

ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

APPENDIX

TO

MINUTES OF EVIDENCE

TAKEN BEFORE THE

ROYAL COMMISSION ON NATIONAL HEALTH
INSURANCE.

PART II.

Statements submitted by certain Approved Societies, Insurance Committees,
Dental Societies, Representative Bodies, etc.



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ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

APPENDIX IV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE HEARTS OF OAK BENEFIT SOCIETY BY MR. HEZEKIAH DUDLEY, CHAIRMAN, EXECUTIVE COUNCIL, AND MR. JAMES PRITCHARD LEWIS, C.A. (SECRETARY). See Minutes of Evidence of the Sixth, Seventh and Eighth Days, Questions 2544 to 3787, and of the Fifteenth Day, Questions 7394 to 7449. For Table of Contents see paragraph 12 below.

PREAMBLE.

1. Persons giving evidence:—

HEZEKIAH DUDLEY, Chairman of the Executive Council of the Hearts of Oak Benefit Society. (Has been a member of the said Council for the past 10 years and has been actively engaged in the administration of National Health Insurance since the inception of the Act).

JAMES PRITCHARD LEWIS, C.A., Secretary of the Hearts of Oak Benefit Society. (Has held this position for the past eight years; has been actively engaged in the administration of National Health Insurance since the inception of the National Health Insurance Act, 1911; and is a Chartered Accountant, being a member of the Institute of Accountants and Actuaries in Glasgow).

2. Witnesses will state that the evidence they submit is on behalf of the Hearts of Oak Benefit Society, brief particulars of which are shown hereunder.

PARTICULARS OF SOCIETY.

3. The Society was approved by the National Health Insurance Joint Committee on the 7th June, 1912, to transact National Health Insurance business in England, Scotland, Ireland and Wales.

4. Its affairs are conducted under central administration, but approximately 80 per cent. of the membership receive their benefits through the medium of 382 agents resident in the principal towns in England and Wales.

5. The membership of the Society at 31st December, 1923, was as follows:—

Country.	Men.	Women.	Total.
England	295,927	95,730	391,657
Scotland	2,593	712	3,305
Northern Ireland	206	100	306
Wales	34,098	4,041	38,139
Totals	332,824	100,583	433,407

6. The amount disbursed by the Society in cash benefits in accordance with the provisions of the National Health Insurance Act for the year 1923 was as follows:—

	£	s.	d.
Men	350,227	6	0
Women	92,007	11	10
Total	442,234	17	10

7. The amount disbursed by the Society for the provision of medical treatment and attendance to

its insured members for the year 1923 was as follows:—

	£	s.	d.
Men	150,864	9	3
Women	45,861	18	8
Total	196,226	7	11

8. The total amount invested by the Society in Trustee Securities at 31st December, 1923, was as follows:—

	Nominal.			Cost.		
	£	s.	d.	£	s.	d.
Men	1,607,431	4	1	1,320,054	12	9
Women	370,843	11	4	303,077	10	4
Total	1,978,274	15	5	1,623,132	3	1

9. The total amount of invested funds held on behalf of the society by the Minister of Health at 31st December, 1923, was:—

	£
Men	1,053,383
Women	292,601
Total	1,345,984

10. The result of the valuation of the Society at 31st December, 1918, as certified by the Government Actuary, disclosed:—

A gross surplus amounting to ... £728,304
A disposable surplus amounting to £480,164

11. The additional benefits granted by the Society as a result of the above surplus for the period July, 1921, to July, 1926, are as follows:—

	Men.		Women.	
	Per week.	Per week.	Per week.	Per week.
Sickness Benefit	3	0	2	6
Disablement Benefit	1	6	1	3
Maternity Benefit	6	0	5	0

Assistance towards the cost of dental treatment for members medically certified to be suffering from a complaint attributable to the condition of the teeth and necessitating urgent dental treatment.

SUMMARY OF MATTERS UPON WHICH EVIDENCE IS TENDERED.

12. The matters upon which evidence is hereinafter submitted are as follows:—

I.—Persons included in the Scheme.

Witnesses will advocate the provision of medical benefit to the dependents of insured persons (paragraphs 13 to 53).

II.—The Money Benefits. Penalties for Arrears of Contributions.

Witnesses will advocate:—

- (1) The continuance of the existing scheme of arrears, subject to a reduction in the number of scales now in force (paragraphs 53 to 58).
- (2) The amendment of the existing penalty applicable to the late surrender of contribution cards (paragraphs 59 to 67).
- (3) The amendment of the regulations applicable to the granting of "Free credit" of contributions (paragraphs 68 to 74).
- (4) The amendment of the provisions of the Prolongation of Insurance Act (paragraphs 75 to 88).

III.—Special Provisions for Particular Classes of Insured Persons.

Witnesses will advocate:—

- (1) The abolition of deposit contributors (paragraphs 89 to 107).
- (2) The amendment of the Act in its application to married women (paragraphs 108 to 128).
- (3) The amendment of the Act relating to re-qualification for Disablement Benefit of Discharged Sailors, Soldiers and Airmen in receipt of a 100 per cent. pension (paragraphs 129 to 133).
- (4) The amendment of the Act relating to the insurance of members of Approved Societies who join His Majesty's Forces (paragraphs 134 to 143).

IV.—Administration of Money Benefits. Approved Societies.

Witnesses will advocate:—

- (1) The limitation of additional cash benefits (paragraphs 144 to 157).
- (2) The amendment of the Act relating to the payment of benefits to persons whilst inpatients of hospitals (paragraphs 158 to 173).
- (3) The adjustment and re-allocation of the existing Benