fully justified, Appendix D gives the correspondence between the Institute and the Department concerning the Report of the Departmental Committee of the Ministry of Health on the "Causes and Prevention of Blindness."

63. In paragraph 264 of the above Report the following passage appears: "The question of the provision of adequate ophthalmic facilities affects so vitally the interests of insured persons that we hope every effort will be made to extend such arrangements on a satisfactory basis."

64. In so far as "ophthalmic facilities" are meant to cover medical and surgical ophthalmic treatment, the Council does not consider it within its province to make suggestions, but in so far as these facilities are meant to cover the supply of optical treatment and appliances, the Council does consider it can speak with some authority on the question of what would be a satisfactory basis.

#### PRACTICAL SUGGESTIONS.

65. A comprehensive and practical scheme for dealing with the correction of optical defects of sight as an integral part of the general problem of National Health does not appear to have been put forward. It has therefore been considered desirable that some constructive suggestions, practical and financial, should be laid before the present Commission.

66. From the evidence already given it will be seen that the organisation of a service which would adequately meet the refractive needs of all insured persons would require a panel of anything from 2,500 to 3,500 competent and qualified refractionists, the number varying according to whether full-time or part-time refractionists are engaged on the work.

67. Assuming that the incidence of refractive cases would work out at ten per cent. per annum, the cost to the Approved Societies of providing optical benefits for those insured persons at present entitled to this additional benefit—including testing and spectacles would be covered by the allocation of '333 of 1d. per week from the present weekly contribution.

#### FINANCIAL CONSIDERATIONS.

68. Whether the present funds would be sufficient to allow this expenditure it is necessary to examine the latest available figures. According to the Appendix to the Minutes of Evidence, the first disposable surplus was approximately £9,000,000, but as this amount was arrived at on the old valuation, a truer perspective of the present financial condition of the Insurance Fund is obtained by considering the table of figures covering the last few years, and more especially the year ending December, 1923.

69. Reference to Appendix XVII in the Fifth Annual Report of the Ministry of Health, 1924 (Cmd. 2218) provides an interesting resumé of the receipts and expenditure during each of the ten years, 1914 to 1923, the growing arithmetical difference between receipts and expenditure and the influence of compound interest in creating a geometric increase in the item "Interest, etc.," being particularly noteworthy features.

70. Taking the year 1923 alone, the figures show that the total receipts for England alone, including interest and Parliamentary grants, were just over £32,000,000, and that the total of benefits paid out was just over £20,000,000.

71. Details of the expenditure given in the same table show that against these receipts of £32,000,000 the amounts paid out for the whole of the additional non cash benefits totalled only just over £500,000.

72. Out of this £500,000 the nett total payment for optical benefits, excluding administrative

charges, was only £12,969 (Table B, submitted by Sir Walter Kinnear, Minutes of Evidence—Second Day.)

73. The Council is aware that the reason for the small amount paid for optical benefit was the lack of knowledge of the insured persons that such benefit was actually available, but would point out that the total amount allocated for the year and including sums brought forward from previous years was only £66,144.

74. The Council contends that such an amount is quite inadequate for the needs of the 9,784,000 persons for whom it was allocated, and is convinced that had any considerable proportion of such persons been aware of their title to this benefit the monthly letters of complaint received by the Ministry would have been very much more numerous than those reported.

#### AVAILABLE RESOURCES.

75. It is extremely doubtful whether many persons, outside official circles, are aware of the large amount of the accumulated funds under the Health Insurance Acts, and as this is a matter which not only affects, very materially, insured persons, employers, and tax-payers generally, but is also cognate to the Council's suggestions, attention is drawn to these figures.

76. Reference to Table XV in the Appendix of the above-quoted Report (Cmd. 2218) shows that the accumulated Health Insurance Funds for England alone at the end of the year 1923 amounted to nearly £100,000,000, a sum equal to the whole of the contributions of employers and insured persons for the last five years.

77. The Council considers that however large may be the actuarial contingencies which have to be provided against, the accumulation of such immense reserves has been affected on a somewhat conservative basis of reservation.

78. Whilst the statement of the Government Actuary is true that, "Taking the results as a whole, no student of social conditions can fail to be impressed by the financial strength of the system," the Council submits that these figures show great possibilities for the extension "the capacity of the system to minister to some of the most urgent needs of the industrial population." (Cmd. 1662, par. 76.)

79. Further the Council submits that the present annual allocation of approximately £40,000 for optical benefits to cover 3,758,000 insured persons will be quite inadequate to touch even the fringe of the problem of Refractive Service when the insured person becomes fully conscious of his title to optical benefit.

80. When it is borne in mind that the correction of errors of refraction is an active factor in reducing the general incidence of sickness, and also a proved factor in considerably increasing industrial efficiency, the Council considers that a small percentage of such huge surplus funds could not better be utilised than by extending optical benefit to the whole of the insured persons, as the present allocation—which amounts to less than one per cent. of the sums spent in administrative expenses alone—is so extremely inadequate as to prove eventually a source of irritation rather than an ameliorative asset to the administration of the Act.

#### OPTICIANS AND THE MEDICAL PROFESSION.

81. In conclusion, the Council of the Institute would desire to express its sincere regret should it appear that in presenting the foregoing evidence as to the relative merits of various methods of administering optical benefits, the medical standpoint has been unduly criticised. The Council has the utmost respect for what may justly be denominated the Mother of all professions.

82. The Members of the Institute are on most intimate terms, and work in closest co-operation, with thousands of general medical practitioners, and indeed, with many ophthalmic surgeons throughout the country. By all these medical practitioners the services of the qualified ophthalmic optician as a skilled refractionist are fully recognised and freely utilised. On this point the representatives of the Council are prepared to submit the fullest evidence.

83. The large majority of medical insurance practitioners do not profess to know anything of refraction, and, as fully occupied public servants, are only too glad to avail themselves of the services of the qualified optician, knowing from experience that he can not only carry out the refraction work well and to the patients' satisfaction, but also, which is equally important from the doctor's point of view, that he can—and does—refer back any cases of ocular disease to the medical practitioner for further advice. With the views of the great majority of the medical profession, then, the Council of the Institute is in accord.

84. The criticism of the Council has been aimed solely at the proposals of that very small minority of ophthalmologists, who mistakenly, the Council believes, have endeavoured, and are endeavouring, to overlook and to depreciate the widespread and efficient public service the qualified opticians have created, in order to secure the transfer of this important work to a relatively very small section of medical specialists.

85. Were this small section adequately trained and qualified by a definite examination in sight-testing as qualified opticians are, the proposal submitted by the Ophthalmic Benefit Committee might be understood, though not justified. But, as the Council has intimated, this is very far from being the case.

#### RECOMMENDATIONS.

86. It is, therefore, with a full knowledge of the actual facts concerning the administration of optical benefits to insured persons, and fully recognising the responsibilities and implications imposed by so doing, that the Council of the Institute recommends for the consideration of the Commission:—

- (1) That optical benefit being a considerable factor in reducing the incidence of sickness, and in increasing industrial efficiency, it is desirable that it should be extended to every insured person, preferably
  - (a) on a cash basis.
  - (b) To be paid for by a small and definite allocation of the present weekly contributions.

#### SUPPLEMENTARY STATEMENT, 19th May, 1925.

87. In submitting the original statement of evidence of The Institute of Ophthalmic Opticians, it was not foreseen that new Regulations and Orders dealing with the administration of optical and ophthalmic benefits would be promulgated before the report of the Commission was issued.

88. It was originally pointed out to the Council of the Institute of Ophthalmic Opticians that the whole matter of the consideration of opticians' claims put before the Ministry of Health, would have to be deferred until the Royal Commission on National Health Insurance had made its report.

The Council now understands:—

- (a) That the Statutory Orders and Regulations dealing with optical benefit have been twice altered since this information came to hand, viz., December, 1924, and again in March, 1925. The first of these Orders still included the terms "optical treatment and appliances" but with certain excluding provisos; and the second drastically removed the specific terms above referred to, substituting the term "ophthalmic treatment."
- (b) That in a letter dated 11th May, 1925, from the Ministry of Health to the Joint Council of Qualified Opticians and communicated to the Institute's Representatives on the said Council the information was conveyed, that "when the model forms have been promulgated, the Department will forward for your information a copy of the Schedule relating to Ophthalmic benefit."

89. For these reasons, the Council of the Institute of Ophthalmic Opticians feels compelled to submit Supplementary Evidence and Recommendations, covering the entirely new position.

- (2) That so long as optical benefit is administered as an additional benefit, the model schedule and regulations should be amended, to enable every insured person entitled thereto, to receive payment towards the cost of optical treatment and appliances, when supplied by any refractionist on the Register of the Joint Council of Qualified Opticians.
- (3) That steps be taken by the Minister of Health to set up a Departmental Committee, to consider:
  - (a) The need of a national service of refractionists which would work under the National Health Insurance Act;
  - (b) The definition of a standard of qualification for National Health refractionists, and
  - (c) Any matters connected with and arising out of (a) and (b).
- (4) That the personnel of the Departmental Committee mentioned in Recommendation (3) should include adequate representation of Opticians who have received the approval of the various organisations representing Sight-Testing Opticians.
- (5) Should refraction work be included as a specialist service "involving the application of special skill and experience," future regulations defining such specialists as those quoted in Sec. C, paragraph 39 of the Appendix to Evidence, should be amended, so as to include duly qualified opticians for the performance of refraction work and the supply of optical appliances.
- (6) That qualified refractionists who are on the Register of the Joint Council of Qualified Opticians, should be represented by duly elected and accredited representatives on all central and local councils and committees, or other bodies, dealing with refraction work for insured persons.

90. The Council can only conclude from the above recited facts, that these administrative alterations have been made, in order to preclude the possibility in the future of qualified opticians being allowed to undertake refraction work for insured persons, and to facilitate, by substituting the word "ophthalmic" for "optical," the monopoly of this work by a very small and restricted section of medical practitioners.

91. The following paragraph appears in the Statement of Evidence submitted on behalf of The British Medical Association under heading Appendix C, Ophthalmic Benefit:—

"7. Further, as examination of the refraction of the eye for the purpose of fitting spectacles is regarded as a form of medical treatment, medical practitioners, with due regard to the disciplinary disabilities that would follow, or with proper regard for the welfare of their patients, cannot send their patients or be party to sending their patients to persons not on the Medical Register."

92. The Council of the Institute takes strong exception to the statement, "as examination of the refraction of the eye for the purpose of fitting spectacles is regarded as a form of medical treatment," and this contention would appear to be fully substantiated by the following facts taken from medical sources.

93. According to the 1924 Medical Directory, the numerical summary of the medical profession shows a total of 35,000 persons in the British Isles.

The report of the Council of the British Medical Association to its members states, that a list has been prepared of some 500 ophthalmologists throughout the country who are prepared to see insured persons at a uniform fee of one guinea on behalf of Approved Societies.

94. The Council of the Institute submits that if refraction work is a matter requiring medical treatment, and that opticians should not be allowed to perform this work, the above facts constitute a grave indictment of the medical profession, as they indicate that out of 35,000 registered medical practitioners only about 500, less than 1.5 per cent. of the total, are qualified and willing to undertake the vast amount of public work required in this direction.

95. The fact that sight-testing opticians realised the public need over thirty years ago, by establishing specific examinations to ensure efficiency in refraction work (whereas it is only during recent years, that specific examinations in ophthalmology for medical practitioners have been instituted), shows, that the opticians have given much greater consideration to the refractive needs of the public, than has the medical profession.

96. Furthermore, the official qualifications for a medical specialist adopted by the Ministry of Health, include such a questionable definition as "He is generally recognised by other practitioners in the area as having special proficiency and experience in the subject," whereas the Joint Council of Qualified Opticians requires that every optician undertaking refraction work for insured persons shall have passed a definite examination in the subject. From these facts it appears that the medical contention is totally unwarranted and unsupported.

97. As further evidence of the opticians' desire fully to keep abreast of the public need for an efficient service, the Council of the Institute of Ophthalmic Opticians encloses for the consideration of the members of the Royal Commission, the Prospectus of the Refraction Hospital.

98. The criticism directed against the optician by the British Medical Association emphasises especially the allegation of his inability to detect the presence of disease. On the other hand, the Council of the Institute would point out that the very comprehensive curriculum of the Refraction Hospital is particularly designed to afford specialised instruction in this very subject.

99. In view of the Supplementary Evidence the Council of the Institute of Ophthalmic Opticians submits for the consideration of the Royal Commission the following additional recommendations:—

- (7) That any Statutory Orders or Regulations affecting the administration of optical and/or ophthalmic benefit which have already been made or may be promulgated in the future shall be withdrawn or held in abeyance until proper opportunity has been afforded by the Ministry of Health for representations to be submitted and evidence heard from bodies representing qualified ophthalmic opticians.
- (8) That any Approved Societies which may have already made provision for the administration of optical and/or ophthalmic benefits under the new valuation and which contain clauses precluding or tending to preclude the freedom of choice of insured persons as to the selection of medical or optical practitioner for advice concerning optical treatment, whether as a part of optical or ophthalmic benefit, shall be allowed to modify any such arrangements should they so desire.

#### APPENDIX A.

SUMMARY OF TOWNS (POSSESSING QUALIFIED OPTICIANS), SHOWING APPROXIMATELY THE RESPECTIVE NUMBERS OF OPHTHALMIC SURGEONS, AND QUALIFIED OPTICIANS.

(Compiled from over five hundred reports received from various towns in the British Isles.)

County.	No. of Towns reported.	Inclusive Population.	Number of Ophthalmic Surgeons.	No. of Towns WITHOUT Ophthalmic Surgeon.	Distances in miles to nearest Ophthalmic Surgeon.	Total No. of Qualified Opticians.
Ayrshire ... ..	5	80,350	0	5	40, 20, 21, 37, 30 ...	10
Cheshire ... ..	7	396,890	0	6	4, 18, 20, 3, 6 ...	24
Cornwall ... ..	7	57,850	2	5	50, 12, 18, 10, 30 ...	15
Cumberland ... ..	5	111,718	2	3	28, 6 ... ..	10
Derbyshire ... ..	9	217,300	4	6	25, 9, 12, 17, 10 ...	21
Devonshire ... ..	8	385,000	5	5	10, 3, 6, 2, 21 ...	27
Durham ... ..	12	660,000	6	7	14, 16, 8, 15, 12, 11, 36...	32
Essex ... ..	11	330,200	3	9	23, 18, 20, 21, 10, 12 ...	40
Glamorgan ... ..	8	526,900	6	6	10, 25, 23, 12, 16 ...	30
Hants ... ..	7	615,900	9	3	10, 16, 14 ... ..	35
Hertford ... ..	5	116,500	2	3	18, 24, 12 ... ..	13
Kent ... ..	18	470,630	14	7	19, 15, 9, 8, 10, 4 ...	59
Lanark ... ..	6	1,078,900	30	4	12, 20, 5, 17, 10 ...	62
Lancashire ... ..	27	3,115,000	25	17	18, 9, 11, 5, 21, 4, 7, 12...	170
Lincs. ... ..	8	175,740	3	5	38, 24, 16, 21, 20 ...	16
Middlesex ... ..	5	81,950	1	4	4, 6, 5 ... ..	9
Norfolk ... ..	6	214,500	5	3	20, 16, 22 ... ..	19
Somerset ... ..	6	150,430	5	3	28, 25, 25 ... ..	22
Staffs. ... ..	11	426,000	8	5	16, 3, 2, 12 ... ..	35
Surrey ... ..	12	408,550	5	8	7, 6, 19, 12, 10, 8 ...	45
Sussex ... ..	11	426,000	17	5	14, 8, 3, 10 ... ..	54
Warwick ... ..	6	753,000	11	2	21, 15 ... ..	44
Worcester ... ..	6	134,800	1	4	15, 16, 3, 5 ... ..	13
Yorkshire ... ..	24	2,454,800	29	12	11, 6, 10, 9, 7, 20, 13, 5...	147
Further Reports (unclassified).	71	3,340,000	74	48	Average 25 ... ..	324
County of London ... ..	57 (distr.)	7,000,000	130	38	2 to 10 ... ..	357
<b>Totals</b> ... ..	<b>358</b>	<b>23,728,900</b>	<b>397*</b>	<b>223†</b>	—	<b>1,632‡</b>

\* Does not include certain Ophthalmic Surgeons engaged solely as School Medical Officers.

† This total includes 84 towns which have neither an Ophthalmic Surgeon, nor a General Medical Practitioner engaged in refraction work.

‡ The large number of rural areas served by the remaining 700 qualified opticians appear to have practically no local service of medical practitioners occupied in refraction work.

## APPENDIX B.

COMPARATIVE TABLES SHOWING THE CONTRAST BETWEEN THE MEDICAL REFRACTIVE SERVICE IN INDUSTRIAL TOWNS, AND IN HEALTH RESORTS.

Also (in the last column) the number of Qualified Opticians.

## TEN INDUSTRIAL CENTRES:

Town.	Population.	Ophthalmic Surgeons and G.M.P.s.	Opticians (Qualified).
A ... ..	54,000	4	9
B ... ..	52,000	1	5
C ... ..	80,160	1	4
D ... ..	64,000	1	3
E ... ..	55,000	1	4
F ... ..	103,175	2	5
G ... ..	110,120	2	13
H ... ..	54,000	1	3
I ... ..	52,800	1	2
J ... ..	128,000	3	7
	753,255	17	55

## TEN HEALTH RESORTS.

Town.	Population.	Ophthalmic Surgeons and G.M.P.s.	Opticians (Qualified).
K ... ..	44,000	6	3
L ... ..	69,000	10	9
M ... ..	90,000	7	9
N ... ..	20,000	3	2
O ... ..	62,000	6	7
P ... ..	66,000	5	7
Q ... ..	46,000	7	9
R ... ..	38,000	3	4
S ... ..	46,000	4	4
T ... ..	84,000	9	5
	565,000	60	59

\* G.M.P.s doing a certain amount of sight-testing.

## APPENDIX C.

Extracts from an Open Letter by A. Freeland Fergus, M.D., F.R.F.P.S.G.

Published by A. Macdougall, Glasgow, 1924.

WHAT IS AN EYE SPECIALIST? OR THE GENERAL MEDICAL COUNCIL AND OPHTHALMOLOGY.

## PART I.

October, 1924.

MY DEAR DR. ADAMS,

I am taking the liberty of inditing to you a somewhat lengthy memorandum on the subjects of ophthalmology and of ophthalmic teaching in the United Kingdom.

Ophthalmic teaching has interested me a good deal for at least thirty years.

At the moment, there is no recognised qualification; any registered practitioner who is able to buy a set of trial lenses and the necessary test-types can call himself an eye specialist, and can practise as such.

The ordinary medical student cannot in his short course master the minutiae of ophthalmic localisation, but he certainly should be taught the use of the ophthalmoscope and of the perimetre, and should be instructed in the analysis of diplopia and in the methods of testing pupillary reflexes. When I had large classes of students I always took pains to give, either personally or by my assistants, ample instruction on these matters. Needless to say, that

the prescribed twenty meetings were quite inadequate, and I always had from thirty-five to forty meetings.

One subject should be rigorously excluded from this general course for students, and that is the teaching of refraction testing.

The above synopsis shows that the ground to be covered is very considerable, and will very fully occupy the time allotted to ophthalmic instruction in the ordinary medical curriculum. The subject of refraction testing is a very large one, and I do not think any adequate training in this subject can be obtained in less time than a year, and therefore it seems to me that it is nothing short of a farce to crush it in with the other subjects already mentioned.

A number of opticians now undergo a tolerably extensive training in optical work. They begin with the elements of mathematics, including trigonometry, and from that proceed to the study of the properties of lenses, then to the study of the refraction of the eye, and its errors of refraction and the optical correction, spherical and cylindrical, of the errors of refraction and accommodation found in practice. Their training lasts for more than a year, and the examinations which they pass are thorough and searching. Now, to attempt to teach refraction properly, along with all the subjects already indicated, seems to me to be an attempt to do the impossible, and if it be made it will mean that important subjects which every medical practitioner should know will be dealt with quite inadequately. You cannot teach students, even the most apt of students, more than a limited amount in a limited time, and the more a syllabus of instruction is congested, the less the pupils will learn.

Further, the opticians who have undergone the thorough training above indicated are making demands to have their qualifications registered. While I at once recognise the fact that many of them are excellently trained in their own especial work, still they are not, as they themselves admit, qualified for ophthalmic practice. It is only right to say that the regulations drawn up by some of the bodies giving these optical diplomas very strenuously discourage the persons to whom they are given to go beyond their own special sphere. To my mind, it would be very dangerous to allow anybody who is not a fully qualified medical man to take charge of an ophthalmic clinic.

I regret to find that the General Medical Council has recently put refraction testing into the ophthalmic syllabus for medical students. The opticians spend more than a year in the study of it; the medical student is supposed to study external disease of the eye, fundus changes, lachrymal diseases, cataract, glaucoma, diplopia, perimetry and refraction in a short summer course. Such an arrangement must seem to the opticians very ridiculous, to say the least of it. To myself it seems a complete farce.

Again, a certain number of so-called eye specialists are employed giving courses of instruction to medical students in University and other medical schools. I cordially admit that almost all of the gentlemen so engaged are admirably fitted for that work, being well trained and erudite men. That this is not always the case is shown by the following incidents:—Not very long ago a paper appeared in a British ophthalmic publication in which the author informed his readers that Maddox had said that the hypotenuse of a right angled triangle is equal to the square root of the sum of the squares of the other two sides. In the same paper the reader was also informed that Maddox had announced that the angle between any two straight lines is given by the sine of the angle. Such is an example of ophthalmic teaching in one British University.

It is quite certain that a man who does not recognise that the first statement is not a discovery of Maddox, but is an application of the forty-seventh proposition of the first book of Euclid's elements, and who also is absolutely unacquainted with the trigonometrical functions of an angle has never read, and is quite incapable of reading, any of the standard text-books on the physiology of vision, which text-books form the basis of any ophthalmic practice worthy of the name. Apart from the physical side of the question, ophthalmic practice is only a special application

of ordinary surgery and medicine and neurology. Anything in ophthalmic practice which is entitled to be called a speciality is the application of physiological optics and physics (as in the study of muscular anomalies) to ophthalmic practice.

All during my school and college career I was much troubled with headache to the extent that I was never able to read for as long as an hour continuously without violent headache. My father took me repeatedly to see an eye specialist, who prescribed certain lotions, which, however, gave me no relief. About two years after graduation, I had the good fortune to fall into the hands of Sir William Bowman, who at once found that I had two dioptries of hypermetropia, and, in addition, nearly two dioptries of hypermetropic astigmatism in each eye. Accurate correction at once put me right. It is worthy of remark that at the times of my examination by Sir William I still had six-sixths of visual acuteness. The importance of this remark arises from the fact that school children who have vision of six-sixths or even six-twelfths are by some of the examiners supposed not to require ophthalmic treatment. Terrible rumours have reached me of no fewer than one hundred and fifty children having their vision taken in an hour. If these figures be true—and I have no reason to doubt them—the average is twelve seconds for each eye. I have great difficulty in believing that such things could occur if all the examiners were thoroughly trained ophthalmologists.

Immediately after I received the glasses prescribed by Sir William Bowman, I found that I could use my eyes for hours together without the slightest discomfort. That led me, I think about the year 1886, to write to the then vice-chairman of the Glasgow School Board, whom I happened to know, to say that every child in the schools of Glasgow should have his or her eyes examined. The reply was that there was no need of any such course being adopted. It was not till many years afterwards that the examination of children's eyesight was introduced. When it was, it was largely a farce. The teachers took the visual acuteness, and only if it were below a certain figure was the child sent to the eye specialist. . . . Nor could I approve of the methods in which the children who were said to be defective were tested. One of the examiners was known to say that twelve of these cases could be done in an hour. That figure worked out at two and a half minutes per eye, if all the children have two eyes each. . . . Any examiner who professes to examine and fit an eye in two and a half minutes is either quite incompetent for the work or is quite unscrupulous.

The course of study for an ophthalmic diploma extend to at least two years.

My objection to the diplomas given at present is that they do not, so far as I can learn, represent a thorough training. I understand, for example, that for the Oxford diploma a student requires to be at Oxford for two months, not for two years, as ought to be the case.

I have written this somewhat lengthy communication, because I think something is radically wrong, and it is specially up to the General Medical Council to put it right. I have, moreover, a feeling that all persons who are paid at the expense of the taxpayer should be thoroughly qualified for their work.

With kind regards, I remain, yours sincerely,

(Signed) FREELAND FERGUS.

#### APPENDIX D.

##### CORRESPONDENCE WITH THE MINISTRY OF HEALTH.

115668/20.

Ministry of Health,  
Whitehall, S.W.1.  
11th November, 1920.

SIR,

I am directed by the Minister of Health to inform you that your letter of the 27th ultimo, with regard to the representation of the Institute of Ophthalmic Opticians upon the Committee on the Causes and Prevention of Blindness has received full consideration but that the Minister does not consider it desirable for the Committee to be increased beyond its present numbers.

I am at the same time to state that your letter will be brought to the notice of the Committee in order that they may, if they see fit, have the opportunity to hear the evidence of representatives of the Institute.

I am, Sir,  
Your obedient Servant.  
Signed

The Secretary of the  
Institute of Ophthalmic Opticians,  
Staple Inn Buildings, W.C.1.

(The Report was published in October, 1923.)

15th December, 1922.

The Secretary of  
The Ministry of Health,  
Whitehall, S.W.1.

SIR,

I am directed by the Council of this Institute to ask you to be so good as to lay before the Ministry the following observations on section 16 of the Report of the Departmental Committee on the Causes and Prevention of Blindness, recently published.

In the first place my Council views with the utmost astonishment the publication of such an *ex parte* attack on Sight-Testing Opticians by a Committee which made no effort to obtain evidence from either individual opticians or their well-known organisations.

Apparently, the only witnesses, who it could be suggested in any way spoke from the opticians' point of view, were Sir Alfred Keogh and Admiral Smith-Dorien. Sir Alfred Keogh's work as Chairman of the Technical Optics Committee is highly esteemed by opticians, but he is not an optician and cannot speak with either the knowledge or the authority of one daily engaged in the work. Admiral Smith-Dorien is a layman and consequently can no more speak for opticians than for medical men.

When the Committee was first set up this Institute applied for representation thereon, as it was felt that particularly useful service could have been given in view of the fact that its members are daily occupied in Sight-Testing and the fitting of spectacles. The letter from the Ministry refusing this, on the ground that it was undesirable to increase the Committee, stated that "your letter will be brought to the notice of the Committee in order that they may, if they see fit, have the opportunity to hear the evidence of representatives of the Institute."

It is therefore the more astonishing that, without hearing a single optician, sweeping charges of incompetency should be made.

My Council denies these charges.

The question of the benefit or otherwise of a legal register of opticians does not require to be argued from the theoretical standpoint, for it is already in existence in some of the most progressive parts of the world.

In the Dominions of Canada and Australia and the U.S.A. it has been tried for many years. The first Optometry Law was passed in the State of Minnesota, U.S.A., in the year 1901, and after several years' experience of its working the Governor of the State, in replying to an enquiry as to whether the State Board of Optometry had been of service to the State said, "I take pleasure in answering this question in the affirmative, believing unreservedly that the Board has performed a service in this, that it has prevented many persons from practising optometry who are not competent and has thereby protected the public health. I am sure that the intelligent judgment of the legislature of this State would not for a moment countenance the repeal of the act under which your Board was created, and under which it has done such good work."

Once begun, matters rapidly progressed, and to-day every State (including Alaska and the Philippines) has its Optometry Law. In the British Empire similar laws are in force in Canada and parts of Australia. In almost, if not in every case, the bills had to encounter strong opposition from the Medical Organisations who used exactly the same arguments as those used in the Report. It is impossible to believe that, had there been any real force in these

arguments, the work of passing these laws would have gone steadily forward for over twenty years.

In view of these facts my Council asks:—

1. That as these and other statements could have been given in evidence, had such evidence been invited (which is what my Council was led by the letter from the Ministry to believe would have been the case), a note should be inserted in all copies of the report issued in future and sent for insertion in all copies which have been supplied to public institutions, to the effect that "No evidence was called for or heard by the Committee, from Sight-Testing Opticians."

2. That on any future Committee which may be appointed to consider any point in connection with the Nation's eyesight, Sight-Testing Opticians shall be given representation.

My Council hopes it may be favoured with an early reply.

I am, Sir,  
Your obedient Servant,  
J. HARCOMBE CUFF,  
Secretary.

Ministry of Health,  
Whitehall, S.W.1.  
19th December, 1922.

190147/21.

SIR,

I am directed by the Minister of Health to acknowledge the receipt of your letter of the 15th December, respecting the Report of the Departmental Committee on the Causes and Prevention of Blindness and to state that it shall receive attention.

I am, Sir,  
Your obedient Servant,  
Sgd.

The Secretary,  
The Institute of Ophthalmic Opticians,  
Staple Inn Buildings, W.C.1.

29th January, 1923.

The Secretary of the  
Ministry of Health,  
Whitehall.

190147/21.

SIR,

Referring to yours of the 19th ult., acknowledging the receipt of my letter of the 15th December, 1922. As I shall shortly have to report to my Council on the matter, I should be much obliged if you would let me know when a reply may be expected.

Yours faithfully,  
J. HARCOMBE CUFF,  
Secretary.

Ministry of Health,  
Whitehall, S.W.1.  
17th February, 1923.

190147/21.

SIR,

I am directed by the Minister of Health to advert to your letter of the 15th December and to your further letter of the 29th ultimo, with reference to section 16 of the Departmental Committee's Report on the Causes and Prevention of Blindness and to state that the Minister cannot undertake to give effect to the suggestion regarding the Report which makes it clear that the Committee were expressing their own opinion only on the evidence of Sir Alfred Keogh and the Technical Optics Committee's report. In regard to representation on any further Committee, the Minister at present can only note that the claim has been made.

The delay in reply to your letters is regretted.

I am, Sir,  
Your obedient servant,  
Sgd.

The Secretary,  
The Institute of Ophthalmic  
Opticians,  
Staple Inn Buildings,  
W.C.1.

## APPENDIX LXI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE JOINT COUNCIL OF QUALIFIED OPTICIANS BY MR J. H. SUTCLIFFE, O.B.E., F.INST.P., REGISTRAR, MR. F. W. BATEMAN, A LIVERYMAN OF THE WORSHIPFUL COMPANY OF SPECTACLE MAKERS AND TREASURER OF THE JOINT COUNCIL OF QUALIFIED OPTICIANS, AND DR. MARGARET B. DOBSON, M.D.  
See Minute of Evidence of the Thirty-First Day, Questions 17,618 to 17,704.

### OBJECT OF EVIDENCE.

1. The reasons for submitting evidence are based upon the information that the Ministry intends to promulgate new Orders and Regulations which will prove as unsatisfactory and against the public interest as was the Model Schedule which is now admitted by the Ministry to be inappropriate.

### CONSTITUTION.

2. The Joint Council of Qualified Opticians is a body of ophthalmic opticians registered in March, 1923, under section 20 of the Companies' Acts as an Association with limited liability, but without profit to its members, and licensed by the Board of Trade to dispense with the word "Limited."

3. The Joint Council consists of 22 members. For the purposes of registration the number is limited to 1,000. The Executive comprises 14 members, 4 being delegates elected by the Institute of Ophthalmic Opticians, 4 by the British Optical Association, and 6 by the postal vote of the 2,500 members of the Register. The annual subscription is one guinea. Membership does not confer any privilege or benefit beyond that of eligibility to serve as a member of the Executive. It is unlikely, therefore, that there will be much increase over its present numbers. Its Articles, which allow of disciplinary control over the members of the Register, cannot be altered without the previous sanction of the Board of Trade.

4. The members of the Executive are qualified opticians of long technical experience, and all in

administrative positions on other optical bodies. The Registrar, who is not a member of the Joint Council, acts as technical adviser to the Approved Societies and the Joint Council, and is also the Director of Examinations to the British Optical Association, Superintendent of the Optical Appliances Depot (Ministry of Pensions) and formerly (1916-1920) Superintendent of the Army Spectacle Depot (Army Medical Services).

5. Although the Memorandum of Association is fairly wide, so far the Executive has applied itself solely to the publication (March, 1924) of an official Register of opticians who have passed either the examination of the Worshipful Company of Spectacle Makers or of the British Optical Association, and to the administration of a Scheme whereby it has been able to act as a technical adviser, a disciplinary body and a clearing house between the Approved Societies and the members of its Register.

6. Through its Register, as regards optical treatment in insurance work, the Joint Council claims to represent every qualified optician.

The definition of "qualification" for the Register for sight-testing opticians is similar to that in the official revised list of occupations certified by the Ministry of National Service to be of national importance issued on the 26th September, 1918, when only sight-testing opticians who had passed the two recognised examinations were included. Only such qualified opticians were approved by the Army Medical Department for enlistment as opticians in the Royal Army Medical Corps during the War.

#### THE REGISTER OF OPTICIANS.

7. The Register of March, 1924, is arranged alphabetically, and also topographically for the use of Approved Societies, of firms and opticians willing to undertake insurance work. A new edition (July, 1925) is in the press.

8. There is at present no subscription or payment required for the insertion of the name of a qualified optician upon the Register. A charge of 5s. is made for members of the Register who wish their names to be placed in the topographical list. The Register consists only of the names of persons who have passed one of the two qualifying examinations, with the addition of the names of certain reputable optical firms who dispense to prescription only, and who under no conditions are engaged in the practice of sight-testing.

#### REASONS FOR ITS FORMATION.

9. As nearly every insured person entitled to optical benefit was already a client of the sight-testing optician, the question of optical benefit did not particularly appeal to either of the above two bodies representing all qualified opticians, in that it meant a transference of the regular client of the optician at reduced terms to the Approved Societies, and as first proposed the submission of the client to the compulsory examination of a non-optically trained ordinary medical practitioner.

10. In 1921, the National Insurance Beneficent Society proposed to the Institute of Ophthalmic Opticians a scheme for the supply of spectacles on the basis of a 5s. sight-testing fee and the wholesale cost of spectacles without any profit. Later the Institute of Ophthalmic Opticians approached the British Optical Association for its views in the matter. An interview took place between three delegates of the British Optical Association, the Institute of Ophthalmic Opticians and the National Insurance Beneficent Society. The British Optical Association representative rejected the proposition as unsound, but was asked to lay the "N.I.B.S." scheme before the B.O.A. Council. The next day it was suggested that he should initial the "points agreed upon." As no such agreement had been made, beyond a promise to bring it before the B.O.A. Council, he refused. The respective Councils of the British Optical Association and Institute of Ophthalmic Opticians in joint conference unanimously decided to reject the "N.I.B.S." scheme as being unbusinesslike, non-practical and against the best interests of the insured person.

11. The "N.I.B.S." then approached a body of unqualified men—the National Association of Opticians—a body without any definite constitution; the "N.A.O." appears to have accepted their scheme without any reservations.

12. From the point of view of the qualified opticians, this meant not only the compulsory diversion of their legitimate clients by the Approved Societies controlled by the "N.I.B.S.," but it was placing the examination of the eyesight of the insured person in the hands of unqualified and untrained men who, for the first time in their business experience, were to receive a professional fee—in our opinion quite as misleading a matter to the spectacle-wearing public as the Model Schedule proposed by the Ministry. We understand that evidence has been submitted that the N.A.O. men were qualified, but we would submit that at that time the N.A.O. examination was newly-formed. Even at the present time there is no satisfactory information available concerning the methods of such an examination or its examiners.

13. In January, 1923, therefore, delegates from the sight-testing organisations formed a Joint Committee and applied to the Board of Trade for a licence as an Association without profit under the title of the Joint Council of Qualified Opticians. This at first was objected to by the Board of Trade, acting as we understand on the advice of the Ministry of Health, on the ground that there was already one body—the National Insurance Beneficent Society—which had applied or was applying for a similar licence. Any objections were overcome eventually by the contention that the opticians represented by the Joint Com-

mittee had passed a recognised examination, as opposed to that of a comparatively newly-formed examination. Conditionally, therefore, that only men who had passed one of the two qualifying examinations should be placed upon our Register and that no work should be undertaken by the Joint Council that was not ordinarily undertaken by qualified opticians, a licence was granted.

14. Later, owing to strong representations being made by one or two unqualified opticians who claimed an experience equal to a qualification, application was made to the Board of Trade to place such men upon the Register, but was most decidedly refused with unusual emphasis, it being pointed out to us that it was on the question of definition of qualification submitted by the Joint Committee that the licence had been granted.

15. The Model Schedule insisted that an insured person may receive a grant for spectacles only on production of a prescription from an ordinary medical practitioner or a hospital.

It has therefore been interpreted by some of the smaller Societies that an insured person must be declared "medically sick" before he can be supplied even with an ordinary pair of reading glasses.

16. The Council submits in the public interest that the action of the Ministry in issuing the Model Schedule with respect to the administration of optical benefits was undesirable for the following reasons:—

- (1) It overlooked the fact that the majority of insured persons are clients of qualified opticians.
- (2) In attempting to direct insured persons to medical practitioners for refraction work it was unduly coercing the insured person to consult a medical man instead of the qualified optician, whom he might prefer to have consulted.
- (3) The provision did not attempt to ensure that the medical practitioner should be a competent refractionist, as the provision merely reads—"on the production of a prescription from a qualified practitioner or a hospital"—despite the fact that the Departmental Committee on the "Causes and Prevention of Blindness" had reported the submission of evidence as to the insufficiency of "the number of medical practitioners competent to prescribe glasses for ordinary errors of refraction" (para. 278), and in view of this, and also in view of the "inadequate knowledge of diseases of the eye possessed by the large majority of the medical profession" (para. 68) recommended "an increase in the number of the medical profession having a special knowledge of refraction and diseases of the eye" (para. 280).

17. All the available evidence shows that the Model Schedule of the Ministry has been almost a complete failure, and that some such scheme as that so successfully worked by the Joint Council, which has been almost universally adopted by the major Approved Societies, is the solution of the difficulty in which the Ministry has been placed.

18. The average spectacle wearer, as represented by the insured person, does prefer, and always has preferred, the services of a qualified sight-testing optician rather than undergo the expense of the fee of an ophthalmic surgeon, or be submitted to the routine delays and unsatisfactory results of the refraction department of a hospital or clinic. It is inconceivable that he would apply, except under official compulsion, for optical treatment to an ordinary medical practitioner, who would himself be the first to disclaim any particular optical knowledge or skill. The ability of ophthalmic surgeons is not disputed, but such practitioners are not usually available except in large cities and fashionable health resorts. We are of opinion that the alternative of the ordinary general medical practitioner being classified by the Ministry as a refraction expert, or



even as an expert in ophthalmoscopic diagnosis, is unsound, and a danger to the public welfare.

19. Despite the fact that an Approved Society approaching the Ministry for sanction for optical benefits (section 75, N.H.I. Act, 1924) has, we understand, invariably been faced with the Model Schedule as an instruction rather than a recommendation, and although the scheme of the Joint Council allows the insured person also the choice of being tested by an ophthalmic surgeon, at an eye hospital, or even by an ordinary medical practitioner, yet our statistics, of 35,755 insured persons treated by the Joint Council scheme in the last year, with Approved Society grants of nearly £18,000, show that the major portion of the total sum allowed by all the Approved Societies together has passed through the hands of qualified opticians registered by the Joint Council. That our percentage is so very large is due to the desire of the larger societies to save their members unnecessary trouble and expense.

20. The proposed compulsory direction by the Ministry of the insured person to a medical practitioner instead of allowing the alternative of an optical practitioner is bound to result in widespread dissatisfaction amongst insured persons. Its application is considered by us to be a financial hardship upon the insured person, in that the grant allowed by his society would be more than spent in the payment of what undoubtedly is an unnecessary medical fee.

21. The Joint Council approached the Ministry to point out the unsoundness of the Model Schedule, and asked that all, especially the smaller Approved Societies, in future should have the option of adopting the scheme of the Joint Council, in a similar manner to the larger Societies who were already working under our scheme. The deputation was informed that in the face of the adverse report of a Ministry of Health Departmental Committee on the Causes and Prevention of Blindness, no assurance could be given to us.

22. Strong protests against the findings of that Committee as being biassed and unjust have only received bare acknowledgment of our letters, and it appears almost impossible to get any kind of hearing whatever, or satisfaction from the Ministry.

23. In spite of the Ministry's pressing recommendation of the Model Schedule, the list of Societies about to adopt Joint Council is steadily growing, and there are now over 240 other Societies considering the question of its adoption.

#### OPTICAL v. OPHTHALMIC BENEFITS.

24. The provision of spectacles and glasses, which after all in 95 per cent. of refraction cases is the interposition of a suitable, even if complicated, lens between the object viewed and the eye of the person in order to create a conjugate focus, differs from that of the extraction of teeth and dentures, or medical advice and medicine, both of which alter the physical condition of the patient.

25. The practice of sight-testing by qualified opticians has been in existence for over 30 years. Such opticians pass stringent examinations and are usually quite capable of detecting cases coming to them that require medical and not optical advice. Such cases of eye disease as are generally not fairly obvious to the patient himself, may and do come to the optician, but it is particularly signs of such departures from the normal that the qualified optician is trained to detect.

26. It appears to us to be a matter of doubt as to whether the Ministry is justified in connecting the terms "ophthalmic" with "optical" treatment, in view of the wording of section 17 of the Statutory Rules and Orders, 1924, No. 1516, Art. 235, Fifteenth Schedule, which states as a supplementary additional benefit, "the payment of the whole or any part of the cost of optical treatment and appliances other than as provided as part of medical benefit."

27. The introduction of additional benefit involves—as the name implies—benefits which, though having relation to health, are not necessarily medical, and therefore do not need that medical men only should

administer them (e.g., cash benefits, premises for convalescent homes, dental, optical and nursing benefits, and so forth).

28. Taking two of the above-mentioned examples, viz., dental and nursing, the Ministry of Health would hardly be likely to issue a Model Schedule recommending that no payment should be sanctioned unless the dentist or the nurse rendering the service were also to be registered medical practitioners.

29. Had the Ministry of Health suggested such a course for the administration of dental and nursing benefits, the public would have had a legitimate grievance that the Ministry were using undue influence in limiting the choice to purely medical circles, and preventing attendance by the overwhelming majority of dentists and nurses who were not medical practitioners.

30. The Joint Council submits that in the administration of optical benefits, Dr. Addison, the Minister of Health at that time, appears to have been unduly influenced by a relatively small section of medical practitioners who engage in refraction work, to issue a Model Schedule which, if its advice had been followed by all the Approved Societies, would have had the effect of transferring the whole of the refraction work, which had hitherto been carried on by a large number of qualified ophthalmic opticians, to a relatively small section of medical men.

31. The Joint Council further contends that at a later stage, and under the direction of the Rt. Hon. J. R. Wheatley, the Department (in its Statement of Evidence to the members of the Royal Commission published in the Appendix Section B, para. 212, page 53) continued to manifest by the implication of the words "of course" partiality towards the services of a medical practitioner for refraction work carried out under the Act.

32. We understand that it was not the intention of the framers of the National Health Insurance Acts that the supply of spectacles should come under the provision of the Act.

#### THE SUPPLY SCHEME OF THE JOINT COUNCIL.

33. The scheme consists of two classes:—

- (a) Where a good, sound spectacle, termed "Utility," can be supplied at such a price that any Approved Society is able to make a grant covering the whole cost of sight-testing, spectacles and case. This has been made possible by the whole-hearted co-operation of the Association of Wholesale and Manufacturing Opticians, which has agreed to supply to registered opticians requiring "Utility" spectacles for definite insurance work, an article at a minimum cost of production.
- (b) Where, as an alternative, the insured person can have free choice of any quality of lenses and frame at the regular, ordinary, known prices of the optician less a discount of 15 per cent. A fee of 5s. is allowed for sight-testing, but as the 15 per cent. is calculated on the spectacles alone, the optician, on making his quotation, deducts the sum of 5s. from his usual charges, deducts 15 per cent., and then adds 5s. for testing fee. This fee is not allowed where an optical prescription from an ophthalmic surgeon or a hospital is produced. The estimate in the case of alternative charges is submitted to the Approved Society, which then inscribes on it the amount of grant to be allowed. The amount averages 10s. 6d., but there are Societies paying the whole cost, and other Societies allowing a definite proportion in each case. The insured person, who is thereby fully informed of the prices and qualities he is about to receive, is then prepared to pay the optician any difference there may be between the grant allowed and the cost of the spectacles. The reduction of 15 per cent. therefore goes to the insured person. This is the class of supply generally chosen by the insured person.

## PROCEDURE AND ADMINISTRATION.

34. The scheme of optical supply, receiving the approval of almost the whole of the Register, was laid before the National Amalgamated and Prudential Approved Societies and began to work almost immediately upon the formation of the Joint Council. Since its inception the scheme has worked satisfactorily in every respect. We have every reason to believe that this entire satisfaction exists from the point of view of the Approved Societies and the optician as well as the insured persons receiving optical benefit.

35. At the beginning of the working of the scheme some trouble was experienced as a result of unqualified spectacle sellers representing themselves to the insured persons as being fully qualified.

36. In order to overcome any difficulty as to the direction of the insured person to a qualified optician as opposed to an unqualified optician or to an optician exhibiting an unauthorised certificate, the symbol of the J.C.Q.O. is now usually exhibited by the registered optician, and in some cases is printed on the optical treatment letter issued by the Approved Society.

37. There is no financial obligation on the part of the Approved Society to the Joint Council of Qualified Opticians or commission of any kind for administration expenses—which are met by an agreed nominal commission of 2½ per cent. payable by the optician and deducted by the Joint Council from the monthly cheque sent to the optician.

38. No binding agreement is required from the Approved Society with the Joint Council. All that is necessary to bring the scheme into immediate operation is for formal application to be made to the Executive to be included in the scheme, accompanied by 15 copies of the proposed optical treatment letter (for the inspection of the Executive). On the application being approved, a printed copy of the official Register is sent to the Society and the scheme immediately comes into force. The scheme has so far worked sufficiently well for the arrangement to be agreeable on both sides without any forms or agreement beyond an understanding that all the optical work of the Approved Society passes through the medium of the Joint Council and the qualified opticians on the Register.

39. The specimen optical treatment letter is intended only as a suggestion to Approved Societies, and follows very closely the lines of the treatment letters of the Prudential and National Amalgamated Societies. There are some Approved Societies requiring all estimates to be first submitted to them for sanction, with some a higher or lower preliminary amount (other than 10s. 6d.) is fixed, while others do not require an estimate for "Utility" glasses.

40. As it is impracticable and unnecessary to supply a copy of the Register to every insured person, it is customary for the Approved Society to supply the insured person with a list of the registered opticians in his immediate locality, with an intimation that it also applies to any qualified and registered optician.

41. It follows that the administrative and clerical work on the part of the Approved Society is reduced to a minimum.

The usual procedure is as follows:—

- (a) The insured person applies to the Approved Society for an optical treatment letter.
- (b) An optical treatment letter is sent by the Approved Society to the insured person.
- (c) The insured person takes the letter to an optician, secures an estimate for the necessary glasses, leaving letter with the optician.
- (d) If the estimate is above 10s. 6d., the optician sends the letter with the estimate to the Approved Society for consideration as to amount of grant. Usually, if the amount does not exceed 10s. 6d., the optician proceeds with the work and sends the optical treatment letter direct to the Joint Council.
- (e) The optical treatment letter is returned with sanction and amount of grant to either the optician, insured person or Approved Society agent.

(f) The optician supplies the glasses, collects balance from insured person (if amount exceeds the grant) and sends all completed optical treatment letters to the Joint Council for collection of amount of grant.

42. The administration of accounts is simple. At the end of the month the original optical treatment letters, signed by the insured person as receipt of supply, are returned to the Approved Society with a tabulated list of names, numbers and grants for a total for the cheque due to the Joint Council for distribution to the opticians. One cheque is thus payable each month to the Joint Council by the Approved Society for the exact amount of the grants, without any additions or deductions. One cheque only is paid by the Joint Council to each optician for the collective amounts of the various Approved Societies, with a deduction of 2½ per cent. for administration expenses.

43. In the rare cases of refraction requiring medical treatment, the optician returns the optical treatment letter to the Society—with his remarks—the usual fee of 5s. being payable. The Approved Society then makes its own arrangements for the insured person to visit a hospital, medical man, or ophthalmic surgeon. The usual fee paid direct by the Society to the medical man is one guinea.

44. In preparing this scheme the Executive had to provide a good service that would meet the requirements of all classes of insured persons, and one that would attract the greatest possible number of qualified opticians, so that the choice of the insured person should be as wide as possible.

45. From the point of view of the insured person the scheme of the Joint Council of Qualified Opticians guarantees:—

- (1) Efficiency of service by fully-qualified optical practitioners.
- (2) For the insured person of limited means free choice in selection of his or her own qualified optician, or hospital, or medical adviser, and the supply of well-made standard spectacles; together with some contribution from the Approved Society covering the full cost of the spectacles and testing. For the insured person of ample means freedom of choice, with a substantial discount, the services of a competent optician, together with some contribution from the funds of the Approved Society.
- (3) Competent optical service in every town in the United Kingdom.
- (4) Freedom of choice in selecting the type of fitting suitable to the particular work and circumstances of the insured person.
- (5) Immediacy of treatment and avoidance of delay in settlement of claims and delivery of spectacles.
- (6) A standard spectacle of good quality at standardised prices for those who desire "Utility" frames.
- (7) The same comprehensive treatment as is given by dentists tending to avoid misunderstanding, and to allow of continuity of interest in the patient's requirements.

46. From the point of view of the Approved Societies it offers:—

- (1) A central clearing house for the administration, without any cost of administration to the Approved Societies, of optical benefits, economical in its working. The Approved Societies do not hand over any grant until the optical treatment has actually been given to the satisfaction of the insured person.
- (2) A ready means for the settlement of innumerable technical points arising from day to day.
- (3) Alternative rates which enable the individual preference of each member to be adequately met whilst at the same time leaving the Approved Societies full control of the individual and total grants made by the respective Societies.

- (4) A universal refraction service in every large and small town throughout the United Kingdom.
- (5) Every inducement for the qualified optician to carry out the work to the utmost of his ability, and to refer those cases which require medical or surgical treatment back to the Approved Society for further appropriate treatment.
- (6) A service which is the utmost efficient and economical in its administration, as it avoids duplication of forms for the Approved Society and the optician and misunderstandings arising from conflict between separate individuals carrying out different sections of the same work.

47. From the point of view of the qualified optician:—

While it inspires the fullest confidence that his highly specialised services can be fully utilised, as adequately remunerated in the circumstances as possible, the optician occasionally suffers in cases where an insured person, although the amount of the Society grant is clearly specified, orders alternative quality spectacles and does not call or pay for them. The optician in such a case receives only 5s. from the Society, whereas in ordinary practice, a deposit would have been charged.

#### COMPLAINTS.

48. The optician invariably sends the very small percentage of disease or apparent disease for reference to an ophthalmic surgeon. In this respect we have received only two complaints, one from a large Approved Society that a certain optician appeared to be sending cases unnecessarily to the ophthalmic surgeon, and so causing the insured person needless trouble and unnecessary expense, and a similar complaint from a West-end ophthalmic surgeon that cases of refraction were being sent to him which the optician should have treated.

49. Eight instances of irregular advertising by opticians have been brought to the notice of the Joint Council by the Ministry and dealt with by the Disciplinary Committee. Cases for technical advice and arbitration are often submitted by the Approved Societies, complaints investigated and at once dealt with by the Executive or the Registrar. So far any irregularities have on inquiry proved to be almost entirely negligible.

50. One complaint has been received from a medical practitioner who demanded to be placed upon our Register on the grounds that he was a medical man, an ophthalmic surgeon, a pharmacist, and also sold spectacles.

51. There have been a few cases where medical men in addition to charging a guinea for a sight-testing fee, have also sold the spectacles to the insured persons at a fairly high figure. Such claims have been disallowed.

52. We have had one case of an ophthalmic surgeon who, after charging a guinea fee, insisted upon the insured person going to a specified optician not on our Register, although using our optical treatment letter. He appealed to the British Medical Association, which complained to the Board of Trade. We were able to show that we were acting strictly within our rights.

53. It is very significant that out of the 60,000 cases treated by the Joint Council members, not a single complaint of error of judgment in the detection of disease has been lodged, despite the fact that the whole of these clients are under medical observation as insured persons.

54. The proposed regulations about to be promulgated could at once be made workable by the inclusion of the words "or qualified optical practitioner."

#### APPENDIX A.

COPY OF CORRESPONDENCE BETWEEN THE MINISTRY OF HEALTH AND THE JOINT COUNCIL.

10th May, 1922.

FROM THE MINISTRY TO THE JOINT COUNCIL.

SIR,—We received from you on the 1st February last, copies of various papers relating to the qualifi-

cations of opticians, in reference to the payments for optical treatment as an additional benefit under the National Health Insurance Acts, and it was understood that you would be sending us a memorandum with further particulars on the subject.

As we have not yet heard further from you, I should be obliged if you could let me know how the matter stands and whether anything has since transpired in the direction of arrangements between your Council and Approved Societies.—Yours, &c.

19th July, 1922.

FROM THE JOINT COUNCIL TO THE MINISTRY.

SIR,—I am enclosing herewith for your perusal, a circular that we have issued to all qualified opticians. We are still awaiting full replies and as soon as a proper response has been received (sufficient to form a register) I will, as promised, send to you a formal application for your sanction, together with our proposed scheme and, incidentally, our constitution.

I send you also for your perusal in the interim, a draft copy of our Memorandum and Articles of Association, similar to what has just been sent by our solicitors to the Board of Trade. I send these to you in order to show you the action that we have taken so far, but will write you again later.—Yours, &c.

20th July, 1922.

FROM THE MINISTRY TO THE JOINT COUNCIL.

The Secretary is directed to state that your letter, dated 19th instant, was duly received and is receiving attention.

16th December, 1922.

FROM THE MINISTRY TO THE JOINT COUNCIL.

SIR,—I am directed by the Minister of Health to acknowledge the receipt of your letter of the 14th December with regard to the Registration of Opticians and to state that it shall receive attention.—I am, Sir, &c.

3rd November, 1924.

FROM THE MINISTRY TO THE JOINT COUNCIL.

SIR,—We have noted your request to be supplied with the list of Approved Societies which have included optical benefit in their schemes of additional benefits. As to this, I am afraid I can only say at the moment that, as certain matters relating to this benefit are now under consideration, I cannot give you a definite reply, but your request will be borne in mind and I hope to be able to communicate with you again on the subject in a few weeks' time.

I return herewith the letters you were good enough to send with your letter of the 15th October regarding an advertisement to which attention had been drawn.—Yours, &c.

17th March, 1925.

FROM THE MINISTRY TO THE JOINT COUNCIL.

SIR,—I have to acknowledge the receipt of your letter dated 12th March, 1925, enclosing a letter which you have received from the Secretary of the . . . and to state that in accordance with the provisions of section 75 of the National Health Insurance Act, 1924, and the Regulations made thereunder, the sanction of the Minister of Health is required to any scheme of additional benefits before a Society or branch may distribute the additional benefit or benefits included in the scheme.—I am, Sir, &c.

April, 29th, 1925.

FROM THE JOINT COUNCIL TO THE MINISTRY.

SIR,—I am informed by the Secretary of an important Approved Society (who had for some time been considering very favourably our scheme for the supply of glasses to insured persons under the National Health Insurance Acts), upon his approaching you for the sanction necessary for the administration of optical benefits, that you not only recommended to him the adoption of your Model Schedule, but impressed it almost as an "Instruction."

Whatever views his Committee may have had as to the advantages of adopting our scheme in preference to the Model Schedule, he felt compelled, in the face of your very strong "recommendation," to instruct

the whole of his Sub-Committees to insist upon all their members applying to an ordinary medical practitioner (or failing him an ophthalmic surgeon) for optical advice or treatment.

We have already pointed out to you (October 16th, 1924) that such a recommendation is not in the best interests of the public. We asked you for your close inquiry into the matter.

I am to ask if such a recommendation is given to all Approved Societies applying to you for sanction to administer optical benefits, and if so, under what authority or section of the Act is such a recommendation made, or insisted upon?

I am, Sir,

May 11th, 1925.

**FROM THE MINISTRY TO THE JOINT COUNCIL.**

SIR,—I have to acknowledge the receipt of your letter of 29th April, and to point out that under section 75 of the National Health Insurance Act, 1924, a scheme submitted by an Approved Society for distributing any one or more additional benefits among its members requires to be sanctioned by the Minister before it can come into operation. The new schemes of Societies and Branches valued as at 31st December, 1922, will commence on 6th July next, and the Department has had under consideration the conditions that should be embodied in those schemes with respect to ophthalmic benefit.

As you are aware, the Model Schedule relating to optical treatment and appliances in schemes consequent upon the first valuation of Approved Societies contained a provision to the effect that payment in respect of the cost of an optical appliance should only be made on the production of a prescription from a qualified medical practitioner or a hospital, except in respect of the renewal of an appliance. In the light of experience, this provision is not considered to be altogether appropriate for inclusion in the new schemes as an invariable requirement, and a modification thereof has accordingly been under consideration. When the model forms of new schemes have been promulgated, the Department will forward for your information a copy of the schedule relating to ophthalmic benefit. It will be understood that this will not for the present affect the societies that are being valued as at 31st December, 1923, as in their case the existing schemes will continue in force till July, 1926.

I am, Sir, &c.

**APPENDIX B.**

*Specimen of Optical Treatment letter as issued by the Prudential and National Amalgamated Approved Societies.*

**OPTICAL TREATMENT LETTER.**

Approved Society  
Registered Office

Membership No. ....

Member's Name  
Address

(This authority applies only to opticians on the Register of the Joint Council of Qualified Opticians.)

*To the Optician.*

The above member has applied for Optical Treatment under the Society's Scheme of additional benefits. It is understood that optical service under the authority of this letter is rendered under the scale of fees, and under the terms of the arrangement with the Joint Council of Qualified Opticians for treatment under the National Health Insurance Acts. If the member is not already in possession of a prescription, please test sight, and if the cost of supplying the necessary glasses, including the sight-testing fee, does not exceed 10s. 6d., kindly proceed forthwith.

A description of the lenses supplied to member should be inserted hereunder in Section A. Section B should be completed by the member and Section C

completed by yourself, and the form forwarded to the Joint Council of Qualified Opticians, Clifford's Inn Hall, Fleet Street, London, E.C.4, for collection of the account.

Where the cost exceeds 10s. 6d. the estimate on the reverse side of this form should be completed and submitted to this Society, at above address, before the work is proceeded with.

.....Chairman.

**A. (1) DESCRIPTION OF LENSES:—**

(2) INCLUSIVE CHARGE ... .. £ : :

**B. To be signed by the Member**

I hereby acknowledge that I have been supplied and fitted with the optical appliance specified above.

Date.....192 .

Signature of Member .....

**C. To the Joint Council of Qualified Opticians.**

The above service has been rendered under the terms of the arrangement with the Joint Council. Please credit my account with £ : : , being the amount due in respect of this case from the Society.

Signature of Optician.

Reg. No.

Name of Firm

Full Address ..... Date .....

*For the information of the Optician.*

Where the cost of the appliance exceeds 10s. 6d. an estimate, under the agreed scheme, must first be submitted to the Society on Section D of this form. On receiving back from the Society the form with Section E completed, authorising the optician to proceed, an appointment should be made with the member for that purpose, and the account subsequently rendered to the Joint Council of Qualified Opticians by completing Section G of this form. The member's receipt for the appliance should be obtained in Section F.

It should be noted that whilst no restrictions are imposed upon a member as to the kind or quality of frames selected, the Society will only contribute towards the cost on the basis of steel frames. The Society will be responsible for the sight-testing fee provided the member is not already in possession of a prescription.

**D. ESTIMATE:—**

(1) Nett charge for Utility glasses, frames and testing ... .. £ : :

(2) Alternative charges (when member chooses other than Utility glasses and/or frames):—

Description of lenses Price : :  
Description of frame Price : :

Total ... .. £ : :

Less special discount (15%) : :

Sight-testing fee ... .. : :

**NETT** ... .. £ : :

Signature of Optician

Reg. No.

Name of Firm

Full address ..... Date ..... 192

**E. To the Optician.**

The Society is prepared to contribute £ : : towards the cost of the above-mentioned appliance. The balance of £ : : should be collected from the member, and on this understanding, please proceed.

Date ..... 192 .

.....Chairman.

F. To be signed by the Member.

I hereby acknowledge that I have been supplied and fitted with the optical appliance specified above.

Date ..... 192 ..

Signature of Member .....

G. To the Joint Council of Qualified Opticians.

The above service has been rendered under the terms of the arrangement with the Joint Council. Please credit my account with £ : : , being the amount due in respect of this case from the Society.

Signature of Optician.....

Date.....

APPENDIX C.

THE JOINT COUNCIL OF QUALIFIED OPTICIANS.

Revenue Account for the Twelve Months ended 31st October, 1924.

EXPENDITURE.				INCOME.						
Dr.	£	s.	d.	£	s.	d.	Cr.			
To opticians' Monthly Accounts ... ..	17,561	2	1				By Subscriptions, Register Fees, etc. ...	204	4	1
(for Approved Societies grants) less 2½ per cent. commission from opticians based upon a full turnover of fees and spectacles of £35,216 16s. 11d.										
= £880 8s. 3d.										
Less certain cases without commission ...	15	16	0	=	864	12	3			
				16,096	9	10				
„ Printing ... ..	47	18	10							
„ Stationery ... ..	8	7	9							
„ Advertising ... ..	6	0	0							
„ Postage, etc. ... ..	87	15	11½							
„ Travelling and Sundry Expenses ... ..	12	16	0							
„ Bank Charges ... ..	75	0	0							
				237	18	6½				
„ Honorarium to Registrar, 1923 ... ..				100	0	0				
„ Staff, Machinery and Rent Charges, 1924 ...	250	0	0							
„ Honorarium to Registrar, 1924 ... ..	250	0	0							
				500	0	0				
„ Accountancy and Audit Charges, 1923.				32	18	0				
„ Accountancy and Audit Charges, 1924.				73	10	0				
„ Balance, carried to Balance Sheet ...				124	9	9½				
				£17,765	6	2				
								£17,765	6	2

SERVANTS OF INDIA SOCIETY'S  
BRANCH LIBRARY  
BOMBAY

Balance Sheet, 31st October, 1924.

£	s.	d.	£	s.	d.	£	s.	d.	£	s.	d.
Sundry Creditors, including Opticians' Accounts estimated for month of October ... ..			1,738	6	5	Cash at Bank per Cash Book ... ..	305	14	11		
Revenue Account:						Cash in Hand per Petty Cash Book ... ..	13	12	0½		
Balance from Account to 31st October, 1923 ...	292	18	11						319	6	11
Balance from Account to date ... ..	124	9	9½			Sundry Debtors, including Approved Societies for October Accounts ...			1,754	5	11
			417	8	8½	Registration Expenses ...			82	2	3
			£2,155	15	1½				£2,155	15	1½

AUDITORS' REPORT TO THE MEMBERS.

We report that we have examined the above Balance Sheet, together with the books and vouchers of the Association and that we have obtained all the information we have required. In our opinion the Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Association according to the best of our information and the explanations given to us and as shown by the books of the Association.

5, Budge Row, Cannon Street,  
London, E.C.4.  
2nd February, 1925.

BUZZACOTT, LILLYWHITE & Co.,  
Incorporated Accountants,  
Auditors.

## APPENDIX LXII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE BRITISH OPTICAL ASSOCIATION BY MR. W. B. BARKER, F.B.O.A. (Hons.), PRESIDENT, MR. J. McHOUL, M.B., CH.B., F.R.C.S.E., AN EXAMINER OF THE ASSOCIATION, MR. J. L. MEYNELL, M.R.C.S., M.D., D.P.H., AN EXAMINER OF THE ASSOCIATION. See Minutes of Evidence of the Thirty-First Day, Questions 17,705 to 17,771.

1. The object of the British Optical Association in submitting evidence before the Royal Commission on Insurance is:—

- (a) To demonstrate the special fitness of the properly qualified optician to deal with optical treatment for insured persons (now being termed ophthalmic benefit) under the National Health Insurance Act.
- (b) To show that the proposal of the Ministry of Health to enforce regulations whereby all such insured persons shall receive optical treatment only from a medical practitioner, is not in the best interests of the insured person.

## CONSTITUTION AND OBJECTS.

2. The British Optical Association is an Association registered in 1895 under the provision of section 23 of the Companies Act, 1867 (replaced by section 20 of the Companies (Consolidation) Act, 1908).

The liability of the members is limited; the Association is licensed by the Board of Trade to dispense with the word "limited."

3. The objects of the Association as stated in the Memorandum of Association are:—

- (1) The encouragement of (a) the science of optics and (b) the art of the application of the science of optics to the improvement of human vision.
- (2) The protection of the members of the Association from influence inimical to the prosperity of the profession of an optician.
- (3) The doing of all such other lawful things as are incidental or conducive to the attainment of the above objects, but so that the Association shall not impose on its members or support with its funds any regulation or object which, if an object of the Association, would make it a trade union.

4. The Association now consists of nearly 1,400 members. Its average annual income for the last four years derived from subscriptions and examination fees amounts to about £5,000. The Hall and headquarters of the Association are at Clifford's Inn, Fleet Street, where the Association possesses a very fine optical library, modern ophthalmic apparatus, and a good historical collection of ophthalmological appliances and spectacles, and holds lectures, meetings and minor examinations.

All the members have an opportunity at general meetings of discussing and approving, or otherwise, the policy of the Association.

5. The Association, since the year 1896, has published a special monthly journal under the present title of "The Dioptric Bulletin," which records the transactions of the Association and deals especially with matters calculated to improve the science of optics.

6. The policy of the Association is to ensure by means of courses of instruction and examination that all the members of the Association have a thorough knowledge of the best methods of sight-testing and of the most efficient optical aids to human vision, and to inculcate a high ethical standard of business morality amongst the members.

## EXAMINATIONS.

7. During the last 30 years the Association has examined 3,661 candidates and has issued about 250 honours certificates and about 1,650 fellowship certificates.

8. The standard required of successful candidates is a high one, and on an average not more than 40 per cent. of the candidates qualify. The Board of Examiners appointed by the Council consists of the following scientific men, several of whom are ophthalmic surgeons, so that the examiners are not necessarily members of the Association, but are independently selected for their efficiency and practical scientific knowledge of the subjects dealt with.

## LIST OF ASSOCIATION EXAMINERS.

9. P. E. Belas, B.A., M.Sc., Professor of Physics, University of Cork.
- R. S. Clay, D.Sc. (Lond.), B.A. (Cantab.), Principal, Northern Polytechnic Institute.
- \*M. B. Dobson, M.D. (Lond.).  
Edwin Edser, A.R.C.S., Lecturer, Goldsmith's College.
- R. W. Forsyth, A.R.C.S., Asst. Professor, Imperial College of Science and Technology.
- W. W. Haldane Gee, B.Sc. (Vict.), M.Sc. (Tech.), Prof. College of Technology, Manchester.
- \*C. W. Graham, M.B., F.R.C.S.E.  
Albert Griffiths, D.Sc. (Lond.), Lecturer, Birkbeck Institute, Professor of Physics, University of London.
- \*G. O. Hume, M.B., B.S. (Lond.), D.O. (Oxon.).
- \*J. L. Meynell, M.R.C.S., M.D., D.P.H. (Vict.).
- \*J. McHoul, M.B., Ch.B., F.R.C.S.E.  
L. S. Palmer, Ph.D., Head of the Department of Physics, College of Technology, University of Manchester.
- J. S. B. Stopford, M.D., M.Ch., Professor of Anatomy, Dean of the Medical Faculty, University of Manchester.
- W. E. Thrift, Professor of Physics, University of Dublin.
- W. Watson, M.A., B.Sc., F.R.S.E.
- R. Whiddington, M.A., D.Sc., Cavendish Professor of Physics, University of Leeds.

and the following members, holding the honours certificate of the Association, appointed by the Council:—  
O. Aves, W. B. Barker, S. Cowan, J. Harwood, F. G. Huntley, G. W. Milner, R. S. Moles, Robert Sutcliffe, and A. S. Taylor.

10. With a desire to ascertain as to whether there was any foundation for the statements in the Final Report of the Ministry as to the alleged incapability of the qualified optician to detect eye-disease or departure from the normal, the Council instituted temporarily a supplementary examination for such of its members as did not hold the honours certificate. The result has been to show definitely that fully 80 per cent. of the members had the necessary skill and knowledge.

11. The Association would welcome any inquiry and personal inspection by the Commission into the

\* Ophthalmic Surgeons.

character and efficiency of the examinations held by them.

Such an examination will be held at the Imperial College of Science and Technology, London, on May 29th, 1925.

12. The Foundation lecturers are:—Professor J. S. B. Stopford, M.D., M.Ch., Professor of Anatomy, Dean of the Medical Faculty, University of Manchester; Sir Arthur Keith, M.D., LL.D., F.R.C.S., Hunterian Professor of Anatomy, Royal College of Surgeons; and Professor G. Elliot-Smith, Professor of Anatomy, University of London.

13. The Association issues after examination two certificates of qualification, the Fellowship, and the higher one the "Honours." Its rules and practice are modelled upon those which prevail in the medical and dental professions. The Association aims at raising its members to a professional grade, inculcates ethical principles and sets its face strongly against anything approaching blatant advertisement on the part of its members. The treatment of defective eyes otherwise than by glasses is strongly discouraged by the Association, and the prohibition is enforced where necessary (like other disciplinary measures) by the withdrawal of the Association's certificate of qualification. The aim of the British Optical Association, in short, is to render opticians better qualified for their work and to enforce a code of ethics on its members.

14. There are exceedingly good facilities in respect of educational training for sight-testing opticians. The Northampton Institute, Clerkenwell, the College of Technology at Manchester, and the Heriot-Watt College at Edinburgh, all have 3-year courses specially arranged for the examinations of the Association. The Northampton Institute syllabus is too lengthy for reproduction, but an abbreviated syllabus is appended of the two latter Colleges. There are also numerous private training institutions providing practical and theoretical studies.

There are also recently introduced special classes solely for the training of ophthalmic opticians at the Bradford Technical School and the Birmingham Municipal School.

The Refraction Hospital at Newington Causeway, London, has an excellent course of training, with facilities for refraction work and the detection of abnormal and pathological ocular conditions.

15. The examinations have been held for many years at the University of London, South Kensington, and the Imperial College of Science and Technology. They are also held periodically at the Universities of Belfast, Bristol, Cork, Dublin, Leeds, Liverpool, Nottingham and Sheffield; at the Heriot-Watt College, Edinburgh, the College of Technology, Manchester, and the Birmingham Municipal Technical School.

The regulations and syllabus of examinations are appended.

16. It has already been shown by other optical bodies, giving evidence before the present Commission, that the needs of the insured public are best met by utilising the services of the qualified optician.

17. We have been informed by the Ministry that our very strong protests against the Final Report of the Departmental Committee (see paragraphs 23, 26) on the Causes and Prevention of Blindness (1922) would receive careful consideration (see Appendix A), but the only information there is as to such consideration is that the Ministry is about to promulgate immediately a new schedule, which we have every reason to believe will be as unjust and unfair to the large and honourable profession of opticians as was the former Model Schedule.

18. All that remains for us is to show that the examination as instanced in the case of the British Optical Association is thorough and satisfactory. Apart from our list of examiners, the syllabus of examination and the written papers—there is only a personal inspection of our practical examination required.

19. If it should be found necessary to institute a public service for optical treatment, there is ample evidence that immediately, with almost little or no further organisation, there can be available the services of a numerous body of highly skilled refractionists in every way capable of carrying out such a scheme.

20. Nearly all these refractionists are already well-experienced in dealing with Approved Society work and have loyally co-operated through the Joint Council of Qualified Opticians in successfully working the Scheme which has already been substituted for the Model Schedule.

#### APPENDIX A.

##### COPY OF CORRESPONDENCE BETWEEN THE MINISTRY OF HEALTH AND THE BRITISH OPTICAL ASSOCIATION.

22nd November, 1922.

##### FROM THE ASSOCIATION TO THE MINISTRY.

SIR,—With reference to the visit of your representative here some time ago on inquiry as to our examinations, and educational facilities, if your representative cares to come for a few minutes to see our practical examination in working order, I am desired by my Committee to extend to him an invitation to do so on Friday, November 24th, at the Imperial College of Science and Technology, South Kensington, S.W., at any time between eleven and three o'clock. It might give him further information as to the way our examinations are conducted in a portion of their practical work.—Yours, etc.

##### FROM THE MINISTRY TO THE ASSOCIATION.

27th November, 1922.

SIR,—I have to thank you for your letter of 22nd November and to express regret that it was not found possible to arrange for the attendance of a representative at the examination held by your Association.—I am, Sir, etc.

##### FROM THE ASSOCIATION TO THE MINISTRY.

12th December, 1922.

SIR,—I am instructed by a resolution of the Council of the British Optical Association, to write to you in protest against the conclusions and recommendations arrived at in the Report by your Committee, on the question of the State Registration of Qualified Opticians.

The Council some considerable time ago, wrote to the Secretary of the Departmental Committee offering to give evidence. Although they received an acknowledgment, no advantage was taken of that offer. We understand also that another important optical organisation wrote to you in similar terms, but that the offer was refused. Nor does there appear to have been any evidence given by any opticians or by any person speaking on their behalf (except Sir Alfred Keogh).

The Council consider that the conclusions and recommendations laid down in the report are entirely "ex parte" statements, greatly biased and unfair. The report, indeed, appears almost to have departed from its main useful intended purpose, in an attempt to vilify an honourable, ancient and skilled body of men, who comprise the two societies of examined and qualified opticians.

The Council, as a matter of common fairness, ask you to be kind enough to allow them to present to you their view of the case in full, and also to submit witnesses, both ophthalmic surgeons and opticians of repute, in order to give evidence before you as to the utter worthlessness of the charges and the gross misrepresentations contained in the Report.

The Council believe that the Report does not represent accurately the true state of affairs, and further that the views contained therein are responsible to a great extent for the backward state of the art or science of refraction as practised amongst medical

men in this country, compared with conditions prevailing in other English-speaking countries, such as America. At the present moment, Great Britain is the only English-speaking country without some definite State Registration. Such a Registration prevails in most of the British Colonies, and in every State (43) in America without exception, and also in the provinces of Canada.—I am, Sir, etc.

FROM THE ASSOCIATION TO THE MINISTRY.

17th October, 1924.

SIR,—I am enclosing a copy of the reply to the Final Report. To facilitate reference, both the Report and the reply have been printed.

I am instructed by the Council to suggest to you that should you wish, every opportunity will be available for your inspection of the organisation and practical working of the Fellowship and Honours examination on Friday, 21st November, at the Imperial College of Science and Technology, South Kensington, S.W. As these examinations take place in London only twice yearly, it to be hoped that you will be able to see your way to visit the examination.—I am Sir, etc.

FROM THE ASSOCIATION TO THE MINISTRY.

*Extracts from Reply.*

17th October, 1924.

SIR,—Immediately following the publication of the above Report, the Council of the British Optical Association addressed to you a strongly worded protest against the biased nature of the Report, its unfairness and total lack of accuracy so far as it concerned the sight-testing optician, on the partisan and personally interested constitution of the Committee and its intentional omission to call upon or hear any evidence dealing with the point of view of the optician.

- \* \* \* \* \*
- (1) The statements made therein are generally untrue and so worded as to convey an impression to the spectacle-wearing public that opticians who have passed the examinations of the British Optical Association are incompetent and dangerous to the public welfare.
  - (2) Every opportunity has been seized in the public lay Press by the Council of British Ophthalmologists and other medical Press to draw attention to the findings of the report, to the detriment of properly qualified opticians.
  - (3) As a consequence much unnecessary feeling has been caused, and in some cases our educational work and plans for its State development have been severely burdened and delayed by such publication.

\* \* \* \* \*

The bulk of persons insured under National Health Insurance Acts have, up to the present, preferred to consult an optician rather than a surgeon, and this view is concurred in by the Approved Societies concerned.

\* \* \* \* \*

The Council would respectively submit that the real solution lies rather in the proper regulation of sight-testing, and the provision of legislative means to ensure that refraction work shall only be undertaken by registered and competent persons.

\* \* \* \* \*

The Council of the British Optical Association therefore suggests that a public Inquiry or Commission should be held by the Ministry at an early date to consider:—

- (1) The advisability of a State Register of certified sight-testing opticians.
- (2) An inquiry into the nature, procedure and constitution of the various existing optical examining bodies.

(3) The adequacy of the present syllabus of education available to the sight-testing optician, and any extension thereof which may be deemed desirable.

(4) The best form of legislation necessary to provide an efficient and widespread refraction service.

We are, Sirs, etc.

23rd October, 1924.

FROM THE MINISTRY TO THE ASSOCIATION.

SIR,—I am directed by the Minister of Health to acknowledge the receipt of your letter of 17th instant and enclosure respecting the Departmental Committee on the Causes and Prevention of Blindness and the Regulations of Sight Testing.—I am, Sir, etc.

FROM THE MINISTRY TO THE ASSOCIATION.

19th November, 1924.

SIR,—I am directed by the Minister of Health to acknowledge with thanks the receipt of your letter of the 17th instant, enclosing your Association's reply to the Final Report of the Departmental Committee on the Causes and Prevention of Blindness which is receiving careful consideration.

I am also to thank you for the offer of your Council to arrange for an inspection to be made on behalf of the Minister of the examination to be held on Friday, the 21st instant, and to state that it is not desired to inspect the examination.—I am, Sir, etc.

FROM THE ASSOCIATION TO THE MINISTRY.

Your ref.: V. 115/887/23.

7th January, 1925.

SIR,—In view of the evidence that is about to be given before the Royal Commission on National Health Insurance, I shall be glad to know if the reply of the British Optical Association of 19th October, 1924, to the Final Report of the Departmental Committee on the Causes and Prevention of Blindness has now received the careful consideration referred to in your letter of 19th November, 1924.—I am, Sir, etc.

FROM THE MINISTRY TO THE ASSOCIATION.

SIR,—In reply to your letter of the 7th ultimo, I am directed by the Minister of Health to state that he is not at present in a position to make any statement on the subject.—I am, Sir, etc.

FROM THE ASSOCIATION TO THE MINISTRY.

28th March, 1925.

SIR,—On the 14th November, 1924, acting upon the instructions of the Council, I wrote to you asking you to inspect the workings of our practical examination, with a special view to their consideration in allowing you to form an opinion and enable you to reply to our letter addressed to you of 17th October, 1924, criticising the findings of the Departmental Committee on the Causes and Prevention of Blindness.

You replied at the time that "it was not desired to inspect the examinations." I am asked to point out to you that a personal inspection of the examination will help you very much in forming such an opinion.

The examinations are held twice yearly. The practical portion of the next examination will be held at the Imperial College of Science and Technology, South Kensington, S.W., on Friday, 29th May, 1925, in the large physical laboratory, when there will be an opportunity of seeing every phase of the examination except the written portion. Other parts of the examination will be held at the University of London, South Kensington, S.W., on the preceding days. I am enclosing a new syllabus of examinations which will then be in force.—I am, Sir, etc.

18th May, 1925.

FROM THE MINISTRY TO THE ASSOCIATION.

SIR,—I am directed by the Minister of Health to refer to your letter of the 28th March, concerning the examination to be held at the end of this month.

In reply I am to state that the Minister does not desire to make arrangements for an inspection of the



examination. I am to express regret that an earlier reply has not been sent to your letter.—I am, Sir, etc.

The following notes of telephone conversations between the Secretary of the Association and the Ministry are illustrative of the difficulties attendant upon securing that consideration which the Association should receive from the hands of the Ministry.

“‘Phoned Dr. ——— 14th November, 1924, as to whether a representative of the Ministry of Health would be able to attend the examination on Friday, November 21st. Informed, as far as he knew, his department was not taking any action, in view that the matter was under consideration in other quarters. Referred to Mr. ———, one of the Secretaries of the original Departmental Committee.”

“‘Phoned Mr. ——— 15th November, 1924, with same query. Was informed that matter was now out of his hands, but that he would interview the proper quarter as to whether someone could be sent. Promised to telephone on 16th November, 1924.”

“‘Phoned Mr. ——— 17th November, 1924, who put me through to Dr. ——— ‘who had the matter in hand.’ Spoke to Dr. ——— who stated that as the Insurance Department was considering the matter it was not proposed to take any action by his Department. Informed him that we entertained the view that the Ministry was shelving the matter. He denied this, and said that the Ministry was giving it every consideration, but he could not guarantee an expert to come as he thought it was inadvisable at this stage. Pressed him to give me a decision, and I suggested I should write to him, but this he did not wish, and stated that if they did come, they would give me notice as much as possible. I also pressed him for the personal attendance of the Minister with an expert.”

“‘Phoned Dr. ——— 17th November, 1924, for an interview on 18th November, 1924, with myself and Mr. Barker. Interview refused as matter was no longer in his hands. Refused any further help or information.”

## APPENDIX B.

### BRITISH OPTICAL ASSOCIATION.

#### REGULATIONS FOR EXAMINATION.

##### GENERAL RULES

1. Membership of the Association is obtainable only by examination. There are only two grades of examination—Fellowship and Honours.

2. Examinations are held twice yearly in London in May and November, yearly in Edinburgh in September, in Manchester about June, and occasionally in other centres.

3. The annual subscription of members is three guineas, payable in advance on 23rd October of each year. This subscription entitles the subscriber to receive the Certificate of the Association, to attend discussions and meetings, to have postal use of the library, to be supplied free of charge with the publications of the Association, to be substantially insured against possible damages for optical errors, and to receive such legal protection and support as the Council may deem advisable. There is at present no entrance fee.

4. Candidates must be of respectable character and good antecedents, and must give two references.

5. The examinations are open to persons of both sexes over 18 years of age. Successful candidates over the age of 21, or on attaining the age of 21, will be required to take up the membership of the Association. Certificates are not supplied until the applicant has reached the age of 21 and thus entitled to become a member of the Association.

6. Each candidate must sign an application form for examination, agreeing to abide by the regulations of the Association. The last date of application is 16 days before the date of each examination.

7. Every candidate must furnish the name of some responsible person residing in the United Kingdom

who will become bond to the extent of £10 (ten pounds) for the safe return to the Secretary (in case of death, bankruptcy or misconduct of the member) of the certificate.

8. All certificates are the property of the Association and not of the members named therein, and are subject to the conditions of the Articles of Association. The holder of a certificate, on ceasing to be a member, or in case of death his legal personal representatives, must forward the certificate to the Secretary.

9. If a candidate for any grade of examination shall withdraw his name, or fail to present himself at the examination, or fail to pass such examination, he is entitled to present himself at a subsequent examination for the same grade upon payment of a fee of one half of the original fee, or less as the Council shall direct for each subsequent examination. Provided always that after presenting himself for two subsequent examinations, he shall not be entitled to present himself at any other examination or examinations without the previous consent in writing of the Council. The withdrawal by a candidate of his name from any examination for which he shall have entered and paid a fee, does not entitle him to a return of the fee or any part thereof.

10. Candidates who pass in one of the sections and fail in the others may not be required to sit for the sections in which they were successful. Candidates who fail in any part of a section may be required to sit again for the whole of that section. Candidates may sit for one only or more sections at one time.

11. Any candidate for the B.O.A. examinations who has been attending an optical class at a recognised public scientific Polytechnic or Institute, can, on production of a letter from his instructor certifying that he has attended satisfactorily, have the amount paid in fees for the said class or classes deducted from his examination fee on entry for the examinations of the British Optical Association up to the amount of £1 (one pound). Candidates are urged to take advantage of the numerous classes in optics or light in view of the fact that considerably more attention is now paid by the examiners to the practical work of demonstrating optical laws. The concession does not apply to students of private tutors, and applies only to those who are about to sit for the optical bench portion of Section C of the Fellowship examination.

12. Candidates must in every instance supply their own test-cases, trial frames, test-types, pliers, rules, drawing instruments, dissecting knife, &c., unless otherwise provided for. Lens spherometers are not permitted at the examination. Pen, ink and paper will be found by the examiners. Illumination for testing purposes will be supplied. Test-types and excellent test-cases and trial frame can be loaned by the Association by pre-arrangement with the Secretary.

A certificate of suitability will be required from each candidate for the Fellowship examination—such certificate to be signed by a medical practitioner, lawyer, magistrate, or minister of religion.

##### FEES.

###### FELLOWSHIP EXAMINATION.

In order to avoid confusion with the syllabus in force prior to December 31st, 1924, the sections are classified alphabetically, and the sub-divisions or parts numerically.

Subjective Examination (Section A, part 1, Section C, parts 1, 2, 3, 4). Four guineas.

Objective Examination (Section A, part 2, Section D, part 5, and Section E). Four guineas.

Written Papers (all Sections). Two guineas.

Whole Examination. Ten guineas.

###### HONOURS EXAMINATION.

Written Papers (all Sections). One guinea.

Oral Examination (all Sections). One guinea.

Practical Examination (Section D and Parts 1, 2 of Section B) Three guineas.

Whole Examination. Five guineas.

## PRELIMINARY EXAMINATIONS.

After December 31st, 1925, no candidate (unless his application shall have been specially sanctioned by the Council) shall be accepted for the Fellowship examination of the British Optical Association unless he shall previously have passed:—

One of the following examinations:—

- (a) The Preliminary examination of the British Optical Association.
- (b) The Matriculation examination of a British University.
- (c) The First Class College of Preceptors.
- (d) The Senior Oxford or Cambridge Local.
- (e) The Higher School leaving certificate.
- (f) The Educational Institute of Scotland.

or such other examination as may be approved from time to time by the Council, provided that the candidate had passed in any of the above examinations in the following subjects:—Mathematics, English and one scientific subject.

The Preliminary Examination of the British Optical Association, shall be in the following subjects:—

1. English and English composition.
2. Elementary mathematics.
3. French German or Latin.
4. Elementary physics, or elementary physiology.

1. *English and English Composition.*

- (a) Questions testing knowledge and command of English. These may include syntax, parsing and analysis, *précis* writing, paraphrase, and general rules of English grammar.
- (b) Questions relating to general reading and knowledge of six authors and one of each of their chosen books, which shall be specified.
- (c) An essay to be chosen by the candidate from several subjects set, the main object being to test the power of expression, thought and arrangement, general reading and knowledge.

Time allowed—3 hours.

2. *Elementary Mathematics.*

- (a) *Arithmetic.*—Numeration, vulgar and decimal fractions, metric system, approximations, contracted multiplication and division, ratio and proportion, percentage averages, problems.
- (b) *Algebra.*—Algebraic laws (simple) and their application factors, binomials, simple and quadratic equations, arithmetic, harmonic and geometric progression, square roots, problems.
- (c) *Geometry.*—The subjects of Euclid I-IV with simple deductions. Euclid's proofs not be insisted upon, but geometrical proofs will be required, the use of the properties of similar figures being allowed.

Time allowed—3 hours.

3. *French, German or Latin.*

- (a) Fairly simple translation from French, German or Latin into English.
- (b) Easy translation into French, German or Latin from English.
- (c) Simple subjects for free composition into French, German or Latin.

Time allowed—3 hours.

4. *Elementary Physics.*

- (a) *Heat Temperature.*—Thermometers and scales. Expansion and contraction, quantity of heat, specific heat, change of state, latent heat, conservation of energy.
- (b) *Light.*—Propagation of light, shadows, photometry, laws of inverse squares, reflection and refraction, images formed by simple, convex and concave mirrors and lenses.

(c) *Sound.*—Production and propagation of sound, wave motion, amplitude, wave length, frequency, velocity of sound in air, vibration of strings.

Or instead of *Elementary Physics*,

5. *Elementary Physiology.*

Time allowed—3 hours.

Candidates for the preliminary examination of the British Optical Association must have attained the age of 16 years.

A candidate who has passed any of the above sections will not be required to sit again for that section in case of failure in other sections.

The fee for this examination shall be £2 12s. 6d. In case of failure the fee for re-examination will be £1 6s. 3d.

Text-books recommended:—

The University Tutorial Series:—in English, Mathematics, French, German, Latin, Heat, Light and Sound, and any modern elementary work.

THE FELLOWSHIP EXAMINATION.—*Written papers will be set upon the following subjects. Practical and oral examinations will be held in the subjects marked with an asterisk (\*).*

The Fellowship examination of the Association on and after 31st December, 1924, shall be in the following subjects:—

*Section A.—The Estimation of Refractive Errors.*

- \*1. Subjective sight-testing and recording including phorometry, perimetry, colour vision, and the estimation of accommodation and the correction of presbyopia.
- \*2. Objective testing including retinoscopy.

*Section B.—Physiologic Optics.*

1. The human eye as a refracting instrument.
2. Defects of vision and their correction.
3. The schematic and reduced eye.
4. Accommodation and convergence.
5. Muscular anomalies and their optical consequences.
6. The principles underlying the construction of test-types.
7. The visual field.
8. Colour blindness and colour perception theories.
9. Binocular vision.

*Section C.—Mechanical and Visual Optics.*

- \*1. Various forms of ophthalmic lenses, including neutralising and transposition and examination for homogeneity and clarity of the medium.
- \*2. Prescription work including the reading and checking of optical prescriptions, the copying of a specimen pair of spectacles and writing of prescription for a duplicate pair. Facial measurements and frame fitting.
- \*3. Workshop practice. Frame bending and soldering, frame valuation, quality of lens surfaces, marking and setting out of lenses for cutting.
- \*4. Laws of reflection and refraction; problems on focal length, conjugate foci, magnification and reduction, spherical, chromatic and radial aberrations, Gauss theory, Prisms and their nomenclature, properties of cylindrical, toric and other special forms of ophthalmic lenses, the principles of polarisation, interference and diffraction. The spherometer, prismeter, strain-tester and polariser.

*Section D.—Anatomy and Physiology*

1. Elements of general physiology and pathology.

2. The anatomy of the eye, its appendages and connected organs.
3. The various ocular functions
4. The effect of mydriatics, myotics and cycloplegics.
- \*5. Dissection of the mammalian eye.

*Section E.—Recognition of Abnormal Conditions.*

\*The technique of focal and oblique illumination, ophthalmoscopy and perimetry, with a view to testing candidates' ability to recognise the presence of pathological conditions. \*\*

**THE HONOURS EXAMINATION.**—*Written papers will be set upon the following subjects. Practical and oral examinations will be held in subjects marked with an asterisk (\*)*

The Honours examinations of the Association on and after 31st December, 1924, shall be in the following subjects:—

*Section A.—Advanced Physiologic Optics.*

1. The construction and optical principles of ophthalmic sight-testing instruments.
2. The advanced testing of the ocular functions and the discussion of anomalies connected therewith.

*Section B.—Ocular Embryology and Physiology.*

- \*1. The development and dissection of the mammalian eye.
- \*2. The structural anatomy of the visual apparatus and its connections—with demonstrations under the microscope.
3. Advanced physiology and pathology of the eye.
4. First aid treatment in accidents and emergencies.

*Section C.—Ophthalmic Instrumentation.*

1. Advanced technique in ophthalmoscopy, retinoscopy, keratometry, phorometry and perimetry.
2. Advanced and hygienic methods of routine refraction examination.

*Section D.—Clinical examination for recognition of pathologic conditions of the eye. Thorough examination, both objective and subjective, of the living subject, to demonstrate familiarity with:—*

- \*1. Focal illumination for recognition of cataract, corneal opacities, etc.
- \*2. The use of the ophthalmoscope for ascertaining the condition of the fundus, vitreous lens, etc.
- \*3. The ophthalmometer for estimation of corneal curvature and deductions therefrom.
- \*4. The perimeter and scotometer for investigation of the field of vision.
- \*5. The retinoscope for estimating the refractive condition.
- \*6. The phorometer, etc., for testing muscular anomalies.
- \*7. The various tests for colour perception and colour blindness.

*Section E.—Ethics and Etymology.*

1. The relations of the refractionist to the medical practitioner and the dispensing optician and the discussion of possible problems arising therefrom.
2. The meanings of prefixes and suffixes in ophthalmological words and phrases.
3. The history, biography, bibliography of refraction and ophthalmology.

The Council may accept an original written thesis, the subject of which shall bear testimony of the required theoretical knowledge and hospital, clinical

or other research work—in lieu of the written portion of the Honours examination. The candidate submitting such a thesis will be required to take the practical portions of the examination and to pass an oral examination on questions arising out of the thesis, and such other portions of the usual written examination as shall be required by the examining Committee.

APPENDIX C.

HERIOT-WATT COLLEGE, EDINBURGH.

APPLIED OPTICS.

*Lecturers:*

W. WATSON, M.A., B.Sc., F.R.S.E., and Staff of Physics Department, C. W. GRAHAM, M.B., F.R.C.S.E., Ophthalmic Surgeon.

The Courses in Optics are arranged so as to cover the Syllabus for the B.O.A. Fellowship Examinations, and extend over three years.

OPTICS I.

*Mathematics, Practical or Stage I. Fee 10/-*

*Elementary Physics—Mondays, 7 to 9. Fee 20/-*

Attendance on these Classes is compulsory in the first year if any reasonable progress is to be made in the following years. The practical work in Physics will be mainly confined to experiments in Optics.

*Syllabus for Practical Physics.*—Use of vernier, callipers, and spherometer; reflection in plane, inclined, and curved mirrors; refraction by plates, prisms, and lenses; simple optical instruments; exercises on conjugate foci, focal length, and magnification.

OPTICS II.

Wednesdays, 7.15 to 9.15. Fee 25s.

N.B.—This class is held alternately with Optics III (see next page), and is not held this year 1924-25.

This class, held again in 1925-26, will be open to all students who have passed Optics I.

*Syllabus.*—Revisal and fuller treatment of subjects in 1st year's syllabus; refraction by prisms, curved surfaces, spherical and cylindrical lenses; transposition torics; neutralisation; decentration; effectivity and equivalence; chromatic and spherical aberration; refraction of the human eye; polarisation, interference, and diffraction.

In addition, a few lectures on general physiology will be given, dealing mainly with the eye.

OPTICS III.

Wednesdays, 7.15 to 9.15. Fee 25s.

N.B.—This class is held alternately with Optics II (see previous page), and will be held this year 1924-25.

The subjects of instruction will deal mainly with visual optics and subjective sight testing and recording. A more detailed Syllabus will be available at the opening of the Session.

APPENDIX D.

MANCHESTER MUNICIPAL COLLEGE OF TECHNOLOGY.

SESSION 1924-25.

APPLIED OPTICS.

*Lecturers:*

A. ADAMSON, M.Sc.Tech., A.R.C.S.

J. L. MEYNELL, M.D., M.R.C.S., D.P.H. (Vic.), Ophthalmic Surgeon

W. B. BARKER, F.B.O.A. (Hons.)

P. A. L. GAVIN, F.B.O.A. (Hons.)

OPTICS I.\*

Thursday, 6.30 to 9 p.m. Room, 67.

Fee: Ratepayers of the City £2 2s. 0d. Non-ratepayers of the City £2 12s. 6d.

**Physical Optics:**

Laws of reflection and refraction; problems on focal length, conjugate foci, magnification and reduction, spherical, chromatic and radial aberrations; prisms and their nomenclature. Properties of special forms of ophthalmic lenses; neutralisation of lenses.

**Workshop Practice:**

Frame bending and soldering; marking and setting out of lenses for cutting.

**Prescription Work:**

Transposition; facial measurements; frame fitting.

**Mathematics:**

Mathematics required for ophthalmic optics including trigonometrical functions.

**OPTICS II.\***

Tuesday, 6.30 to 9 p.m. Rooms, C7 and C9.

Fee: Ratepayers of the City £4 4s. 0d. Non-ratepayers of the City £5 5s. 0d.

**Subjective Sight Testing and Recording:**

Including Phorometry, Perimetry, Colour Vision, and the estimation of accommodation; the correction of presbyopia; objective testing, including Retinoscopy.

**Physiologic Optics:**

The Human Eye as a refractive instrument; defects of the eye and their correction; the schematic and reduced eye; accommodation and convergence; Muscular Anomalies and Colour Vision; the Visual Field; colour blindness and colour perception.

**Physical Optics:**

Revision of the Physical Optics in Optics I; theory of Gauss; principles of polarisation; Interference and Diffraction; the Spectrometer, Spherometer, Strain Tester, and Polariser.

**Anatomy and Physiology:**

The elements of general Physiology and Pathology; the anatomy of the eye—its appendages and connected organs; the ocular functions; effects of mydriatics, myotics, and cycloplegics.

**Practical Section of Mammalian Eye.****Recognition of Abnormal Conditions:**

Technique of focal and oblique illumination; ophthalmoscopy and perimetry, with a view to the recognition of the presences of pathological conditions.

\* Optics I and II prepare students for the Fellowship Examination of the British Association—new regulations.

Students attending Optics II will be required to attend for approximately ten Thursday evenings in addition.

**OPTICS III.**

Thursday, 6.30 to 9 p.m. Room, B6.

Fee: Ratepayers of the City £6 6 0d. Non-ratepayers of the City £7 7s. 0d.

**Advanced Physiologic Optics:**

The construction and optical principles of ophthalmic sight-testing instruments; the advanced testing of the ocular functions and the discussion of anomalies connected therewith.

**Ocular Embryology and Physiology:**

The development and dissection of the mammalian eye; the structural anatomy of the visual apparatus and its connection—with demonstrations under the microscope; advanced physiology and pathology of the eye; first-aid treatment in accidents and emergencies.

**Ophthalmic Instrumentation:**

Advanced technique in ophthalmoscopy, retinoscopy, keratometry, phorometry and perimetry; advanced and hygienic methods of routine refraction examination.

**Clinical Examination for Recognition of Pathologic Conditions of the Eye:**

Thorough examination, both objective and subjective, of the living subject, to demonstrate familiarity with focal illumination for recognition of cataract, corneal opacities, etc.; the use of the ophthalmoscope for ascertaining the condition of the fundus, vitreous, lens; and the ophthalmometer for estimation of corneal curvature and deductions therefrom; the perimeter and scotometer for investigation of the field of vision; the retinoscope for estimating the refractive condition; the phorometer, etc., for testing muscular anomalies; the various tests for colour perception and colour blindness.

**Ethics and Etymology:**

The relations of the refractionist to the medical practitioner and the dispensing optician and the discussion of possible problems arising therefrom; the meanings of prefixes and suffixes in ophthalmological words and phrases.

The history, biography, bibliography of refraction and ophthalmology.

**SUPPLEMENTARY COURSES.**

Special classes will be arranged to conform to the new examination regulations in preparation for the Supplementary Examination to enable holders of the D.B.O.A. Certificate to qualify for the F.B.O.A. It is anticipated that this course will extend over a period of about six weeks. Further particulars can be obtained from the Registrar.

Providing a sufficient number of students desire to attend, arrangements will be made at the end of the evening session for a special revision class preparing for the B.O.A. examinations.

**APPENDIX LXIII.**

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE COUNCIL OF BRITISH OPHTHALMOLOGISTS BY MR. E. TREACHER COLLINS, F.R.C.S., PRESIDENT, MR. J. HERBERT FISHER, F.R.C.S., MEMBER, AND MR. M. S. MAYOU, F.R.C.S., MEMBER. See Minutes of Evidence of the Thirty-First Day, Questions 17,772 to 17,934.

1. For some time past the Council has had under consideration the question of the provision of optical benefit as an additional benefit by some Approved Societies. It appears that optical benefit is taken to mean examination of the eyes and provision of glasses.

2. By some Approved Societies arrangements have been made for examination of the eyes, as well as provision of glasses, to be undertaken by opticians.

The Council of British Ophthalmologists is strongly of opinion that the examination of the eyes should be carried out by qualified medical practitioners. The chief reasons for this contention are set out in the Report of the Council on Sight-Testing by Opticians, which was published on December 1st, 1922. (See Appendix.)

3. The Council also desires to draw the attention of the Royal Commission to Sections XV. and XVI.

of the report of the Departmental Committee on the Causes and Prevention of Blindness, in which the importance of the provision of adequate facilities for ophthalmic treatment is emphasised, and a definite recommendation made that "all persons with defective vision should first consult a competent medical practitioner." (Section XVI., paragraph 278.)

4. Recently a joint sub-committee of this Council and of the British Medical Association made the following recommendations, which this Council has approved and desires to support:

- (1) That the so-called optical benefit should be designated ophthalmic benefit.
 

••

Ophthalmic benefit would include examination and prescription for spectacles, if required, and such operative treatment and advice as can be given at a single consultation at the consulting room. A report, when necessary, would be given for the guidance of the private practitioner.
- (2) That, in order to ensure the satisfactory working of the proposed scheme, it is essential that the insured members of every Approved Society should in any case of ocular disorder or visual defect apply to their insurance practitioner.
- (3) If the insurance practitioner considered the case one requiring special advice or treatment he would give the applicant a certificate, enabling him to consult a specialist at a reduced fee, and at the same time a list of the ophthalmic medical practitioners, in the district in which he resided, who were willing to see him for such a fee.
- (4) A list of ophthalmic medical practitioners qualified and willing to see members of Approved Societies at a consultation fee of £1 ls. should be prepared in accordance with the following principles:—
  - (a) That they have held hospital or other appointments affording opportunities for acquiring special skill and experience of the kind required for the performance of the service to be rendered, and have had actual recent practice in performing such service or services of a similar character, or
  - (b) That they have made special academic or post-graduate study of a subject which comprises the service to be rendered, and had actual recent practice as aforesaid, or
  - (c) That they be generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service to be rendered.
- (5) That a list be prepared of opticians who are willing to supply optical appliances prescribed by medical practitioners for insured members of Approved Societies in accordance with an agreed schedule of charges.
- (6) In the event of the surplus funds of an Approved Society being insufficient to allow of it paying the specialist's reduced fee of £1 ls. for consultation, the patient himself would be required to furnish the amount necessary in addition to that which the Approved Society was able to grant for this purpose.

W. H. McMULLEN,  
Honorary Secretary.

27th November, 1924.

#### APPENDIX.

#### COUNCIL OF BRITISH OPHTHALMOLOGISTS— REPORT ON SIGHT-TESTING BY OPTICIANS.

In 1906, and again in 1919, opticians have made application to the Legislature that their craft may be legally recognized for the purpose of sight-testing,

and it is consequent upon these efforts that the Council of British Ophthalmologists has thought it desirable to consider the matter in the interests of the general public.

#### TRAINING OF OPTICIANS.

The Council would warmly welcome any scheme which would lead to greater efficiency in the making and fitting of spectacles. It fully recognizes that there is a very definite need for a greater supply of properly trained opticians, and ophthalmic surgeons often have cause to deplore the inefficiency displayed in carrying out their prescriptions for glasses.

#### SIGHT-TESTING BY OPTICIANS.

In a recent petition (1919), the British Optical Association claimed that opticians should be recognized as capable, not only of carrying out the optician's art of making and fitting glasses in conformity with prescriptions, but also of measuring and determining what glasses are required to compensate for defects of vision in any member of the public who may apply to them. Paragraph 10 of the petition stated:—"In a very large majority of refraction cases which can be treated by glasses, members of the public do, in fact, visit an optician rather than an ophthalmic surgeon or medical man, and the Association humbly submit that it is eminently in the public interest that the optician should be a skilled man and under suitable supervision. A qualified optician, especially when holding a Fellowship Certificate of the Association, would recognize a case in which the eye, through disease or otherwise, could not be properly treated by glasses, and would direct the patient to an ophthalmic surgeon or medical man. An ignorant optician would be likely to supply the patient with glasses which might do great harm."

#### TRAINING NECESSARY FOR SIGHT-TESTING.

The Council, however, considers that no course of training short of that required for full medical qualification can produce the skill and judgment necessary to secure the requirements stated in the above paragraph. Every medical man dealing with ophthalmic cases must be equipped with the knowledge necessary for ordinary qualification in medicine and, in addition, with special knowledge of the most delicate and complex sense organ in the body. *It is the opinion of the Council that any State recognition of sight-testing by persons possessing only an optical qualification would not be in the interests of the community.*

#### THE SCIENTIFIC PRINCIPLES OF SIGHT-TESTING.

The art of prescribing glasses can be divided into two periods—the purely empirical period preceding 1850, when only subjective methods of testing were available, and the period following 1850, when accurate objective measurements began to be used. (See last paragraph.) Those scientific methods have been developed by medical research, and to a great extent they are not available to the optician. The statement that where defective vision is due to other than optical conditions it should be treated by a duly qualified medical practitioner (see petition of the British Optical Association, par. 10, quoted above) is in itself sufficient argument against the optician's claim, since it is well known that changes in the refraction of the eye are often produced in the early stages of serious eye disease. In many such cases an optician may be successful in raising the acuteness of vision to a normal standard, but he would almost inevitably fail to recognize the disease which is the cause of the refractive error. In fact, disease very serious to the eye, or threatening even life, may occur in an eye with perfect acuity of central vision.

#### USE OF DRUGS.

An adequate examination of the eyes and a correct determination of the error of refraction cannot be made in young children, especially in cases of squint, while the accommodation (i.e., focussing power) is active. The absence of accommodation effort can only be ensured by the use of certain drugs, which

also dilate the pupil. These drugs must not be used in an indiscriminate manner. In certain conditions of the eye their employment is attended by grave risk to sight. In some individuals they produce serious constitutional disturbances. As dilators of the pupil their use is frequently essential in order to determine the presence or absence of changes in the retina or optic nerve. Such changes may be the first indication of general disease, by the prompt treatment of which the life of the patient may be saved or prolonged.

#### EYE DEFECTS AND GENERAL DISEASE.

The treatment of headaches, associated with errors of refraction, demands not only the use of glasses, but also constitutional treatment, which can only be determined by a medical man. In some cases of defects of the muscular balance of the eyes, the use of prisms is necessary. The correct estimation of these and a complete investigation of the case are most difficult problems, since some of these muscular defects are among the earliest signs of serious diseases of the nervous system.

Changes in the refraction of the eyes are often produced in the early stages of eye disease. For example, myopia ("shortsight") often appears in the early stages of cataract, or of chronic glaucoma, a disease which untreated inevitably leads to blindness. Hypermetropia ("longsight") may be met with in the early stages of a malignant tumour. In such cases glasses may bring visual acuity up to a normal standard, but the optician will fail to recognise the disease, which will thus be left to run its course.

Optical defects and disease constantly overlap; the former cannot be differentiated with certainty from the latter, nor the latter definitely excluded by any but a medical practitioner who has had special training and experience.

#### OPTICIAN'S STANDPOINT.

The "sight-testing optician" endeavours either to supply spectacles with which the customer considers he can see to his liking, or to provide such lenses as will convert optically imperfect eye into accurately focussing instruments. All are agreed that the former procedure is indefensible; the latter needs further consideration.

The eye is an integral part of the human body. Developmentally it is, in its most essential elements, an off-shoot of the brain. There is practically no organ of the body which does not react upon it to its advantage or its detriment. Without exposing it to the gravest misfortune it cannot be dealt with as an inert, isolated optical instrument, yet it is in this way only that the optician can view it, and in this way only can he adapt mechanical apparatus to such of its optical defects as his limited means may enable him to recognise. Without the use of drugs to dilate the pupil or paralyse the focussing muscle, in many cases he cannot measure accurately the error of refraction, or be in a position to identify the cases which demand medical advice and treatment. If he were allowed to use such drugs he would become an even greater danger to the community by reason of serious disease which he in his ignorance might produce.

#### OPHTHALMIC SURGEON'S STANDPOINT.

The ophthalmic surgeon approaches his refraction work from an entirely different standpoint. To him the eye is an optical instrument, but it is also an integral part of the human body in complex interrelation with the other parts. Its anatomical proportions and its physiological activities are before his mind. Its pathological disturbances, both local and those dependent on general disease, are known to him. He has at his disposal the use of all drugs necessary for his purposes, and of the indications for and against their employment he is fully aware.

In the investigation of diseases of the eye, the measurement of the acuteness of vision, both with and without lenses, is one of the first steps in the examination of the patient. In refraction work the surgeon takes into consideration the physiological activities of the normal eye. The hypermetropic eye he regards as developmentally imperfect. Astigmatism may be

due either to developmental malformation or to disease. Presbyopia (loss of focussing power associated with advancing age) is a physiological condition, but undue rapidity in its progress may herald glaucoma, and apparent recovery of focussing power may indicate the earliest stage of cataract. Myopia is in many instances pathological, and the myopic eye is exposed to grave disorders. With a comprehensive knowledge of facts such as these, the ophthalmic surgeon decides in a pure refraction case what lenses should be prescribed. With what lens the patient sees best is only one point he takes into consideration when prescribing. His aim is not only to improve vision, but also to secure the health and comfort of the patient. No case is dismissed until full ophthalmoscopic and other examination has excluded all objective signs of disorder.

If disease be present, its causation, whether local or general, has to be ascertained, and this demands knowledge of the diseases of the other organs of the body which produce changes in the eye. The ophthalmic surgeon must have an adequate knowledge of diseases of the brain and central nervous system, of the blood vessels and vascular system, of the kidneys, of the nose and its accessory sinuses, of the various ductless glands, etc. In fact, there is no branch of medicine which is not in close relationship with this special domain, nor is there any specialty in which a general medical knowledge is of greater importance.

#### THE PUBLIC INTEREST.

It cannot be in the interests of the community to allow such grave responsibilities to pass into the hands of men with no medical training, and to hall mark by official recognition a practice involving such dangers.

Many people in the past have gone to opticians to obtain glasses for failing vision under the impression that they are fully qualified to prescribe. Official recognition of sight-testing opticians would encourage the practice and would increase the feeling of security which our arguments show to be unwarranted. There can be little doubt that this impression has been fostered by such "qualifications" as F.S.M.C., F.B.O.A. (Fellowship of the Spectacle Makers' Co., Fellowship of the British Optical Association), etc. It is the duty of the State to guard against legislation which may in any way entail detriment to the community.

#### HISTORICAL.

An enquiry into the history of the science and art of refraction will show that this branch of ophthalmic work has been initiated and developed by medical men, and that even at the present day the optician works and must of necessity work largely on the more purely empirical lines of the early part of the nineteenth century.

The discovery of spectacles as an aid to vision dates from the thirteenth century. There is no absolute certainty as to their first inventor, but the probabilities point to Roger Bacon (1214-1294), who, in his "Opus Majus," wrote of the enlarging power of a plano-convex glass and of its value "senibus et habentibus oculos debiles." Either directly from Bacon, or from some other monk, the discovery became known in Italy, and at the end of the thirteenth century, spectacles were being made by Alessandro de Spina, a Dominican Friar, of Pisa. He did not claim to be the actual inventor, but had seen glasses made by someone else who was unwilling to reveal the secret. It may have been from Salvino d'Armato, of Florence, that Spina obtained the secret, since Armato's tombstone bears the inscription:—"Here lies Salvino d'Armato degl'Armati, of Florence, inventor of spectacles. God forgive him. Anno D. 1317."

If Roger Bacon invented spectacles it was probably sometime before the year 1267, when the "Opus Majus" was written for Pope Clement IV.

By the middle of the 14th century, convex glasses had become fairly common.

Concave glasses seem to have come into use first in the sixteenth century, and early in the seventeenth century Kepler wrote the first important scientific work on the use of spherical lenses.

The next important discovery did not take place till the beginning of the nineteenth century, when Thomas Young, the distinguished physician and physicist, in his "Memoir on the Mechanism of the Eye" (*Phil. Trans. Roy. Soc.*, 1801), gave the first description and measurement of astigmatism and a table of optical constants in close agreement with modern determinations. He had previously (1793) written a paper on the mechanism of accommodation which secured his election to the Fellowship of the Royal Society. His observations were subsequently confirmed by Airy in 1823, but remained practically unknown to opticians.

Until the year 1858 the prescribing of spectacles was entirely empirical. It was known that men, as they reached middle life, had difficulty in seeing to read, and that their difficulty was relieved by wearing suitable convex glasses. It was occasionally found that younger people also were helped in reading by the use of convex glasses, and they were said to have "old sight," a phrase still to be heard in use amongst opticians.

Another group of people was said to have "weak sight," and it was found that they were enabled to see more clearly in the distance by the use of concave glasses. The sale of spectacles was often in the hands of country pedlars, and people chose from the stock what seemed to suit them best.

With the discovery by Helmholtz of the ophthalmoscope and the ophthalmometer in 1853, the scientific investigation of the refractive media of the eye became possible, and the work of Donders, the great Dutch surgeon, speedily laid the foundations on which all modern refraction work is built. He showed the way in which a hypermetropic eye and a myopic eye depart from the normal, and the

liability to disease existing in the myopic eye. He showed the relationship between the long-sighted eye and squint, and the essential difference between long-sight and old-sight. He discovered the frequency of astigmatism and laid down the rules for its detection and estimation, and showed how to determine the strength and position of the cylindrical glasses necessary for its correction. Donders also established a standard for normal vision, and for the first time rendered accurate "sight-testing" possible. He reconstructed the scale of lenses, substituting the meter for the inch as the unit of measurement.

This work has been continued and extended, corrected and amplified but the progress has been entirely due to the work of medical men.

In 1873 Guignet, a French military surgeon, discovered an additional method of measuring the refractive condition of an eye, which rendered the ophthalmic surgeon still less dependent on the subjective methods previously in use. By the method of retinoscopy the skilled ophthalmic surgeon is enabled to make accurate measurements of the static error of refraction. These measurements can only be accurate in the absence of any accommodative effort on the part of the patient under examination. This condition of absence of accommodative effort can only be ensured by the use of drugs which paralyse the ciliary muscles.

At a later date the use of prismatic glasses was introduced by medical men to alleviate symptoms due to errors in the muscular balance of the two eyes, and the determination of the conditions under which prisms should be ordered is one of the most difficult problems an ophthalmic surgeon has to solve. It involves the knowledge not only of the inborn defects of musculature, but also of acquired defects, and of the pathological causes which may produce them

## APPENDIX LXIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE OPHTHALMIC BENEFIT COMMITTEE, by Mr. H. L. EASON, C.B., C.M.G., M.D., M.S., CHAIRMAN OF THE COMMITTEE, Mr. G. H. POOLEY, F.R.C.S., MEMBER, AND Mr. CHARLES F. HARFORD, M.A., M.D., M.R.C.S., L.R.C.P., HON. SECRETARY. *See Minutes of Evidence of the Thirty-First Day, Questions 17,935 to 18,029.*

### GENERAL.

1. The Ophthalmic Benefit Committee which represents the interests of Ophthalmic Medical Practitioners who are willing to take part in an Ophthalmic Medical Service, in general accordance with the Scheme presented to the Ministry of Health (as published in the Supplement to the "British Medical Journal" of June 28th, 1924) desire to submit to the Royal Commission on National Health Insurance the following Statement.

2. They ask for the strict application of the plan put forward by the Ministry of Health which stipulates that payment in respect of the cost of an optical appliance should only be made on the production of a prescription from a qualified practitioner, it being understood that the term "qualified practitioner" means a qualified medical practitioner.

3. They submit in Appendix A hereto a reprint from the "Lancet" on Ophthalmic Benefit for members of Approved Societies for the information of the Commission as to the general situation, and would emphasise the fact that the Ophthalmic Benefit Committee are in hearty agreement with the evidence submitted by the Council of British Ophthalmologists and the British Medical Association.

4. They strongly support Appendix C (Ophthalmic Benefit) of the Statement of Evidence of the British Medical Association and particularly paragraphs 4 and 5 with reference to the employment of sight-testing opticians in the examination and treatment of the eyesight of insured persons in connection with the

Insurance Act, and would draw attention to the practice of continental nations with reference to sight-testing opticians who are not recognised by law.

5. They desire to adopt in the main the finding of the Departmental Committee on the Causes and Prevention of Blindness (1922) which deal with "unqualified practice," (Sections 263-284 of the Report) as carried out by sight-testing Opticians. Seeing that the Council of the British Optical Association have addressed to the Ministry of Health a detailed criticism of certain Sections of the Report, it may be useful to consider these criticisms in detail as the Committee have done in paragraphs 7 to 15 following.

6. The Ophthalmic Benefit Committee do not profess to deal in what follows, with the general problem of "unqualified practice" here unfolded, which would naturally be dealt with by the General Medical Council. They do, however, respectfully submit to the Royal Commission that "ophthalmic" or "optical" benefit should only be granted in those cases where a skilled Ophthalmic Medical Practitioner is consulted, and optical appliances supplied on a prescription given by such a registered Practitioner of medicine whose qualifications are approved by a properly constituted authority.

7. The Ophthalmic Benefit Committee make the following observations on the Memorandum submitted by the British Optical Association to the Ministry of Health as contained in the "Optician" for November 7th, 1924.

## THE PRESENT SITUATION.

8. It is suggested by the British Optical Association that "the public do not as a general practice consult any but medical men when in a state of acute pain . . . but for spectacles invariably consult a sight-testing optician," and later in the same memorandum that "the average registered medical practitioner (other than an oculist), from very natural motives, does not send an ordinary case of refraction to another medical man professing to do optical work, and not often to an oculist. He has found that it is a safer and more satisfactory procedure to direct such persons requiring glasses to a competent optician."

9. The Ophthalmic Benefit Committee submit that these statements should be carefully considered in their relation to the interests of the people of this country.

10. The opticians by their specious advertisements are able to put before the public a statement of their own claims to which Ophthalmic Surgeons have no means of replying. The Committee have a number of specimens of these statements made by individual opticians, but they submit (see Appendix B) an advertisement from a recent issue of "The Times" issued by a body which styles itself "The National Council for the Preservation of Eyesight," which is understood to be representative of the British Optical Association among other Societies of Opticians. In Appendix C is given a copy of a circular inaugurating this Council.

11. The following recommendation is made as to the treatment of headaches due to "eye strain" which the advertisement states is responsible for "ninety out of a hundred cases of recurring headaches." So the advertisement continues "the one way of permanently curing such headaches is to obtain the advice of a really competent optician."

12. That the public are being deceived is not unnatural in view of these statements, but the Ophthalmic Benefit Committee are certainly not prepared to believe that practitioners of medicine generally are willing to accept this position. There appears, however, to be a serious misunderstanding as to the difficulty of obtaining the services of a competent Ophthalmic Medical Practitioner and the fees which would be charged for their services.

## AVAILABILITY OF OPHTHALMIC MEDICAL PRACTITIONERS.

13. It is probable that the suggestion that there were not sufficient of the above has been one of the chief difficulties in securing a proper system of specialist treatment in eye diseases.

14. The idea that nothing has been done by the Profession to improve matters is wholly fallacious. The chief stages of progress may be summarised as follows:—

(1) *Experience of the War.*—One of the triumphs of the medical history of the war was the marshalling of a great Ophthalmic Specialist Service. In this instance, in spite of many difficulties, full co-operation between the Ophthalmic Medical Specialists and the Opticians' Department was secured with the best results. A generous tribute would be paid by the former to the efficient work done by the Opticians who assisted them and to the good work of the Army Spectacle Department, and if this can be arranged in time of war, it cannot be impossible to devise a scheme suitable for peace. The basis of the scheme was that every man and woman in the services was entitled to the advice of a competent ophthalmic medical practitioner, and in cases where spectacles were needed that they should be provided and fitted by skilled opticians. This is the only system which could be satisfactory not only in war but in peace.

(2) *Ministry of Pensions.*—The work of the War has been continued in the arrangements of the Ministry of Pensions, for which specialists have been available in all parts of the country.

(3) *The Board of Education.*—The most extensive development of the ophthalmic system in relation to the public services is in connection with school clinics throughout the country, which existed before the War, but have developed mainly since that time. This system, as indeed the whole problem of ophthalmic practice, has been wholly misunderstood by the British Optical Association.

They have confused the school medical officers who conduct the school medical examinations with the ophthalmic specialists who are responsible for the clinics.

These specialists cover a large area of country, and the number of specialists is not great, but in many instances, if a post falls vacant there are many who would be glad to fill the vacancy.

For various reasons these posts are not usually advertised in the medical press, so that there is little opportunity for due competition for them.

In figures supplied by the Boards of Education for 1919, there were:—

155 part time Ophthalmic Surgeons,  
7 whole time,  
91 Members of the Staff of the School Medical Service who were qualified to undertake refraction work.

In 48 cases the staff of hospitals carried on school clinics at the hospitals. In 1920 there were 240 Education Authorities who had provided for refraction work. No doubt there has been great expansion of this service since then, but the figures given indicate the general manner in which this work is being carried out.

Those who are familiar with this work are convinced of its vital importance in its relation to the eyesight and general well-being of the nation, and also of the extreme difficulty of dealing adequately with these refraction cases, which are some of the most difficult problems with which the medical profession is called upon to deal.

(4) *Hospital Refraction Posts.*—The appointment in connection with many of the greater hospitals of refraction assistants in addition to the clinical assistants, who have in the past dealt with a large part of this work, is an evidence of the large number of cases which must be dealt with and the necessity of securing the services of skilled ophthalmologists to whom is entrusted this most exacting duty.

It is clear from this that the great importance of refraction work is fully recognised in medical ophthalmic circles, which in fact forms the bulk of the work of every ophthalmic specialist in his private practice.

(5) *Modern Ophthalmic Practice.*—The change which has taken place since the War in ophthalmic private practice consists in the decentralisation of this branch of specialist service. Ophthalmic practitioners have to a large extent divided the country between them so that there is probably no section of the country which is not covered. Many have consulting rooms in different centres, and if it should be found that any important area is not provided for at all, or inadequately supplied, there are many who would take advantage of the opening. A large number of members of the medical profession in general practice have had special ophthalmic training, either as ophthalmic house-surgeons or clinical assistants in the ophthalmic hospitals or the ophthalmic departments of the general hospitals, so that there would be no difficulty in obtaining the services of medical practitioners qualified to meet any new demand for skilled ophthalmic work.



(6) *Ophthalmic Diplomas*.—The institution of special diplomas is given in the report as evidence of the recent developments in ophthalmic education. These are like the diplomas in tropical and psychological medicine additional tests, which will be of great advantage in the future, but they are no indication of the number of practitioners who may be regarded as fully trained ophthalmic surgeons.

Post-graduate study in ophthalmic practice is one of the oldest and most efficient of any of the medical or surgical special departments, and it is only the younger practitioners who can be expected to submit themselves to these examination tests.

#### CLAIMS OF THE BRITISH OPTICAL ASSOCIATION.

15. The Report of the Departmental Committee on the Causes and Prevention of Blindness has clearly stated the general claims of sight-testing opticians, and the difficulties arising from them and the criticisms of the British Optical Association indicate that these claims are even greater than those stated in the report, for

- (1) They claim to have the right to use mydriatics, and
- (2) The skill to diagnose glaucoma and other obscure diseases of the eye which even the highest ophthalmic experts find difficulty in recognising.

If this is the position adopted by the leading sight-testing opticians the door is open for unqualified specialism in every other department of medicine.

The advertisement referred to above and quoted in Appendix B, claims that medical practitioners are not the proper people to deal with the commonest of all human ills, but that "a really competent optician" is the proper person to be consulted.

#### APPENDIX A.

(Reprinted from "The Lancet," Jan. 3rd, 1925, p. 49.)

#### OPHTHALMIC BENEFIT FOR MEMBERS OF APPROVED SOCIETIES.

One of the subjects before the Royal Commission on National Health Insurance now sitting is the best way to dispose of the surpluses which some of the Approved Societies possess and which are available for the granting of certain additional benefits to their members. There are 18 of these additional benefits, and according to an official statement prepared for the use of the Commission and already published (Appendix to Minutes of Evidence, Part I. Statement prepared by certain Government Departments. H.M. Stationery Office. 8s. 6d.) the most popular of the additional benefits, next to dental treatment, is the so-called optical benefit. For the year 1924 nearly £40,000 is available for it. In one very large Society, already, the claims have numbered 500 a week. A "model schedule" provides that "payment in respect of the cost of an optical appliance shall only be made on the production of a prescription from a qualified practitioner or a hospital." In some instances, says the statement, and in particular in rural districts it has been found that to insist on this condition is impracticable and its strict enforcement has been relaxed. If we may believe a writer in the *Optician*, as a matter of fact, all the largest Approved Societies (and many of the smaller ones) send their members to an optician, and not to a qualified practitioner or a hospital. Whether or not this statement of the case requires qualification, there is, at any rate, sufficient truth in it to demand the attention of those medical bodies whose duty it is to have regard both to the professional interests of their members and to the preservation of the nation's eyesight. Three such bodies exist and are at present jointly concerned in considering the various problems under review with the object of ensuring that the model schedule of the Ministry of Health, just quoted, which at

present, unfortunately, is in danger of becoming a dead-letter, may become really effective. The first of these three bodies is the Council of British Ophthalmologists, formed in 1918, representative of the Ophthalmological Society and the Ophthalmological Section of the Royal Society of Medicine; the second is the Ophthalmic Committee of the British Medical Association, and the third is the Ophthalmic Benefit Committee, which has been formed during the past year, membership of which is open to those who hold or have held posts as surgeons, assistant surgeons, clinical, or refraction assistants at the ophthalmic hospitals or general hospitals with ophthalmic departments, and are in regular ophthalmic practice. The chairman of this Committee is Mr. H. L. Eason, senior ophthalmic surgeon to Guy's Hospital. It is understood that the aims of these three bodies with regard to the matter at issue are in perfect harmony.

Last spring a joint committee was formed by the first two bodies, which drafted a scheme for ophthalmic benefit, and this committee has now agreed to allow equal representation to the Ophthalmic Benefit Committee in any approach to the Ministry of Health and in considering the various problems under review. It is proposed that a list of ophthalmic medical practitioners qualified and willing to see insured members of Approved Societies should be prepared in accordance with the following principles. Anyone desiring to join in the scheme will have to furnish evidence (a) that he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character; or (b) that he has had special academic or post-graduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid; or (c) that he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

We understand that in the opinion of the three bodies there will be no difficulty in providing a satisfactory ophthalmic service on these lines. At one time it was thought that this could only be done in London and in the larger towns, but with the development of school clinics and duties in connexion with the Ministry of Pensions, ophthalmic surgeons are arranging not only to have their consulting-rooms at these larger centres where they are usually engaged in some capacity in the ophthalmic departments of the hospitals, but they visit, periodically, minor centres, and as soon as the demand is apparent there is little doubt that the supply will be equal to it. This is the first essential. The second is of at least equal importance—that the standard of work should be maintained at a high level. At a recent meeting of the Ophthalmic Benefit Committee, three members representing the North of England Ophthalmological Society were elected on to the executive, the conditions on which they agreed to serve meeting with general approval. They were as follows: (1) That there should be no lowering of the standard of work of ophthalmic surgeons, but that, on the contrary, it should be rendered more highly efficient; (2) that there should be an adequate fee for those taking part in the service; and (3) that their society should be responsible for the organising of the work in their area. A note in the supplement to the *British Medical Journal* for December 13th states that the Medical Secretary would be glad to receive the names of medical men habitually doing ophthalmic work and complying with the conditions already mentioned, whose names are not already in the list, and who are willing to do the work. This list, the note states, can be supplied to the Approved Societies on application. An agreed fee of one guinea for each completed case of refraction has been mentioned, and it is believed that this would prove generally acceptable. At present the most urgent necessity is to demonstrate to the Ministry of Health that there are enough men and women in the medical profession competent and willing to do this work. To this end further names should be sent without delay, either to the Medical Secretary of the British

Medical Association or to the Secretary of the Ophthalmic Benefit Committee at 30, Finsbury Square, London, E.C.

#### APPENDIX B.

*Copy of advertisement issued by the National Council for the Preservation of Eyesight in "The Times."*

##### WHAT CAUSES HEADACHES?

It is probably not an exaggeration to say that ninety out of a hundred cases of recurring headaches arise from some minor eye trouble.

In some instances grossly defective vision is responsible, but much more numerous are cases of unsuspected and unavoidable eye-strain. The word "unavoidable" is used advisedly, because the very nature of many people's daily work involves constant use of the eyes under conditions in which strain is inevitable.

It naturally follows that the one way of permanently curing such headaches is to obtain the advice of a really competent optician.

It will generally be found that, taken in time, eye-strain can be first relieved and ultimately prevented by the use of suitable glasses for work, and for reading or sewing.

If the optician consulted prescribes glasses it is advisable to possess two pairs. Glasses are easily broken and as easily left at home or at work, and on such occasions the man who has a spare pair at hand can congratulate himself on his foresight.

A word of warning. Where such sensitive and delicate organs as the eyes are concerned the greatest care should be taken to consult only those opticians who were fully qualified to give advice and treatment.

Every optician who is registered by the National Council for the Preservation of Eyesight, and who displays the Council's symbol, has satisfied the Council of his technical and professional qualities and may be consulted with entire confidence.

#### APPENDIX C.

*("The Optician and Scientific Instrument Maker," July 4, 1924.)*

##### THE NATIONAL COUNCIL FOR THE PRESERVATION OF EYESIGHT.

(The following circular was addressed to every qualified optician in Great Britain, by the N.C.P.E., under date 30th April, last.)

DEAR SIR,

As you are aware, it was unanimously decided at a Joint Conference of Retail and Wholesale Opticians (November 7th, 1923) that a scheme should be inaugurated forthwith for the following purposes:—

To inform and educate public opinion as to the necessity of conserving vision; and

To ensure fullest publicity regarding the services which the qualified optician can render the community.

Since that date further steps have been taken, the most important of which is the formation of a Council under the above title for the purpose of conducting a National Co-operative Advertising Campaign for the benefit of the whole industry.

The Council has decided that this scheme should be confined strictly to members of the Association of Wholesale and Manufacturing Opticians and those registered by the Joint Council of Qualified Opticians.

A Co-operative Advertising Campaign by a properly organised and representative body furnishes the best means whereby the services rendered by the whole optical industry to the community can be rapidly and regularly increased.

The advertisements are to appear as a regular series in leading newspapers throughout the Kingdom. They will deal with the subject from many angles

of public interest, but will consistently concentrate on two points, viz:—

- (1) Thoroughly arousing public interest in the necessity for preserving the sight.
- (2) Directing the public to competent opticians who are approved as subscribers to the Collective Campaign and qualified to perform the important work of testing the sight scientifically and supplying proper glasses.

Among the other points that will be dealt with are:—

The fact that millions of people require glasses who do not realise their need.

Signs that the eyesight requires testing.

The importance of having glasses fitted that will enhance rather than detract from personal appearance.

Different styles of glasses for different occasions and different work.

The necessity of always having at least one spare pair of glasses.

Etc. etc.

You, as a business man, will recognise the importance of advertising, but you will also realise that claims made for you by the National Council as being specially able to render public service have a much more powerful effect on public confidence than the same claims made for you by yourself. Indeed, any advertising you do now for the sake of your own individual firm will be very much enhanced in value by the simultaneous appearance of the Collective advertisements.

A simple calculation will show that a firm with an average sight-testing and spectacle turnover of say £1,000 per annum would only have to contribute a sum of just over 3s. per week. As the turnover of such a firm participating in the scheme should be increased by at least 10 to 20 per cent. (£100 to £200 per annum), if the lines of the National advertisements are carefully watched and plans laid accordingly, this cost would be recovered many times over. Whether a firm's turnover is much larger or much smaller does not affect the proposition—the proportion of profit in relation to outlay would be the same.

The result of this great education propaganda in all the leading newspapers will be a steadily increasing volume of optical work which will benefit you personally in direct proportion to the extent to which you identify yourself with the scheme. No individual firms will be advertised, but those firms who subscribe will receive special bulletins and thus have fore-knowledge of the lines to be dwelt upon and the dates of publication of forthcoming advertisements.

Thus individual subscribers' advertisements can be so drafted as to anticipate or coincide with the appearance of National Council announcements in the papers, and thus enable subscribers to reap individually where the collective advertising has sown. Moreover, the symbol of the National Council will only be issued to subscribers who must be on the Register of the J.C.Q.O., and this symbol, exhibited on your premises and in your advertisements, will identify your business with the National campaign and so direct new customers to the opticians from whom they can obtain the special services advertised broadcast in the newspapers.

The wholehearted support of every qualified optician to this National scheme will mean the spending of such a large amount in the public press as will ensure the focussing of public attention on the services rendered by opticians. Owing to the interest created by these collective advertisements, articles in the Press on optical matters will undoubtedly receive the greater consideration they deserve and still further widen the demand for efficient optical service.

The total funds required, though large, will represent an almost negligible contribution from each firm subscribing—roughly less than one per cent. of the average turnover. Subscriptions will be collected through the wholesale trade only, and in the following manner:—

Retail opticians' contributions will be automatically paid by their agreeing to accept from any wholesale house which is a member of the A.W.M.O., a

monthly cash discount of two and a half per cent., instead of the usual five per cent. on all ophthalmic supplies. To the two and a half per cent. thus paid over to the wholesale house for the Co-operative Advertising Fund the wholesaler has agreed to add twenty per cent. of the totals thus collected each month. The three per cent. thus levied by agreement on all ophthalmic sales will be forwarded each month to the National Council by every member of the Wholesale and Manufacturers' Association.

A system of counterfoiled and numbered voucher receipts will enable the Auditors to verify amounts without any individual firm's returns being disclosed to anyone on the Council.

The scheme has been thoroughly discussed by representatives of the British Optical Association and the Institute of Ophthalmic Opticians, and among many well-known qualified opticians throughout the Country who have all given their full support to the scheme as it now stands.

The support thus obtained from both the retail and wholesale sides of the industry will ensure to the National Council for the Preservation of Eyesight a fund sufficient to allow for a thoroughly effective campaign. The whole of the money subscribed (with the exception of a small amount spent for administrative purposes) will be spent directly on the various forms of publicity adopted.

The Council have retained for this campaign the services of the house with the widest experience of co-operative advertising. The London Press Exchange has created and conducted with conspicuous success all the most important co-operative campaigns of this country, including those of the British Commercial Gas Association, the Scottish Woollen Trade Mark Association, the National Milk Publicity Council, and the British Glasshouse Produce Marketing Association, as well as campaigns for such well-known commodities as Kruschen Salts, etc.

We are assured that you have at heart the welfare and standing of the Optical Industry of the country. We are confident that no better means can be devised to gain for the members the recognition, appreciation and public support that are their due.

You are therefore asked to fill in and forward at once the form below, expressing your general agree-

ment with the proposed co-operative advertising campaign and your willingness to accept a discount of two and a half per cent. on your monthly accounts with wholesalers or manufacturers on the condition and for the purpose laid down above.

Yours faithfully,

HARRY L. TAYLOR, Chairman, N.C.P.E.	E. A. ARCHER, Chairman, A.W.M.O.
B. G. ARTHUR, Secretary, A.W.M.O.	W. B. BARKER, Chairman, B.O.A.
JOHN H. SUTCLIFFE, Secretary, B.O.A.	G. E. HOUGHTON, Chairman, I.O.O.
FRAS. T. GREGG, Secretary, I.O.O.	S. COWAN, Chairman, J.C.Q.O.

Fill up this Form.

To the National Council for the Preservation of Eyesight,

110, Saint Martin's Lane,  
London, W.C.2.

I (being on the Register of the J.C.Q.O.) agree to support the Publicity Campaign of the N.C.P.E. and I further agree that all my accounts with my wholesalers who are members of the A.W.M.O. for ophthalmic supplies (prescription work, spectacles, frames, lenses, cases, eyeglass chains, etc.), shall be subject to a monthly cash discount of two and a half per cent. (instead of the usual five per cent.), it being understood that the difference of two and a half per cent. shall be admitted by the wholesaler together with his own added contribution of twenty per cent. of the total thus received to the National Council for the Preservation of Eyesight.

Signed .....

Address .....

Registered J.C.Q.O. No.

An official receipt will be sent to you each month by your wholesale house for the amount of your contribution.

In order that sufficient funds may be in hand for an immediate start during the coming Autumn, the scheme will commence on April 30th, the two and a half per cent. discounts being deducted on April accounts payable in May and so onwards.

## APPENDIX LXV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE RETAIL PHARMACISTS' UNION, BY MR. A. R. MELHUISH, EX-CHAIRMAN OF THE UNION AND MR. G. A. MALLINSON, SECRETARY OF THE UNION AND OF THE CHEMISTS' DEFENCE ASSOCIATION See Minutes of Evidence of the Thirty-Second Day, Questions 18,030 to 18,265.

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**PREFATORY NOTE ON THE RETAIL PHARMACISTS' UNION.**

1. The Retail Pharmacists' Union was founded to carry on, in addition to other activities, certain work formerly undertaken by the Pharmaceutical Society of Great Britain, which, as the result of a test case in the High Courts, was deemed to be outside the Society's charter. The Society afterwards voluntarily relinquished their control of the Chemists' National Health Insurance Organisation in favour of the Retail Pharmacists' Union. The membership of the Union is limited to those carrying on retail businesses as chemists, and it represents the whole of the Panel Chemists of the country through the Pharmaceutical Committees, all of which acknowledge the Union as the representative body; further, by its individual membership, it also represents proprietor chemists as a class, and the arrangements made for co-operation between the Union and the company chemists give representation of the multiple shops, thus including every class of chemist contracting with the Insurance Committees. Scotland has a separate National Health Insurance Organisation for chemists, and any evidence given by the Retail Pharmacists' Union must be understood to apply to the conditions existing in England and Wales only.

**THE POSITION OF CHEMISTS UNDER THE NATIONAL HEALTH INSURANCE ACTS.**

2. The National Health Insurance Act, 1911 (section 15 (5), iii), provided that arrangements must be made for the dispensing of medicines with persons, firms or bodies corporate, entitled to carry on the business of a chemist under the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908. An exception to this rule was provided in order that doctors might supply medicines in rural areas and in cases of emergency. Whilst the chemists have a right under the Act to be the dispensers of medicines, it is contingent upon an adequate service being provided by them.

**THE QUALIFICATION AND EDUCATION OF THE CHEMIST.**

3. A chemist is a person who has been through the course of training, both practical and theoretical, prescribed by the Pharmaceutical Society, and who has passed the qualifying examinations of that body. The Pharmaceutical Society possesses statutory powers, under which its examinations are held, and in connection therewith, has power to prescribe the course and duration of training. Further, all schools of pharmacy must be approved by the Society, both in regard to equipment and the course of study provided therein.

**EXAMINATION REGULATIONS.**

The following is a *précis* of the Regulations of the Society governing the qualification and training of chemists:—

4. The qualification of the Pharmaceutical Society entitling to registration as a Chemist and Druggist is the legal qualification required to be held by a person keeping open shop for the retailing, dispensing or compounding of poisons, and it is also the qualification required in connection with the dispensing of medicines under the National Health Insurance Act. Further, it gives to individuals the absolute personal right to the title of Pharmacist.

5. Training for this examination extends over a minimum of three and often over four or five years. The first step consists in passing a preliminary examination, which is nearly equal to the standard of the London Matriculation Examination. The preliminary certificate entitles its holder to registration by the Society as an "Apprentice or Student." The student must receive instruction in both practical and academic work. He receives his practical training in a retail pharmacy or in the dispensary of a hospital under conditions which have been approved by the Council of the Society. The minimum period of practical training required by the Regulations is 4,000

hours, spread over not less than two years. In practice, however, the student frequently serves for three or four years. The academic training for both parts of the qualifying examination must be taken in institutions which have been approved by the Society for the purpose.

6. The examination itself is divided into two parts, which at present may be taken either at the same time or separately, and it is possible for students to receive their academic training for both parts concurrently, although in the near future it will be necessary for a student to have passed the first part of the examination before he commences his training for the second part.

7. The first part of the examination comprises Chemistry, Physics and Botany, and the Council of the Society have recently taken power to accept certificates such as the certificates of University Intermediate Examinations in Science in place of this part of the Society's examination. The second part of the examination comprises the specialised Pharmaceutical subjects of Pharmacognosy and Pharmacy, Pharmaceutical Chemistry, and Forensic Pharmacy.

8. A student is required to spend at least one academic year, but more often spends two academic years in attending courses of instruction in preparation for the examinations.

9. After passing the examination entitling to registration as a chemist and druggist, a student may enter for the higher examination of the Society entitling to registration as a Pharmaceutical Chemist. The regulations for this examination have been revised recently and have been co-ordinated with the examination and training for the Degree of Bachelor of Pharmacy of the University of London.

**THE POSITION OF CORPORATE BODIES.**

10. Attention is directed to the fact that although the qualification of "Chemist" is a personal one, the Poisons and Pharmacy Act, 1908, recognises the right of corporate bodies to carry on the business of Chemist and Druggist, provided that such corporate bodies employ a qualified chemist as superintendent and that a qualified chemist is employed in every shop carrying on business under the Pharmacy Act. It is for this reason that corporate bodies may be included as contractors for dispensing prescriptions under the National Health Insurance Act.

11. Any corporate body using the title "Chemist and Druggist," or "Chemist" must include on its Board of Directors at least one qualified chemist, who must be the superintendent, and registered as such by the Pharmaceutical Society. Each shop must have a qualified chemist who acts under the direction of the superintendent.

12. For the purpose of the National Health Insurance Act, and the administration of medical benefit so far as the provision of drugs, medicines and appliances are concerned, these corporate bodies are in exactly the same position as the individual chemist. In this evidence, therefore, whenever the word "Chemist" is used, it includes all persons, firms and corporate bodies carrying on business under the Pharmacy Acts who are undertaking National Health Insurance dispensing.

**THE SPECIAL TRAINING OF THE CHEMIST.**

13. The education, training and qualification of the chemist under the Pharmacy Acts is to-day directed especially towards fitting him for the dispensing of medicines, and the carrying out of other functions in connection with any national scheme of medical benefit.

14. The chemist is a specialist in this matter, and devotes a long period of time to fitting himself for the demands which may be made upon him. In addition, he is the only person who is qualified by law to keep an open shop for the retailing, dispensing or compounding of poisons.

THE SERVICE RENDERED BY CHEMISTS UNDER THE  
NATIONAL HEALTH INSURANCE ACT.

*Supply of Drugs and Appliances.*

15. The chemist is bound by his contract to give the insured person such medicines as the doctor orders and such articles as are ordered if included in the schedule of appliances.

16. The chemist has no control over the supply of drugs and appliances, and whether it be stated that there is an excessive supply or an insufficient supply, the chemist is not responsible. It is his business to meet the requirements of the doctors' prescriptions. This he endeavours to do, sometimes at great inconvenience to himself. The Drug Tariff sets out an extensive list of drugs, but this by no means represents the range of medicines the chemist keeps in stock against the doctor's requirements.

17. A continuous service of from 10 to 12 hours per day is usually provided by the chemist, and at any time during that period the insured person may present his prescription, and his requirements will be met with reasonable promptness.

18. Although chemists are not paid for a delivery service in connection with National Health Insurance, in cases of emergency they have undertaken delivery of medicines.

19. The chemist, in supplying insured persons, is frequently required to explain what the doctor's intentions are in relation to the use of the medicines, e.g., gargles, inhalations, fomentations, etc. Many misunderstandings have been prevented, and a very considerable service has been and is constantly being rendered by chemists to insured persons in this and similar directions. In no sense is it suggested that the doctor's instructions are inadequate, but that in a technical sense, the instructions are often misunderstood or are forgotten when the prescription is presented to the chemist.

*Adequacy of the Service.*

20. There are more than 9,000 shops on the panel lists, employing over 13,000 qualified chemists, available for dispensing prescriptions under the National Health Insurance Scheme, and on an average between 60 and 70 prescriptions per week are dispensed in each shop. Ample service is therefore provided if proper distribution of the work is secured. As between shop and shop there is no difficulty; it is in connection with the daily and hourly distribution that difficulty sometimes occurs. Nevertheless, considering the fact that the chemist has no control whatever over the number of prescriptions which may be presented to him, there is little real delay, even at the busiest times.

21. Taking into consideration the enormous number of prescriptions dispensed and bearing in mind that in no sense is an insured person obliged to go to any particular chemist, the number of complaints against the chemist's service has been almost negligible.

22. Complaints regarding the adequacy of the service from the distribution point of view have been very small in number.

23. Complaints of a personal nature, such as discourtesy, rudeness, etc., are practically unknown.

24. Very few complaints have been made against chemists because of failure to supply medicines with reasonable promptness. In this connection, it is easy to understand that it must happen occasionally that the chemist receives more prescriptions than he can dispense immediately, and his usual course is to dispense those first which he assumes are the most urgent. Co-operation between Panel and Pharmaceutical Committees in regard to surgery hours would eliminate this class of complaint, and any necessary improvement can be secured by such action. The provision of medicines at any hour of the night or day is not a duty imposed on the chemist by his agreement. Arrangements are made by means of a

rota to provide an extended service, but the doctors have always been paid a special allowance for the provision of such medicines as may be required in an emergency.

25. The quality of the drugs and medicines supplied by chemists is an important matter, and in this connection it is only necessary to mention that, in addition to the testing undertaken by the Insurance Committees, the drugs and medicines in a chemist's shop may be tested under the Food and Drugs Acts by the Public Health Authority. A doctor's surgery, a hospital dispensary and medical institutions are not liable to that check and supervision. It is because a chemist sells drugs that his stock comes within the scope of the Food and Drugs Act. The drugs and medicines dispensed by the chemist are those which he sells, and which may be sampled at any time under the Food and Drugs Act, or by the Insurance Committee.

THE ADVANTAGES OF THE PRESENT METHOD OF  
SUPPLYING DRUGS AND APPLIANCES THROUGH  
CHEMISTS TO INSURED PERSONS.

26. The arrangements under the National Health Insurance Act for the supply of medicines through the chemists are as complete as any which exist in private practice, and are a vast improvement on the conditions previously existing under what is known as the "club" practice system.

27. The insured person can now have exactly the same medicines as the most wealthy patient can purchase. He has the right to the same range and quality of drugs and medicines. The doctor is the deciding factor, and whatever he orders the National Health Insurance patient will get from the panel chemist. The doctor is not limited when prescribing, as formerly, to the things he knows he has in his dispensary, but can now prescribe freely without any thought as to the availability of any particular drug. This is a great advantage to the insured person, and it places his treatment on a level with the highest class of medical practice.

28. The freedom from responsibility for supply of the medicines leaves the doctor at liberty to devote all his time to his own work. The comparative importance of dispensing to a doctor is judged by the time spent on his training in that subject. The medical curriculum allows a few hours per week during one academic year for pharmacy and dispensing out of about five to six years. The chemist specialises in dispensing and spends about four years on his training in pharmacy and dispensing.

29. The separation of prescribing from dispensing is a natural result of the developments in medical science. The doctor has now no time to spare to make himself a specialist in pharmacy and dispensing. His energies are needed to keep himself abreast of medical developments. The present medical curriculum gives the doctor the requisite knowledge of drugs, etc., as a prescriber, but not as a dispenser. In Scotland, where the doctors do not, as a rule, dispense any medicines, and have for many years been accustomed to prescribing only, the frequency rate of medicines per patient is distinctly less than in England and Wales.

30. The wider range of drugs and medicines available has already been mentioned, but, in addition, there is also the abolition of the stock medicine. The present arrangements provide for a special prescription to be written for each patient exactly in the same way as a consulting physician writes his prescription for his patient. It may be argued that in connection with the National Health Insurance Scheme the hospital practice of using stock mixtures might be adopted. Chemists, on the other hand, maintain that the tendency should be in the other direction, towards the higher-class medical practice of writing individual prescriptions.

31. Attention has already been directed to the checks upon the quality and purity of the drugs and the analyses of medicines; there is a further check involved in the National Health Insurance system.

The prescriptions issued by doctors are a written record of the treatment, which is available for inspection when necessary.

32. The chemist and doctor act as a check upon one another when the prescribing is separated from the dispensing, which is a protection and an advantage to the patient.

33. From the purely ethical point of view, insured persons have been put into a higher class than ordinary members of the public, because in this country it is only in the best medical practices that prescribing and dispensing are separated. The practice of prescribing by the doctor, and dispensing by the chemist, is universal on the Continent, where the Governmental control over pharmacy is much more stringent than in this country.

34. An advantage upon which too much stress cannot be laid is that the doctor may prescribe during his rounds and the patient can get the medicine without waiting for the doctor to return home, because the chemist gives a continuous all-day service.

Further, the fact that a patient can be dismissed immediately his prescription has been written lessens the congestion in doctors' waiting rooms.

35. Chemists appreciate their position under the National Health Insurance Act, and contend that they have given a good service, which has been a material and substantial benefit to insured persons.

Chemists have also assisted in removing the prejudice which existed at the outset against the National Health Insurance Act.

#### ADMINISTRATION OF MEDICAL BENEFIT (DRUGS AND APPLIANCES).

##### *Insurance Committees.*

36. The administration of medical benefit by Insurance Committees, so far as drugs and appliances are concerned, and in connection with chemists, has on the whole been carried out with tact and consideration. Insurance Committees have, as a rule, realised the difficulties which had to be faced, and have helped both the chemist and the Pharmaceutical Committee to provide an efficient service.

37. The Pharmaceutical Committees and the Insurance Committees in every area are on good terms with each other, and only very rarely is there any friction between the two bodies. The only criticism which chemists have to make is regarding the tendency of some Insurance Committees to discuss in public matters connected with the agreements for supplying drugs and appliances and the conduct of chemists in connection therewith. Such discussions are usually on points of detail, but during the course of a discussion opportunities arise for making statements which do much harm to the service generally and to the chemist individually.

38. The representation of chemists on the Insurance Committee is not satisfactory. As a rule only one chemist is appointed, and in his absence through illness or other causes there is no representative. In some cases a chemist is appointed as one of the representatives of a Friendly Society or Local Authority.

##### *Prescription Pricing*

39. The arrangements for pricing prescriptions are working well, the standard of accuracy having reached a satisfactory level. The work is of such a detailed character that many errors would occur without adequate care, supervision and proper checking.

40. A difficulty arises when the Pricing Office rule that something ordered by an insurance practitioner is not a legitimate charge upon the drug funds. The information regarding disallowance does not come to the chemist until perhaps two months after the article has been supplied, and chemists recommend, therefore, that the principle should be established that whatever is ordered on a National

Health Insurance prescription should be supplied by the chemist without question, and that payment should be made to him in the ordinary way. The onus of refusing to supply an article ordered by the doctor should not be placed upon the chemist.

#### THE PHARMACEUTICAL COMMITTEE AND ITS ACTIVITIES.

41. The primary function of the Pharmaceutical Committee is that of maintaining an adequate and efficient pharmaceutical service in the area for which it is responsible. The secondary function is that of representing the chemists of that area in their dealings with the Insurance Committee.

42. Pharmaceutical Committees have from the outset treated the duty of providing an efficient and adequate service as a very serious matter, and have employed their resources to the fullest extent in securing a high standard for the medicines supplied to insured persons. They have, in difficult circumstances on many occasions, maintained a full list of contractors, so that at the present time practically every chemist is available for dispensing National Health Insurance prescriptions, and insured persons need not travel far in any area to get their supplies. In regard to the standard of drugs and medicines, the Pharmaceutical Committees have had their own machinery for testing medicines and examining the medicines supplied. This has been done to keep a check upon the work of the staffs employed by panel chemists.

43. In conjunction with the Insurance Committees they have also adopted various measures intended to promote the efficiency of the service in relation to such matters as hours of service, rota arrangements and formularies.

44. The cordial relationship which exists in practically every area between the Pharmaceutical Committee and the Insurance Committee has rendered the work of the Pharmaceutical Committee much easier, and has made for efficiency in the service.

45. Co-operation between the Panel and Pharmaceutical Committees, where it exists, is also a factor in increasing the standard of the service, but in this connection chemists feel that there ought to be definite provision made in the regulations for a greater measure of co-operation between the Panel and Pharmaceutical Committees on such questions as consulting hours, formularies, urgent medicines, etc. At present these are not subject to compulsory agreement between the two Committees. Whilst an agreement is obtained on most occasions by means of the Insurance Committee consulting each body separately, it is felt that, if provision were made whereby it was clearly laid down that direct arrangements between these two Committees had to be made on such matters, the small number of complaints which now arise would be entirely eliminated. The case of surgery hours and closing hours for shops is typical. Each Committee regards the other as having no right to interfere in the fixing of these hours, yet they are interdependent, and neither should fix their hours so as to inconvenience the other or the insured persons.

#### THE CHEMISTS' AGREEMENT WITH INSURANCE COMMITTEES.

##### *The Terms of Service.*

46. The chemist's duty under his contract with the Insurance Committee is to supply such drugs, medicines and appliances as may be prescribed by a doctor on an official form, and in regard to appliances, only those which are included in the schedule.

The terms of service for the supply of drugs and appliances are contained in the Third Schedule of the Medical Benefit Consolidated Regulations, and are reproduced in Appendix A of this Statement.

##### *Multiplicity of Agreements.*

47. A chemist often finds it necessary to be upon the panel of more than one Insurance Committee, his geographical position being such that in some instances he gets prescriptions from three or four

insurance areas. The chemists suggest that agreement with the Insurance Committee in whose area the business is situated should suffice, but that an insurance prescription from any other area should be acceptable by the chemist, who would send in separate accounts as hitherto. This would give a freedom of choice of chemists a little wider than that which exists at present, and would make for economy in administration.

#### *The Payments to Chemists.*

48. These cannot be said to be extravagant when the total sum expended per insured person is taken into consideration. That amount is regarded by some people as the chemist's income from National Health Insurance dispensing. It is a total payment out of which the chemist has to supply drugs and appliances; the balance of approximately half may be regarded as the chemist's gross income, out of which he has his normal outgoings for staff, rent, rates, etc., to pay. It is certain that the actual net remuneration is not extravagant for persons undertaking such responsible service, and having to undergo a training such as that to which chemists are subjected. On the score of national economy a reduction was made in 1922 in the chemists' payments, and it is hoped that the remuneration will be increased when it is financially possible.

#### THE DRUG TARIFF AND ITS DEVELOPMENT.

##### *The Drug Tariff.*

49. The Drug Tariff as it exists to-day is the result of ten years' experience and a considerable amount of thought on the part of the Ministry, the Insurance Committees, and the chemists. The original tariff and method of payment were entirely different from those in use at the present time. The scope of the tariff was smaller, and the printing and publication which was then undertaken by the chemists themselves has since been considerably improved.

50. The method of payment in force up to 1916 was a small dispensing fee, and a profit on the drugs, etc. In 1916, after a Departmental Committee inquiry, the method was changed to a larger dispensing fee and payment of the cost price for drugs, etc.

51. Originally the capitation allowance for drugs and appliances was the only financial provision made for the payment of chemists' accounts. If the chemists' accounts in any area exceeded the total sum represented by the capitation allowance, the chemists' bills were discounted in proportion, and this discounting in some areas amounted to nearly 40 per cent. of the chemists' accounts. There were no arrangements for transferring credit balances from one area to another, and if there had been, the total over the whole country was insufficient to meet the bills. It was impossible for chemists to continue under a system which gave them no real control over the drugs ordered, or the number of prescriptions written and yet limited the amount of money they could receive. During those years a large sum of money was lost by chemists, and this is proved by the fact that under the conditions subsequently established in accordance with the recommendations of the Departmental Committee, those areas which had been discounted heavily in the past continued to exceed the capitation allowance in the majority of cases.

52. The new system of payment by cost prices involved the calculation of prices to the second place of decimals, and required the production of pricing charts and ready-reckoners for the use of pricing clerks. The Pharmaceutical Society, which, as the predecessor of the Retail Pharmacists' Union, then undertook negotiations with the Insurance Commissioners, placed the services of their staff at the disposal of the Commissioners. The original charts were prepared, therefore, by the chemists, but they have been improved by the Ministry and the Retail Pharmacists' Union in consultation with one another, until to-day they represent a very handy means of carrying out pricing of this kind.

53. The tariff itself has been modified in many ways since 1916, when the Tariff recommended by the Departmental Committee had just come into use, and to-day, it is simpler both in method of calculating prices, and in the scale of dispensing fees.

54. Important changes were made in the Drug Tariff on April 1st, 1921, as a result of negotiations between the chemist's representatives and the Ministry of Health. These changes included the abolition of stock mixtures, the deletion of all decimal figures from the dispensing fees, and the simplification of the scale of fees.

55. The aim was to fix the fees for various classes of medicaments in such a way that chemists need be in no doubt as to the precise fee payable in respect of any preparation. At the end of 1921, a general reduction was decided upon, which took effect from May 1st, 1922. This decrease was insisted upon by the Ministry of Health on the score of national economy.

56. Negotiations between the union and the Ministry of Health were again opened during the early part of the year 1924, on the subject of the terms of service for chemists for the next contractual period. The only important changes which resulted were a small increase in the dispensing fees, payable in respect of appliances, sera, vaccines, insulin, and proprietary preparations exceeding 2s. 6d. in value, and an allowance to chemists in respect of out-of-pocket expenses. These alterations came into force on May 1st, 1924, and the scale of dispensing fees is now as shown in Appendix B.

57. Arrangements were also made to continue discussions with the Ministry regarding changes in the list of items in the Tariff, the prescribing of proprietary articles, the basis of the deductions from chemists' accounts in respect of Pharmaceutical Committee expenses, and also regarding a testing of dispensing scheme. These discussions resulted in the Tariff being revised and republished in a handier form, some items being deleted as obsolete and many new ones added, the prescribing of proprietary articles being placed on a more satisfactory footing so far as the Chemist was concerned, and the deductions for the Pharmaceutical Committees' expenses were arranged to be made from the fees payable to Chemists.

##### *Testing of Dispensing.*

58. A testing of dispensing scheme was agreed; the following is the complete model scheme arranged between the Ministry of Health and the Retail Pharmacists' Union, as shown in Appendix C.

59. This scheme will be a great improvement on those hitherto in operation, and has the advantage of retaining the control within the jurisdiction of the Insurance Committees and the Ministry of Health in every respect.

##### *Standards of quality for Drugs and Appliances.*

60. During the period since 1916, a considerable amount of attention has been given to the standards of quality of both drugs and appliances. Specifications wherever possible have been introduced into the Tariff, and arrangements made to adopt British Pharmaceutical Codex standards for cotton-wool, lint, bandages, etc.

61. These standards were arranged by consultation between the Ministry of Health and the Retail Pharmacists' Union. Chemists have welcomed standardisation as a protection against misunderstanding as to the quality of the drugs or appliances to be supplied to insured persons.

62. By reason of these activities in regard to standardisation on the part of the Ministry of Health and the Retail Pharmacists' Union, the supply of drugs and appliances to insured persons is better safeguarded than is the case with supplies received in private practice, either through doctors or chemists. It is a notable fact that it is only in connection with National Health Insurance that there is a compulsory standard for appliances.

*Formularies.*

63. The prescribing of stock mixtures as such is now abolished, but recognised formulæ may be prescribed by the doctor. A small local formulary prepared to meet local requirements may possibly be necessary in some areas, but every effort should be made to limit the use of formularies.

64. The ordering of medicines by a number is liable to cause errors through mistakes in figures, and gives the insured person an unsatisfactory impression of the treatment he is receiving. All formulary preparations should be ordered by name.

*Repeat Mixtures.*

65. The practice of writing prescriptions by reference to a previous prescription known as "repeat" prescribing, was abolished in 1920, with satisfactory results.

66. The abolition of this practice was an important factor in maintaining the insured person's right of free choice of chemist. At the present time each prescription an insured person receives is complete in itself and may be dispensed by any chemist on the panel; formerly this was not the case, and the insured person was compelled to go to the same chemist on every occasion when a "repeat" was ordered.

*Urgent Prescriptions.*

67. The arrangement made in 1920 placed the "Urgent" prescription fee on a better basis. Previously such fees were allowed in some areas but not in others.

68. The hours of business have to be notified to the Insurance Committee, and 8 p.m. is generally taken as the closing hour. A double dispensing fee is allowable for prescriptions dispensed after that time if the prescription is marked "Urgent" by the doctor and the chemist endorses the prescription with a declaration as to the hour when it was dispensed. This urgent fee is also payable for prescriptions dispensed outside the normal opening hours on Bank holidays, Sundays and public holidays.

*EXTENSION OF MEDICAL BENEFIT.*

69. The extension of medical benefit so far as the wives and dependants of insured persons are concerned would not present any serious difficulties from the chemist's point of view. It has already been mentioned that the service at present provided by chemists is capable of dealing with a very much larger number of prescriptions and no problem would arise in regard to the additional supplies necessary for the increased number of insured persons.

70. The experience of chemists tends to show that the extension of medical benefit would be greatly appreciated by the dependants, and further, the supply of drugs and appliances would not be so expensive in proportion as the increased number of patients would seem to indicate, children's medicines in particular being usually less costly than those required for adults.

71. The extension of medical benefit so far as chemists are concerned may be considered under three headings:—

- (a) Extensions of medical benefit for those who are included at present in the National Health Insurance Scheme;
- (b) Extension of medical benefit to the wives of insured persons;
- (c) Extension of medical benefit to the children of insured persons.

*Extensions of Benefits for Insured Persons.*

72. Regarding the supply of drugs and medicines, there is no scope for further extension since there is no limit to the range of the doctor's prescribing of drugs and medicines.

73. The list of appliances is not sufficiently wide to provide certain articles which, in the opinion of chemists, should be available for proper application or use of the medicaments ordered by the doctor.

74. A throat paint may be ordered, but not a throat brush with which to apply the paint. Eye drops may be ordered by the doctor, but not an eye dropper; these are simple illustrations of incompleteness looked at from the point of view of efficiency in treatment. Other additions in this category are: eye baths, eye shades, camel hair pencils, vaccination pads, ear and nose syringes. These are in a different category to the demand for trusses, crutches, etc., which are not, in the opinion of the chemist, additions within the scope of ordinary medical treatment.

*Inclusion of the Wives of Insured Persons.*

75. The extension of medical benefit to the wives of insured persons is, in the opinion of chemists, very desirable. The chemist is inevitably the recipient of much information regarding the circumstances in which the families of insured persons live, and there is no doubt that the extension of medical benefit to the wives would relieve many families from a heavy burden and give increased financial security. The value to the nation of the extension of medical benefit to the wives of insured persons cannot be overestimated.

*Inclusion of the Children of Insured Persons.*

76. The children are cared for in many ways at the present time, but not entirely. The school clinics and infants' welfare centres give a large amount of medical attention to the children, but there is the home treatment to be provided, and as a general rule the chief function of the centres is to prevent avoidable sickness and injury among children; patients needing treatment are referred to a doctor.

77. In the case of children, so far as medicines are concerned, the cost per head is not likely to be so great as the present average for insured persons. There is, however, one factor which might make a great difference if there were no satisfactory control in that respect—the prescribing of such articles as cod liver oil, cod liver oil emulsion, and extract of malt and cod liver oil might reach enormous proportions where children are concerned, but these articles are already distributed free of charge in large quantities though the welfare centres, hence the nation is already paying for these supplies to a considerable number of children. There is abuse of the welfare centres in this connection by persons well able to purchase their own supplies.

78. A complete scheme, including both wives and children, would tend to give a greater sense of security to the insured person. Further, the welfare centres could then confine their activities to real welfare work, thus preventing overlapping and lessening of the standard of independence.

*CONCLUSIONS AND RECOMMENDATIONS.*

79. The Union submit that from every point of view the arrangements for the supply of drugs and appliances through chemists have been successful, and that they provide insured persons with a service of a purely private character as distinct from the institutional or hospital dispensary service type.

80. Further, that the system is sound from an economical point of view, being free from any capital commitments or any financial obligations beyond the period of the contract, and in addition that the administration of medical benefit, so far as drugs are concerned, is, comparatively speaking, easy and inexpensive.

81. In conclusion, the Union submit that insured persons have benefited very greatly by the arrangements for Medical Benefit under the National Health Insurance Acts.

82. The Union recommend therefore:—

- (a) That the present method of administering medical benefit through the Insurance Committees be continued.



- (b) That provision be made under the regulations for a greater measure of co-operation between the Panel and Pharmaceutical Committees.
- (c) That direct and increased representation of chemists on Insurance Committees be provided.
- (d) That the onus of refusal to supply an appliance not included in the schedule or any other article ordered by the doctor should be removed from the chemist.
- (e) That Eye Baths, Eye Shades, Camel Hair Pencils, Vaccination Pads, Ear and Nose Syringes be added to the list of scheduled appliances.
- (f) That medical benefit be extended to the dependants of insured persons.

19, Tavistock Square,  
London, W.C.1.  
14th May, 1925.

#### APPENDIX A.

##### *Provisions of the Third Schedule to the National Health Insurance (Medical Benefit) Consolidated Regulations, 1924.*

NOTE.—The following provisions relate to persons, firms or bodies corporate entitled to carry on the business of a chemist and druggist under the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908 (in this Schedule referred to as "Chemists"), who undertake the supply of both drugs and appliances.

#### PART I.

##### *Terms of Service for Persons Supplying Drugs or Appliances.*

##### *Admission to and Withdrawal from List: Method of Altering Terms of Service.*

1. *Admission to the List.*—Every person, other than one who is disqualified from undertaking service by reason of his name having been excluded or removed, after an inquiry, from any list of persons supplying drugs or appliances in Great Britain or in respect of whom an inquiry under Part VII of the Regulations is pending, who gives notice to the Committee in the form set out in Part III of this Schedule, with such modifications as the case may require, that he accepts service upon the terms for the time being in operation in the Committee's area, will have his name included in the Committee's list, but no person shall be entitled to undertake the dispensing of medicine unless he is entitled to carry on the business of a chemist and druggist under the provisions of the Pharmacy Act, 1868 (31 and 32 Vict., c. 121), as amended by the Poisons and Pharmacy Act, 1908 (8 Edw. 7, c. 55), and undertakes that all medicines supplied by him to insured persons under the arrangements made by the Committee shall be dispensed either by or under the direct supervision of a registered pharmacist or by a person who for three years immediately prior to the 16th day of December, 1911, has acted as a dispenser to a practitioner or a public institution.

In this schedule "person" includes a firm or body corporate.

2. *Revision of Terms of Service.*—The Committee may, subject to the approval of the Minister, alter the terms of service as from such date as he may approve by giving notice of the proposed alterations to each person supplying drugs or appliances:—

Provided that, except in the case of an alteration which results from the coming into operation of any Act of Parliament, or of an alteration made by the Minister in the Drug Tariff, or which has been approved by the Minister after consultation with a body which is in his opinion representative of the general body of persons supplying drugs or appliances, the Committee shall before making any alteration consult with the Pharmaceutical Committee, and the alteration shall not come into operation within a period of three months from the date of the issue of the notice.

3. *Withdrawal from List.*—(1) A chemist is entitled at any time to give notice to the Committee that he desires to withdraw his name from the list, and his name shall be removed therefrom at the expiration of three months from the date of such notice or of such shorter period as the Committee may agree.—

Provided that—

(i) If such notice is given by the chemist within one month after the issue to him by the Committee of a notice informing him of a proposed alteration in the terms of the service, two months shall be substituted for three months as the maximum period for which he may be required to continue to undertake the supply of drugs or appliances; and

(ii) If representations have been made to the Minister that the continuance of the chemist on the list would be prejudicial to the efficiency of the service, he is not entitled to withdraw his name from the list, except with the consent of the Minister, and subject to such conditions (if any) as the Minister may impose, during the period while an inquiry under Part VII of the Regulations, or action by the Minister as a result of such inquiry, is pending.

(2) The name of any person supplying drugs or appliances who dies during the year, or whose name is directed to be removed from the list by the Minister, will thereupon be removed from the list:—

Provided that where upon the death of any person supplying drugs or appliances the business is carried on in accordance with the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908, by a person who is his executor or administrator or the trustee of his estate, within the meaning of section 16 of the former Act, that person shall be deemed to be a person included in the list so long as the business is carried on by him in accordance with the provisions of those Acts.

##### *Supply of Drugs and Appliances.*

4.—(1) The expression "appliances" in this schedule means such medical and surgical appliances as may for the time being be prescribed by any Regulations as forming part of medical benefit.

(2) A chemist is required to supply with reasonable promptness to any person who presents an order for drugs or appliances on a prescription form provided by the Committee for the purpose and signed by any practitioner on the medical list of the Committee or his deputy or assistant, such drugs or appliances as are so ordered, and shall so far as practicable keep in stock for that purpose the drugs and appliances mentioned in the Drug Tariff for the time being in force.

(3) All drugs and appliances so supplied which are included in the Drug Tariff shall be of a grade or quality not lower than the grade or quality specified therein. Drugs so supplied which are not included in the Drug Tariff shall be of a grade or quality not lower than the grade or quality ordinarily used for medical purposes.

##### *Place and Hours of Business.*

5.—(1) Drugs and appliances will be supplied at the place or places of business specified in the application made by the chemist for inclusion in the Committee's list, and the hours during which the place or places will be open for the supply of such drugs and appliances are those specified in the scheme to be made for that purpose under the Regulations.

(2) At each place of business at which a chemist supplies drugs or appliances he is required (i) to exhibit a notice to be provided by the Committee in the form prescribed in Part IV of this Schedule, and (ii) to exhibit at times when the place of business is not open and in such a manner as to be visible at such times a notice to be provided by the Committee in the form prescribed in Part V of this Schedule, indicating the days and hours on and at which the

places of business of other persons supplying drugs or appliances in the immediate neighbourhood are open.

*Provision of Containers.*

6. If a person, upon presenting an order for any drug or appliance for which a bottle or other vessel, the price of which is specified in the Drug Tariff, is necessary, requests the chemist to supply such bottle or other vessel and deposits with him the price thereof as specified in the Drug Tariff, the chemist shall supply such bottle or other vessel and shall, upon the return of it in a clean condition, pay back the sum so deposited.

*Dispensing of Medicines.*

7. The dispensing of medicines shall be performed either by or under the direct supervision of a registered pharmacist or by a person who for three years immediately prior to the 16th December, 1911, has acted as a dispenser to a practitioner or a public institution.

*Names and Qualifications of Dispensers.*

8. A chemist shall, if so required by the Committee, furnish to the Committee a statement of the names and qualifications, if any, of any persons employed by him in dispensing medicines for insured persons.

*Drugs, etc., to be Supplied without Charge.*

9. All drugs and appliances shall be supplied to the person presenting such order as aforesaid free of charge to that person:—

Provided nevertheless that the chemist shall sell to any one of the persons mentioned in Section 13 of the Sale of Food and Drugs Act, 1875 (38 and 39 Vict., c. 63), or to any person authorised by such person, at the price usually charged to private customers, any drug or medicine prescribed or specified on the appropriate prescription form provided by the Committee for the use of insured persons and signed by an insurance practitioner.

*Disputes and Inquiries.*

10. The terms of service relating to the following matters are contained in Parts V and VII respectively of the Regulations:—

- (a) The investigation of complaints made by or on behalf of insured persons against persons supplying drugs or appliances, and other investigations to be made by the Pharmaceutical Service Sub-Committee and the Joint Services Sub-Committee, and the action which may be taken by the Committee as a result of such investigations, including the recovery from the person supplying drugs or appliances of any amount deducted from money payable to the Committee for defraying the cost of medical benefit:—
- (b) Appeals to the Minister from decisions of the Committee; and
- (c) Inquiries with regard to the continuance of persons on the list of persons supplying drugs or appliances.

*Power of Minister to Suspend the System.*

11. In the event of the Ministry exercising any of the powers conferred on him by the proviso to sub-section (2) of Section 24 of the Act, or by proviso (i) to sub-section (5) of that section, in respect of the area of the Committee or any portion of that area, the Committee may, if the Minister so requires, determine the chemist's right to supply drugs and appliances under the foregoing arrangements by giving him such notice as the Minister may require.

*Interpretation.*

12. Words or expressions in these terms of service have the same meaning as in the National Health Insurance (Medical Benefit) Consolidated Regulations, 1924 (herein referred to as "the Regulations"), and

the Regulations shall, so far as they affect the rights and obligations of persons supplying drugs or appliances, be deemed to form part of these terms of service.

**PART II.**

*Method of Payment.*

1. A chemist is required to furnish to the Committee or to such other person or body as they may direct, on dates to be appointed by the Minister, the forms upon which the orders for drugs and appliances supplied by him were given, together with a statement of accounts containing such particulars relating to the supply by him of drugs and appliances as the Committee, with the approval of the Minister, may from time to time require.

2.—(1) The Committee shall, if any person supplying drugs or appliances so requires, afford him reasonable facilities for examining all or any of the forms on which the drugs or appliances supplied by him were ordered, together with particulars of the amounts calculated to be payable in respect of such drugs and appliances, and if he takes objection thereto, the Committee will take such objection into consideration.

(2) The Committee shall, if so required by the Pharmaceutical Committee, afford that Committee similar facilities for examining such forms and particulars relating to all or any of the persons supplying drugs or appliances, and will take into consideration any objections made thereto by the Pharmaceutical Committee.

3. Payment will be made for drugs and appliances mentioned in the Tariff at the prices specified in the Tariff, and for drugs or for any variety of appliances not mentioned in the Tariff in the manner set forth therein. A fee for dispensing, calculated in the manner set forth in the Tariff, will also be paid.

4. If, at the request of the Pharmaceutical Committee, any sum has been allotted by the Committee to defray the administrative expenses of the Pharmaceutical Committee, such sum will be deducted from the amounts payable to the persons (other than practitioners) supplying drugs or appliances in proportion to the amount of the fees for dispensing payable to each such person.

5. In this part of this Schedule "Tariff" means the Drug Tariff for the time being in operation in the area of the Committee.

**PART III.**

*Form of Application for Admission to the List of Persons Supplying Drugs or Appliances.*

**NATIONAL HEALTH INSURANCE.**

To the Insurance Committee for the County (or County Borough) of .....

I (We) ..... of ..... hereby undertake to supply drugs and appliances upon the terms for the time being in operation in the area of the Committee, and apply to have my (our) name(s) included in the Committee's list of persons supplying drugs or appliances. My (our) place(s) of business for this purpose will be

Signed .....  
Date .....

**PART IV.**

*Form of Notice to be Exhibited by Persons Supplying Drugs or Appliances.*

**NATIONAL HEALTH INSURANCE.**

(Name of Person, Firm or Company contracting.)

Under contract with the Insurance Committee for the County (or County Borough) of .....

- \* To dispense medicines.
- \* To supply drugs.
- \* To supply drugs (except scheduled poisons).
- \* To supply appliances.

This shop is open at the following times:—

[\*Strike out words not applicable.]

## PART V.

*Form of Notice to be Exhibited by Persons Supplying Drugs or Appliances at Times when the Shop is Closed.*

## NATIONAL HEALTH INSURANCE.

When this shop is closed, the nearest shops for the supply to insured persons of medicines and appliances are:—

*List of Appliances (as provided by the Second Schedule to the National Health Insurance (Medical Benefit) Consolidated Regulations, 1924).*

Adhesive plaster.  
Bandages, Rolled:  
Calico.  
Crepe.  
Dometts.  
Elastic-web.  
Flannel.  
India-rubber.  
Muslin.  
Open-weave.  
Plaster of Paris.  
Catheters:  
Gum elastic.  
Soft rubber.  
Cotton Wools, Absorbent:  
Boric.  
Sal-Alembroth.  
Unmedicated.  
Gauzes:  
Boric.  
Carbolic.  
Double cyanide.  
Iodoform.  
Picric.  
Sal-Alembroth.  
Sublimate.  
Unmedicated.  
Gauze and cotton wool tissue.  
Ice bags:  
Check sheeting.  
India-rubber.  
Lints:  
Boric.  
Sal-Alembroth.  
Unmedicated.  
Protectives:  
Gutta-percha tissue.  
Jaconet.  
Oiled cambric.  
Oiled paper.  
Oiled silk.  
Splints.  
Suspensory bandages:  
Cotton.  
Tows:  
Carbolised.  
Unmedicated.  
Wood wool.

## APPENDIX B.

*Scale of Dispensing Fees.*

	<i>Pence per Prescription.</i>
1. <i>Liquid Medicaments.</i>	
All classes of <i>Compound Liquid Medicaments</i> , excluding those referred to under 3 and 7 below ... ..	5.0
Where directed by the prescription to be supplied in more than one container, each extra quantity supplied ... ..	5.0
2. <i>Solid Medicaments</i> , excluding those referred to under 3 and 7 below:—	
(i) <i>Ampoules, Bougies, Pessaries and Suppositories</i> :—	
Not exceeding 12 ... ..	11.0
Each extra dozen or part of a dozen ... ..	2.0
(ii) <i>Blisters and Plasters</i> ... ..	5.0

*Pence per Prescription.*

(iii) <i>Cachets</i> :—	
Not exceeding 6 ... ..	7.0
Each extra half dozen or part of half dozen ... ..	2.0
(iv) <i>Capsules, Lozenges, Pastilles and Tablets</i> :—	
Not exceeding 24 ... ..	5.0
Each extra two dozen or part of two dozen ... ..	2.0
(v) <i>Confections, Ointments and Pastes</i> ... ..	5.0
(vi) <i>Pills</i> :—	
Not exceeding 24 ... ..	7.0
Each extra two dozen or part of two dozen ... ..	2.0
(vii) <i>Powders</i> :—	
Over 1 and not exceeding 6 ... ..	5.0
Each extra half dozen or part of half dozen ... ..	2.0
(viii) <i>Powders, mixed bulk, and Granules</i> ... ..	5.0
3. Any <i>solid or liquid drug or preparation</i> specified in the Table of Prices for Drugs and Preparations ( <i>see note (a)</i> ) ... ..	3.0
4. Any <i>non-compound liquid or solid drug</i> ordered alone ... ..	3.0
5. <i>Oxygen</i> ( <i>see note (b)</i> ) ... ..	8.0
6. <i>Appliances</i> :—( <i>see note (c)</i> )	
Up to and including the value of 2s. 6d. ... ..	2.0
Over the value of 2s. 6d. and up to and including the value of 5s. ... ..	4.0
Over the value of 5s. and up to and including the value of 10s. ... ..	5.0
Over the value of 10s., each additional value of 5s. or part of 5s. ... ..	3.0
7. <i>Proprietary Preparations</i> supplied without dilution or admixture ( <i>see note (c)</i> ):—	
Up to and including the value of 2s. 6d. ... ..	3.0
Over the value of 2s. 6d. and up to and including the value of 5s. ... ..	5.0
Over the value of 5s. and up to and including the value of 10s. ... ..	6.0
Over the value of 10s., each additional value of 5s. or part of 5s. ... ..	3.0
8. <i>Insulin, Serums and Vaccines</i> ( <i>see note (d)</i> ):—	
Up to and including the value of 2s. 6d. ... ..	3.0
Over the value of 2s. 6d. and up to and including the value of 5s. ... ..	5.0
Over the value of 5s. and up to and including the value of 10s. ... ..	6.0
Over the value of 10s., each additional value of 5s. or part of 5s. ... ..	3.0
9. Any <i>Preparation</i> required by the order to be specially <i>sterilized</i> , additional to the ordinary fee ... ..	6.0

## Notes.

(a) The fee of 3.0d. will apply (*inter alia*) to any order for any solid or liquid drug or preparation specified in the Table of Prices for Drugs and Preparations (*see Part IIIA*), except (i) where the order specially indicates that the medicament is to be freshly compounded or prepared by the chemist, or (ii) in the case of a powder priced in the Table by weight, the order requires the medicament to be prepared by the chemist in separate doses.

(b) In addition to the fee of 8.0d. the following allowances will be payable in the case of oxygen:—

(i) For use by patient of cylinder, 9d. per week (or part of a week) after the first 14 days.

(ii) For use by patient of fittings, 9d. per week (or part of a week).

(iii) The actual carriage charges, if any, to the chemist.

Particulars of claims for fees under (i), (ii) or (iii) must be submitted with the appropriate prescription form, the transmission of the form to the Pricing Office being delayed, if necessary, until the total amount of the claim is ascertainable. The payment of the additional fees is subject to the condition that should the fittings or cylinder be retained

by the patient for a period exceeding 14 days, immediate notice to this effect is given to the Insurance Committee.

(c) In addition to the fee specified in the scale, actual out-of-pocket expenses will be payable in the case of proprietary preparations and scheduled appliances not included in the Tables of Prices (see IIIA and IIIB) and required to be obtained specially by the chemist, provided that the Insurance Committee may, if they think it necessary to do so, require the chemist to satisfy them that such expenses have been reasonably and necessarily incurred. Particulars of the claim for any expenses incurred under this head must be forwarded to the Pricing Office with the appropriate prescription form.

(d) In addition to the fee specified in the scale, actual out-of-pocket expenses will be payable in the case of insulin, serums and vaccines. Particulars of the claim for any expenses incurred under this head must be forwarded to the Pricing Office with the appropriate prescription form.

### APPENDIX C.

#### *Scheme for Testing Drugs and Appliances Supplied to Insured Persons.*

1. The Pharmaceutical Service Sub-Committee, in consultation with the Analyst, shall select from time to time the prescriptions to be used for the purpose of this scheme.

In making such selection the Sub-Committee shall have regard to any recommendations made by the Pharmaceutical Committee or the Panel Committee.

2. Subject to the general direction of the Pharmaceutical Service Sub-Committee, the Clerk to the Insurance Committee shall from time to time select the person or persons supplying drugs or appliances who are to be subject to tests. The Sub-Committee shall have regard to any recommendations made by the Pharmaceutical Committee or the Panel Committee.

3. When a test is to be carried out, the Clerk shall arrange for an Insurance prescription to be written in duplicate and signed by a practitioner on the Committee's medical list, and the practitioner shall not be informed of the names of the Chemists to be tested. The prescription shall be presented for dispensing to the person supplying drugs or appliances by an agent of the Committee (hereinafter referred to as "the agent") who shall be authorised in writing for the purpose. When the prescription has been dispensed the agent shall inform the person supplying drugs or appliances that the medicine or appliances ordered on the prescription form are required for the purposes of a test and shall, if so requested, produce his written authorisation.

4. The medicine dispensed shall be forthwith divided in the presence of the agent by the person supplying drugs or appliances into two equal parts, a suitable container for this purpose being supplied in a clean condition by the agent. In the case of liquid medicaments, before the division is effected, the agent shall mark on the container the height to which the contents reach in the original container. In the case of solid medicaments the person supplying drugs or appliances shall weigh the original container and contents in the presence of the agent, who shall mark on the container the total weight so ascertained. The agent shall seal both containers with the seal provided by the Committee for the purpose in the presence of the person supplying drugs or appliances who shall be informed that he may, if he so desires, affix his own seal in addition. In the case of appliances the articles supplied shall not be divided, but shall be securely packed and sealed by the agent in the presence of the person supplying the drugs or appliances who may similarly affix his own seal. The agent shall, before leaving the premises, mark the prescription form and the duplicate with an identification number, and the person supplying drugs or appliances shall stamp the forms

with his name and address. The original prescription shall be retained by the person supplying drugs or appliances until he is informed by the Committee that he may forward it to the Pricing Bureau for pricing.

5. Both containers shall, in the case of medicaments, be marked by the agent, before leaving the premises, with the same identification number as that affixed to the prescription. The original container shall be immediately forwarded to the analyst with whom arrangements have been made by the Minister together with the duplicate copy of the prescription, and the other container shall be kept under lock and key in the Committee's office; the Committee shall, if so requested by the person supplying drugs or appliances by whom it was dispensed, forward it direct by registered post to any analyst duly named in writing by him. The Committee shall not be liable for any expenditure incurred by the person supplying drugs and appliances in obtaining an independent analysis. In the case of appliances the sealed parcel shall be similarly marked with an identification number and shall forthwith be forwarded by registered post direct to the analyst.

6. The Pharmaceutical Service Sub-Committee shall arrange (a) for drugs and medicines dispensed under this Scheme to be analysed by analysts with whom arrangements may have been made for the purpose by the Minister; and (b) for appliances supplied under this scheme to be analysed by the Testing House established by the Manchester Chamber of Commerce.

7. The certificate of analysis shall be in the form appended to this Scheme and shall not contain any statements other than those provided for in the form.

8. The analyst's certificate shall on receipt be considered by the Chairman of the Pharmaceutical Service Sub-Committee and one of the members of the Sub-Committee who is a registered pharmacist, and if it appears to them that the report of the analyst is of such a character as to make further action on the part of the Committee desirable, the matter shall stand referred to the Pharmaceutical Service Sub-Committee, and the person supplying the drugs and appliances shall forthwith be informed accordingly, and shall be notified that it is open to him within such time as may be specified in the notice, to require the Committee to forward to the analyst named by him the container retained in the Committee's office. The Chemist shall immediately upon receipt of the analyst's report submit it to the Committee or notify them that he does not propose to do so. If the report of the Committee's analyst is of such a character as not to necessitate any further action by the Pharmaceutical Service Sub-Committee the person supplying drugs or appliances shall be informed that he may forward the prescription to the Pricing Bureau for pricing.

9.

#### CERTIFICATE OF ANALYSIS.

To the *Insurance Committee.*

A. I/We the undersigned do hereby certify that I/we received on the \_\_\_\_\_ day of 192\_\_\_\_ (1) a sealed sample of medicament bearing the mark No. \_\_\_\_\_ and (2) a duplicate copy of a prescription bearing the mark No. \_\_\_\_\_ and stamped with the name of \_\_\_\_\_

B. I/We further certify that I/we have analysed the said sample of medicament and I/we hereby declare that the results of my/our analysis are as follows:—

(1) *General Data.*

(a) *Nature of medicament.*

(i.e., mixture for internal use, liniment, ointment, powder, etc.)

(b) *Net weight or volume of sample received.*

(c) *Total fluid capacity of container.*

(If medicament is a fluid.)

(2) *Particular Data.*

Ingredients and quantities thereof of the medicament specified by the prescription referred to under A (2) above.			RESULTS OF ANALYSIS.			
Ingredients.	Total quantities prescribed.	Percentage which each ingredient constitutes of total weight or volume prescribed.	Total quantities of ingredients present in sample referred to under A (1) above.	Percentage which each ingredient shown in Column 4 constitutes of total weight or volume of sample indicated under B (1) (b).	Percentage excess or deficit (if any).	Total quantities of ingredients estimated to be present in total volume of liquid dispensed as indicated by mark on container.
(1)	(2)	(3)	(4)	(5)	(6)	(7)
			••			

(3) *Additional Data.*

C. In my/our opinion the ingredients ( ) contained in the above medicament are/are not likely to have deteriorated since the date when the medicament was dispensed.

Signed

Date

Notes.

1.—In the case of any ingredient which is not capable of accurate determination, an indication should be given whether such ingredient is present or absent.

2.—In the case of a medicament found to contain any substance not specified in the prescription, particulars should be given under "Additional Data."

3.—In the case of a powder prescribed in separate doses the weight of each separate powder should be given under "Additional Data," in addition to the results of the analysis of the powder as a whole.

## APPENDIX LXVI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INCORPORATED SOCIETY OF PHARMACY AND DRUG STORE PROPRIETORS OF GREAT BRITAIN LTD., BY MR. W. HUNTRODS, PRESIDENT, AND MR. A. HUTCHINSON, VICE-PRESIDENT. See Minutes of Evidence of the Thirty-Second Day, Questions 18,266 to 18,436.

## PERSONS EARNING MORE THAN £100 PER ANNUM.

1. Representatives of the above Society, as a result of being brought into intimate and daily contact with persons earning more than £100 per annum are firmly of the opinion that such persons should not be compelled to come under the operation of the National Health Insurance Act because

(1) Such persons are generally of a higher form of education and social standing than the average working man and by their common knowledge are quite competent to treat minor ailments just as well as the average surgeon carrying on his profession as general medical practitioner.

(2) He is not desirous of being compelled to pay a weekly contribution to a compulsory measure, preferring to associate himself with either a Sick Benefit Society or one of the various Benefit Societies or Penny Banks or Insurance Societies, so that in the event of serious sickness he can consult his general medical practitioner knowing that he will get full attention, and that he has some sort of a reserve to fall back upon.

2. If the above suggestion were carried out it would greatly relieve the undue pressure which is put upon the general medical practitioners because if you compel a person against his will to contribute to a National Scheme, which he is not only opposed to but does not require, then, when he is suffering from a simple ailment which, under ordinary circumstances, he would treat himself—he harbours a revengeful feeling. Having been compelled to contribute to a scheme which he considers in his own particular case unnecessary, he is determined to have some sort of a return for his compulsory weekly contributions, hence we get a number of unnecessary

patients crowding a very often inadequate surgery and even queueing for medical attention.

We are also of the opinion if this suggestion were carried out it would help to operate in connection with the question of decreasing the cost of administration and of the weekly contribution.

## CONTRIBUTION CARDS.

3. We think that the employer should pay the whole contribution and be empowered to deduct the necessary amounts from his employees and that an auditor's certificate should be accepted showing the periodical contributions. This would simplify matters and do away with what is considered by the working man a nuisance, viz., the contribution card, and incidentally considerably reduce administrative expenses.

## MONETARY BENEFITS.

4. It is suggested that monetary benefits should be decreased during the early days of sickness because there is no doubt that there is a vast number of

(1) Malingerers

(2) Cases where an insured person could, as stated above, easily treat himself.

5. The effect of this suggestion would be to considerably reduce the pressure and the time of the general medical practitioner and enable him to devote time and diagnose cases of a more serious character. We also think the penalties for arrears of contributions should be made more severe.

6. No special classes of contributors should be recognised.

7. It would facilitate payment and reduce the work of the Friendly Societies if money benefits were paid over through the Post Office.

**MEDICAL BENEFIT.**

8. We think that doctors should be required to do their own dispensing subject to further regulations which will be suggested. Dental treatment should come under the direct supervision of registered dentists and not of doctors. It should be an offence for a doctor to recommend any dentist or any dentist to recommend any doctor for treatment, such offence, if proved, to be the subject to a severe penalty. The same conditions might apply to optical treatment.

9. The administration of medical benefit should be simplified by establishing State medical officers and dispensaries.

10. The Insurance Committees should be re-organised.

**DISPENSING AND SUPPLYING DRUGS AND APPLIANCES.**

11. Full detailed evidence will be given in person, in the event of the Commission deciding to hear oral evidence on the question of dispensing and supplying drugs and appliances, which is undoubtedly an enormous drain on the contributors.

12. There will not be the slightest difficulty in proving to the Royal Commission that insured persons are not getting adequate dispensing service.

13. It is desirable that the Commission should have brought to their notice instances of the alteration of prescriptions by dispensing chemists for their own pecuniary benefit, also supplying short measure, inaccurate dispensing and inferior articles.

14. Further, that whilst the Medical, Legal and Clerical professions do not allow anyone to "cover" it is well known, and can be proved, that some limited companies employ registered men to act as cover.

15. Ample evidence can be produced showing that the system upon which the Drug Tariff Scale is worked is altogether erroneous and results in an enormous public expenditure and waste of money to the benefit of dispensing chemists only.

16. The Tariff allowances are supposed to be based upon the net cost of drugs plus a dispensing fee of 5d. The witnesses will be able to prove that in addition to the excessive dispensing fee allowed, dispensers are making a profit of from 5 per cent. to 50 per cent. in addition.

**APPROVED SOCIETIES.**

17. The witnesses are firmly of opinion that Approved Societies can more adequately, efficiently and economically carry out the principles of a National Health Insurance scheme because—

- (1) A great amount of work is carried out voluntarily by the members who have a direct interest in the administration work.
- (2) The competition between the various Societies for the enrolment of members would tend to give economic and efficient services.
- (3) It must be admitted that representatives of the various trades know the requirements of its members and can organise and carry out the various benefits in a much more economical and different method from that of a National scheme.

18. By way of example. The Society representing say agricultural labourers would require a much less weekly contribution than that of a Society representing skilled men working in a congested industrial area earning perhaps two or three times the amount of wage of the former, whereas the Labourers' Union can give just as adequate benefit as the other Unions.

19. In the case of domestic servants and charwomen it is suggested that the present system of compulsory contributions should be entirely annulled

and that a voluntary system should be adopted because—

- (1) Domestic servants often change their situations not only from place to place but from town to town.
- (2) It is a difficult matter to carry out the present terms of the N.H.I. Act in connection with charwomen.

20. For instance, a woman desirous of earning a little more, either regularly or temporarily, may do either half-a-day's cleaning in a tradesman's shop, a full day at another, and a few hours at a private house or washing a shop or office floor which would perhaps occupy but one hour.

21. We are firmly of opinion that some voluntary scheme could be devised whereby such a person could obtain certain medical—not out of work—benefits. We would also point out that the employers of such persons generally supplement the wages paid by perquisites and, in the case of sickness, usually send little delicacies to restore the person's health.

22. In the case of apprentices and youths, we consider that if the various Friendly Societies undertook the administration of a National Health Insurance Act considerable concessions in the way of contributions would be allowed to youths under the age of twenty-one and indentured apprentices. At present a youth under the age of twenty-one earning a small wage is compelled to pay just as much as a young man of twenty-two earning full rate of wages. This happens at a time when the mother has to provide extra food and clothing.

**DENTAL TREATMENT.**

23. We agree with the whole of the witnesses that dental treatment should become a main and integral part of any compulsory or voluntary scheme because it is generally admitted that apart from senile decay at least 50 per cent. of sickness is traceable to lack of dental treatment.

24. While Education Authorities have, for some little time past, interested themselves in this particular matter we think there is further room for improvement by making it a rule that the teacher should examine children's teeth (such examination does not require dental knowledge) to see that the child is keeping the mouth clean and in a healthy condition.

25. We are opposed to the Friendly Societies having any power to establish either dental or medical clinics. On the other hand we favour the idea that members of Approved Societies should have absolute freedom of choice of medical practitioners or dentists and that it should be constituted an offence for a dentist to recommend a medical man or vice versa. The above also applies to optical treatment.

26. The witnesses are fully aware that there is not the slightest doubt that the present operation of the N.H.I. Act has created a neurotic drug loving Nation, an ample proof of which can be supplied.

27. Careful consideration should, we think, be given to wider considerations, viz.:

- (1) Repeal of the Act.
- (2) The taking of a plebiscite.
- (3) Making the Act voluntary.

Signed for and on behalf of  
W. HUNTERDODS,  
Dentist, President of the Society.

A. HUTCHINSON,  
Senior Vice-President, Nottingham.

J. FRASER,  
Dentist, Hull, Member of the Council.

all of whom are in business in industrial areas as pharmacy proprietors.

NORMAN D. VINE,  
Secretary.

## APPENDIX LXVII.

STATEMENT OF EVIDENCE, SUBMITTED ON BEHALF OF THE CHARTERED SOCIETY OF MASSAGE AND MEDICAL GYMNASTICS, By SIR COOPER PERRY, M.D., F.R.C.P., AND DR. JAMES B. MENNELL, M.D., B.Ch., Members of the Council of the Society. See Minutes of Evidence of the Thirty-Second Day, Questions 18,437 to 18,519.

**Proposals for the inclusion of Massage and Electrical Treatment as an additional benefit to be provided by Approved Societies, when prescribed, for persons insured under the National Health Insurance Scheme.**

## HISTORICAL.

1. The profession of massage was first organised in 1894 as the Society of Trained Masseuses, in order to raise the standard of massage and to protect a necessary profession, making it a desirable and honourable occupation for educated women. To attain these aims provision was made for training, for the examination of candidates, the supply of lectures and demonstrations, of a reference library, for the keeping of a roll of members and the maintenance of an organisation to which members can apply for advice and help. Acting on the advice of many eminent medical men, certain rules for members were made which have governed the Society since its formation:

Not to undertake any cases of massage except under the direction of a registered medical practitioner.

Not to advertise except in recognised medical and nursing papers.

Not to sell goods to patients in a professional capacity, and not to accept secret commissions on the sale of goods.

2. In 1900, with a growing membership, the Society sought incorporation under the Companies Act, and a few years later (1905) the scope of the work was extended when, at the request of the War Office, arrangements were made for the instruction and examination of hospital orderlies at Netley.

3. In 1914, when the organisation represented over 3,000 certificated workers, it was possible to meet the need for qualified masseuses to work amongst the wounded. A corps of masseuses was formed as early as August, 1914, to supply the demand, and members of the Society were appointed by the various authorities to Massage Departments at Naval and Military Hospitals and at Convalescent Camps throughout the country.

4. In 1920, with a membership of 4,000 the Society sought, and was granted, incorporation by Royal Charter, and as thus reconstituted was enabled to offer the advantages and privileges of membership to men as well as women.

5. The efforts of the Chartered Society are directed towards the establishment and maintenance of a uniform training and examination for the profession. Independent examinations are provided and supervised in London and at various centres in the provinces, in Scotland and Ireland. The subject of examinations extend to massage, remedial exercises and medical electricity, and many well-known medical men and women specialists act as examiners in these subjects.

6. Over 5,400 masseuses and masseurs are now registered with the Chartered Society, the majority are qualified to administer, under medical directions, the treatments by massage, remedial exercises and medical electricity now so generally ordered for a variety of medical and surgical conditions, and, as reference to the Society's Register will show, are practising throughout the United Kingdom, in the Colonies and elsewhere. The certificates granted by the Chartered Society are recog-

nised by the Admiralty, War Office, Ministry of Pensions, British Red Cross Society and the medical profession generally.

## INCREASING APPRECIATION OF THE VALUE OF PHYSICAL TREATMENT.

7. The increasing appreciation of massage and electricity as an adjunct to treatment is evidenced by the growth of Physio-Therapy Departments in Hospitals. In 1910 the only institutions at which departments devoted to this treatment could be found were some of the London Hospitals and a few scattered over the country, and even where these were established they were small and insignificant. Now these Departments have been established in practically every General Hospital, and in most of the Special Hospitals and at Clinics throughout the country. The Chartered Society has had special opportunity for noting the rapid increase of such Departments from 1910 onwards by the number of candidates presented for examinations from Schools of Massage established in connection with these Hospital Departments which provide clinical work for those in training.

8. The demand occasioned by the need for treatment of the wounded has led to a more general recognition of the value of massage and medical electricity, and the Chartered Society's appeal is made with a view to bringing this additional benefit within the reach of all insured persons.

9. In further evidence of the value of the treatment and the increasing recognition of it letters are appended from medical experts.

## CONFERENCE WITH REPRESENTATIVES OF THE APPROVED SOCIETIES.

10. Being desirous of including massage and medical electricity amongst the additional benefits which may be provided by Approved Societies out of their surplus funds as revealed on valuation, the Society took an early opportunity to discuss its proposal with representatives from the Approved Societies so as to receive their support in appealing to the Ministry of Health, and, at a meeting held in July, 1924, it was ascertained that the societies represented were in favour of the inclusion of massage and electricity amongst the additional benefits which they might offer to persons insured under the National Health Insurance Act. There were present at this meeting:—

Mr. Izard, Prudential Assurance Company.

Mr. Hutton, Hearts of Oak Insurance Society.

Mr. Pike, National Amalgamated Society, and

Mr. Percy Rockliff, National Insurance Beneficent Society.

## FEASIBILITY OF AFFORDING THE BENEFIT.

11. In order to secure information as to the practicability of affording this additional benefit the Chartered Society has endeavoured to obtain information as to the percentage of sick insured persons who might be presumed as likely to be recommended for the treatment, and is able to produce figures from two hospitals in which the Physio-Therapy Departments are probably more fully developed than in other corresponding institutions. The figures appended have reference to male patients only between the ages of 16 and 70. For the purposes of these statistics it has been assumed that all men between these ages are insured persons.

## GUY'S HOSPITAL, 1923.

## Male Patients—(16-70 years).

In-Patient and Out-Patient Departments 9,840

## Received Treatment.

Massage and exercises ... ..	770
Electricity ... ..	242
(i.e. 10 per cent. of total)	1,021

## Average Number of Treatments per Patient.

Massage and exercises ... (34 per patient)	27,042
Electricity ... (17 " " )	4,319

## ST. THOMAS' HOSPITAL, 1923.

## Male Patients—(16-70 years).

In-Patient and Out-Patient Departments  
(less 233 Police Constables) ... .. 7,724

## Received Treatment.

Massage and exercises ... ..	647
Electricity ... ..	174
(i.e. 10.6 per cent. of total)	821

## Average Number of Treatments per Patient.

Massage and exercises ... (23 per patient)	14,925
Electricity ... (25 " " )	4,309

12. Finding then that in these Hospitals, where it must be explained that the Departments are long established and unusually well patronised, 10 per cent. of insured male patients are found to require physical treatment, and finding from figures obtained from the Hearts of Oak Benefit Society that 20 per cent. of the total membership claims sickness benefit during the year, it may be assumed that not more than 2 per cent. of the total number of insured persons are likely to require physical treatment benefit in any one year.

## FINANCIAL VALUE OF PHYSICAL TREATMENT BENEFIT.

13. It should not be difficult, by the selection of suitable cases for the proposed physical treatment benefit, to recoup the expense of treatment from the amount saved by reduction of sick pay (*cf* Appendix for evidence).

## FEASIBILITY OF SECURING THE PROPOSED TREATMENT.

14. With regard to obtaining treatment, this should be an easy matter in London and other cities, considering the number of Hospital Departments, Red Cross and other clinics at which it is available, and the number of qualified persons already established in practice in and around the cities. Similar opportunities are available in most of the large towns. In country districts where villages are scattered and often at a considerable distance from the local hospital, some organisation would be necessary, but it would not be difficult in every part of the country to secure the services of qualified workers willing to attend on patients within a definite radius. In time, as the demand increases, it may be presumed that members working in the smaller places will co-operate and establish central clinics in given areas in order to provide treatment for insured persons and others.

## METHODS OF ADMINISTRATION.

15. In the event of massage and electrical treatment being included in the list of additional benefits which may be offered to insured persons, the Chartered Society would be prepared to assist in the administration of the benefit through a Joint Committee on which representation should be given to the Approved Societies, the British Hospitals Association, the British Medical Association, the British Red Cross Society, and any other bodies recommended by the Ministry of Health. If the Ministry of Health would itself consent to appoint representatives on this Administrative Committee, such action would be very welcome, and the Chartered Society would greatly appreciate this proof of interest in their work.

## EXISTING ARRANGEMENTS UNDER WHICH THE BENEFIT IS PROVIDED AT THE PRESENT TIME.

16. There are existing already arrangements for supplying these forms of treatment if, and when, any of the Approved Societies are willing to provide it, when prescribed, for persons insured with them.

Approved Societies willing to give assistance towards extra benefits, such as dental, ophthalmic, surgical instruments, massage, etc., have done so through the medium of the National Insurance Beneficent Society, which, by arrangements with bodies representative of the benefits mentioned, is able to secure these benefits at special terms for insured persons. In regard to massage and electricity, the National Massage and Electrical Treatment Society (57, Compton Road, N.5) maintains a panel of qualified masseuses and masseurs practising in towns and in country districts willing to undertake treatment for insured persons. This Society is able to supply, on request, the address of the clinic or treatment room or masseuse nearest to the insured person for whom the treatment has been prescribed. When the doctor has advised a definite course of treatment, it is also possible to supply at once, for the Approved Society, particulars of the probable cost of the course based on the flat rate of fees which the National Massage and Electrical Treatment Society has agreed to accept for treatment given by those on their panel to insured persons. These fees are 4s. 6d. a treatment by massage and electricity; 7s. 6d. if the patient has to be visited in his house, with travelling expenses in addition if the visit is outside the radius of three miles. The average cost of treatment provided in this way for insured persons is given as £5 10s. per person.

## APPENDIX.

Written evidence of the value of the treatment, and the increasing recognition of it, from the following:—

Reginald Cheyne Elmslie, O.B.E., M.S., M.B., F.R.C.S.

Sir Robert Jones, K.B.E., C.B., F.R.C.S.

Miss Florence Barrie Lambert, C.B.E., L.C.C., M.B., B.S., D.P.H.

\*James B. Mennell, M.D. Cantab, M.A., M.B., B.Ch., M.R.C.S.

From REGINALD CHEYNE ELSLIE, O.B.E., M.S., F.R.C.S., Orthopaedic Surgeon to St. Bartholomew's Hospital; Surgeon, Royal National Orthopaedic Hospital.

"Treatment by massage, electrical methods and exercises has now become the routine in the case of almost all injuries, whether minor, such as sprains, or major, such as fractures and dislocations, and also in many illnesses which in any way affect the physical condition, for example, in rheumatic affections of muscles, tendons, and joints. There is no doubt that these forms of treatment very greatly shorten the period of recovery after an injury and the period of convalescence after illness. They help to restore the normal use of the muscles, joints and limbs generally more rapidly than it could be restored by any other means.

Treatment by massage, etc., should be in every case prescribed by a medical man and carried out by someone who is properly trained and experienced in the work. The greater the experience of the worker, the more rapid is likely to be the result. All hospitals of any size now have Massage Departments, in which a very large amount of work is done. These departments are, as a rule, rather a heavy expense to the hospitals because of the necessity for skilled individual work and close supervision. For this reason hospitals are perhaps not very eager to enlarge the department, unless in some way the additional expense can be covered. Patients under treatment by massage, etc., are not as a rule retained in hospital, but the work is carried out whilst they are attending as out-patients. In the case of large towns with adequate travelling facilities this attendance is simple; in other cases it is not so easy to arrange for patients who live at some distance from hospital to secure adequate treatment. Other systems, however, are in



being by which such treatment can be secured. For example, in many areas massage and orthopaedic clinics are now established for the treatment of all sorts of physical disabilities. In these clinics adequate out-patient treatment can be obtained under the necessary supervision. Again it must be emphasised that these clinics are expensive to run because of the necessity of having skilled workers. There is, however, nothing to prevent the very general extension of such clinics all over the country, if sufficient support in the shape of payment for current expenditure is obtainable."

From Sir ROBERT JONES, K.B.E., C.B., F.R.C.S. Eng., F.R.C.S. Edin., Hon. F.R.C.S.I., Surgeon, Royal National Orthopaedic Hospital and Royal Liverpool Country Hospital for Children; Cons. Surgeon, Royal Southern Hospital; Cons. Orthopaedic Surgeon, Royal Infirmary, Liverpool; Inspector, Military Orthopaedics, Army Medical Service; President, British Orthopaedic Association, etc.

"I am glad to hear that the proposal to include physical treatment amongst the additional benefits available under the National Health Insurance Act is being pushed forward. Thirty years ago this treatment was, for the most part, crude, unscientific and, to all intents and purposes, entirely in the hands of untrained men and women, except for a few foreigners of very valuable training and capacity. At the present day it is hard to imagine anyone living in such seclusion that treatment by a fully-qualified masseuse cannot be obtained.

I have watched the growth of this form of treatment carefully and with interest, and as time has gone on, I have witnessed its development year by year, and noted with considerable gratification the general spread not only in amount, but in usefulness.

There are many conditions of which it must be said that physical treatment offers, if not the only hope of cure, at any rate, the only hope of saving prolonged and tedious convalescence. Take, for example, an ordinary synovitis of the knee. Where physical treatment is begun at once and carried out with skilled conscientiousness, recovery is often rapid and complete. Where physical treatment is unavailable, or is not sought, not only is convalescence considerably prolonged, but, in addition, the danger of relapse is enormously increased. Thus, it is not infrequently possible by the use of physical treatment to reduce the duration of disability by anything from a half to two-thirds, while at the same time rendering the liability to recurrence comparatively small.

It is, of course, impossible to multiply examples here, but speaking in general terms, the same applies to almost every form of recent injury, other than where an open wound exists. Even then physical treatment can often hasten recovery. Take, for example, any ordinary fracture, such as a Potts' or Colles' fracture. As soon as the period of unbroken fixation in the splint has terminated, recovery can be enormously hastened by restoring mobility to the joints in which it has been lost, by restoring muscle strength, and the power of co-ordination on which depends the return of function.

It is true, of course, that many patients who are unable to secure this treatment do recover, and are able to resume their former occupations; but, had they been able to secure the advantages of skilled physical treatment, it is safe to say that recovery would have been considerably more rapid, and that a large amount of unnecessary pain and disability would have been saved. A percentage of cases who do not recover sufficiently to resume their former employment after injury in the absence of physical treatment would be able to do so if the treatment had been available; while those whom nothing can help to restore sufficiently to send them back to their former occupation would, for the most part, be restored to a higher state of efficiency by physical treatment than if they were left without its advantages.

It is almost my invariable custom now to invoke the aid of physical treatment after many orthopaedic operations, and unquestionably recovery has been hastened, and my treatment often rendered more effective, as the result.

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I prefer to confine my remarks entirely to the surgical uses of physical treatment, as it is in these matters that its advantages have been most conspicuously brought to my notice. I understand, however, that it is no less serviceable in the treatment of many medical conditions. I would, however, add one word of warning; there are scattered over the country a very large number of people who practise as masseurs and masseuses, who have had little training, and that of a very indifferent nature. These people are to be avoided. It is essential, before employing anyone for physical treatment to ascertain that their training and qualifications justify the trust reposed in them, for, although, of course, the possession of a qualification is, as we know in any profession, not necessarily a guarantee of proficiency, the absence of such training and qualification is a reasonably certain guarantee of inefficiency."

From Miss FLORENCE BARRIE LAMBERT, C.B.E., L.C.C., M.B., B.S., D.P.H., late Inspector, Military Massage and Electrical Services, War Office; late Medical Officer, Therapeutic Department, Convalescent Camps, Eastbourne, Epsom and Dartford, War Office; late Medical Officer, Ministry of Health and Board of Education (Expert adviser on Remedial Gymnastics); late Medical Tutor, Bergman Osterberg Physical Training College; Alderman, London County Council; Hon. Director, Central Council for Infant and Child Welfare.

"I have much pleasure in testifying to the therapeutic value of physiotherapy, by which is included massage, electrical treatment, remedial exercises and hydrotherapy.

In 1914 I was instrumental in helping to organise the first Out-Patient Physiotherapy Clinic for men returning wounded from the Front, and acted as Medical Officer to the Clinic.

This was inspected in 1915 by Sir Alfred Keogh, Director-General of Medical Services, who was so impressed with the results obtained that I was asked to help in the organisation of a Physiotherapeutic Department at a convalescent camp for men at Eastbourne, and to act as medical officer. From 800 to 1,000 men were treated daily in the department.

The War Office considered the results so satisfactory that further convalescent camps were started at Epsom and at Dartford, where also I acted as medical officer. Later it was found necessary to increase the number of convalescent camps all over the country, and these were followed by some eight or nine Command Depots, all having large Physiotherapeutic Departments.

The majority of the cases under treatment were men suffering from the results of wounds, but patients suffering from rheumatism, arthritis, debility, shell shock, etc., were also frequent.

In all, some 4,000 masseuses were employed by the War Office, and the Pensions Ministry continued the work started by the War Office.

The War Office from the beginning insisted on a high standard of qualification for all their masseuses. The certificates of the Chartered Society of Massage and Medical Gymnastics, or of one of the Physical Training Colleges recognised by the Ling were accepted as the standard. The qualifications of candidates holding other certificates were carefully scrutinised by the Selection Board, and most were rejected. I cannot too strongly urge the necessity of a high standard of qualification for those employed in this work; otherwise the results obtained are in most cases nil, and the treatment which can be of such inestimable benefit falls into disrepute. The value of therapeutic treatment lies not only in its curative properties, but also in the fact that it hastens convalescence: a most important factor for those dependent on their work for their livelihood."

From JAMES BEAVER MENNELL, M.D. (Cantab), M.A., M.B., B.Ch., M.R.C.S. Medical Officer, Physio-Therapeutic Department, St. Thomas' Hospital; Physician, Civilian Clinic, Kensington Division British Red Cross; President, Section

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Physio-Therapy Bi-lingual Congress, Radiology and Physio-Therapy; late Physician in Charge, Massage Department, Special Surgical Hospital, Shepherd's Bush.

"It is difficult to write anything which can tend to prove the 'increasing value' of treatment by massage, medical gymnastics, and electricity. Beyond the fact that technique has improved during the last 17 years, which represents the length of time that I have devoted to the study of physical treatment, I cannot say that there has been any 'increasing value,' though that value has been increasingly recognised. I think, perhaps, my personal history will go far to prove this claim.

When I first began to take an active interest in physical treatment in 1907, I was only recently qualified, and a deputation of my fellow-students waited upon me one evening to beg me not to degrade my profession by treading on such unhallowed ground.

In those days there was only one man on the staff at St. Thomas', the late Mr. H. H. Clutton, who gave me the faintest encouragement, and it was entirely as the result of his good services that I was even allowed to practice physical treatment in cases of recent injury attending the Hospital.

In spite of this, at the outbreak of the War, seven years later, I was asked by the authorities of the Hospital to form a special Department for the physical treatment of both civilian and war injury fractures.

Two years later the value of the Department was so widely recognised that, when it was proposed that the British Red Cross should start a clinic for physical treatment on the same lines as was being done at the Grand Palais in Paris, a committee was sent over to inquire into the work being done there and at the Anglo-Belge Hospital at Rouen. A committee of three was sent, the three being a physician, Dr. Grainger Stewart; an orthopaedic surgeon, Mr. Elmslie; and myself as a physical-therapist.

It was on our return from this investigation that Sir Robert Jones was asked to organise the first of the Orthopaedic Military Hospitals at Shepherd's Bush, and it was here that he asked me to undertake the foundation and care of the 'Massage Department.' I believe it was the first hospital of this type that had ever had an official member of the staff as an expert in purely physical treatment.

In those days the staff in this hospital consisted of four surgeons, a neurologist, and myself. This Department was regarded as an integral and essential part of the whole institution, and from that point onwards every orthopaedic hospital that was opened (they were subsequently referred to as Special Surgical Hospitals) was equipped with a Physical Treatment Department; as it had become recognised that no hospital, in which injuries were dealt with, could do efficient work unless the so-called 'Massage Department' was as efficient as the other branches of the institution.

After having worked there for four and a half years I found it impossible any longer to continue my connection with two such important Institutions, and I therefore resigned from the staff at Shepherd's Bush. Soon afterwards the question arose as to whether the British Red Cross Clinic at Kensington (which had worked first for the War Office, then for the Pensions Ministry) should close down, or whether an attempt should be made to utilise the accommodation and equipment for the treatment of civilian patients.

Fortunately the Committee had the foresight and enterprise to give the matter a trial, and I volunteered to help them until the Clinic was established. We opened in February, 1922, and within four years we have six whole-time masseuses employed, a whole-time Sister in charge, and a whole-time Almoner, to say nothing of a small army of V.A.D.s, and other helpers. This Clinic was founded for the treatment of patients who, from social status, were unwilling to attend the ordinary out-patients' departments at hospitals; or who could not secure adequate treatment owing to the congestion

in these departments; or who were not able to attend for treatment at hospital without interrupting their work. The latter represent a very large proportion of our patients, and the busiest time at the Clinic is invariably from 6 to 9 p.m. We are now attempting to secure new and more commodious premises.

A further proof of the growing recognition of the value of physical treatment is, I think, afforded by the nature of the visitors to my Department at St. Thomas'. Recently, Dr. Madden, of the Egyptian Medical Service, wrote to me to ask for details as regards the organisation of a Physical Treatment Department at the proposed new hospital in Cairo. He subsequently visited us, and although the new hospital had temporarily fallen through, he made careful and detailed inquiry as to what steps should be taken should the new hospital be built subsequently.

Another visitor who came to London for a few hours in order to make similar inquiries, was the head of the new Freemasons' scheme in the U.S.A. and in Canada, for the formation of a continental system for the care of crippled children. He, too, had recognised how essential it was that each centre should be properly equipped with a Physical Treatment Department, in spite of the fact that departments of this nature were very rare indeed in American Hospitals until the American surgeons visited this country during the War, and learnt their essential need.

In proof of this I might say that when I visited the Mayo Clinic, Rochester, Minnesota, in 1919, there were two whole-time orthopaedic surgeons at work, and they had as auxiliaries two trained masseuses. At this point I had working for myself a team of about 80! Yet, in 1919, only two masseuses were employed in the enormous medical enterprise at Rochester. In 1924, when orthopaedic hospitals are to be founded all over Canada and the United States, a Physical Treatment Department is considered a vital necessity in each. Other visitors from all parts of the world are frequently to be found in the Department.

During the past year I have been asked to provide the names of people who would be willing to go out and work in such widely separated spots as Montreal and Dunedin, and constantly I am being brought into touch with growing signs of interest.

In 1922 there was held in this country a bi-lingual Congress in radiology and physical-therapy. A corresponding congress had been frequently held before consisting of two sections; radiology and electro-therapy. On this occasion, when it was proposed to hold the Congress in England, a large number of members of the continental societies interested, replied that it was useless coming to this country, as we had nothing in physical-therapy to show them. I was asked to become President of the Physical-Therapy Section of this Congress, and to prove to our continental brethren that we were not so behind-hand as they thought, and in this we were successful.

Taken from another view I cannot, of course, say how many Scottish members of the Chartered Society there may have been in 1907, which I imagine was about the time that I gave my first lecture to the Society in London. When I visited Glasgow to attend the Congress of the Scottish Local Board last month, there were certainly more members present than I used to see in the earlier days of lecturing in London. More than that, one point, very significant of the change in the times, is that in 1907 there were few, if any, qualified medical men who took an active interest in physical treatment. At my opening lecture at this Congress the Chair was taken by Professor Paterson, and there were present many medical men; one of whom had travelled from Edinburgh in order to spend the Saturday at the Congress.

I cannot say that in 1907 there was no officially recognised Massage Departments at any hospital in the country. There were several, fairly well established, but their recognition was negligible. They were permitted to exist on sufferance rather

than as an essential part of the institution. Now, day by day, any hospital of any size throughout the country has provided itself with some form of accommodation for physical treatment, and practically whenever a building scheme is contemplated, the department which of necessity is to be provided with increased accommodation is the Physical Treatment Department.

Another proof of the increasing recognition of physical treatment is, I think, afforded by the story of the Metropolitan Police.

(The following remarks have been submitted to, and approved by, Sir Charles Ballance, Chief Surgeon of the Metropolitan Police).

The last Chief Surgeon, Mr. Clinton Dent, published a statement to the effect that no member of the Metropolitan Police Force, who had sustained a fracture near the ankle-joint, had returned to full duty. Fortunately this is no longer so. Practically every case of injury that is not progressing favourably and rapidly is sent to my Department at St. Thomas' provided he is able to travel, and many of them are brought for treatment in ambulances, day by day, rather than rely on getting well by other means.

A short time ago I had occasion to be disappointed with the slow progress towards recovery of many of these patients who had sustained comparatively trivial injuries. I therefore notified the Chief Surgeon who, at once, circularised the whole of the Divisional Surgeons that members of the Force with injuries such as synovitis of the knee, were not to be treated by rest and applications at home, but were to be reported forthwith to Headquarters, so that physical treatment could begin at the earliest possible moment.

In 1922, 177 new cases reported in my Department from this source alone, although their advent was a comparative innovation. This year the members of the Force under treatment have included the Chief Commissioner, one of the Assistant Commissioners, and the Engineer.

It may I think, be broadly stated, that whereas in 1907, a Physical Treatment Department was looked upon as a luxury, and regarded by many with disapproval, in 17 years it has become regarded as essential in all of the larger hospitals, and now many of the small suburban and provincial cottage hospitals have their regular massage staffs."

## APPENDIX LXVIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE IVORY CROSS BY MR. W. FRANCIS MELLERSH, VICE-CHAIRMAN OF COUNCIL, MR. CHARLES DAVIS, HON. SOLICITOR, MR. H. D. GRANT, CHAIRMAN OF THE APPOINTING COMMITTEE, MR. JOHN HALL, VICE-CHAIRMAN OF THE APPEALS COMMITTEE, AND MISS A. E. FLETCHER, HON. SECRETARY.  
See Minutes of Evidence of the Thirty-Second Day, Questions 18,519 to 18,657.

1. The following observations upon matters touching the organisation of Dental Service on a large scale are submitted as the result of experience as Hon. Organiser and Hon. Secretary of the Ivory Cross.

2. This institution was founded in November, 1914, for the purpose of supplying dental treatment to soldiers and sailors and recruits, under the name of the Soldiers' and Sailors' Dental Aid Fund, when it was chiefly concerned with cases sent to it by the War Office and the Admiralty.

3. Since its foundation, the organisation has dealt with over 106,000 dental cases, including those sent to it for treatment by the Ministry of Pensions. Besides its branches of work, great numbers of its patients are sent by Friendly Societies who have included dental treatment among their additional benefits, and by large firms which arrange for the treatment of their employees.

### METHODS OF OBTAINING EFFICIENCY IN DENTAL TREATMENT.

4. *Dental Hospitals and Clinics.*—Complaints, apparently justifiable, are frequently made of treatment obtained at

- (1) Dental Hospitals and
- (2) Dental Clinics.

About 100 a day during the War were sent to such, and of these at least two a day returned to complain.

In consequence, no patients have been sent to hospitals, except occasionally to special consultants attached thereto.

5. *Treatment performed by Dental Practitioners.*—After ceasing to send patients to hospitals and clinics, a Roll or Panel of Dentists willing to accept the Schedule of Fees proposed was formed.

Good treatment could only be guaranteed with reasonable certainty when the patient was sent to a practitioner who was qualified as an L.D.S. and had

a large practice. Unless the practitioner was (a) qualified by a British Degree and (b) a man of experience, the results were unsatisfactory. About 25 per cent. of the patients sent to men who were, at that period (*i.e.*, 1915), unregistered or of small practice, complained. In each case of complaint the patient was sent to a consultant, who reported, in practically 98 per cent. of the cases so sent to him, that the complaint was, at any rate in some measure, justified.

### METHODS OF DISCOVERING CASES WHERE TREATMENT IS NECESSARY AND BRINGING SUCH CASES UNDER TREATMENT.

6. From reports made by Health Visitors, Maternity Centres and similar Authorities, it appears that there is among the poorer classes a general reluctance to submit themselves for dental treatment, even though it is palpably necessary. In many cases it would appear that this reluctance is due to lack of confidence. So far, no method of dispelling this lack of confidence, has been found, except by results; that is to say, applicants for the assistance of the Ivory Cross have very often been prompted to apply owing to the success of treatment given under its auspices to a previous applicant, or because they have heard that the treatment given by the Ivory Cross is of the most competent available.

7. Whatever be the cause, it is the fact that the Ivory Cross receives from all over Great Britain and Ireland an average of 2,000 applications per month for treatment. This number represents persons applying of their own accord, and is independent of the much more numerous applications which are received in bulk through other charitable bodies, from whom, no doubt, further figures could be obtained. These facts are some evidence of the enormous demand for dental treatment throughout the country, but it only represents a fraction of the number of cases which require treatment, but do not ask for it, or will not submit to it.

8. Although this organisation has dealt with funds amounting to, roughly, over £27,000 per year, it is only able to touch the fringe of the work asked of it. But it was proved that the system was capable of almost indefinite expansion when the Ivory Cross was called upon to deal with all the dental cases under the charge of the Ministry of Pensions for 18 months, covering the period June, 1917, to January, 1919, during the time the greatest demobilisation of the forces was in progress.

#### THE ORGANISATION ADOPTED FOR TREATMENT OF IVORY CROSS PATIENTS.

9. The following methods have been found in practice to be most satisfactory in ensuring the supply of thoroughly efficient treatment:—

(1) *The Appointing Committee.*—A Committee consisting of Surgeon-Dentists selects from the Roll of Surgeon-Dentists referred to above the surgeon who is to deal with each case presented for treatment. In practice, such dentist is always the practitioner nearest to the patient's home, and one who has not got too many other Ivory Cross cases to deal with. At the same time, the Committee sends a dental chart for diagnosis, which is returned by the practitioner after the patient has had his first appointment, showing the treatment recommended for the case.

(2) *The Dental Committee* examines the chart and issues a certificate authorising treatment at the fees allowed, which certificate the practitioner and the patient sign at the conclusion of the treatment to their mutual satisfaction. It is important to note that this Committee

(a) consists of at least six Surgeon-Dentists of experience, and

(b) makes a practice of criticising the proposed treatment or suggesting variations in it where it is deemed advisable.

This practice proves valuable in two ways:

(a) it tends to keep the individual practitioner up to a high standard, since he knows that his proposals will come before a Committee of experts, and

(b) errors in treatment (other than errors of diagnosis) are to a large extent obviated.

It was found that after a few weeks of practice at this critical work the Committee was able to pass an extremely large number of charts at each sitting, though under a National system, embracing the whole population, no doubt more than one committee would be required.

(3) *Central control* has been found the most satisfactory for two reasons:

(a) The Dental Committee has as its members some of the Consulting Surgeon-Dentists in Harley Street, and is a body such as it would be probably impossible to constitute in the provinces.

(b) Local practitioners have sometimes intimated that they would not be prepared to submit their charts containing recommended treatment to local and possibly competing members of the Profession. It is likely that this reluctance would be general if provincial committees were set up, unless they consisted of men of recognised standing amongst their fellow practitioners.

10. In a short précis such as this, it is difficult to give the results of 10 years' experience of such pioneer work, but it is believed that the most important points have been touched on.

## APPENDIX LXIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE GENERAL COUNCIL OF PANEL CHEMISTS (SCOTLAND) BY MR. JOHN RUTHERFORD HILL, Ph.C., SECRETARY TO THE COUNCIL. See Minutes of Evidence of the Thirty-Third Day, Questions 18,658 to 18,892.

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### GENERAL COUNCIL OF PANEL CHEMISTS (SCOTLAND).

1. The General Council of Panel Chemists (Scotland) consists of representatives elected by each of the 54 Pharmaceutical Committees in Scotland, along with two pharmacists elected by the bodies corporate who are Scottish panel chemists, and the Chairman and Vice-Chairman of the Executive of the North British Branch of the Pharmaceutical Society of Great Britain. The General Council elect from their number 15 members who constitute the Pharmaceutical Standing Committee (Scotland), which acts as the Executive Committee of the General Council of Panel Chemists (Scotland).

2. The General Council and the Pharmaceutical Standing Committee (Scotland) are recognised by the Scottish Board of Health as representing Scottish panel chemists, and all details and agreements as to the terms and conditions for pharmaceutical service in Scotland are arranged directly with the Scottish Board of Health and in conference, whenever necessary, with the Executive of the Scottish Association of Insurance Committees, the British Medical Association Scottish Committee on National Health Insurance, and the Drug Accounts Committee. From the outset the relationship between these central representative bodies has been that of good will and friendly co-operation. Such differences as have occasionally arisen have been amicably adjusted, and the organisation has worked smoothly and satisfactorily. From the very outset the Scottish Insurance Commissioners, now the Scottish Board of Health, have

appreciated the value of the high standard of pharmaceutical service for which Mr. Lloyd George gave credit to Scottish pharmacists in introducing the *National Health Insurance Bill*. Taken as a whole, we believe the Scottish system for the provision of drugs and appliances is about as nearly perfect as is practically attainable. There are some minor points on which improvements could be made, such as are indicated in the evidence now tendered. These we believe to be easily practicable.

#### HOW THE PANEL SYSTEM WORKS.

3. Our experience leads us to say we think the administration of National Health Insurance through Insurance Committees under the supervision of the Scottish Board of Health has amply demonstrated the wisdom of the scheme. This has been largely due to the frank and friendly way in which the Central Authority has listened to and negotiated with those who have had to carry out the National Health Insurance Service. While constantly aiming at the highest possible efficiency, there has been a feeling of freedom from irksome technical interference and an understanding and sympathetic appreciation of practical difficulties which have encouraged the best endeavour of all parties engaged in National Health Insurance Service. We have no hesitation in saying also that the panel system for medical and pharmaceutical service has worked well. Despite the acute difficulties created by the Great War, the system successfully surmounted the strain. But for these difficulties, the system might have developed before now many of those services in the advancement of public health, and particularly in preventive medicine and health propaganda, for which it is admirably adapted. We are, therefore, of opinion that the administration through Insurance Committees and under the panel system should be continued.

#### SHOULD HEALTH INSURANCE BE TRANSFERRED TO APPROVED SOCIETIES?

4. At the inception of National Health Insurance and in considering plans for the supply of drugs and appliances, Scottish pharmacists collected information as to the supplying of drugs and appliances in the case of Friendly Societies and Clubs over a period of 15 years. While thoroughly appreciating the great public services rendered by Friendly Societies, it has to be said that in our experience medical treatment and the supply of medicines and appliances under the panel system under the control of the Insurance Committee and the Scottish Board of Health is a very great improvement on the previously existing arrangements. We are satisfied that to take Health Insurance out of the National Insurance Acts and hand it over to the Friendly Societies would be a retrograde step that would be a great disadvantage to members of the Friendly Societies, and would result in a lowering of the standard of both the medical and the pharmaceutical practice.

#### PROPER AND SUFFICIENT DRUGS AND APPLIANCES.

5. Questions have been raised as to what is comprehended under "Proper and Sufficient Drugs and Medicines." At the outset Scottish pharmacists suggested that it should include all medicinal substances, not of a secret or proprietary nature, comprehended in the four British medicine books, namely, "The British Pharmacopœia," "The British Pharmaceutical Codex," Squire's "Companion to the British Pharmacopœia," and Martindale's "Extra Pharmacopœia." A drug tariff was actually framed and submitted on that basis. The proposal was rejected by the Joint Insurance Commissioners in London, who intimated that a limited but sufficiently representative list of drugs was being compiled which would serve the purpose. This was issued, and became practically what is known now as the drug tariff. It soon became apparent that the medical profession would not submit to any such limitation in the ordinary medical treatment of insured persons. From the very beginning, therefore, there has in practice been ample freedom in the choice of medicines, and it has never been suggested

or admitted for a moment that the cost of medical treatment should be allowed to debar any sick insured person from receiving first-class treatment or the use in ample amount of any drug however costly it might be.

#### QUALITY OF DRUGS AND STYLE OF DISPENSING.

6. Panel chemists in Scotland have from the outset maintained that there should be no such thing as any differentiation in style or quality of dispensing between prescriptions for insured persons and prescriptions for private patients. It is the experience of Scottish panel chemists as dispensers that the same high standard has been maintained by Scottish panel practitioners. We particularly deprecate the baseless fallacy sometimes met with that an insured person could have better medical treatment as a private patient, because the prescriber could employ superior or more effective medicines which are beyond the resources of the Drug Fund. We maintain that the Drug Fund can, and does, provide all necessary medicines for insured persons which are just as good and as effective as any that can be obtained by the millionaire. The Panel Chemists' contract requires that all drugs must be of good quality. Good quality of a drug means the British Pharmacopœial standard, and that means the highest quality obtainable in the market. It may be truly said, therefore, that in regard to medical treatment and medicines the insured person has a guarantee and a security which does not obtain in the case of any private person.

#### STOCK MIXTURES AND FORMULARIES.

7. The original draft of the List of Drugs or Drug Tariff compiled by the Joint Insurance Commissioners, included some 70 formulæ for Stock Mixtures. This met with such a storm of condemnation, especially from the medical profession in Scotland, that they were instantly dropped. In Scotland what is known as "Stock Mixture Medical Treatment" is regarded as an inferior service, not in keeping with the high standard of medical treatment prevailing in Scotland, degrading to the practice of pharmacy, and injurious to the sick insured person. It is a remnant of the old bad practice of club medical service dispensing. Its tendency is to induce slackness in diagnosis, sloppy prescribing, and the adaptation of the patient to the medicine, rather than of the medicine to the patient. The same adverse criticism applies to the schemes of National Health Insurance Formularies. These two features are practically unknown in pharmaceutical practice in Scotland, and we regard that as a desirable and advantageous condition. The pamphlet now in preparation on "Hints on Prescribing," proceeds on wholly different lines in keeping with the Scottish practice. While furnishing useful information to the practitioner, he is given entire freedom to prescribe the appropriate medicine which is indicated by his diagnosis. There are no stereotyped formulæ.

#### MEDICAL AND SURGICAL APPLIANCES.

8. Medical and surgical appliances are limited to those prescribed by the Scottish Board of Health in the Second Schedule of Regulations, and are required to conform to the standards of the British Pharmaceutical Codex. If the Schedule appliances are found inadequate, the list can be enlarged at any time. In the main, our experience is that the present Schedule gives general satisfaction. It would be reasonable, however, we think, that such appliances as throat brushes, eye douches, droppers, and such like, required in applying medicines prescribed should be added. More costly appliances, such as trusses, spectacles, or such like, designed as supports or for defective eyesight or physical deformity, might unduly load the charges on the Drug Fund. These latter are more appropriately additional benefits to be provided out of surplus funds. But even these, it is suggested, should be prescribed on ordinary National Health Insurance forms, under some scheme which would provide the control secured by the machinery of the Central Pricing and Checking Bureau, and through persons, firms, or bodies

corporate under contract with the Insurance Committee. It would also be advantageous if the Health Insurance Scheme could secure additional benefits equally for members of all Approved Societies.

#### SCOTTISH DRUG TARIFF AND DISPENSING FEES.

9. The Drug Tariff for Scotland is prepared under the approval of the Scottish Board of Health by the Pharmaceutical Standing Committee (Scotland) and the Drug Accounts Committee. In the framing of the Drug Tariff the aim has been to obviate, as far as possible, any consideration as to the particular form or quantity of a medicament on the part of a Medical Practitioner from a monetary point of view regarding Dispensing Fees. Apart altogether from the prescribing of needlessly costly ingredients, it is regarded as highly important that the only consideration in the mind of the prescriber, so far as the particular medicament is concerned, should be the most appropriate treatment of his patient. From the point of view of the dispenser, the scale of Dispensing Fees is so framed that the Panel Chemist should have no monetary interest in any particular form of medicament. The Scale of Dispensing Fees is as follows:—

Mixtures, Paints, Lotions, Liniments, Gargles and all Liquid Preparations for external and internal use, and Bulk Powders, 5d.  
 Powders, 1 or 2, 2½d.; 3 to 6, 4d.; 7 to 12, 5d.; then 3½d. for each dozen over the first 12 or part thereof.  
 Ointments, Creams, Pastes and Confections, all quantities, 5d.  
 Pills, Cachets, Capsules, Lozenges, Pastilles and Tablets, 1 to 6, 5d.; 7 to 24, 7½d.; then 2½d. for each dozen over first 24 or part thereof.  
 Suppositories, Pessaries and Bougies, 1 to 6, 5d.; 7 to 12, 7½d.; then 7½d. per dozen or part thereof.  
 Plasters, 7½d.  
 Blisters, 5d.

At the outset of National Health Insurance it was assumed that a professional fee for dispensing equal to an average of 2s. per hour would be secured by the Scale of Dispensing Fees then adopted. Scottish Panel Chemists disputed this assumption, and accepted it only under protest. Time showed that instead of working out at 2s. per hour, the result was only approximately 1s. per hour, the average dispensing fee per prescription being 2.212d. per prescription. A demand was therefore made in 1913 for an amended scale, which was practically double the original. Owing to the War conditions Scottish Panel Chemists agreed to carry on without any increase till the War finished. Thereafter the demand was renewed with a request for a further increase of 50 per cent. on the amended scale asked for in 1913. In 1919 agreement was reached for a 25 per cent. increase in the amended scale of Dispensing Fees of 1913 as against the 50 per cent. asked by Panel Chemists. It was contended that if remuneration at the rate of 2s. per hour was considered necessary prior to the War, remuneration at the rate of 3s. per hour was reasonable under post-War conditions. But chiefly out of consideration for the pressing need for national economy, Chemists agreed meantime to accept the offer of 25 per cent. increase, giving an average fee per prescription of approximately 5d. or 2s. 6d. per hour. These results are based on an analysis of about a quarter of a million consecutive National Health Insurance prescriptions, which by repeated tests were found to require an average of 10 minutes each for proper dispensing. Scottish Panel Chemists maintain that an average of 6d. per prescription or 3s. per hour is a fair professional fee.

#### DRUG ACCOUNTS COMMITTEE AND CHECKING BUREAU.

10. With regard to chemists' accounts there is no complaint in Scotland. At the very outset of National Health Insurance, Scottish Pharmacists strongly urged the setting up of a Central Pricing

and Checking Bureau by the Scottish Insurance Commissioners, on grounds of economy and efficiency, but the suggestion was not accepted. After a short experience the difficulties we had foreshadowed persuaded the Commissioners that our suggestion was a good one, and the Central Pricing and Checking Bureau in Glasgow was established in 1915. Under the able management of Mr. A. B. Gilmour, qualified Pharmacist, the Bureau has more than justified all our anticipations, and is now one of the most perfect and efficient departments of National Health Insurance administration in Scotland. The Bureau provides the machinery for collecting valuable statistics and exercising most effective control over the whole system of medical benefit, and providing, on thoroughly satisfactory and economical lines, a supply of proper and sufficient drugs and medicines and prescribed appliances to insured persons. It is controlled by the Drug Accounts Committee, which includes representatives elected by all Insurance Committees, Panel Committees and Pharmaceutical Committees in Scotland, and it secures justice and fair play to practitioners and pharmacists, as well as Insurance Committees and insured persons.

#### TWO OCCASIONS OF LOSS TO PANEL CHEMISTS.

11. There are two occasions of loss to panel chemists for which it would be reasonable to make some provision. Sometimes a bottle of medicine is smashed or the medicine is otherwise accidentally destroyed and has to be replaced. In such cases it should be competent for the prescriber to mark the prescription "Medicine destroyed, second supply given," and to vouch for it by adhibiting his initials. The Central Pricing and Checking Bureau would then allow for the double supply. The second occasion arises particularly in the Highlands and Islands, where medicines have to be securely packed and sent by train or boat a considerable distance, and it is frequently impracticable to recover the costs of packing and carriage. An Insurance Committee might be permitted to make some allowance in approved cases under the very abnormal conditions in the Highlands and Islands of Scotland.

#### PRESCRIBING OF PROPRIETARY MEDICINES.

12. While panel chemists approve the utmost freedom and latitude to prescribers, and deprecate most strongly any policy that even suggests something less than the highest medical skill and the best and most ample pharmaceutical service, there is a common occasion of expenditure which is without any compensating advantage. The prescribing of proprietary medicines by certain practitioners is a cause of financial waste of the Drug Fund, and adds needlessly to the cost, and makes the whole working of the pharmaceutical service more expensive. Most proprietary medicines are combinations of well known and usually not very costly drugs. The composition in many cases is not disclosed or only partially disclosed. The maker gets a monopoly price. There is no guarantee that the composition of the medicine will conform to a uniform standard. As a matter of fact it is known that the composition of some well known proprietary medicines has been altered, although they continue to be sold under the same name and with no indication of any alteration. There ought to be no hesitation in prohibiting the prescribing under a proprietary name of medicines which are well known definite chemical substances, or the prescribing of secret remedies the composition of which is not adequately disclosed. Generally speaking, it would be a distinct advantage if the prescribing of proprietary medicines was discouraged and sanctioned only in the case of some new medicament which is a new remedy and for which there is no equivalent non-monopoly substitute.

#### FALSE STATEMENTS AS TO QUALITY OF DRUGS AND APPLIANCES.

13. The persistent and baseless allegation that drugs and appliances supplied to panel patients are inferior in quality to those supplied to private patients, or are limited on the ground of cost, or the

practice of writing prescriptions for drugs or appliances which patients are told they will require to pay for, or the taking of payment for such drugs or appliances, knowing them to have been prescribed by a panel practitioner for an insured person should be regarded as an offence prejudicial to the medical or pharmaceutical service, if made or done by a panel practitioner or a panel chemist. Unless in an emergency it should be regarded as a breach of contract for a panel chemist to dispense a prescription more than once for an insured person without a fresh order, or in any circumstances to ask or accept payment for any medicine dispensed on the prescription of a panel practitioner issued on the official form for an insured person. Any panel practitioner or panel chemist proved to have acted in any such manner should be liable to removal from the panel list.

#### PREScriptions SHOULD BE IN DUPLICATE.

14. In every area it should be compulsory that every order or prescription issued to an insured person by a panel practitioner should be written in duplicate, an A form for the Insurance Committee, and a B form for the chemist. Pharmacists deem it essential to have a record of all medicines dispensed, and for this reason a copying fee, as well as a dispensing fee, was asked for at the inception of National Health Insurance dispensing. In lieu of a copying fee it was agreed that the chemist should be furnished with a duplicate to be filed. For his own protection, in case of any question being raised as to a medicine dispensed, the chemist is entitled to have an order vouched for by the signature of the prescriber. In the event of any accident or mishap through the supplying of any medicine it may be necessary to quickly discover the source of supply and the contents of the medicine, and this would be impossible in the absence of any readily available authentic prescription. It may happen that the prescription for a medicine dispensed may be sent away to the Insurance Committee within a few hours of being dispensed. There is thus no authentic record of what was ordered available, if required by any question raised, unless the chemist has the duplicate B form. There have been a good many instances of bundles of prescriptions being lost or destroyed in transmission between chemist and Committee or Pricing and Checking Bureau. In such cases the difficulty is met by the B form. Very frequently the B form has enabled the Pricing and Checking Bureau to detect unauthorised alterations in ingredients or quantities on a prescription. While generally in Scotland the prescriptions have been written in duplicate according to the original agreement, there are some areas where panel practitioners have failed to comply either through carelessness or unwillingness, or ignorance of the agreement. It has been quite definitely and unanimously agreed by the Scottish Committee of the British Medical Association, the Executive of the Scottish Association of Insurance Committees, the General Council of Panel Chemists, Scotland, and the Scottish Board of Health, that all prescriptions should be written in duplicate. For these and other reasons it is suggested that it should be made universally compulsory, and that panel chemists should be told to refuse to dispense any order or prescription not written in duplicate.

#### FREE CHOICE OF CHEMIST.

15. Many complaints have been received alleging that certain panel practitioners habitually instruct patients to take Insurance prescriptions to a particular chemist in areas where several other chemists, often more convenient, are under contract with the Insurance Committee. This is particularly so in a number of instances where panel practitioners use the premises of a panel chemist as a consulting room. Not infrequently collusion between prescriber and dispenser is alleged. It is suggested that it should be a term of service for a panel practitioner that he shall not attempt to influence any panel patient, either directly or indirectly, by instructing him to go to a particular chemist, or otherwise interfere with that free choice of chemist which is the right of every insured person. It is further suggested that Insurance Committees

should strictly adhere to the intention of section 9, sub-section (3) of the Terms of Service for Practitioners by refusing to sanction the using of a panel chemist's premises as a consulting room.

#### IRREGULARITIES IN PRESCRIPTION WRITING.

16. While panel practitioners may employ an amanuensis or clerk to write prescriptions, it should be regarded as improper that any panel chemist or any employee of a panel chemist should act in that capacity. It should also be regarded as improper for any panel practitioner to sign a blank prescription form and allow it to be filled up by some other person without his seeing it again. No form should be signed until the prescription has been written. The book of forms should never be kept in the premises of a panel chemist. Panel practitioners who habitually write prescriptions in an illegible manner and so as to make their intentions ambiguous should be warned that panel chemists may be authorised to refuse to dispense such prescriptions, and that the writer will be held responsible for any mistakes made in the dispensing of such prescriptions, or for any inconvenience or injury to any insured person.

#### CAUSES OF HIGH COST OF DRUGS AND APPLIANCES.

17. The increasing frequency in prescriptions and the steadily rising expenditure on drugs and appliances, despite a special investigation directed to discovering the real causes, are not easy to explain satisfactorily. The causes are probably many. Owing to trade depression, unemployment, bad housing and high prices, the industrial population is compelled to live on a less generous, less varied, and less nutritious diet and in unhygienic conditions which result in a lowered vitality which makes them more liable to illness. Recurrent epidemics of influenza have seriously raised the drug bill. Ex-service workmen and women who were engaged in strenuous War service suffered from impaired health, shattered nerves, and more or less chronic invalidity. Climatic conditions, due to prolonged cold, sunless, wet weather, have had a depressing and devitalising effect. The stamina of many children of the War period tends to produce a C3 worker. All these factors make people apprehensive so that they go in larger numbers and for comparatively trivial ailments to the doctor. These causes may, and probably will, pass away.

18. But there are other factors that may be permanent. The lingering suspicion resulting from interested and biased alarmist criticisms to the effect that medical treatment and medicines under the panel system are inferior to that in private practice have now almost wholly disappeared. The result is that only a very small proportion of insured persons abstain from taking advantage of the medical benefit to which they are entitled. Moreover, insured persons are coming more and more to realise that the Health Insurance Acts provide for them medical treatment and advice, without any extra cost, at any time they may require it. The result is that instead of, as formerly, trying to treat themselves and buying what drugs they think useful, they go at the very outset of illness to consult their panel doctor. Many have found also that medicines they thought they had to purchase themselves, such as household medicines, cod liver oil, Parrish's chemical food, paraffin emulsion, castor oil, etc., may be obtained through their panel doctor at the expense of the Drug Fund. There is also what may be a fairly prolonged increase in the cost of some drugs in common use. The greater freedom in changing from one doctor to another also tends to create increased expenditure.

19. It seems not unlikely, therefore, that for a considerable time to come, we may have to face a higher expenditure on drugs and appliances. At the outset, in the pre-War days, it was calculated that 2s. *per capita* would be required to provide proper and sufficient drugs and appliances for insured persons. In Scotland this has proved sufficient, but,

as already noted, chemists have maintained that they are inadequately paid. The expenditure in Scotland has always been considerably lower than in England and Wales. In 1923 the expenditure in Scotland amounted to about 1s. 8½d. per capita. But in 1924, for the first time in Scotland since the inception of National Health Insurance Medical Benefit, the cost exceeded 2s. per capita and reached 2s. 0½d. In England and Wales in 1924 it reached 2s. 3½d. per capita. But, given a general revival of trade and a relief from heavy taxation, this greater readiness to take advantage of National Health Insurance Medical Benefit, which is all in the right direction, should bring about a better state of health in the community, with a corresponding decrease in the expenditure of drugs and appliances, as well as a decreased expenditure on sickness benefit.

20. There is another cause of increased cost. When an insured man has a cold or influenza, it not infrequently happens that his wife, as well as other members of his household, are suffering in the same way. Medicine is prescribed for the insured man, but what is good for him is assumed to be good also for his wife and others in the house. The result is the medicine prescribed for him is shared with the others. That doubtless explains many cases in which the medicine has been renewed much more frequently than if the man alone were taking it. This happens frequently in private practice, and where the household income is curtailed owing to unemployment and high prices, it is small wonder that father's medicine should be shared by his wife and family. If the scheme of Health Insurance was extended to include dependants, according to the original intention, this particular cause of increased expenditure would disappear. Such an extension, by which medical benefit would be provided for many children, whose case without it is pathetic, would also result in such an improvement in general health and physical stamina, that expenditure on drugs and appliances, as well as on sickness benefit, would be substantially reduced, and public well-being would be enhanced.

#### HOW TO SECURE ECONOMY WITH EFFICIENCY.

21. The sudden and continuing increase in expenditure on drugs and appliances indicates the need for wise control and the avoidance of any preventable waste. Scottish panel chemists appreciate the necessity for economy and are desirous of co-operating with the Scottish Board of Health, Insurance Committees, and Panel Committees in every possible way to secure real economy, consistently with efficiency, in the National Health Insurance Service. In the early days of National Health Insurance, in connection with the prescribing and dispensing of medicines, Pharmaceutical Committees held a more effective position and right of control than has been the case since the abolition of the "floating sixpence" and discounting. Pharmacists, from their experience and special knowledge, are well qualified to greatly assist in matters of this kind. They would do so with advantage to both the medical and pharmaceutical service, if they had some security that their opinions and advice would have weight attached to them, and be effective in producing the desired improvement. It is suggested, therefore, that Pharmaceutical Committees should be restored to the more effective position they formerly held, and should be consulted equally with the Panel Committees in all matters bearing upon the prescribing and supplying of drugs and appliances.

22. In providing for and enforcing economy with efficiency in the prescribing and supplying of medicines and appliances, some better method than leaving it to local Insurance Committees or Panel Committees, or Pharmaceutical Committees is necessary. In Scotland, a burgh population of 20,000 constitutes a Health Insurance area. The larger Committees may, and generally do, function fairly satisfactorily. But some other plan is necessary, particularly in the case of small areas where a Panel Committee or a Pharmaceutical Committee has a very natural reluctance to

criticise or put pressure upon any individual practitioner or pharmacist, and where even the Insurance Committee in such matters is quite naturally dominated by the medical members of the Committee who are deterred from taking action by the reasons indicated. The result in very many areas is that although matters requiring attention are reported monthly by the Central Checking Bureau, nothing at all is done. Another fact that makes the local Insurance Committee an ineffective instrument is that many County Insurance Committees meet only once in three months. It is suggested that either the Drug Accounts Committee, or some other competent Central Authority, should have sufficient powers to require that proper and timely steps shall be taken by all Insurance Committees, Panel Committees, and Pharmaceutical Committees, and that the Drug Accounts Committee, or other competent Central Authority, shall be empowered to call for a report from the respective Committees, indicating their diligence in the matter. In this way the responsibility for initiating action would be vested in the competent Central Authority, and the invidious onus of so doing would be removed from the local Committee. This does not imply the taking from Insurance Committees any right or duty. What is proposed is supplementary and auxiliary.

#### TESTING OF MEDICINES AND APPLIANCES.

23. At present there are no sufficient powers by which an Insurance Committee can avail itself of the provisions of the Food and Drugs Acts for checking the dispensing of medicines for insured persons. It is provided under section 9 of the terms of service for persons supplying drugs and appliances that the panel chemist shall dispense for any inspector under the Food and Drugs Acts, or any person acting under his authority, any prescription written on a National Health Insurance form and signed by a panel practitioner. He is not bound to dispense any other prescription unless for a panel patient, or for a panel practitioner's supply of emergency drugs. Inspectors under the Food and Drugs Acts are officials of the local Public Health Authority, and will not take instructions from, or act for, the Insurance Committee. On the other hand, panel practitioners are under no obligation to write prescriptions otherwise than for sick insured persons, and they very naturally refuse to write prescriptions to be used as evidence against a local pharmacist. There would require to be power by which an Insurance Committee could have the services of a Local Authority Food and Drugs Acts Inspector, or it might be made competent for an officer of the Insurance Committee to be recognised as an Inspector under the Food and Drugs Acts. It would also require to be provided that an Insurance Committee could have the necessary prescriptions written by some of the medical staff of the Scottish Board of Health, or otherwise that it should be a term of service for panel practitioners that they should write such prescriptions as the Insurance Committee require for the testing of dispensing. It would also be necessary to secure that, in the administration of these powers, inspectors would not be seen by any insured persons who might be waiting for medicines in a pharmacy, so as by any possibility to suggest to such insured persons that there is anything wrong in the pharmacy or in the medicines dispensed therein. Pharmacists are acutely aware of the extreme undesirability of allowing anything to upset the confidence of a sick person in the medicine he is to take. On the whole matter it is suggested as a preferable alternative that any scheme for procedure under the Food and Drugs Acts should be abandoned, and that a scheme to be arranged between the panel chemists and the Insurance Committee in consultation with the Panel Committee, and to be administered through the Pharmaceutical Services Sub-Committee should be adopted. The present statutory powers of the Insurance Committees and their right to take disciplinary procedure, and impose, if need be, an appropriate penalty on any defaulter, seem quite adequate, and would be preferable to the procedure required to be taken under the Food and Drugs Acts. Such procedure would apply also to



appliances which do not come under the Food and Drugs Acts.

#### REGULATION OF ADMISSION TO PANEL LISTS.

24. Under present conditions any medical practitioner, and any person, firm, or body corporate, lawfully entitled to carry on business as a chemist and druggist has a right to be included in the list of panel practitioners or the list of panel chemists, as the case may be. Experience suggests that it is for consideration whether an Insurance Committee or the Board of Health should not have a right to say they do not deem it necessary to include an applicant with whom they have reason to think it undesirable to place a contract. This power would be so safeguarded as not to exclude any fit and proper person desiring to be included. While insured persons are free to choose both doctor and chemist they are likely to assume that all those on the panel lists are regarded by the Insurance Committee as competent and reliable practitioners or chemists. But as matters stand the Insurance Committee has no power to secure a really competent and irreproachable panel list from which the insured person is to choose. Any person holding a medical or pharmaceutical qualification may demand to be included, and cannot be refused.

#### EXPENSES OF CENTRAL BUREAU AND PHARMACEUTICAL COMMITTEES.

25. It has been suggested by the Scottish Board of Health that the payment presently made out of the Drug Fund towards the expenses of the Central Pricing and Checking Bureau, and the administrative expenses of the Pharmaceutical Committees should be deducted from the amount payable to panel chemists for drugs and appliances dispensed. It would be unreasonable to make such a deduction without an equivalent increase in the contract terms for pharmaceutical service in dispensing and supplying drugs and appliances. It is alleged that the making of such a deduction would put panel chemists on the same level as panel practitioners. That is quite inaccurate. From the outset the cost of the Central Pricing and Checking Bureau and the administrative expenses of Panel and Pharmaceutical Committees have been a first charge on the Practitioners Fund and the Drug Fund respectively. The whole of the Practitioners Fund is disbursed to panel practitioners annually, so that they receive not only the *per capita* payment for persons actually on their panel lists, to many of whom they render no service, but also the *per capita* payment for those persons who never choose a practitioner, and most of whom never avail themselves of the medical benefit to which they are entitled. The panel chemist, on the other hand, is paid only for services actually rendered, and for goods actually supplied, according to the prices fixed by the Drug Tariff. He, unlike the panel practitioner, has no claim on the

Drug Fund in respect of services he might have been called upon to render but has not, or goods he might have been called upon to supply, but has not. Unlike the Practitioners' Fund, the Drug Fund is not exhausted. A balance remains, and it is only reasonable that that balance should be used to meet the expenses of the Central Pricing and Checking Bureau and the Pharmaceutical Committees. These are both necessary administrative machinery in the scheme of medical benefit and a proper charge on the Drug Fund.

#### REPRESENTATION ON INSURANCE COMMITTEES.

26. Pharmacists in Scotland have no statutory right to representation on Insurance Committees as is the case in England and Wales. This is a serious defect and disability. It is recognised as such by the Scottish Board of Health who, in exercising their right to nominate certain persons as members of Insurance Committees have been good enough to nominate a pharmacist whenever possible. Owing to the small size of many Insurance Committees in Scotland, however, and the fact that the Board are required to secure representation of particular interests, the Board cannot nominate a pharmacist, and in such cases pharmacists have no representation. It is claimed that in the interests of efficient pharmaceutical service and from their special knowledge of health matters, pharmacists, like medical practitioners, should by statutory right be represented on all Insurance Committees, and that such representation should not be less than two pharmacists on each Insurance Committee. In this connection we mention a suggestion made by us some years ago that the Scottish Board of Health should include a pharmacist.

#### SEAMEN'S NATIONAL INSURANCE SOCIETY.

27. The suggestion that the exceptional arrangements for the Seamen's National Insurance Society should now be discontinued has the cordial approval of Scottish pharmacists. The arrangements have always been troublesome and unsatisfactory.

#### NATIONAL HEALTH INSURANCE MEDICAL AND PHARMACEUTICAL SERVICE IN SCOTLAND.

28. Lest there should be any misunderstanding, it may be desirable to say in conclusion that it is well known to Scottish panel chemists, and to all who are acquainted with the facts, that prescribing by panel practitioners in Scotland, as a whole, is on a very high level, and that the relationship between practitioners and pharmacists is one of mutual respect and confidence and helpful co-operation. The matters referred to as needing amendment are relatively few and are mentioned with a view to their elimination, so that a service already on the whole satisfactory may be brought still nearer to the ultimate ideal. These remarks apply equally to the pharmaceutical service.

## APPENDIX LXX.

### STATEMENT OF EVIDENCE SUBMITTED BY DR. ALEXANDER ASHER, M.B., C.M. See Minutes of Evidence of the Thirty-Third Day, Questions 18,893 to 19,171.

1. I am a duly qualified Medical Practitioner and hold the degrees of Bachelor of Medicine and Master in Surgery of Edinburgh University. I am a J.P. for Caithness, a Member of the Caithness Insurance Committee, Secretary of Caithness Panel Committee and Secretary of the Caithness and Sutherland Division of the British Medical Association.

2. Since 1889 I have been in practice on my own account in Thurso, Caithness. My practice, however, extends to the Western division of the County of Caithness, as well as to the North West Coast and various other parts of the neighbouring County of Sutherlandshire. Under the National Health Insurance the number of insured persons on my list, if not

the largest, is one of the largest in the North of Scotland.

3. The population of the districts served by my practice may be said to be comprised of those engaged in,

- (1) Agriculture,
- (2) Fishing, and
- (3) General Trades.

4. My experience of the working of the National Health Insurance, established by the National Health Insurance Acts, has led me to form the opinion that, while the Scheme has more than justified expectations and is being more appreciated, there is a growing

public opinion that the time has come when drastic extensions and developments should be given effect to.

#### PERSONS INCLUDED IN THE SCHEME.

5. In my opinion, much could be done to extend the beneficial operations of National Health Insurance if the present limitations as to insurable persons were abolished and a much more comprehensive Scheme adopted. Under existing regulations, only persons working under an employer and paid wages at fixed times are included in the Scheme and the contributions are paid jointly by employer and employee. Under this Scheme one person in three throughout the country is insured, but, when applied to the rural districts of Caithness and Sutherland, the statement is misleading as I find that in those districts the number of insured persons is only about one in eight.

6. The explanation of this is that many of those engaged in the agricultural and fishing industries are not compulsorily insured persons. For example, in the case of those engaged in agriculture, the area referred to by me forms part of the Highland crofting area, and the average rental of these crofts will not exceed £10 per annum. In most cases the croft is worked by the crofter with the assistance of a member of his family to whom no fixed wages are paid and as a result exemption from Insurance follows. The same applies to those engaged in the fishing industry where a boat's crew share only in the profits.

7. My experience has showed me that in each of the classes referred to compulsory Health Insurance would prove a great boon.

8. I am, therefore, very strongly of opinion that the success which has attended the experimental process of National Health Insurance, has been such as to warrant the inauguration of a much more extended sphere of operations, the result of which would be for the general well-being of the country. In my view, I would favour a scheme which would have the effect of making every person over 16 years of age, whose income is less than £120 per annum, insurable. For those having an income from £120 to £250, I would leave the question of Insurance optional to the individual, but at a rate of contribution proportionate to income.

9. Another direction in which I am of opinion that an extension of the Health Insurance would prove particularly beneficial is the development of a scheme under which the dependants of an insured person could participate in the benefits of Insurance. I have frequently, in the course of my practice, when in attendance on insured patients, had this suggestion put forward. I quite realise that there might be difficulty in formulating such a scheme, but I do not think that this is insurmountable.

#### SOURCES OF REVENUE AND COLLECTION OF CONTRIBUTIONS.

10. Proceeding on the assumption that National Health Insurance is for the well-being of the State, and that in effect it must have saved Local Authorities charged with the relief of the poor a very considerable amount, I would suggest that, in order to keep as low as possible the contributions payable by employer and employee, the Government contribution should be as liberal as the importance of the Scheme demands. In addition, I think that a rate not to exceed 2d. in the £ should be levied by the County Council of each County and the proceeds thereof paid over to the County Insurance Fund, which sum would be specially used for the purposes referred to in paragraph 18 below (Other Treatment).

11. While the collection of contributions is meantime in the hands of the Approved Societies, I would prefer to have the collection of contributions centralised and placed under a public official, upon whom would devolve the duty of seeing that the provisions of the Insurance Acts were being complied with by those resident in their respective areas. A suitable official might be the Collector of Parish

Rates, who, in rural areas, invariably acts as Clerk to the Parish Council, and, as such, knows and is known by most people in the parish.

#### MONEY BENEFITS AND PENALTIES FOR ARREARS OF CONTRIBUTIONS.

12. Payment of flat rates to insured persons under the initial operations of the Insurance Acts was perhaps unavoidable, but I think the time has arrived when an improvement might be effected under which a sliding scale differentiating between married persons with families and single persons could be adopted. I would also favour a stipulation that in the case of insured persons under 21 years of age during any period of their disablement they would not be entitled to draw a higher benefit than their wages at the time of the commencement of their sickness benefit.

13. As persons of the crofter and cottar class, share fishermen, etc., who are not at present insured, are as needful when illness affects the bread winner, I consider that they would require the same money benefits as are paid to employed persons, along with medical benefits, and that the same penalties for arrears of contributions should be imposed.

#### SPECIAL PROVISION FOR PARTICULAR CLASSES OF INSURED PERSONS.

14. I am of opinion that the present regulations might, with advantage, be greatly improved. In the case of deposit contributors, it seems to me that this method should be done away with, and that every person within the prescribed limits should be accepted on equal terms. Granted that this might, in a few cases, operate against Approved Societies accumulating vast sums, it is only reasonable that these Societies should bear the burden of weaker members of the community and be deprived of the power of accepting only those cases where there is little likelihood of sickness. For those engaged in seasonal occupations (fishing, harvesting, etc.), where the full rate of insurance is paid during actual employment, I would suggest that, provided the employee's contribution is paid during the period of non-employment, the insured person should be entitled to the full benefits of insurance. There are also men and women in the capacity of school cleaners, etc., whose annual remuneration does not usually exceed £12 who are insured, and as such become entitled to full benefits at the rate of three or four times their income. Here some alteration is desirable.

15. Special provision should be made for insured persons with a number of dependants, and I consider that sickness benefit should be proportionate to the size of the family and should be such as would maintain them in a measure of comfort without having recourse to the relief provided under the Poor Law Acts.

#### ADMINISTRATION OF MONEY BENEFITS AND THE APPROVED SOCIETIES.

16. I may frankly say that, in place of the existing Approved Societies, I would much prefer to have the whole Scheme of Health Insurance placed under entire National Control, so that all insured persons would have the same treatment meted out to them. Failing this, some alteration in the present condition is urgently called for. While some Societies pay sickness benefit with promptitude and with the least possible trouble to all concerned, it is unfortunately the case that some Societies are not only dilatory but will pay only when pressure is brought to bear on them. Some secretaries err on the side of generosity, while others are constantly raising all manner of technical objections which create a good deal of irritation to insured persons as well as to the doctors. If the administration of the Scheme were centralised in the manner suggested, insured persons would enjoy the same benefits and would establish a confidence amongst insured persons that treatment of their claims would be dealt with in the same manner.

17. Local administration of money benefits would be an advantage and, in my view, the most suitable person for doing so in the Highlands and Islands is the Clerk to the Parish Council, who is in a great many parishes at the present time connected with Health Insurance work.

#### OTHER TREATMENT BENEFITS.

18. In addition to the medical benefits allowed under the Insurance Acts, there is, especially in remote areas, urgent need for specialist treatment such as cannot be expected from the general practitioner. To meet this much-felt want, I would suggest that in all cases of emergency an insured person should have the benefit of the services of a competent surgeon or of a specialist in diseases of the eye, ear, nose and throat, X-ray specialist, &c.

19. In this connection I would suggest that the proceeds of the local rate suggested in paragraph 10 (Sources of Revenue) should be available for the equipment or development of hospital accommodation within the county area, for the establishment of an efficient nursing service and necessary corollaries or in such manner as in the opinion of the County

Insurance Committee might determine as most needful in their respective districts.

#### ADMINISTRATION OF MEDICAL BENEFITS BY INSURANCE COMMITTEES.

20. This at the present time is mainly done by the Clerk with the approval of the Insurance Committee. I consider that these Committees are, as at present constituted, cumbrous, and that the work of administration would be more efficiently performed by smaller Committees. The provision of extra benefits, such as artificial teeth, surgical appliances, &c., might with advantage be entrusted to Insurance Committees. This at any rate would lead to greater uniformity than at present where Approved Societies are in competition with one another.

#### FINANCE, AUDIT AND VALUATION.

21. As these matters are more closely associated with the Approved Societies, I refrain from expressing my opinion thereon.

ALEXANDER ASHER.

Thurso, 14th November, 1924.

## APPENDIX LXXI.

### STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL FARMERS' UNION OF SCOTLAND. BY MR. JAMES C. HENDERSON, MEMBER OF THE CENTRAL EXECUTIVE OF THE UNION. See Minutes of Evidence of the Thirty-Third Day, Questions 19,172 to 19,399.

1. I am a Member of the Central Executive Committee of the National Farmers' Union of Scotland, and I have been appointed by that body to submit evidence to the Commission in connection with the position of Agricultural workers under the National Health Insurance Scheme.

2. For some years it has been apparent that the agricultural industry has been paying an undue share of the burden of National Health Insurance. It will be agreed that agricultural work is one of the healthiest occupations, and I hope to show from the experience of an Approved Society which deals with agricultural workers that their actual experience confirms this fact.

3. The question of the position of farmers to the National Health Insurance Scheme was considered by the Farmers' Union on various occasions; and a copy of the correspondence which has taken place with the various Departments is attached.

4. The crucial point in our case is that Agriculture is a healthy industry and stands apart from all other industries in this country. In all other respects it is treated separately. For example, it is not included under the Unemployment Insurance Scheme, nor is it included in any projected legislation in regard to limitation of working hours. It makes a distinct claim for separate treatment in this connection.

5. It appears that when in regard to Health Insurance it is placed on a par with other industries it is being asked to bear an undue share of the burden arising from industrial occupations where the health experience is vastly different. The main fact that its health experience justifies this contention has not been denied, and it is assumed that the claim of the industry for special treatment and for reduced contributions has only been refused because of alleged administrative difficulties. Such a reason for the answer to the representations made is regarded as unsatisfactory and inadequate when such a strong case is made out for differential treatment.

6. Contributions should be levied on the different industries according to their claims experience, which principle applies to ordinary Insurance practice; and if the National Health Insurance Scheme

was run by experienced business men the practice of the ordinary Insurance Companies would certainly be adopted. Agriculturists in Scotland emphatically protest against the present system which compels them and their workers to pay Health Insurance premiums out of all proportion to their risk and with the object of bolstering up the less favourable health experience of other industries.

#### EXTRACTS FROM REPORTS OF RURAL WORKERS' APPROVED SOCIETIES SHOWING FAVOURABLE HEALTH EXPERIENCE.

7. It will be necessary for me to endeavour to substantiate the principal premise on which my argument is based, viz., that the health experience in Agriculture is such that the contributions presently demanded are clearly excessive. I take the instance of the Scottish Rural Workers' Friendly Society. That Society was formed on 7th February, 1912, and registered under the Friendly Societies Act. It was founded primarily for the purpose of securing for the rural workers of Scotland the fullest possible advantages of the National Insurance Act, and it entered into an arrangement with the International Ploughmen's Society of Scotland, which had previously been in existence as a Friendly Society—the effect of the arrangement being that the Societies would amalgamate.

8. The membership of the Society at 12th October, 1913 was 67,221. During the first three quarters of the Society's operations when sickness, and maternity benefits were payable, the amounts payable in respect of these benefits was for men a sum equivalent to 52·7 per cent. and for women a sum equivalent to 90·1 per cent. of the official estimate for the whole insured population. The amount payable for men was £12,394 10s. and for women £3,783. On the basis of the official estimate there was therefore an approximate surplus on the Men's Benefit Fund of £11,123 10s. and on the Women's Fund £413.

9. The Report of the Provisional Board of Management submitted to the First General Meeting of the Society held at Edinburgh on 12th and 13th December, 1913, stated—"It will be seen that the claims by the men members have been very moderate, indicating—so far as the experience of a limited period can do so—that the general health of these members

is of a high standard." The Board proceeded to say that they regarded the general result as "highly satisfactory." (See page 19 of bound Volume of Society's Reports.)

*Excerpts from Report of Scottish Rural Workers' Friendly Society for Year Ended December, 1914.*

10. In the Report by the Board of Management to the Second Meeting of the Society held in Edinburgh on 18th and 19th December, 1914, it was stated: "The Society has established its position as one of the leading Approved Societies under the National Insurance Acts in Scotland, and has now a larger membership amongst the insured rural population than any other Society." Further: "Under the Insurance Acts the benefits of the members of Societies which show a deficiency on valuation will be reduced or a levy will be made upon the members to make good the deficiency."

Parenthetically I would observe that this introduces the principle of differentiation which the Farmers' Union submits for acceptance.

The amount of sickness and maternity benefits payable by the Society during the period from 13th January, 1913, to 5th July, 1914 was £26,484 in respect of men and £7,566 in respect of women.

These amounts represent 56·7 per cent. in the case of men and 90·7 per cent. in the case of women of the official estimate of the amount which on an average of the whole insured population would be required to meet the benefits.

11. The Report proceeds—"The result is entirely satisfactory."

In the review of the financial situation on page 14 of the Report there occurs the following: "leaving to the credit of the Benefit Fund Account the substantial sum of £50,985 13s. 7d.," to which it was stated there would ultimately fall to be added the aggregate amount to be credited to the Society in respect of reserve values when these had been ascertained by the Government Actuaries.

In the Address to the Delegates to the Second Annual General Meeting of the Society in December, 1914, Mr. James Falconer, M.P., the President of the Society, said: "I would like to say that it is very gratifying for us to find ourselves after another full year's experience as representatives of a Society whose results continue to be so eminently satisfactory."  
 . . . "With regard to the financial position of the Society, I think I can best show it in a few figures by considering what members are contributing, and what they are receiving, and what is being set aside for the purposes of the Society. The contributions of members for the period of 18 months were £73,315; the total income of the Society from the employers' contributions and the State grants, in addition to the contributions of members, during that period was £147,993, and that sum was applied as follows:—For the benefits—sickness benefit, maternity benefit, and medical benefit £46,587; to provide a sinking fund for future liabilities—which is an essential condition of all sound Friendly Societies—there has been set apart £29,845; and for administration expenses for the 18 months, and also for the previous six months during which the Society was being organised, £20,574. That is a total of £97,007, and when you deduct that from £147,993 it leaves a balance of £50,985—a very satisfactory balance. This balance of £50,985 is to be treated as accumulated reserve to meet future liabilities to the extent of approximately £35,900. That leaves a surplus on the particular benefits which we have been paying of over £15,000. But in order to ascertain the real financial position of the Society at the present time you have to take into account the reserve values provided under the Insurance Act which fall to be credited to the Society. The amount of these reserve values has not yet been ascertained. It is estimated, and I believe on the safe side, that they will amount to something like £250,000, and these reserve values when ascertained will be treated as a debt due by the Insurance Commissioners to the Society. On the amount of the reserve values outstanding from time to time we shall receive from the

Commissioners interest at 3 per cent. per annum, and we shall also receive each year an instalment of principal which by the end of about twenty years will pay the whole amount to the Society. It is impossible to put a figure upon the instalment until the amount of the reserve values is actually fixed. It will be seen from the figures I have given you that the position of the Society with its balance, to which I have referred, and its reserved values, will be one of unshakable stability."

*Excerpt from Report of Scottish Rural Workers' Friendly Society for Year 1915.*

12. In the Report by the Board of Management to the Third Annual General Meeting held in December, 1915 it is stated that "despite the continuance of the War and the abnormal conditions arising therefrom, the period under review has been one of steady progress for the Society." . . . "The favourable sickness experience of the previous 18 months has been maintained." . . . "A very considerable sum has been added to the Society's invested funds." . . . In his address to the Delegates at the Meeting on 17th December, 1915, Mr. James Falconer—then M.P.—was present at the meeting and stated "We have also a surplus on the year's working of £21,885." . . . "I think the results of the year are highly satisfactory."

*Excerpt from Report of Scottish Rural Workers' Friendly Society for Year ended December, 1916.*

13. In the Report of December, 1916, it is stated: "The assets of the Society, exclusive of reserve values, amounted at 31st December, 1916 to £97,120. . . . Since 31st December last further investments have been made."

In his address to the Delegates on 22nd December, 1916, Mr. Falconer, the President, said: "It is a pleasure to be able to present an account which is a record of continued and well-established prosperity." . . . "As regards our financial position, perhaps it is best indicated by the fact that the balance at the credit of our Benefit Fund Account has increased from £72,570—as it stood at the end of 1914—to £90,243 at the end of 1915; an increase of £17,673. To this substantial sums still fall to be added." . . . "It looks as if we had attained practically the same result as in the previous two years, namely, an increase in the balance of the Benefit Fund Account of about £24,000 or £25,000 a year."

*Excerpt from Report of Scottish Rural Workers' Friendly Society for Year 1917.*

14. In the Fifth Annual Report, i.e., for the year 1917 it is stated: "The Board are glad to be able to report that the satisfactory experience of the Society has been well maintained in every respect during the year." The Benefit Fund Account showed a surplus for the year of £27,125 0s. 8d. The balance brought forward at 1st January, 1916 was £90,243 10s. 4d. making the sum at the credit of the Account as at 31st December, 1916, £117,368 10s. 10d.

In a speech delivered by the President of the Society, Mr. James Falconer, M.P. in the House of Commons on 23rd November, 1917, he stated: "I should not have thought it necessary to speak at this stage at all, but that on behalf of Rural Societies dealing with rural matters I think it necessary to make their position quite plain, so far as I understand it. They are in an exceptional position in more ways than one. Perhaps I can best illustrate it by explaining the position of the Society with which I am connected—the Scottish Rural Workers Society. It holds a unique position both as regards the number of its members, the difficulties of its management, and I think, probably, also as regards the surpluses which it has accumulated up till now." . . . "The fundamental principle upon which the Society was built up was that if the rural workers of Scotland combined and managed for themselves an Approved Society under the Act, they would be rewarded by securing additional benefits on account, in the first place, of economic and efficient management, and, in

the second place, of their exceptional healthy condition. . . . If we were to be told that the surpluses which have been so built up were to be made available for making good deficiencies in other Societies, we should have led all these people to do a very worthy thing . . . under false pretences. . . . We cannot recognise any right on the part of the State to take any part of the contributions of our members or their employers or of the State which were promised in respect of them for the purpose of making good deficiencies in other Societies."

I take it that I have quoted sufficient to illustrate our general argument, and in order to shorten the evidence I will omit the remaining Reports and quote the position as it appears from the Eleventh Annual Report of the Board of Management, i.e., for 1923-1924.

*Excerpts from Reports of Scottish Rural Workers Friendly Society for Year 1923-24.*

15. "The valuable additional benefits which are now being provided . . . have added greatly to the popularity of the Society in the rural districts." On page 9 there is a paragraph setting forth the "Additional Non-Cash Benefits." On page 10 a paragraph follows dealing with "Further Additional Benefits."

The surplus in the Benefit Fund Account	£	s.	d.
for the year was . . . . .	30,624	18	8
To which fell to be added credit balance at 31st December, 1922 . . . . .	£736,909	7	2
Further credit from Contingencies Fund as at 31st December, 1918 . . . . .	104	0	0
	736,909	7	2

Making total sum at credit of Benefit Fund Account as at 31st December, 1923 . . . . . £767,534 5 10

The Report goes on to state—page 13—"The Balance Sheet shows that the assets of the Society at 31st December, 1923, amounted to £812,351 10s. 1d. being an increase on the year of £38,161 9s. 1d."

In a Pocket Calendar advertisement issued by the Society for 1924 "Twelve Points regarding the Society" are set forth. No. 3 reads—"Its members are drawn from the healthiest class of the community, and consequently their contributions are sufficient to provide more than the ordinary benefits." I produce the Calendar and refer to pages 14 and 16.

Before leaving the subject of the specially favourable experience in regard to rural workers, I would refer to the Scottish Landed Estates Friendly Society.

*Excerpt from Report of Scottish Landed Estates Friendly Society for Year 1921.*

16. In the Annual Report of 27th June, 1921, it is explained that those members who are entitled to share in the surplus shown by the Valuation as at 31st December, 1918, will receive the following additional benefits:—

"Repayment of twopence in the case of men, and one penny halfpenny in the case of women in respect of each weekly contribution paid by or on behalf of the member.

*Note.*—These repayments will be made at the following times:—

In January 1922, on the Contributions paid for half-year July to December 1921.

In January 1923, on the Contributions paid for year 1922.

In January 1924, on the Contributions paid for year 1923.

In January 1925, on the Contributions paid for year 1924.

In January 1926, on the Contributions paid for year 1925.

In July 1926, on the Contributions paid for half-year January to June 1926."

*Excerpt from Report of Scottish Landed Estates Friendly Society for Year ended 1923-24.*

17. In the Eleventh Report to the Annual General Meeting held on 23rd July, 1924, they say:—"The Board of Management would again impress on the members that it lies almost entirely with themselves to increase the success already attained. This they can do chiefly by letting the marked success of the Society be known."

Paragraphs on page 2 appear under the heading:—

"ADDITIONAL BENEFITS FROM SURPLUS, 31st DECEMBER, 1918" AND "FURTHER ADDITIONAL BENEFITS."

Under the latter paragraph it is stated—"The repayment of contributions not having exhausted the total funds available for payment of additional benefits," it was resolved to institute a provision for Dental Treatment."

GENERAL.

18. Under the 1911 Act power was given to any body of insured persons to register an Approved Society for National Health Insurance purposes, and in order to meet the case of certain classes of insurable persons who had better health experience than others, the system of separate Approved Societies was devised—each Society being entitled to distribute in the form of additional benefits to its own members any surplus funds accumulated.

19. The Society from whose Reports I have so freely quoted was formed under that provision, and I have shown that it has from the ordinary contributions accumulated a very large surplus, notwithstanding the provision of additional benefits and increased rates of ordinary benefits.

20. Amongst these additional benefits are dental treatment; medical, surgical and optical appliances; convalescent home treatment; payments to partially disabled persons between 60 and 70 years of age; and superannuation allowances to persons between the ages of 67 and 70.

21. It is believed that larger benefits are now being provided to members of the Scottish Rural Workers' Society than to members of any other Approved Society.

22. While I have not access to the valuations of all other Approved Societies, I am credibly informed that a large number of these—including one having a membership of over two million—had practically no surplus and were unable to increase their rates of benefits. Members of many of these Societies are now receiving only the ordinary rates of sickness, disablement, and maternity benefits.

23. It has been proposed that the surpluses of the Society should be pooled. We are determined to oppose any such proposal, because it would mean that the agricultural industry—which is already in a difficult position—would be paying contributions which I have demonstrated are far greater than are necessary in order to maintain workers in other industries in the enjoyment of their benefits or for the provision of increased benefits to them.

24. Our case, shortly, is—that it is obvious to anyone that the weekly contributions are in excess of requirements, and that accordingly they should be reduced.

It is no answer to say that the surpluses may be distributed amongst the members of the Society, because that leaves the employer out of account—and it is the employer whom I now represent.

25. I ask the Commission to recommend that in regard to agricultural workers there should be a reduction all round in the contributions payable.

26. Against the proposal to pool the surpluses I would point out that the Societies in which there is the highest rate of sickness (miners, steel workers, &c.) are composed of members who are very much more highly paid than the agricultural worker. It would, therefore, appear to be grossly unfair to ask

the agricultural worker, out of his lower earnings, to pay for the others.

JAMES C. HENDERSON.

May, 1925.

#### APPENDIX.

COPY OF CORRESPONDENCE WHICH HAS PASSED BETWEEN  
—SECRETARY FOR SCOTLAND: SECRETARY TO THE  
CABINET: MINISTRY OF LABOUR: MINISTRY OF  
HEALTH: PRIME MINISTER: CHANCELLOR OF THE  
EXCHEQUER: AND THIS OFFICE.

*Copy Letter to Secretary for Scotland, dated 28th  
January, 1922.*

I beg to draw your attention to the terms of the enclosed copy letter which I have addressed to the Secretary to the Cabinet and I shall be glad if you will let me know whether you will support the views of my Committee on the subject.

*Copy Enclosure Referred to Above:—*

*“ National Health Insurance.*

“ At a Meeting of the Central Executive Committee of this Union held in Edinburgh on 26th inst. I was instructed to point out that in view of the favourable experience in regard to sickness amongst Agricultural Workers the rates of contribution under the National Health Insurance Scheme are excessive in the case of those workers and the result is that the Agricultural Industry is bearing a portion of the burden of sickness insurance arising from less favourable conditions in other industries. I was instructed accordingly to ask that the rates of contribution be revised. In this connection it should be kept in mind that Agriculture is not included in the Unemployment Insurance Scheme and it is in other directions recognised as requiring separate terms. I shall be glad to hear from you after the matter has been considered so that I may be in a position to report to a future meeting.”

*Copy Reply from Secretary for Scotland dated 1st  
March, 1922.*

I am directed by the Secretary for Scotland to refer to your letter of the 28th January last addressed to the Secretary to the Cabinet and your letter of the 22nd ultimo, and to say that the suggestion of the National Farmers' Union that the rates of contribution payable under the National Health Insurance Acts should be reduced in the case of agricultural workers, is noted.

In order to give effect to it, however, legislation would be required involving substantial modification of the principles upon which the existing scheme of National Health Insurance is based; and Mr. Munro is not in a position to give any undertaking with respect to such legislation.

*Copy Letter to Secretary to the Cabinet; Ministry of  
Labour and Secretary for Scotland dated 4th  
April, 1922.*

In support of representations already made, I respectfully direct your attention to the resolution of the East Kilbride and District Branch of the Union, copy of which is enclosed.

*Copy Enclosure above referred to:—*

“ That the East Kilbride and District Branch of the National Farmers' Union in consideration of the fact that agriculture workers are on the whole healthier than any other class of workers and consequently do not receive the same benefit from the National Health Insurance as other sections of the community, a lower rate of payment should be made applicable to them.”

*Copy Letter from Ministry of Health dated  
8th April, 1922.*

I have to acknowledge the receipt of your letter of the 4th instant addressed to the Ministry of Labour and forwarded to this Department, enclosing a copy of a resolution passed by your Union on the subject

of the contributions payable under the National Health Insurance Acts in respect of Agricultural Workers. A copy of the resolution has been sent to the Scottish Board of Health.

*Copy Letter to Board of Health dated 10th April,  
1922.*

I am informed by the Ministry of Health that a resolution passed by this Union on the subject of the contributions payable under the National Health Insurance Acts in respect of agricultural workers has been sent on to your Board, and I shall be glad to have the considered opinion of the Board on the matter so that I may report to the next Meeting of my Committee.

*Copy Letter from Board of Health dated 8th May,  
1922.*

With reference to your letter of the 1st instant and previous correspondence, I am directed by the Scottish Board of Health to refer you to the Parliamentary Debates relative to the inclusion of agricultural workers in the original Bill of 1911 for general discussions of the reasons against differentiating this class of labour from others. Your attention is also directed to the fact that the limited differential treatment afforded to agricultural workers (among other classes) by section 47 of the 1911 Act was repealed in 1918, the difficulties and anomalies involved in it being on all hands agreed to outweigh any advantages. These difficulties and anomalies would be greater in the case of any attempted general differentiation between the rates of benefits and contributions of agricultural workers and other insured persons. Apart from the departure from the principal of national insurance the difficulties attending change of class of employment, casual farm workers, the application of different arrears schemes, &c., would be very formidable. Farmers would have the trouble of stamping at different rates for different employees, and societies would be saddled with a very large amount of additional work. It must be remembered that large numbers of agricultural workers are not members of the Societies that confine their membership to this class.

Apart from the practically insuperable difficulties involved in the proposal, it is to be noted that no conclusive evidence has yet been adduced that over their whole lives agricultural labourers have less than the average amount of sickness. In any event, the savings realised by Societies which have a favourable claims experience are distributed to the members in additional benefits.

*Copy Letter to Chancellor of the Exchequer dated  
1st February, 1923.*

The Central Executive Committee of this Union will be meeting shortly, and amongst other subjects they are to consider the rates charged for National Health Insurance. It has been pointed out that these rates were increased during the war as costs increased, but that, although costs and expenses generally have been reduced, the Insurance contributions still remain at their top level. In anticipation of our meeting I shall be obliged if you will inform me whether the question of a reduction in the contributions has been considered, and if so, what modification is likely to be effected.

*Copy Reply from Chancellor of Exchequer dated  
12th February, 1923.*

In reply to your letter of the 1st February, I am desired by the Chancellor of the Exchequer to say that much as he would like, to see some reduction in all the burdens now pressing upon industry, he can see little prospect of a decrease in the Health Insurance contributions unless a considerable reduction is to be made in the present rates of benefit. At the present time contributions are, in fact, insufficient to meet the expenditure under the scheme (i.e., on cash benefits, capitation payments to doctors and administrative charges), and pending some

reduction in the expenditure the excess is being met from accumulated reserves.

*Copy Letter to Chancellor of Exchequer dated 17th April, 1923.*

With further reference to my letter of 1st February and your reply of 12th February, I am instructed by this Union to press for a reduction in the rates of National Health Contributions—particularly in the case of agricultural employees. Apart from the special case which can be made out for Agriculture, it appeared to my Committee that some substantial reduction should be made in the allowances to doctors and chemists in view of the alteration of circumstances since the high rates were fixed. If some such reduction were made, it is thought that it might be possible to reduce the contributions all over. In particular, however, the case of the agricultural worker deserves special consideration. The health experience of these workers is very favourable, and as matters at present stand, the industry is bearing a considerable share of the burden of providing benefits for other and less healthy occupations. In support of this view I am asked to direct your attention to the Ninth Annual Report by the Board of Management of the Scottish Rural Workers' Approved Society (1921-22). That Report was submitted to an Annual General Meeting of the Society held in Edinburgh on 10th and 11th August, 1922. The Board stated that they were glad to be able to report "Another year of continued prosperity." . . . and "a substantial increase both in the contribution income and in the invested funds of the Society." During the year ended 31st December, 1921, the assets of the Society increased by the sum of £57,512 9s. 9d., bringing the total assets up to £718,667 9s. 7d.

In these circumstances my Committee considers it is reasonable to ask a reduction in the rates of contribution, and I shall be glad to have your considered opinion in the matter.

*Copy Reply to above dated 30th April, 1923.*

In reply to your letter of the 17th April, I am desired by the Chancellor of the Exchequer to say that the question of the terms of remuneration of the doctors and chemists and that of differentiation of contributions according to the character of the industry are primarily matters for the Secretary for Scotland, and he is accordingly causing a copy of your letter to be forwarded to Lord Novar.

Mr. Baldwin understands, however, that it is open to agricultural workers under the existing scheme to join Societies limited to their own class and so to obtain by way of additional benefits full advantage from their low sickness experience. Any differentiation of contributions according to industry would increase very considerably the administrative difficulties of the scheme.

*Copy letter to Secretary for Scotland and Chancellor of Exchequer dated 22nd June, 1923.*

*National Health Insurance.*

I refer to previous correspondence on this subject. It is obvious to anyone who enquires into the facts that agriculture is bearing an undue burden under the Health Insurance Scheme, and is practically supporting other less healthy occupations. The resentment against the present state of affairs is very materially increasing, and something will require to be done. I have already appealed to you for a revision of the rates of contribution, and now I am instructed to suggest as a means of avoiding further conflict on the subject that the terms of section 47 of the 1911 Act should be restored so that agricultural employers who are prepared to accept the responsibility for the first six weeks of sickness might have the option of paying reduced contributions.

As I have to report specially on this subject to the next Central Executive Committee Meeting, I shall be obliged if you will give the matter your best consideration and let me hear from you as soon as possible.

*Copy letter from Secretary for Scotland dated 12th July, 1923.*

With reference to your letter of the 22nd ultimo, I am directed to state that the Secretary for Scotland is informed that section 47 of the Act of 1911 was made use of only to a very limited extent by employers, including agricultural employers, and gave rise to administrative and financial difficulties out of all proportion to its objects. These considerations, together with the strong objection to the principle of differential rates of contribution, led to the repeal of the section by Parliament in 1918 and the Secretary for Scotland is not prepared, on the present information, to support any suggestion that it should be revived.

*Copy letter to Chancellor of Exchequer dated 4th August, 1923.*

At a meeting of the Central Executive Committee of this Union, held in Glasgow on 2nd inst., your reply of 18th ultimo was submitted.

The Committee felt that their case had not received the consideration to which it was entitled. There was a deep feeling of resentment against the treatment of agriculture in this matter. At a time when protests are being made to the effect that agriculture must be assisted we find in this direction agriculture is in fact contributing towards other industries. My Committee does not accept the explanation that it is impossible to differentiate between the industries on the rates of contribution, but as that appears to be the view of the Government we now ask that all the rates of contribution be reduced.

We are intending to co-operate with the Farmers' Unions in England, Wales and Northern Ireland and with the National Confederation of Employers' Organisation, and some means will be adopted to bring the facts before the public.

*Copy reply from Chancellor of Exchequer dated 24th August 1923.*

The Chancellor of the Exchequer has had before him your letters of the 4th and 17th August further respecting the position of agriculture under the National Scheme of Health Insurance and suggesting that the general rates of contribution under the Scheme should be reduced.

In reply he desires me to inform you that he is advised that such a reduction would endanger the financial stability of the scheme.

*Copy letter to Secretary for Scotland and Chancellor of Exchequer, dated 11th September 1923.*

I draw your attention to the following resolution by the Anstruther branch of this Union:—

"That the Anstruther branch of the National Farmers' Union of Scotland beg to support the efforts of the Central Executive Committee in pressing for a general reduction in the rate of contribution under the National Health Insurance Act. This branch considers that as the premiums for other forms of insurance are based on the risk involved, so should the Health Insurance contribution be based on the percentage of sickness among agricultural workers in comparison with all other workers."

*Copy letter to Treasury dated 23rd October, 1923.*

Further to my letters of 4th and 17th August last and your reply of 24th August, I have again been instructed by the Central Executive Committee to press for a reduction in the rates of contribution. The cost of working the scheme should have been reduced substantially now, and in view of the favourable health experience of agriculture—which is entirely distinct in its character from all other industries—it is felt to be grossly unfair to continue the present rates; and the union looks to the Chancellor to give a measure of just relief at this time.

I shall be glad to have the Chancellor's considered reply, so that I may report again to my Committee.

*Copy reply to above dated 31st October, 1923.*

In reply to your letter of the 23rd October regarding National Health Insurance contributions, I am desired by the Chancellor of the Exchequer to say that, as you will be aware, the administration of the Health Insurance Acts does not primarily rest with him or the Treasury, and that on the general financial questions involved he regrets that he is unable to add to the letter sent to you on the 24th August last.

A copy of your letter and of this reply is being forwarded to the Secretary for Scotland.

*Copy reply to above dated 1st February, 1924.*

With reference to your letter of the 23rd ultimo regarding National Health Insurance contributions I am directed by the Secretary for Scotland to say that the question raised by you has been fully and carefully considered by the Departments concerned, and that he is not in a position to add to the letters on the subject you have already received, not only from this Department but from the Treasury and from the Scottish Board of Health.

*Copy letter to Minister of Health dated 5th June, 1924.*

I shall be obliged if you will let me know before the 12th instant whether the names of the members of the Royal Commission have yet been determined.

and whether this Organisation will be invited to submit evidence.

*Copy reply to above dated 11th June, 1924.*

I am desired by Mr. Wheatley to say in reply to your letter of the 5th June that the Royal Commission on National Health Insurance is not yet appointed, but your letter asking whether the National Farmers' Union of Scotland will be invited to submit evidence will be forwarded for the consideration of the Chairman in due course.

*Copy letter to Minister of Health dated 27th June, 1924.*

I am instructed by my Committee to inform you that this Union is prepared to submit evidence to the Royal Commission on National Health Insurance as soon as the Commission is constituted.

I shall be obliged if you will keep me advised of any developments.

*Copy reply to above dated 30th June, 1924.*

I am desired by Mr. Wheatley to acknowledge the receipt of your letter of the 27th June, stating that the National Farmers' Union of Scotland is prepared to submit evidence to the Royal Commission on National Health Insurance, and to say that your letter will be passed to the Secretary of the Commission as soon as it is constituted.

## APPENDIX LXXII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE QUEEN VICTORIA'S JUBILEE INSTITUTE FOR NURSES BY MISS PETERKIN, GENERAL SUPERINTENDENT, MRS. BRUCE RICHMOND, HON. SECRETARY, AND MAJOR H. F. CADELL, W.S., CHAIRMAN OF THE EXECUTIVE COMMITTEE (SCOTTISH BRANCH). See Minutes of Evidence of the Thirty-Fourth Day, Questions 19,400 to 19,582.

### REVIEW OF PRESENT POSITION OF DOMICILIARY NURSING SERVICE.

1. *Queen Victoria's Jubilee Institute for Nurses.*—The State has recently undertaken the responsibility for certain branches of domiciliary nursing, but with this exception all such nursing at present in existence has been provided by voluntary Nursing Associations, of which the largest and most widely spread organisation is the Queen Victoria's Jubilee Institute, incorporated by Royal Charter in 1889 with the object of training and providing nurses for work among the sick poor in their own homes.

2. *Functions of Institute.*—The Provisional Committee then appointed to enquire into and decide on, the best method of attaining this object, agreed to adopt as the particular work of the Institute the organisation of local Nursing Associations to be affiliated to the Institute; the selection, training in the special subjects required for district nursing, and supplying to Nursing Associations of suitable women already trained in hospital; and the supervision of their work whilst in the service of those Associations.

3. The conditions on which Nursing Associations could be accepted for affiliation were made as wide as possible in order that they might be suitable for all parts of the United Kingdom, and the rules laid down as obligatory were few, and only such as experience had already shown to be indispensable for an efficient nursing service. They were chiefly that the work should be carried out under the direction of the medical practitioners; that it should be inspected periodically from the Institute by a nursing expert; that it should be unsectarian; that the nurses' services should be primarily for those unable to employ a private

nurse, and that the necessitous poor should be nursed free.

4. These rules have been tested and proved by many years' practical experience, and so far no alteration, except in minor details, has been found necessary. While ensuring fair working conditions and a minimum salary for the nurse, they guarantee that a high standard of nursing efficiency shall be maintained.

5. *Number of Nursing Associations.*—The Council of the Institute directly controls the work in England and Wales, and indirectly, through their own Governing Bodies, that in Scotland and Ireland. To its original function has been added that of organiser for its affiliated Associations. The number of these Associations has increased by degrees to 688 in England and Wales, with, in addition, about 2,112 Associations belonging to the 34 County Nursing Associations, which are in their turn affiliated to the Institute.

6. It will be obvious that any matter concerning Nursing Associations or district nursing generally must be dealt with by a central body such as the Council of the Institute.

7. *Number of Nurses.*—The Council includes members with a special knowledge of the work; representatives of County Nursing Associations, local Nursing Associations, District Training Homes and various Medical and Allied Bodies concerned with Public Health. On December 31st, 1923, it was responsible for 4,843 nurses, and it is estimated that over 75 per cent. of the working-class population is now within reach, and may obtain the services, of a district nurse. The whole ground is covered in a few counties and the chief obstacle in the way of



covering it in others is lack of funds. The numbers of population in England and Wales for which home nursing is available are as follows:—

*England:*

Total population for which home nursing is available, excluding East and North Ridings of Yorkshire, Rutland and Monmouthshire	30,388,457
Total population for which home nursing is not available, excluding above counties	4,595,717

*Wales:*

Total population for which home nursing is available, excluding Montgomeryshire in which there are about 30 Nursing Associations	1,358,058
Total population for which home nursing is not provided, excluding Montgomeryshire	799,825

NOTE.—The populations taken are in some cases those of the last Census and in others those of January, 1925.

8. *Financial Support.*—The funds needed for the support of a nurse are raised locally and there is often difficulty in obtaining them. In rural areas, nearly all Nursing Associations are on a provident basis with a minimum subscription, but few, if any, are self-supporting in this way and the remainder of the annual sum required is made of subscriptions and donations; of fees for midwifery and maternity nursing; together with grants or payments for work done on behalf of Public Health Authorities or other bodies.

9. *Work of the Nurse and Payment for her Services.*—The best and most economical scheme for home nursing in country districts is the provision of a nurse in a circumscribed area undertaking, and competent to undertake, all branches of work, whether preventive or curative, which entail visits to the home, viz., medical, surgical and maternity nursing; midwifery; health visiting; after-care of school children and supervisory care of cases of tuberculosis, for which the Nursing Association receives payment from the Authorities which have assumed responsibility for the various classes of work. Whilst the combination of duties gives full occupation for a nurse in an area not too large to be worked without undue strain and enables the Nursing Association to provide an efficient service, it prevents duplication of visitors to the home and saves both time and money.

10. In towns, the Provident System has not proved so suitable and in its stead an increasing number of Nursing Associations are making a charge for the services of their nurses in accordance with the patients' means and, where possible, arrangements are made with local and other Authorities for attendance on cases for which they may provide nursing, for example, the Ministry of Pensions has sanctioned payment by local War Pensions Committees for the nursing of discharged disabled soldiers and sailors and Public Health Authorities in various places make payments, or give grants, for supervisory care and nursing of cases of measles and notifiable diseases.

11. *Cost of nursing visit.*—The average cost of each visit paid by a nurse, taking the country as a whole, is about 1s. 4d., but the cost to each Nursing Association varies greatly and is generally somewhat higher in rural areas than in towns on account of the distance to be covered.

AGREEMENTS WITH CERTAIN APPROVED SOCIETIES FOR DOMICILIARY NURSING FOR THEIR MEMBERS.

12. When nursing was included in additional benefits under the National Health Insurance Act, the Institute entered into negotiation with as many of the Approved Societies as were willing to consider the provision of nursing for their members, with the result that a certain number agreed to pay for the

services of nurses through the Institute. This arrangement is still in force and, as far as it goes, is working satisfactorily.

13. The procedure and the terms are not the same in all cases and this has entailed the division of the Approved Societies into two groups, each with a separate agreement. Those in the first group make payment at the rate of 1s. 4d. a visit for the first 30 visits and then at the rate of not more than 5s. a week; those in the second at the rate of 1s. a visit, the Nursing Association collecting from the patient, if it wishes to do so, the additional 4d. a visit which makes up the average cost. Payment for the nursing of chronic cases is not made by certain Societies in the second group; both make a payment of 5s. for a nurse's attendance at an operation. The following are the names of the Approved Societies in each group:—

*Agreement No. 1.*

National Deposit Friendly Society.  
National Insurance Beneficent Society, including the following Societies:—  
Hearts of Oak Benefit Society.  
Baltic and Corn Exchange Health Society.  
London Friendly Institution.  
Post Office Employees' Approved Society.  
New Tabernacle Approved Society.  
Stock Exchange Clerks' Health Insurance Society.  
Sydenham, Forest Hill, and District Benefit Society.  
Vernon Approved Society.  
Stroud Mutual Provident and Sick Benefit Approved Society.  
Seamen's National Insurance Society.  
Liverpool Clerks' Approved Society (for members outside Liverpool area).  
Grand United Order of Oddfellows (for certain Branches)

*Agreement No. 2.*

Prudential Approved Societies.  
National Amalgamated Approved Society.  
Royal Liver Friendly Society.  
The British Iron, Steel and Kindred Trades Approved Society (for those members who are not themselves contributing through their works for the services of a nurse).  
The Independent Order of Rechabites (for members in East Suffolk).

14. The amount due for the work done is paid to the Institute, which remits it to the Nursing Associations, and the total received for 1922 was £4,098; for 1923, £6,107; and for 1924, from January 1st to June 30th, £3,478. With a few exceptions, which include a County Nursing Association which was unable to accept the terms arranged with the Approved Societies and some Associations in the North of England where the nurses are supported by a levy on wages, all the Associations affiliated to the Institute undertook the work, and many of those not in affiliation agreed to do the same. There is, therefore, as complete a nursing service available for insured persons as is possible at the present time, and the un-nursed areas could be covered if money were forthcoming.

NEED FOR DOMICILIARY NURSING FOR ALL INSURED PERSONS.

15. It is generally agreed that treatment prescribed by a doctor loses the greater part of its value when there is no skilled worker to carry it out and that a nursing service is complementary to, and essential for, an effective domiciliary medical service. That being so, it is important that there should be a nursing service for all cases unsuitable for admission to hospital or unable to be moved there and, in order to avoid confusion and the harassment caused by visits from more than one official, the nurse for any particular class of case or person should be the nurse for the whole household. The service must also be acceptable and easily accessible to those concerned, otherwise it will to a large extent fail, and for good results the standard of nursing must be maintained at a high level.

16. In short, the Council of the Queen Victoria's Jubilee Institute desires to point out that there is already in existence a national service which can, and does, provide skilled nursing for all kinds of illnesses at an economical rate and under proper safeguards—a service which though not completely covering the country is capable of being made to do so—and its ventures to urge that nursing should be provided for all insured persons and that in doing so advantage should be taken of the existing organisations.

W. HALE-WHITE,  
Vice-Chairman of Council.

**SUPPLEMENTAL STATEMENT ON BEHALF OF THE COUNCIL OF THE QUEEN VICTORIA'S JUBILEE INSTITUTE FOR NURSES (SCOTTISH BRANCH).**

17. The work of the Queen Victoria's Jubilee Institute for Nurses is carried on in Scotland under the supervision of the Council of the Scottish Branch.

18. The Scottish Council strongly supports the views which are being laid before the Royal Commission by the Council of the Institute, but consider it advisable to place before the Royal Commission the special circumstances in Scotland.

19. The Scottish Council is responsible for the training of nurses for district work in Scotland, and all nurses becoming Queen's Nurses have at least three years' training in a general hospital. There are at present 591 Queen's Nurses working in Scotland, and in addition the work of 45 other nurses is supervised by the Institute, and about thirty new Associations are in course of formation. In a large number of counties throughout Scotland County Nursing Associations have been formed, which are affiliated to the Institute; but there are in affiliation with these County Associations, District Nursing Associations employing upwards of 100 nurses who are not Queen's Nurses. There are also about 100 non-Queen's Nurses employed by Nursing Associations in counties where there are no County Associations, or where such District Associations are not affiliated to the County Associations. There will thus be nearly 900 nurses employed in district nursing throughout Scotland next year.

20. The population of Scotland according to the last Census is 4,882,288, and the persons insured under the National Health Insurance amount to 1,619,202, being about one-third of the total population.

21. The Scottish Council of the Institute would urge upon the Royal Commission on National Health Insurance that as complementary to the home medical service which has been provided under the National Health Insurance Acts, it is also necessary to have a trained Nursing Service for the domiciliary care of the sick, and that this nursing benefit should be provided from National Health Insurance Funds.

22. In all the large cities, burghs, and in the more fully populated parts of Scotland, there are District Nurses already working, but the service would need expansion to meet fully the requirements of a nursing service under the National Health Insurance Acts. There would, however, be no difficulty in arranging for this. The Scottish Council is very anxious to extend the benefits of District Nursing in the sparsely populated rural districts, but such districts have very often difficulty in raising the necessary funds to provide a District Nurse. There is not a large number of insured people in these sparsely populated districts, but, at the same time, a small annual contribution for the nursing benefit would assist in the provision of a District Nurse, and a definite revenue in respect of the nursing of insured persons would be of inestimable help.

23. A nursing benefit complementary to medical benefit has been in contemplation since the inception of the National Health Insurance Acts, and the Scottish Council has been most anxious to provide a Nursing Service under the Acts. In 1922, the Scottish Council approached all Approved Societies having members in Scotland, offering to provide a

Nursing Service. Arrangements were made with certain Approved Societies on the following lines:—

- (1) A *per capita* annual payment of 4d. by the Approved Societies, or
- (2) A payment of 1s. 4d. per visit up to a maximum of 30 visits, or
- (3) A payment of 1s. per visit by the Approved Society, and an additional 4d. recoverable from the insured person.

24. It may be mentioned that the Rural Workers' Approved Society instead of making any payments in respect of the cost, has given many District Nursing Associations throughout Scotland where they have members handsome annual contributions.

25. The payment per visit has not been satisfactory having been found most inadequate, inequitable in incidence and cumbersome in administration, e.g., insured under 22 and over 70 are not eligible for nursing benefit; chronic illnesses (very widely interpreted) are excluded; acute illness is being limited to care not exceeding 20 visits. In general, 60 per cent. to 70 per cent. of nursing care given at present to insured is totally unremunerated from National Health Insurance funds. A great deal of clerical work and correspondence is also entailed, and in rural areas especially, much difficulty and delay is experienced in procuring the necessary voucher forms.

26. The Scottish Council considers that a *per capita* payment for the nursing of insured persons would be the most satisfactory way of providing a Nursing Service, on account of its simplicity, ease of collection and saving of clerical work. Pending the provision of a National Nursing Benefit for insured and dependants, the Scottish Council would be prepared to undertake the provision of this domiciliary Nursing Service throughout Scotland to persons having the right to medical benefit under the National Insurance (Health) Acts for a *per capita* annual payment of 8d. This figure is suggested from full experience of the working of the present schemes—operative mainly in areas where a nursing service has been established. Under a national nursing benefit for insured for the whole county, additional nurses would, undoubtedly, be required to be placed. It is suggested that this *per capita* payment should be paid direct to the Scottish Council, who would divide the money amongst the District Nursing Associations. This money would not, however, be divided amongst the District Nursing Associations according to the number of cases nursed, as it can readily be understood that the provision of Nurses is in addition to the cost of motor transit, more expensive in sparsely populated country districts where patients may live at considerable distances from each other, than in towns where nurses, on account of the congestion of population, are able to pay a large number of visits in the day.

27. The Scottish Council would urge that a separate Nursing Service for insured persons would be retrograde, expensive and unpractical. In country districts a separate Nursing Service would be very expensive, and for acute cases needing twice or thrice daily care could not possibly be efficient because of the distances to be covered. Even in large towns, such a Service would be wasteful of a nurse's time, while in country and town alike the confusion and chaos of having in a home one nurse for insured and another for non-insured would be intolerable and needless intrusion of the home's privacy.

28. At present, in addition to a great deal of maternity nursing in rural areas, insured persons are being nursed by the District Nurses throughout Scotland to a very large extent without payment. This work is undoubtedly saving the Approved Societies a great deal of money in payment of sick benefit, and it is only fair that the District Associations should be paid for the work they are doing. The Scottish Council would urge that in the interests of National Health Insurance finance efficient trained home nursing care means diminution of sickness benefit outlay, and in the interests of national health a Nursing Service is essential.

29. The only satisfactory method of payment for a Nursing Service is by a *per capita* grant. Any system of payment per visit would entail a great amount of clerical work, making it impossible for District Nursing Associations, having Honorary Secretaries, to attend to the details. The Managers of Approved Societies, who have joined the Scheme, have all been interested in arranging for the nursing of certain illnesses as an additional benefit to those of their members coming within the first quinquennial valuation. This, however, does not apply to the agents scattered over the country. Experience has proved that unless such agents are personally interested in the local District Nursing Associations, they show little concern for the giving of a nursing benefit. It is sometimes difficult for a nurse to find out the name of the Society with which a patient is insured, as the latter seems to think that this may affect the benefits which he will receive. The Secretaries of District Nursing Associations have also been slack in collecting the nursing benefit from Approved Societies, as they do not think the small return worth the trouble. In the case of a contributory scheme, District Nursing Associations have sometimes had difficulty in explaining to their subscribers that the yearly contribution is for the whole family, while payments for nursing by Approved Societies is for the insured member only, and in such cases Nursing Associations have preferred not to collect anything from the Approved Society. It has also to be kept in view that nursing benefit has been paid out of the profits previously earned by Approved Societies. For the last two years only 33 per cent. of the nursing attendance was paid for, and for the preceding year only 25 per cent.

30. A nursing benefit would enable the insured person to be restored to health quicker and would

thus save payment of sickness and disablement allowances from Approved Society funds.

31. It must also be kept in view that the hospitals of the country are quite inadequate to meet the sickness care requirements of the population. It is found in the Institute's work that 80 per cent. of the homes of the people are quite suitable for the nursing care of all illnesses excepting only those requiring major surgical operations.

32. It should also be noted that the general evidence has all been in favour of a Nursing Service. 1,350 nurses (exclusive of administrative staff), would be required for a full service in Scotland. At present, 70 per cent. of the population has a nursing service more or less adequate, and the number of fully-trained nurses in Scotland engaged in District Nursing represents 50 per cent. of the total staff required.

33. In general, there are some rural areas still un-nursed, but the greatest need is for an expansion of the existing service in industrial centres, which would not be difficult to arrange.

34. The Scottish Council would be glad to give evidence before the Royal Commission in support of this Statement.

In name of the Council of the Queen  
Victoria's Jubilee Institute for  
Nurses (Scottish Branch).

SUSAN GILMOUR,  
Hon. Secretary.

26, Castle Terrace, Edinburgh.  
7th November, 1924.

## APPENDIX LXXIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE COLLEGE OF NURSING, LTD., BY MISS J. P. WATT (ORGANISER OF COUNTY AND DISTRICT NURSING IN SCOTLAND, Q.V.J.I.N.), MISS G. BREMNER (MEMBER OF COUNCIL OF COLLEGE OF NURSING), and MISS H. VINEY (HON. SECRETARY, PUBLIC HEALTH SECTION, COLLEGE OF NURSING). See Minutes of Evidence of the Thirty-Fourth Day, Questions 19,583 to 19,625.

### IMPORTANCE AND PROVISION OF DOMICILIARY NURSING FOR INSURED PERSONS.

1. The College of Nursing, a Company limited by guarantee, having no share capital, has a membership of over 23,000 trained nurses, and is the largest organisation of trained nurses in the Kingdom.

It is governed by a Council of 36 elected entirely by the postal votes of members.

The College has 35 branches throughout the United Kingdom and some of its varied activities to date are set out in a leaflet submitted.

It stands for efficiency in Nursing, and security for Nurses.

2. Among its objects, as set out in the Memorandum and Articles of Association, are "to promote the better education and training of Nurses," to fit them for all branches of service so that they may be fully equipped to serve the community: "to promote Bills in Parliament for any object connected with the interests of the Nursing Profession."

3. The Council would urge:—

- (1) The provision of a statutory nursing benefit complementary to medical benefit from National Health Insurance Funds.
- (2) That the staff employed for visiting care be fully qualified General Trained Nurses with additional district training.

(3) That the visiting nursing care to insured be co-ordinated with other Public Nursing Services, and that where resident care is required, the services of private nurses be utilised.

### DOMICILIARY NURSING.

4. The National Insurance (Health) Acts were promulgated to provide for insurance against loss of health, and for the prevention and cure of sickness.

Sickness amongst insured persons is dealt with in hospital, and in the homes of insured.

In hospital, trained medical and nursing care operate as inseparable, supplementary, complementary activities.

In the homes, for all illnesses other than minor disorders of short duration, the same dual service must function if treatment prescribed by the doctor is not to lose the greater part of its value and fail largely of its purpose because undertaken by unskilled workers—if convalescence is to be hastened, suffering minimised and complications prevented.

5. The progressively increasing appreciation of the value of trained domiciliary nursing was greatly stimulated by the Insurance Acts which helped as the Prime Minister stated early in 1914 "to make it clear that any system of doctoring is hopelessly inefficient which is not supplemented by a good system of nursing." Though doubtless the outbreak of War and all that followed materially blocked progress, it is regrettable and anomalous that after fourteen years

of Insurance Act administration, practical expression of that stimulated appreciation has been left to voluntary enterprise—that statutory provision for this essential service is not yet forthcoming.

#### AILING INSURED REQUIRING DOMICILIARY NURSING.

6. *For all insured.*—Semi-acute illnesses not requiring hospital care, and obviated same because receiving at outset dual expert domiciliary medical and nursing treatment.

Acute illnesses not desiring and not able to be moved for hospital treatment, including major surgical operations.

Post hospital cases able to be discharged more quickly because domiciliary nursing available.

Chronic illnesses for which hospital treatment not available or suitable.

All minor operative surgery.

Extensive dressings, or other acute localised conditions involving constitutional illness and therefore needing general nursing care; or local treatments more frequent than doctor can alone undertake.

Massage and electrical treatment in areas too far distant from hospital or private service.

Minor treatments (eyes, ears, skin, etc.) and dressings.

7. *For women insured.*—Pre-natal, post-partum, and gynaecological nursing care.

8. *Under maternity benefit.*—Midwifery and maternity nursing in rural and semi-urban areas where certified midwife not in practice.

Maternity nursing of abnormal and complicated cases in all districts.

#### EXISTING SERVICE.

9. It is known that a few Approved Societies from reserve moneys are providing nursing care for certain illnesses to a section of their members and are utilising the staffs of District Nursing Associations for the purpose; but this provision is inequitable, fragmentary, and wholly inadequate.

10. Then too, because of their appreciation of its value and need, insured persons themselves, largely by a system of "provident" maintenance, have sought progressively to evolve a domiciliary nursing service for themselves and dependants. But there are still un-nursed areas and many areas quite inadequately nursed.

11. Difficulties of finance very largely prevent development of a complete service.

#### ESSENTIALS OF A SATISFACTORY SERVICE.

12. The Council are of opinion:—

- (1) That nurses engaged in domiciliary work need in addition to full hospital qualification, further training in the adaptation of hospital methods to home conditions, i.e., training in district nursing; also midwifery training when that work is to be undertaken.
- (2) That as necessary to the maintenance of a high standard of nursing efficiency, a system of periodic professional supervision of staff work is essential.
- (3) That the nurse for any particular class of case or person, should be the nurse for the household: that any sectional arrangement would create confusion and harassment in the home, and overlapping and extravagance of administration; would gravely jeopardise a service to those not statutorily provided for.

(4) That for efficient work the area to be undertaken per nurse must be limited in extent, so that her care is readily accessible and possible of at least twice daily frequency for all acute cases.

(5) That there be available in each County (or such other area as may be decided on) a staff of nurses for:

- (a) Resident care in very isolated homes or for grave illnesses;
- (b) Emergency, epidemic and staff relief duty.

#### DEVELOPMENT.

13. The Council therefore believe that an adequate efficient, domiciliary nursing service for insured can best be secured by co-ordinating it with other public nursing services, viz:—

Domiciliary nursing of diseases and defects of school children as disclosed by the system of school medical inspections.

Domiciliary treatment of tuberculosis.

Domiciliary nursing of notifiable diseases.

Domiciliary nursing of the registered sick poor and old age pensioners.

Domiciliary nursing of disabled soldiers.

Domiciliary nursing of specified illnesses under the Maternity and Child Welfare Schemes.

Domiciliary nursing of all other illnesses in homes unable to afford a private service.

#### FINANCE.

14. It is submitted that a *per capita* grant of 1s. per annum to cover the nursing of the insured persons (this sum to be exclusive of training costs, and additional to the income derived from other sources) would go far to provide the requisite finance. At present insured persons are frequently nursed by the Nursing Associations without any adequate payment being made to assist the Association for this service. The Nursing Associations are in a sense being exploited because of their elastic constitution, and charitable foundation.

This grant of money should, it is felt, be disbursed either for services rendered or per number of insured persons resident within the respective nursing areas, according to a graded scale of payment based on the economic cost of the service, having regard to the mileage, and a retaining fee in respect of the service available.

Concerning costs of training, it is recommended that an additional grant be available for same, and that it be disbursed in the proportion of one-fifth to the costs incurred.

As to resident care, it is recommended that for a year or two an additional sum be earmarked from which to pay for this special service until it is seen to what extent it is utilised.

15. Therefore, the Council would urge the provision of a Statutory Nursing Benefit complementary to medical benefit in the interests of the ailing insured; in the interests of National Health Insurance finance since efficient domiciliary nursing would inevitably result in diminution of sickness benefit outlay, while home education in preventive hygiene under the same service offers like prospects; in the interests of a service essential to national health and well-being; a just remuneration for services rendered.

16. The Council will be glad to give evidence before the Royal Commission in support of this Statement.

April 20th, 1925.

## APPENDIX LXXIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INCORPORATED MIDWIVES' INSTITUTE BY Miss E. DOUBLEDAY AND Miss M. GILLIGAN, Members of the Institute. See Minutes of Evidence of the Thirty-Fourth Day, Questions 19,626 to 19,793.

## GENERAL.

1. In the opinion of The Midwives' Institute, the maternity benefit is a useful institution, and should be maintained.

2. The system of paying the benefit through the Approved Societies is, on the whole, satisfactory, but is open to the following criticism:—

- (1) There is often considerable delay. In some cases the benefit is not received until long after the midwife has ceased her attendance.
- (2) Approved Societies should make it clear to their agents paying the benefit that no gratuities are to be received from the member, nor is the member required to take out a life policy as a condition of receiving prompt payment of the benefit.
- (3) The form of claim should be as simple as possible, and the Approved Societies should insist on the insertion of the midwife's number on the Roll in the place to be provided for the purpose. Wherever

practicable, the form should be in the possession of the member, or his wife, as the case may be, before the confinement takes place.

- (4) The Approved Society's official sent to pay the maternity benefit should be a woman.
- (5) It should be possible for a woman whose husband has deserted her to obtain the benefit without his signature.

## ANTE-NATAL TREATMENT.

3. Maternity benefit should include ante-natal treatment, that is to say, the maternity benefit should not only mean a cash benefit, but also, when needed, a treatment benefit, directed especially to the condition of pregnancy, and it should be given to the woman who is the wife of an insured person, and to the woman who is herself an insured person.

4. Sick pay should be given for four weeks after confinement both to the woman who is the wife of an insured person, and to the woman who is herself an insured person.

## APPENDIX LXXV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SCOTTISH MIDWIVES' ASSOCIATION BY Miss J. C. BARKER. See Minutes of Evidence of the Thirty-Fourth Day, Questions 19,626 to 19,793.

## THE SCOTTISH MIDWIVES' ASSOCIATION.

1. The Scottish Midwives' Association is the only organisation of its kind in Scotland; it functions through Branches in different areas of the country, and a Central Council (hereinafter referred to as "The Council") decide policy and general government.

## CONFIRMATION OF EVIDENCE OF ENGLISH MIDWIVES' INSTITUTE.

2. Other than that they have no knowledge of the subject matter of paragraph 2 (2) in the Statement of evidence submitted by the English Midwives' Institute, the Council strongly support the views which have been laid before the Royal Commission by the English Organisation; but consider it advisable to lay before the Royal Commission the special circumstances in Scotland.

## EXTENT OF UNTRAINED CARE: PRESENT ADVERSE ECONOMIC POSITION OF PRACTISING MIDWIVES.

3. Medical practitioners in general during the War period sought to progressively diminish their midwifery practice in other than middle-class and better-class homes. Now, in Scotland, they are resuming this work, but instead of utilising the certified midwife, are having employed untrained women to do the nursing. Certified midwives, therefore, are not only losing midwifery practice, but also the maternity nursing previously undertaken when medical confinement fees were considerably lower than at present. Untrained, unsupervised maternity care is a danger to motherhood and infant life; the Council are convinced it is the cause of much prolonged and disabling post-natal illness, and entails corresponding outlay in sickness benefit. The establishment of a good midwifery and maternity nursing service is imperilled and its realisation made impossible so long as existing midwives have to fight for barest livelihood because their legitimate work is being done instead by an army of untrained unqualified women.

## RECOMMENDATIONS.

4. As an effective means, therefore, of raising the standard of midwifery and maternity care; as a practical and practicable way of attracting to the work the best type of women because ensuring her reliable and adequate remuneration, the Council respectfully submit to the Royal Commission for consideration, and it is hoped adoption, these recommendations:—

- (1) That the application form for maternity benefit in use under this provision of the National Insurance (Health) Acts shall bear the name, qualification and signature of
  - (a) the person actually conducting labour
  - (b) the person undertaking nursing care of puerperium.
- (2) That payment of the maternity benefit be legal only when (excepting in cases of emergency where doctor or midwife engaged but not available) the signature under recommendation (1) (a) above is that of a registered medical practitioner or certified midwife.
- (3) That an additional maternity nursing benefit be made available in respect of the additional essential trained service utilised, when the benefit form is signed under recommendation (1) (a) above by a doctor and under recommendation (1) (b) above by a certified midwife.
- (4) That there be extended to midwives' practice the arrangement increasingly operative in maternity hospitals whereby with the consent of the mother, payment of the midwifery or maternity nursing fee is made direct to the midwife.

The Council would be glad to give evidence before the Royal Commission in support of this Statement.

In Name of the Council of the

Scottish Midwives Association,  
 SUSAN GILMOUR, President.  
 J. A. ELLIS, Secretary.

## APPENDIX LXXVI.

STATEMENT OF EVIDENCE SUBMITTED BY MR. JOSEPH COHEN, DEPARTMENT OF ECONOMICS, CAMBRIDGE UNIVERSITY, MEMBER OF THE CORRESPONDING COMMITTEE OF SOCIAL INSURANCE OF THE INTERNATIONAL LABOUR OFFICE. See Minutes of Evidence of the Thirty-Fourth Day, Questions 19,794 to 19,899.

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I beg to submit in evidence a number of recent publications by the International Labour Office on this and related subjects:—

Sickness Insurance. Compensation for Industrial Accidents and Occupational Diseases. Problems of Social Insurance.

These give a valuable comparative analysis of the National Laws of most countries, and a statement of the most important problems to which they give rise.

## I. THE PURPOSE OF HEALTH INSURANCE.

1. The two objects of Health Insurance when introduced in this country were the reduction of ill-health, and the provision of some income when the wage-earner fell ill and his wages were cut off. What light thirteen years' experience has thrown on the former question, and infinitely the more important one, what should be the part played by insurance in a scheme of prevention is definitely left out from this Statement. If it is true that in England and Wales alone one million and a half persons are always on the sick list, if thirteen and a half million weeks are lost every year through sickness, if our present treatment of sickness represents an expenditure through public channels alone of £46,000,000 per annum, it is evident that we have here one of the greatest sources of waste in our national life. It would indeed be a great service if this Commission calculated or even estimated the total loss to the nation in wealth, leaving alone the incalculable human cost of personal suffering which results from the existing amount of ill health. Such an estimate would provide the ground work for our next step in the fight against disease. It is hoped also that the Commission will advise Parliament what policy for prevention of disease should be pursued.

## THE EXPERIMENT OF 1911.

2. The Act of 1911 constituted in many respects a new departure in social policy. It is true that Workmen's Compensation was already instituted, but the juridical justification was entirely different, whilst the State was, and still is, very little interested in its actual administration. The Old Age Pensions Act was clearly the offspring of the old idea of Poor Law and it was very easy to administer. The new device of contributory insurance conveying a legal right to a definite amount was unknown previously in this country. The 1911 Act, both the Health Insurance and Unemployment Insurance sections, were, in fact, novel experiments.

This is the first opportunity for a comprehensive survey of the whole working of the scheme. What emergencies shall it cover, what shall be the rate of benefits, shall it provide for the insured member or for his family, how raise the funds, is the Approved Society a satisfactory machinery for administration? The decisions of this Royal Commission in favour of any existing feature will doubtless tend to make it a permanent part of a new scheme. But now we are to investigate the workings of a scheme which has hitherto been purely an experiment. A Royal Commission on the working of the Factory Acts would know that it was dealing with a permanent group of ideas and certain definite institutions, and recommendations would necessarily be confined to comparatively minor questions of adaptation, amplification and codification. This Commission may, if it desires, propose the abolition of Health Insurance. It certainly will feel free to recommend fundamental changes.

## SIGNIFICANCE OF INADEQUATE BENEFITS.

3. What is the object of providing money benefits during illness? The ten shillings paid in the early days of the working of the scheme and the fifteen shillings of to-day were experiments in this new type of State activity. They bear no relation to any significant fact in our industrial life—either to the rate of wages, or to the maintenance of an average family at a given standard of living, or to some agreed minimum wage, or to the cost of maintaining a workman, or of maintaining him and the average-sized family in the workhouse.

This same question emerges when discussing other branches of social insurance. What ought to be the rate of benefits? One can point to but one fundamental object in justifying these different Governmental activities and Health Insurance was first instituted to meet it. Sickness, it was demonstrated, was the cause of a considerable amount of poverty. Moreover, in this it is from the social point of view like all the main emergencies in the workman's life. It matters little whether he is suffering from illness, unemployment or an accident. Financial loss, exhaustion of savings, distress and the dread of destitution confront him whatever the immediate emergency.

All these branches of social insurance aim then at giving the workman's family some sense of security against the hazards of life in a modern community. The fear and shame of destitution are thus to be banished as far as possible. It follows therefore that there should be benefits adequate to achieve this purpose. To grant a rate of benefits which does not have this effect is to throw away the anticipated social gains.

## THE PERVERSION OF FEAR.

4. Two considerations of peculiar gravity must be taken into account in estimating the importance of the sense of insecurity and the pervasion of fear which characterise the modern workman's outlook. The workman of to-day is fully aware of the uncertainties, the financial and human costs resulting from illness, disability, maternity, industrial accidents and diseases, old age, death, widowhood, orphanhood and unemployment. For twenty years at least the workman has been made more conscious of these emergencies by the preaching of party propagandists than his own growing education and provision would have inspired. But whilst they were satisfied with experiments with low benefits he himself was roused to the reality of these terrors and to the menace to his family and to their standard of living, and he began to spend more and more on supplementary voluntary insurance. Tens of thousands of workmen, perhaps even hundreds of thousands, are spending 4s., 5s., and 6s. a week, i.e., some 10 per cent. of their income or more on their various insurances.

If the State to-day makes provision for a low benefit rate for sickness insurance many workmen will insure in three, four or more organisations in order to obtain an adequate amount of benefit.

This was clearly shown in the case of two insured workmen known to the writer.

The former, a very thrifty and foresighted workman, has joined a number of organisations, so that during a recent illness his benefit amounted to 61s. a week. This enabled him to obtain proper treatment whilst ill, and then to spend three weeks at the seashore whilst convalescent. His brother-in-law, who was insured only in the State scheme and the Trade Union scheme, i.e., a man who belongs to the type who waits for some compulsion to be brought to bear upon him, found during his recent attack of influenza that he could not afford to be away from work, so that he went to work as usual. He has a wife and three children. His 27s. a week in benefits were not sufficient, seeing that 9s. a week was necessary for rent.

Let us note the provision for insurance made by these two workmen.

	Contribution per week.		Benefits.
	s.	d.	
*National Insurance Schemes.	1	3	Unemployment, 15s. plus extra provision for dependants for 26 weeks. Sickness, 15s. for 26 weeks.
The Northampton Boot Operatives Trade Union.	1	0	Strike and lock-out pay, 18s. a week for 10 weeks. Unemployment pay, 18s. a week for 10 weeks. Sick benefit, 12s. a week for 10 weeks. Death benefit, £6 for a member, £3 for his wife.
The Independent Order of Rechabites.	0	7½	Sickness, 15s. for 26 weeks. Death, £5.
The Free Gardeners' Friendly Society.	0	6	Sickness, 8s. for 52 weeks. Death, £10 a member, £6 his wife.
The Factory Sick Club.	0	3	Sickness, 10s. a week for 13 weeks. Death, £2.
The Royal Liver Insurance Co., Ltd.	0	4	Death, £28.
	0	1	Death of wife, £7.

The former workman is paying 4s. 0½d. a week for his insurance contributions to six organisations. The latter is paying only 2s. 3d. a week through his Trade Union and the National Insurance Scheme, and finds that he must carry on with his work even when he has an attack of the "flu," and is advised by his doctor to keep in bed.

\* The employer will as a rule insure his workpeople against industrial accidents in another insurance organisation. Nor must we forget the amount spent by the State on them.

The writer knows many workmen who are spending 4s. to 6s. a week on their insurance of their families. And still the sense of fear persists.

## CHEAP STATE INSURANCE VERSUS DEAR VOLUNTARY INSURANCE.

5. How much is spent by workmen to-day on voluntary social insurance? This is another question on which we should welcome the researches of the assistants of this Royal Commission. Inquiries in places so very different industrially as Cambridge, Northampton, Manchester and London show that it is very much higher than the 2s. it is usually assumed to be.

An adequate system of social insurance is the best way of guaranteeing the workman the security he needs. Refuse it, and the better-paid workman who is thoughtful and thrifty will buy very expensive insurance in voluntary organisations, whilst those with low incomes and lacking in foresight will drift into the Poor Law.

## II. EXTENSION OF BENEFITS ADVOCATED.

6. How then can we complete and round out our system of Health Insurance? It is submitted that great extensions are desirable. (1) Benefits should be provided not only for the insured workman, but also for his dependants. (2) Medical services should include more provision for the service of specialists. (3) Money benefits should be raised. (4) The Maternity Benefit in particular should be increased at least to the level recommended by the Washington Conference and endorsed by the British representatives; and (5) Burial Benefits should be included, and all industrial and non-industrial accidents and diseases provided for.

## HEALTH INSURANCE AND THE FAMILY.

7. Recent discussion has emphasised the importance of recognising the family in any extension of our system of Health Insurance. This may mean any one of three distinct developments.

- (1) It may be said that the sick insured member requires not only medical treatment and money benefit for himself, but that this money benefit should take into account the needs of his dependants. Just as, it may be argued, our system of Unemployment Insurance now provides money benefit not only for the workman himself but also for his wife and children, similar provision should be made in the scheme of Health Insurance.
- (2) Recognition of the family may be taken to mean that medical benefits should be provided for the wife and children of the insured member. The burden of the illness of a wife or child, borne, as it is, by the workman's wage, has in effect the same influence in reducing his standard of living as similar expenditure resulting from his own illness.
- (3) Recognition of family needs may be taken to mean the provision not only of medical benefits to the wife, but where her illness necessitates absence in a sanatorium or confinement to bed, the payment of a money benefit to enable extra help to be obtained to take care of the children and to provide proper food for the workman's wife.

A former Minister of Health, Sir Alfred Mond, voiced the sentiments of many millions of people when he instanced, as an obvious fault of the National Insurance Scheme, the fact that, "It was based from the first on the individual and not on the family—a serious error."

## EXTENSION OF MEDICAL BENEFITS.

8. The case for an extension of the range of medical service has been the most discussed question relating to the Scheme, and has resulted in greater agreement than any other. There is a wide demand for,

and a convincing case has been made out for, adequate provision of all those medical services which the middle classes are in a position to buy for themselves. These include dental and optical treatment, convalescent home services and the aid of nurses, a certain provision of hospital treatment and the right under given conditions to have specialist treatment and consultant advice. This extended service would, of course, imply the provision of the necessary appliances.

How such extended services should be linked up with those of the existing national and municipal authorities and the local voluntary bodies is a matter for the administrators. It is for them to decide how far additional services should be dependent on the recommendation of the general practitioner or Regional Medical Officer.

It would be extremely helpful to learn also from this Royal Commission whether the suggestion frequently made of local clinics with one or more doctors, (depending on the size of the area served), in constant attendance, is a desirable development which may be expected to remove complaints against the panel by the insured members, and also by the doctors themselves.

#### MONETARY BENEFITS.

9. A money benefit of 15s. to 20s. a week can have little justification, the cost of living being what it is. The guiding idea in Health Insurance should surely be what it is in other branches of insurance—the removal of all risk of loss from a given contingency by the payment of a regular sum. A man who takes out a policy against loss by fire of £1,000 when his house is valued at £2,000 is a fool. Our social insurance schemes will never be very popular if they do not give security for nearly the whole of the risk. Of course, malingering must be guarded against, but improved machinery for checking claims would be the better way of dealing with this matter.

If the benefits provided are on a flat rate then they must not be too high to tempt the worst paid class of labourers. This points to a benefit of 30s. a week for men and 20s. a week for women as long as the illness lasts. (There is no justification at all for the drop of benefits after 26 weeks' illness.) Surely he needs more rather than less as his savings become exhausted.

But with our 13 years' experience we ought to attempt deliberately a more difficult administrative task than that hitherto faced. Benefits should be graded according to wages. All workpeople should be assigned to four wage groups, paying their contributions according to their group, and obtaining corresponding benefits. This method has been successfully attempted in the scheme of invalidity or disablement pensions in Germany and of sickness insurance in Czecho-Slovakia. It should, however, be noted that the contribution made by the State ought, in equity, to be the same to all wage groups.

The British Civil Service, easily the most efficient and honest in the world, could successfully achieve such an administration.

The grading of benefits according to wage group and in conformity with family needs would meet most of the complaints against the inadequacy of benefits.

#### MATERNITY BENEFITS.

10. The fundamental problems raised by maternity in poverty are the same whether a woman is engaged in gainful employment or in running a household for her husband. In both cases there are the same facts: a very small income, as a rule no savings, extra costs for medical attention and special food, and the urgent need for a period of rest and recuperation. Of course, a considerable amount of poverty is due to the large number of children born to those in straitened circumstances. They need to be taught sex hygiene. The object of legislation apart from this should be twofold:—

- (1) To protect the health of both mother and child by ensuring proper rest and providing suitable nourishment to the mother shortly before and after child-birth.

- (2) To protect the health of the child after the mother returns to work.

To secure the first of these, the mother, if she is engaged in industry, is prohibited from employment for a certain period after child-birth. By itself this provision is of doubtful value since it deprives the mother of her income when she needs it most. It naturally leads to the breach of observance of this regulation.

The Health Insurance Act makes no provision for the attainment of the second object. When the mother returns to work there is no special legislation to ensure that the child is adequately protected.\*

The insured woman, then, can claim £4 for maternity insurance. Her claims apart from this are a little uncertain. She does not obtain the free service of doctor or midwife—in fact the chief complaint against the small benefit allowed is that the doctor frequently gets the whole sum. There are, however, in many places maternity centres provided by local authorities, which give advice, nourishment, and nursing for pregnant and lying-in women either cheaply or free of charge.

#### THE WASHINGTON CONVENTION.

11. The Washington Convention under the auspices of the International Labour Organisation, drafted a convention on the subject of maternity protection in 1919, which was approved by the British representatives.

It provided that the period of rest for women employed in industry or commerce should be six weeks before and six weeks after child-birth. The first period is optional and a doctor must certify its desirability—the period after is compulsory. During this time she is to have a full and healthy maintenance grant. These, of course, leave out the problem of the woman working in the household. It is doubtful whether any legislation of this kind could be applied to her; nor is it certain that the woman who takes this enforced period from gainful employment will leave household duties entirely alone.

The cost for the small total of the married women provided for by the convention, with the weekly benefit estimated at 20s. and £2 granted for medical attendance, would be at most £14 for each woman. The total cost would be about £1,250,000 per annum in addition to present maternity benefits.

If the benefits were extended to cover all women in the industrial classes the costs would be some £14,000,000 per annum.

As the law exists at present the gravest charge is that while giving a lump sum benefit (which, however, may be dispensed in medical attention and in kind if the Approved Society thinks fit) all medical attention that is ordinarily supplied to the insured woman is taken away. In effect it works out that what is given with one hand is taken away with the other. Any scheme to be adequate would have to supply both medical and monetary benefits. Besides, there is, surely, some obligation to honour a convention which we have solemnly endorsed.

12. Maternity insurance is perhaps socially the most important branch of social insurance. The chief obstacles against an adequate expenditure on social insurance is seen when dealing with this branch.

- (1) It is difficult to trace the good results directly due to this type of expenditure. In the meanwhile we permit a colossal amount of human suffering resulting from the lack of proper pre-natal, natal and post-natal care. Women die at child-birth and thousands become permanently ill or invalids for life. Last year some three thousand women died in child-birth.
- (2) Even if it is agreed that this expenditure on these purposes is desirable it frequently

\* The most important proposal for dealing with this problem is that advocated by the Family Endowment Society. It is explained and justified in Miss Eleanor Rathbone's book on "The Disinherited Family." A scheme of Family Income Insurance has been worked out for giving it effect.



involves the rich contributing towards them. Their gain from such expenditure is indirect. Assuming that £100 spent in their early years on the children of the poor will yield a return of £500 in later years, the rich may oppose such expenditure because it may involve their bearing £50 of it.

- (3) There are powerful vested interests, against such an expenditure which would be directed and controlled by the State. There is the union of all those who fear and oppose further extensions of Governmental functions, and there is the rich and powerful body of vested interests immediately assailed.

In consequence, the infantile mortality of the children of unskilled workers, i.e., of workers with a low wage is allowed to be double that of the children of the middle and upper classes and we learn that in 1920 some 47.9 per cent. of the total of school children examined were defective, largely because of ante-school conditions.

#### INDUSTRIAL ACCIDENTS AND DISEASES.

13. The view that all cases of sickness and of death, whether due to industrial causes or to non-industrial causes, should be merged and should be made part of a national scheme of sickness and accident insurance has often been urged. To-day the Health Insurance Scheme provides for any cause of illness excepting that traceable to industrial disease. The Government Scheme of Pensions for Widows and Orphans will provide compensation for the dependants of those who suffer death from non-industrial accidents and diseases but the victims of industrial accidents will come under a different scheme.

The Ministry of Health could quite as well provide insurance benefits for those who suffer from industrial causes as for those who suffer from non-industrial causes. Such a development would result in the reduction of administrative expenses, the simplification of procedure, the avoidance of litigation, and in giving the workman indisputable rights to benefit in all cases of illness.

What are the arguments against this proposal? Are they valid?

It may be contended that the risks in different trades vary. Either there must be, therefore, a varying rate, and this would make a general scheme impossible, or if a flat rate is decided upon it would be unjust to the safer trades. It is also argued that a flat-rate policy would take away from the employer an inducement to reduce his risks and thus lessen his liability. There are also objections on administrative grounds to the merging of these different schemes. It is pointed out that the workman contributes directly to the Approved Society which administers Health Insurance benefits, but he does not contribute directly to Workmen's Compensation Insurance, since this is paid by the employer and administered by insurance societies. Employers might object to pay towards the funds of bodies like Trade Unions and Friendly Societies, which are workers' organisations, without wanting to exercise some control over them.

It is true that the risk varies in different industries, but this applies also in the case of sickness and even more so in that of unemployment. If we are satisfied with a flat rate for unemployment insurance and to a modified extent for health insurance, why not also for workmen's compensation? Indeed, the case for it is much weaker in the case of accidents than in the case of unemployment. But there are valid arguments against such variation of rates. Why should not the steel smelter or the railway company pay towards the hazard of getting the coal? Besides, what is the evidence that Insurance Companies in fact vary the rates with the risk? Their rates are kept secret and it is a matter for private bargaining what rate will be fixed and whether it will be made to vary with the risk. Besides, the administrative

expenses of the Insurance Companies are very high. Until recently they were about 50 per cent., and now they are to be reduced to 40 per cent., and later to 37½ per cent. Moreover the economy of insurance costs would be greatest when large numbers are included in one scheme. In short, it is extremely unlikely if a scheme of Workmen's Compensation became part of a comprehensive National Health Insurance system, and employers paid a flat rate, whether it would need to be higher than the lowest rate quoted by Insurance Companies. The claim that the present arrangement offers an inducement to reduce hazards is never supported by any facts. The "Safety First" movement in Great Britain has not been able to induce Insurance Companies to advertise lower rates of premiums for establishments employing their devices. Moreover, it is extremely doubtful whether any employers would take the trouble to think out plans, devices, and set up a special organisation to help reduce accidents merely in order to obtain a very slight reduction in insurance costs.

Clearly the merging of Workmen's Compensation Insurance with Health Insurance will necessitate fundamental changes in administration. But these will not be more difficult to achieve than the Government's present proposals. A non-contributory scheme of Old Age Pensions is to be merged into a contributory scheme. The finances of Old Age Pensions, Health Insurance, Disability, and Maternity Insurance, as well as Pensions for Widows and Orphans are to be associated and related to the Unemployment Insurance Fund. Administration of Old Age Pensions formerly undertaken by the Customs and Excise Department will sooner or later be handed over to the Ministry of Health. We shall surely not be put off by undoubted difficulties in developing a comprehensive system of Health Insurance, if we are certain of advantages. If the latter are considerable we shall willingly face the former.

14. The case for a State Insurance Scheme of Workmen's Compensation as part of the Health Insurance system is so overwhelming and well known that it need only be sketched here. It will mean a saving in administrative expense of some 25 to 35 per cent. It will simplify administration to both employers and workpeople. It will help remove the new batch of anomalies which are likely to result from the adoption of the Government Scheme of Pensions for Widows and Orphans.

These provide that the widow and orphans of any insured workman shall receive on the death of the breadwinner an amount equal to the maximum benefit obtainable under Workmen's Compensation. Whatever the cause of death the dependants will be treated alike. Why not establish a similar maxim when the workman is not killed outright but is incapacitated? Why should the workman who suffers an industrial accident receive 30s. a week whilst the one who is disabled through other causes receive only 7s. 6d.? Are the social consequences in these cases different? Do the families need less?

But it is not certain that cases of large families will not arise where they will receive more under the Widows and Orphans Pensions Scheme than they would receive under the Workmen's Compensation Act. This is a change over with a vengeance from the existing situation where they receive nothing. Moreover, they will no longer be tempted to fight the Insurance Companies in disputed cases. Why should they when they might receive more under the Government Scheme? But this will involve a considerable gain to the Insurance Companies at the public expense.

Another solid advantage from the Government Scheme generally avoided by the Insurance Companies is the provision of benefits weekly rather than by a lump sum.

#### BURIAL BENEFITS.

15. During the early stages of the National Insurance Scheme which became law in 1911, it was proposed to include provision for burial insurance. But in spite of the patent abuses with which it was

administered most working class households had made provision for it, and the Insurance Scheme was itself an experiment. Besides, private interests, powerful financially and politically, were marshalled against it. This proposal was then dropped. But there has been a ceaseless campaign against the many abuses since then. There has been a Departmental Committee of Inquiry. There has been amending legislation. But the campaign of hostility continues. Indeed, the outcry against it has grown with the very great growth of the amounts spent on it. And every extension of other branches of social insurance means an increased number of policies for the Insurance Companies. The case against the present method, apart from incidental abuses, rests briefly on its wasteful administration, on the difficulty of continuing the voluntary method when the compulsory is adopted in related branches of insurance, and on comparison of the cheaper and better way of administration shown by general schemes of insurance adopted in other countries.

In a publication of the Association of Industrial Assurance Companies and Collecting Friendly Societies issued in 1921, it was stated that "there are over fifty million of industrial policies now in force over which over £35,000,000 is paid annually in premiums. (In 1923, a year of great unemployment, the chairman of one of these Companies reported that the premium income of their industrial branch was over £14,800,000.) To this should be added the interest on invested capital. Popular estimates are to the effect that Insurance Companies have some forty to fifty million pounds annually to deal with to provide proper burial insurance.

The 1911 Insurance Act greatly stimulated this form of business, and the new extensions of social insurance are expected to have the same effect.

It would seem that the amount spent by the workers in one year for "death" benefits is three times the amount spent on health, maternity and disablement taken together.

This form of insurance, which is an amazing instance of what salesmanship can do, has long been referred to as a huge scandal, producing suffering and financial loss among the more illiterate of the community; the abuse of lapsed policies, unrealised expectations, princely salaries and huge dividends. But what is constantly ignored is the fact that the heavy expense account of 44 per cent. of the premium income revealed by the Parmoor Committee as the average of the English Companies is due to the very nature of the business. As one American writer puts it, "We are probably within the truth in stating that 40 to 50 per cent. of the premium is an inevitable and necessary carrying charge upon the business of commercially insuring under a voluntary plan great masses of labouring men for small amounts against disabilities arising out of sickness and death."

It is futile, therefore, to attack this or that individual company. This is clearly seen when we think of the Co-operative Society, which need pay no more than 5 per cent. for its capital. Thus the chairman of the Co-operative Insurance Society pointed out that the expenses of management and commission in the industrial section was 41.75 per cent. in 1924, as compared with 43.86 per cent. in 1923, whilst the expenses for their Employer's Liability section was 39 per cent. of the premium income in 1924 as against 40 per cent. in 1923.

It is the system itself. The weekly collections of a few coppers by an army of perhaps seventy thousand agents, who call at the home of every workman, which requires attention quite apart from possible abuses of the system, some of which the 1923 Act may help to eliminate.

If any one company were granted a monopoly of this form of business, the administrative expense could perhaps be reduced to 20 per cent. And, indeed, one company with some twenty million policies has reduced its expense account to 23 per cent.; but that is no solution. Burial Insurance can be administered by the State at an expense of about 2 per cent. This is because of the economies which result from a compulsory scheme applying to the

whole working-class population, and from the stamp method of collection. The forced addition of a small sum to that now abstracted from wages for Health and Unemployment Insurance (and as proposed for old age pensions and pensions for widows and orphans, i.e., the compulsory payment at the source of the income), would eliminate practically all expenses of agents and solicitation. Even the expenses of investigation of claims would be reduced because the official paying out benefits in case of illness would conclude the account by the payment of burial benefit and hand it over to the Pensions Authority. One set of officials could deal with several cases instead of two or three.

#### EXPERIENCE ABROAD.

16. That burial insurance should be provided in a scheme of Health Insurance is justified by an appeal to the experience of a number of countries.\* Indeed, practically all countries with Health Insurance schemes grant this additional benefit. In Norway funeral expenses are assessed at a fixed figure. This is also the case in Roumania. In seven other countries the amount of such funeral grant varies considerably. Thus the grant payable under the

Polish Act amounts to 18 times the basic wage;

Latvian Act amounts to 20 to 30 times the basic wage;

German Act amounts to 20 to 40 times the basic wage;

Hungarian Act amounts to 30 to 40 times the basic wage;

Austrian Act amounts to 30 to 45 times the basic wage;

Czecho-Slovak Act amounts to 30 to 45 times the basic wage;

Jugo-Slav Act amounts to 30 times the basic wage, but not exceeding the amount actually expended.

Some of these Acts (the Polish, Czecho-Slovak, German and Jugo-Slav) provide for funeral grants of the husband or wife of the insured member and to children.

The New York State Health Insurance Bill proposes that funeral benefit shall be included as one of the benefits. It proposes that an amount of not more than \$100 be paid from the funds for the actual expenses of the funeral and burial of a deceased insured person, as arranged for by the family or next of kin.

#### GAINS FROM EXTENDED SCHEMES.

17. If these proposals for including burial insurance and insurance against industrial accidents and disease into the same scheme as Health Insurance be adopted, then the financing of the scheme will have to be regarded as a whole. It will be futile to argue that the workman would in future be obliged to pay towards the costs of Workmen's Compensation which the employer now provides. It will be equally absurd to say that the employer will then be called upon to pay towards the burial of the workman, although to-day he is free from this liability.

What we have to ask is this: Taking into account all the different charges for social insurance, compulsory and private, now borne by workpeople, employers and the State, and taking also into account public opinion on this subject, what is the share that ought to be provided by each of the three parties to the modern wages contract? The system as a whole, it may be assumed, will remain a contributory one. If it is thought that no new distribution of the costs in the first place should be attempted (the ultimate incidence of the costs of social insurance will, of course, be very different), then employers as a class should be made to bear, let us say, £12,000,000 and the workers some £30,000,000 in respect of the costs of industrial accident insurance and burial insurance. An additional charge of about 4d. on every employer for every workman he employs and 8½d. on every workman would cover these amounts.

\* "Sickness Insurance" 1925 by International Labour Office, Genève, p. 99.

## FINANCING EXTENDED SCHEMES.

18. It is clear that the extensions of insurance advocated involve heavy increases in the costs of the scheme of Health Insurance. But they do not involve additional burdens on the community as a whole. The burden, the ill-health, the loss in wage, the expenditure on medical service, these are already with us. Insurance is a device for shifting or transferring the financing of the burden. If, however, the proposals here advocated are adopted, then the extensions can be financed for the most part from the gains in administrative efficiency which will result.

The estimated gain from Workmen's Compensation which can be administered at about 5 per cent., if we collected the amount suggested, would be some £5,000,000. The estimated gain from Burial Insurance, which can be administered like Widows' Pensions, for 2 per cent., would be about £13,000,000. Transference of administration from Approved Societies to the State, together with the accompanying charges, would reduce the annual costs by about £750,000.

These sources would give us some 18 to 19 million pounds per annum with which to finance the extensions advocated.

It would be no disadvantage of this scheme even if it leads to some increase in costs. We should still gain, inasmuch as it would mean less recourse to the Poor Law; better health and greater efficiency.

There is no reason to believe that the working classes, who are now paying very considerable additional sums to Insurance Companies, Collecting Societies and Friendly Societies, would be unwilling to pay more to a State scheme if they were assured of more benefits.

There has been for years questions and criticisms of the operation of both Burial Insurance and Workmen's Compensation Insurance in Parliament. Constant legislative change does not seem to quieten the opposition. The organs of the Insurance Companies frankly confess that they are worried and harassed by the attention which they attract.

This Royal Commission has the opportunity of recommending to Parliament the broad principles that these risks shall be made insurable compulsorily like those of ill-health and old age, and that no profit-making in them shall be permitted, at least until the workers are insured for a certain minimum.

19. All these proposals are, it is submitted, legitimate matters for consideration by this Royal Commission. If, however, they construe their mandate in a less liberal sense, I submit that they should recommend to His Majesty's Government the convening of a Royal Commission on the Unification of Social Insurance.

## III. THE APPROVED SOCIETY SYSTEM.

20. One of the objections against the extension of benefits to-day is that it would inevitably give the Approved Societies more power. These organisations, either brought into being by the Act of 1911 or greatly strengthened by it, talk of "their funds," the small groups of leaders who control them exert no little political influence, and not a few have established vested interests. Even more significant has been the right of entry gained by Insurance Companies and Collecting Societies into millions of homes which they have exploited for their own purposes.

It is noticeable that the Employment Exchange has constantly been suggested for the administration of Mothers' Pensions and Old Age Pensions at 65, because only in this way, it was thought, could the baneful influence of the Approved Societies be avoided. The Government has actually adopted another method which shows equally well the lack of confidence in them assuming additional powers.

Eager as many of us are to see the extension of these benefits, we would desire to have them postponed rather than that they should give an increasing number of their officials claims and vested rights

which would cost the State much to be rid of in the future.

21. The fundamental obstacle in the way of a proper system of Health Insurance is the Approved Society. Granted that we are to have a national system of Health Insurance, the central problem to enquire into is that of administration. A consideration of the advantages and disadvantages of the Approved Society with which we have experimented for over a decade will throw light on it. This is an extremely difficult task, because the machinery which administers the scheme is colossal and complex, and those administering it indulge in extravagant propaganda. The student finds it difficult to trace his way through the fog of lies, contradictions and wild generalisations.

The case for the Approved Societies may be stated briefly:—

- (1) The Friendly Societies paved the way for the Act of 1911, and it was therefore "natural" that they should be approved.
- (2) The scheme has been administered, and administered well, by these Approved Societies. National Health Insurance was something new in the country, and the bodies which could make it feasible have a right to continue to administer it.
- (3) Besides they provide a democratic form of machinery which is divided into units not too large for the officers to have personal touch with the members.
- (4) This contact makes the scheme elastic and human, malingering is lessened and preventive treatment made more possible. Each group, conscious of the expense of its own sickness, is interested in lessening it.

Let us examine these claims.

## 22. What were the facts in 1911?

About six millions were insured in a wide variety of voluntary organisations, Trade Unions and Friendly Societies. Some of these were on an occupational basis, and some on a local basis, but most were in amorphous organisations where membership was not related either to industry, occupation or location. The figures given included (1) women and children and others not to be provided for by the National Health Insurance Scheme, (2) Slate Clubs and Burial Societies, and (3) those who were insured in two or more Societies. Only the better paid workman could as a rule afford to make such provision as was made. Benefits were very low, lapsed policies were numerous and the organisations, in spite of decades of Government aid, were badly administered. The finances of many of these bodies were unsound. Doctors were paid a very low per capita fee. Many of those insured were members of Centralised Societies which made no claim to democratic organisation.

It may be agreed that, taking into account political considerations, it was "natural" that the existing Societies should be approved. But at the same time there was brought into being new bodies for the millions of newly insured members who had no experience of Friendly Societies. The inability of the then existing Societies to absorb any considerable proportion of this new insurable population into their ranks is convincing evidence of their narrowness, their deplorable leadership and their moribund condition. Indeed, had the State not come to the rescue of the Friendly Society Movement in those days, it is likely that the decay which had set in before then would have continued at an increasing rate.

But it should be noticed that approval of existing Societies could have been given equally well in a State-administered scheme with power for these Societies to contract out.

23. Two groups of considerations make it difficult to evaluate the work of the Approved Societies. That work has been carried on during a period when the health of the community has been steadily improving. How far are they responsible for good or

bad administration and how far the Ministry of Health which supervises their activities?

I part their good financial position is due to the War. The period 1914-20 was one of good employment; zeal for work, high rate of wages and great interest in output, the abnormal number of deaths of young members, which all benefitted societies' funds. Those of military age were not welcomed by societies.

The method of organisation adopted necessitates an elaborate system of supervising the work of the Approved Societies. This involves a constant check on their bookkeeping by the Ministry of Health and an extensive audit by the Treasury. Obviously duplication of records is inevitable if the Post Office, the Treasury, the Ministry of Health and the Approved Societies are to have a proper control of the machinery for issuing cards and stamps. One of the most serious indictments against the Approved Society is its unsuitability for supervising medical benefits. It cannot achieve fruitful co-operation with the medical profession.

The thousands of Approved Societies are so split up that they are themselves unable to do much in the way of prevention of sickness, nor if a policy were instituted by the Ministry are they able to carry it out. It cannot function well in a national campaign of education nor in any local activity. On the other hand its very existence is in the way of a better co-ordination of the medical services of the State.

The medical profession, which plays a very important part in the administration of Health, Maternity and Invalidity Insurance, does not gladly suffer the control of the Approved Society officials. Young doctors seeking a practice are obliged to submit to it, but soon they groan under the burden. They resent questions and criticisms from a body of men who have little or no knowledge of their difficulties. There is constant friction leading to threats of strikes, and the doctor's attention is diverted from the doctor's chief function, the prevention of disease. This is all the more significant because the panel system has meant a great increase in their incomes. In order to maintain their status, doctors are increasingly demanding that their services shall be undertaken in direct relationship to the State as their employer, and be independent of the favour of Approved Society officials. There is indeed a marked difference in the relations of the doctors to the Public Health Authorities on the one hand and to the Approved Societies on the other.

Administration of the scheme is for the most part entrusted to part time men, who as Branch Secretaries do this work when they are free from their other work. How is it done? Some light is thrown on the question by the manner in which they administer the voluntary side of their activities.

The more obvious defects mentioned in previous Reports of the Registrar of Friendly Societies were still encountered in the examination of the 1921 Returns.\* They may be summarised briefly as follows:—

- (1) Omission of information required in the accounts and on the front page.
- (2) Disagreement of membership particulars with those shown in previous Return.
- (3) Disagreement of opening balance of funds as compared with closing balances at end of previous year.
- (4) Accounts incomplete, wrongly totalled, or totals of each side not in agreement.
- (5) Absence of signatures.
- (6) Omission to forward Auditor's Special Reports.
- (7) Failure to separate the contributions to or balances of funds which the rules require shall be kept separate.
- (8) Unauthorised transfers from one fund to another.

\* Report of the Chief Registrar of Friendly Societies, 1922. Pages 8-9. Published 1924.

He states also that:—

"An endeavour is being made to simplify some of the forms of the Annual Return to be issued for 1924.

"It has been recognised that the officers of Societies who frequently have but a very meagre knowledge of accounting, and whose Societies do not employ professional auditors, have experienced great difficulty in rendering accurate accounts of income and expenditure."

It is true that these criticisms apply to the smaller societies but they indicate clearly that judgment cannot be passed on Approved Society administration as a whole by treating this or that large society as typical.

24. The method of organisation adopted with responsibility divided between a Government Department and semi-independent bodies leads to certain evils. Approved Societies are apt to claim all the satisfactory achievements as due to their wisdom and effort and all the undesired results as being due to Government meddling. When an Approved Society can show a good reserve it boasts of its good administration. When it suffers a deficit the Government and "their" scheme is to blame. When an insured workman must use the voluntary hospitals, we are told by the Approved Society official that "the Government should not throw its clients on charity." When owing to Government schemes of sanitation, maternity centres, and other provision for the young the health of members improves it is due to the preventive work of the Societies.

When it suits their purpose Societies talk of what they will and what they won't allow the Government to do, what they will and what they won't stand from the doctors, what "they" are going to do with "their" funds. And again when it is more useful they adopt the subdued tone of the National Conference of Industrial Assurance Approved Societies. "I can say that the Approved Societies have been left at the present moment with very little effective authority . . . . If you look at the number of regulations with which the management is hedged around you will see that they must do this and they must do that and they must do the other thing . . . . I do not see what there is they are allowed to do at all except as confidential clerks carrying out the duties prescribed for them by the regulations."

In this atmosphere of uncertain responsibility it is possible for Societies wittingly or unwittingly to mislead members as to their rights. Let us note two cases.

Insured persons whose benefit is discontinued after they have been examined by a district medical officer frequently fail to realise that the decision is "that of their Society and not that of the district medical officer, who merely acts in an advisory capacity."

"From complaints that we have received (states the Fifth Annual Report of the Scottish Board of Health—(Cmd. 2156) it appears that some Societies are in part to blame for the misapprehension. In their desire to avoid dissatisfaction with the Society the intimation of the decision to discontinue benefit is so worded as to imply that the responsibility for it rests on the district medical officer. We regret that some Societies should thus endeavour to avoid responsibility for their decisions."

The next case is one in which Societies do not seem to understand the purport of an Act of Parliament.

"The Prolongation of Insurance Act, 1921, continued in insurance all unemployed members of societies who satisfied the conditions laid down in the Act, and the Arrears Regulations subsequently extended to these members a title to cash benefits at the minimum rate."

Many cases occur\* where an insured person has been told by his Society that he is no longer in membership and accordingly not entitled to benefit,

\* Fifth Annual Report of the Scottish Board of Health, Cmd. 2156.

when subsequent enquiry by us has elicited the fact that the member is entitled to prolongation and to the minimum rate of benefit. It appears that although more than two years have elapsed since the passing of the Act, some Societies regard its application to their members as an "act of grace" only to be carried out if the member specifically advances his claim to the prolongation.

25. It is a notorious fact, and it is valuable to have Sir Thomas Neill's evidence that the machinery for self-government breaks down in the case of the Industrial Assurance Approved Societies. It would seem as if there is very little real democratic activity, vital interest in the working as shown in criticism and changes of the directing bodies in the case of most Centralised Friendly Societies. These have a membership of over 2,800,000 (over 22·8 per cent. of the total) and the Industrial and Collecting Societies with a membership of over 5,100,000 (over 41·5 per cent. of the total). Some 64 per cent. of the insured population seem to be in Societies, in which whatever the written constitution provides do not in fact contrive for its affairs to be subject to the absolute control of its insured members, but rather in the hands of a small cabal. A fundamental and indispensable legal condition for their approval has been either wilfully ignored or the people in charge of them have not known how to interest their members in the serious questions of maternity health and disablement and kindred subjects. There is here a great breach of faith, the ignoring of duties solemnly laid down by Parliament and the misuse of power for non-social purposes. It is inconceivable that this Royal Commission will not advise the Ministry of Health and Parliament to withdraw recognition from Societies that flagrantly break a condition of their trust. It is in that sense that these Societies should be dealt with when the question of compensation is raised.

Personal contact with members is obviously absent in the case of those members who have moved to other parts of the country where their original Society has no local branch.

26. Although it may be convenient to discuss the administration of the scheme through an average Approved Society, in practice, we find that all Societies do not provide the same benefits, nor, as we have seen, do the officials have the same kind of relation with their members.

A flat rate system of contributions was adopted. If then members were to have, roughly, the same kind of benefits the Societies should have contained large numbers of persons with a wide variety of risks, resulting from inequalities due to occupation, locality, sex and age, in order to equalise these variations. The plan actually adopted permitted, and indeed, encouraged Societies to ignore these conditions. Thousands of small Societies were approved. Many of them did not contain a variety of risks. Some had a membership composed predominantly of those engaged in unhealthy occupations and others of those in healthy occupations. Some were located in healthy, some in unhealthy districts. Certain Societies like those of the clerks and the agricultural workers had, as a rule, sickness rates much below the average, whilst miners' Societies had sickness in excess of the average. Thus Societies whose members had most need of benefit got least and soon exhausted their funds. Segregation of good and bad risks is very common. It means not only inequality in money benefits, but also in medical benefits. This tendency for inequality to grow is producing a growing rivalry. This would not become quite so serious if transferences could be effected easily. But these can only be effected with difficulty. Moreover, the newly transferred member cannot, as a rule, share in the "additional benefits" of the Society to which he transfers. Nor is it always known by the members that other Societies may be paying higher benefits. This explains how the erroneous impression became widespread that dental benefit like medical benefit was provided universally. Many complaints arose from insured persons who felt this "grievance."

The miners complain that because of the nature of their occupation and the conditions under which they are housed it is impossible for their Approved Society to have a surplus, and consequently the members are unable to secure more than the minimum of sick benefits. "They had always contended that there should be one contribution and one benefit, as in the case of Unemployment Insurance."

Some of the worst evils of this segregation of risks has been met by four equalisation funds which have been set up.

Further pooling of resources is constantly advocated. But it is clear that those who do so are impaled on the horns of a dilemma. First they urge that it is proper that those subject to different hazards should obtain different benefits and that each Approved Society should have the full advantages of selecting workmen, keeping them well, preventing them from malingering; and then they advocate and institute equalisation schemes to avoid the effects which their own policy has produced, and to meet the criticism of Societies with a higher percentage of morbidity.

Is it desirable that members who suffer different hazards should obtain different benefits for the same contribution?

It is important to recall that it is of the essence of insurance to distribute the burden of risks. Clearly, what is regarded by some as an injustice, the sharing by the fortunate and the unfortunate alike of the hazards of the latter, is willingly desired by most because of the certainty it gives them that they will not be called upon to bear an unduly heavy burden.

The answer made to this consideration is that even if the device of insurance is desired it is possible to distinguish between different groups who are subject to different degrees of the same risk. This may indeed be conceded. But it should be recalled that there is great inconvenience and increased administrative cost in developing different categories. These may even outweigh the advantages of establishing these different groups. Moreover, no one has yet ventured to classify the trades of the country in detail. Any such attempt must result in arbitrary decisions. Besides, since bad health varies with localities as well as with industries, there is a strong case for variation of benefits according to the former.

Surely, both the Approved Society method of organisation and the industrial method are against the wiser modern tendency to regard health as a national question. It was that tendency which justified both the employer and the workman contributing towards the costs of Health Insurance. And it is that same tendency which makes it difficult to see any grave evil in asking the clerk who will use coal, to pay something towards the extra burden of sickness of coal miners. This principle of distributing the total burden of the risk equally over the insured population is adopted in the case of unemployment.

Is it true that a flat rate will result in inefficient management? Those who assert that it will have hitherto given no grounds for that view. Indeed, no attempt has hitherto been made to analyse clearly what is meant by good organisation in the case of Approved Societies. Does it mean more efficient office arrangements and book-keeping, or greater control over entry, or better investment of funds, or less enquiry into claims or more effective use of sick visitors and stricter control of malingers, or an understanding with the local doctor for harsher judgments? Before accepting any or all of these tests, let us note that it is a matter of fortune whether a Society will draw members from a healthy trade or a healthy district. Similarly, the officers cannot easily arrange that they should have members who are not scattered far and wide in ones and twos. Nor can we ignore the fact that a good reserve is not necessarily a sign of efficient administration. Restriction of expenditure on health money benefits or health services is not always an economy. In the same way a harsh and critical policy towards claims by "sick" members is not necessarily a good thing. It is impossible to accept the superficial and in-

interested judgments of Approved Society officials on the merits of their administration.

The chief reason against a flat rate of benefits is that it would show up then more clearly the obvious waste of having thousands of Societies doing badly what could be done well by well situated, well run, fewer offices.

27. It is particularly amusing to note that because the Approved Society is not particularly well suited for any of its functions that those who would have it continue in a modified form are proposing very different tasks for it. Some advocate that it should retain its money benefit features and that its medical service functions should be handed over to a more suitable body; others again that it should retain its medical services and hand over its supervision of money benefits to a more suitable body. This difference arises from an unwillingness to face the fact that the Approved Society is unsuited to any of its present tasks.

There seems not to be the slightest reason for supposing that the money payments cannot be made by one organisation just as well as by another. All types of institution can calculate the varying rates if they are to be according to the hazard, age and sex. Any type of organisation can engage the services of suitable officials to pay out the additional benefits which it has.

Similarly, "the certificate of incapacity" issued by the doctor is for all practical purposes a cheque for the member to draw from his Society certain benefits. This can continue to be the case if the organisation which administers is either the industry or the locality or the State.

Nor is it surprising that the Scheme has not worked well when it is recalled that each of the big groups of Approved Societies existed before Health Insurance began and added it to other work already undertaken. Approved Society work was a supplementary and subsidiary activity.

Industrial Insurance Societies are much more concerned with canvassing for burial insurance. Their assumption of duties under the Act gave them the immediate gain of a statutory right to enter the houses of millions of insured members whom they were able to exploit for other purposes.

To the good Trade Union official what matters are questions of wages, hours, workers' control and political representation. Health Insurance and educational activities have to take their turn.

Friendly Societies were by tradition more in line with the new work to be done, but they too have another side to their work. They still have their voluntary insurance. It is this fact which explains why instead of becoming, as might have been expected, leaders in these activities they have rather opposed extensions of benefits because it might adversely affect their voluntary insurance.

28. Administration of insurance by the Approved Society combines all the faults and none of the virtues of insurance by industry or insurance by the State, or insurance by local authorities. It cannot claim the virtues of being a democratic form of organisation. Nor is it pretended that like other somewhat anomalous institutions it has a hoary tradition. Here is no institution which is the offspring of history, nor has it public sentiment for its support and custom as its justification. It was a crude device brought into being in 1911 and the sooner it is ended the better for the development of social insurance, and the guarantee of the workman against the emergencies which threaten him.

Put briefly the present system involves a number of important technical disadvantages; segregation of numbers, necessity for reserves, the demand for variations of premiums, the break up of homogeneous groups and the consequent difficulties of providing medical care.

What we desire in a scheme is that it should be administered by an efficient, well-trained personnel, that there shall be the minimum of duplication in organisation and supervision, that the doctors and other necessary services shall work the scheme with enthusiasm, that it shall be part of a well-developed system for prevention, cure and relief of sickness,

that it shall not be in the way of an extended scheme of Health Insurance or of a unification of all branches of social insurance.

#### ALTERNATIVE METHODS OF ADMINISTRATION EXAMINED.

29. Assuming then that the experiment made in the 1911 Act of entrusting administration to Approved Societies has not worked as it was desired or expected to work, that it has resulted in great unfairness to many insured members, and that it is a system which, whilst not calling out the enthusiasm or loyalty of autonomous voluntary associations, manages to combine many serious evils in administration and finance, what alternative types of machinery can be proposed? Three main alternatives have been suggested. These are:

- (1) Health Insurance organised on the basis of industry,
- (2) organisation by locality and
- (3) organisation in a State-administered National Scheme.

Some three years ago it would have been necessary carefully to consider the flashy proposal of insurance by industry. But now it is generally realised that it is undesirable both on theoretical and practical grounds.

#### ORGANISATION BY LOCALITY.

30. Some people who calmly tolerate the bureaucratic character of the competitive firm and of the large Approved Society view with horror the bureaucratic tendencies in a Government Department. They find these such a nightmare that they go to the length of urging that local authorities should be used as the agencies for administering social insurance. It is no doubt desirable that local sentiment should be behind schemes of social welfare. In the carrying out of public works which are undertaken by the localities and in the administration of the local health service it is only proper that there should be the greatest possible co-operation between the local authorities and the administrators of the related schemes of social insurance. But those who urge administration of social insurance through local authorities do not seem to have thought out the full implication of their proposal. Can they mean that the State should provide funds towards the cost of social insurance and have no supervision of them? And if the State is to have certain powers, what are to be the respective spheres of influence of the local and central authorities? Will there not be difficulties in cases where the factory is located in one area while the workman lives in another, and possibly the employer in a third? In practice it seems impossible that Parliament should grant money without controlling expenditure, and on the other hand it would destroy the advantages of local government to be rigidly controlled by a central department. It might even be suggested that as the local authority is to administer and will gain by the extension of Health Insurance it should be called upon to contribute towards the costs of the service. Certainly it would seem to be an inevitable corollary that at least part of the burden should fall on the local rates.

This would indeed be a frightful blunder. In respect of their indirect effects rates are one of the worst possible taxes. In so far as they restrict building no revenue is obtained, although there is none the less a very serious injury to the community. The obligation of incurring expenditure on social policies which could equally well be undertaken by the National Government should never be imposed on local authorities. Moreover, the expenditure called for is usually greatest in relatively poor districts, which are least in a position to afford it. The already great differences in rates would be made even greater. Besides, why tie down a new organisation to a division of the country which, though suitable for country areas in certain respects, is most unsuitable for boroughs? Experience shows that social insurance schemes worked through central bodies such as the Post Office and Employment Exchange can be run very satisfactorily. There is no

popular demand that these should be handed over to local authorities. If they were, difficulties and discontent would arise from the existence of areas where the hazards were greater than the average. Transferences from one district to another might be impeded and the mobility of labour shackled. An even more serious objection is the danger that if the local authority became the administrative body it would tend to cause certain evils like unemployment, ill health, motherhood in distress, and industrial accidents to be regarded as local problems. This would be in contradiction to the best thought of the last two decades on these subjects. Only by being regarded as national problems can schemes for prevention and rehabilitation achieve the maximum success.

Another objection is that local authorities are particularly bad organisations for doing this work because they require the specialised services of considerable numbers of people whose work would be to a large extent technical. It is true that the suggested *ad hoc* advisory committees could probably succeed in understanding the nature of their functions, and so might in time aid materially in the administration of social insurance measures, and give real help to the officials. But a town councillor, in office for perhaps a short period, can hardly be expected to assume responsibility for the policy carried out by those officials. Besides, have not the local authorities already enough to do? Nor has the experience of the Central Government in using other bodies for administrative purposes, such as the Approved Society or Trade Union, justified further experiments in the same direction even with the substitution of the local authority for these bodies.

#### OUTLINE OF THE SCHEME ADVOCATED.

31. Most of the advantages and few of these disadvantages apply to the national administration of Health Insurance.

The scheme advocated is a national system of Health Insurance administered directly by the Ministry of Health. Only an outline sketch need be attempted here. Contributions should be made by the workman, his employer and the State in equal amounts. There should be a flat rate contribution by all workmen, another flat rate for women and another for juveniles. Benefits should be on a flat rate for all workmen, but the needs of families should be provided for as it is to-day in the Unemployment Insurance system. This poll tax, as the means of providing the costs of social insurance is far from being a perfect method of taxation and should be examined in any inquiry into our taxation system as a whole. It is recommended here because it is expedient. Its chief advantages are that it makes it easy to define the class of persons to be insured. It raises money with comparative ease. It avoids the temptation to political parties to compete in raising benefits. To many it gives sense of right to benefit lacking in a non-contributory scheme.

Benefits would be paid through the Post Office or the Employment Exchange. The Ministry of Health would supervise the scheme, appoint the doctors and supervise the payment of the money benefits.

All workmen earning below a certain amount should be insured in the Government scheme. It is desirable to include also persons not under a contract of service whose income is not above £350 a year. This raises a new group of administrative problems, but the time has come to face them. The lower middle class are increasingly demanding services provided for the working classes.

32. A complete organisation of Health Insurance would comprise six departments.

- (1) A department of statistics and research.
- (2) A department for outlining measures for the prevention of hazards and of ill health.
- (3) A department for the development of schemes for the rehabilitation of those who are maimed, incapacitated or disabled.
- (4) A department for dealing with the supplementary staffs, the individuals and officials necessary for administration, such as the doctors, chemists and lawyers.

(5) A department for supervising the distribution of benefits in all cases of illness, accident, old age and death.

(6) A department to supervise the collection of funds and the investment of reserves.

The Health Insurance Organization would have to set up local health insurance offices in every part of the country. Main offices would be necessary in every borough and these should be worked in the same buildings as the Employment Exchanges. Branch offices would be desirable in almost every village or group of villages in the country and these would be worked through the local Post Office. Divisional offices with supervisory powers over the branches in their respective areas would probably be desirable. The whole system of offices should be organised centrally and on a geographical basis.

33. A concession may be made in the case of this compulsory scheme to individual choice provided that abuses are not allowed to creep in. Thus, it is suggested that where any Society of workers with a membership of say twenty-five thousand or more already has an active co-operative existence is now organised on strictly democratic lines, with local and national conferences, which has also purposes and objects additional to providing insurance for its members, which is not run for profit, and where the control is in fact as well as in theory in the hands of its members, and which satisfy the Ministry of Health conditions, are to be recognised for purposes of administration.

The fullest powers of transferring quickly and easily without loss of benefits to the National Fund should always be granted. It should be made quite clear that the essential condition for the recognition of autonomous Societies should be that there is a really vitally alive and interested body of members to whom independence means something, and not as now in the case of bureaucratic centralised Collecting Societies and private Insurance Companies where independence gives a small group of officers and officials, power and influence and the opportunity of speaking in the name of millions of members who are indifferent. The State, not these irresponsible bodies and self-seeking leaders, should act as trustee for the vast majority of easy-going insured members.

34. Let us note some of the main features of the scheme.

The organisation visualised would give great powers to advisory committees representing workmen, employers, doctors, chemists and the general public. One of their functions would be to inspire interest in health questions and in "Safety First," and to carry on by every available means educational campaigns. They would suggest reforms to the Ministry of Health. They would form Courts of Appeal from the decisions of the local officials.

The local representatives of the Ministry of Health would unite with the local health authorities and others interested in the health of the community. A better organisation of medical service would be possible, because the intervention of a group of useless bodies, the Approved Societies, would be eliminated, and the insurance doctors now employed directly by the Ministry of Health would be able to plan the public medical service as a whole.

By adopting the flat rate system we could sweep away a lot of the costly and cumbersome machinery of to-day. Reserve values, contingencies funds, grants from the central and the woman's equalisation fund, could be swept away. The system of transfer values could go. All we should need would be a democratic and representative local body to co-operate with the doctors, and with the local agents of the Central Government appointed to distribute the benefits and prevent fraud.

It is one of the advantages of a State fund that it can be expected to be impartial as between employers' and workers' interests. There is no sound reason why the former should not welcome a State fund for the administration of Workmen's Compensation, nor the latter a State administration of Burial Insurance.

THE CASE AGAINST A GOVERNMENT SCHEME.

35. What are the criticisms recently levelled against a State fund? The Minister must be ready at any time to answer any question that may be raised. It follows that precedent noting is inevitable, records must be kept, delays are incurred in making reference to past decisions, consistency must be purchased at any price. Cumbersome and expensive machinery cannot be avoided. The Minister, it is said, is always on the defensive. He fears to take risks because failure is noted. Everyone plays for safety.

Surely this kind of argument against a modern Government Department is essentially theoretical. The delays are not as great as they are with private Insurance Companies. The number of officials and offices are less. The machine is more efficient. Besides, the Government has all the advantages that result from being able to use compulsion. So long as Old Age Pensions are administered at 3·5 per cent., the Unemployed Insurance scheme at 8 per cent., and the expectation is that the new Pensions Scheme will be administered for 2 per cent., it is flat impudence of Insurance Companies who charge some 40 per cent. for burial insurance and for a decade have had a 50 per cent. administrative expense in Workmen's Compensation to accuse Government Departments of inefficiency.

Applying suitable tests to Government insurance schemes and to semi-private bodies like Approved Societies and to private Insurance Company schemes, we find that the former are administered more cheaply, that the insured member is more certain of his benefit in them, and feels that he is more certain, the security of the fund is greater, and benefit is provided more quickly.

The acid test whether given industries would be more efficiently run under competitive conditions or under State monopoly conditions is sometimes said to be their willingness to make experiments with new devices or to take risks. It suffices then to recall that the principles of insurance business are well known and understood and hardly any improvements of practical significance, excepting further amalgamations, are to be expected. What experiments in Workmen's Compensation Insurance or in Burial Insurance can the private companies attempt? These are not undertakings which involve speculation or require risk. They are not "a venture upon unknown seas."

That "Government funds are a milch cow" is more often asserted than proved. All insurance schemes must work out their methods for preventing malingering. And, where a Government scheme has had time to perfect its machinery as in the case of Old Age Pensions, the charge is not heard.

36. Let us summarize the gains that would result from the adoption of this group of proposals.

- (1) The problems of social emergency resulting from a series of hazards will be made to stand out prominently. When huge sums are seen to be spent annually by one Department in dealing with them it is impossible to believe that the question of their prevention will be ignored or neglected.
- (2) There will result huge administrative saving, not merely because the same machinery

can be used for the different emergencies, but because the present wasteful methods of agencies and competitive companies in tasks for which their organisation is no longer necessary will be eliminated or will be on the road to elimination. The same benefits will be provided more cheaply or extra benefits will be provided at the same premium.

- (3) The workman will have dealings with one body only if he elects to do so for a whole series of emergencies, and in any case with a lesser number of bodies, and he is more likely to know what are his rights and how to claim them and make them effective.
- (4) The existing anomalies, e.g., where industrial diseases are treated by one type of machinery with certain principles of administration, and ordinary ill-health by a different machinery run on other administrative principles, where deaths due to industrial accidents are treated differently from those due to non-industrial accidents, will be abolished or on their way to abolition.
- (5) There will be devoted to this group of questions a Department of State directly responsible for its proper treatment with the full power to make the national policy prevail. At present four Departments of State have limited supervision powers. The Ministry of Health will link together the central and local authorities dealing with these questions.
- (6) When all these branches of Social Insurance are unified under the control of one Department, the larger policy of a comprehensive unified system of Social Insurance will become possible. One card and one stamp for Health and Unemployment Insurance impossible to-day would then be an easy matter. Instead of a mechanical co-operation between the branches of social insurance there would be an organic unity. The ideal which has been slowly maturing during the last twenty years would at last become obvious. The State would be seen to guarantee with the necessary checks, a minimum of security against all emergencies. The State would be regarded as an agency which definitely aided the workman in the periods of his greatest trials.

37. It may be that the vision held out of a State guarantee in case of all emergencies in the life of the workman's family of which these recommendations constitute a substantial part, will seem to some a programme for a decade or two ahead. They should not forget that if in 1908 it had been said that in the year 1924 we shall be spending on the various branches of Social Insurance some one hundred and fifty million pounds, besides seventy millions on War Pensions it would have sounded incredible. It is true that some day the movement for Social Insurance will accomplish its main functions and continue at a slower pace, but for the next generation at any rate statesmen of all parties will be looking for policies and searching for programmes. Let us hope that in the proposals of this Royal Commission they will find at least the outline of a policy which will guide them for many years. It has the opportunity of making a historical report.



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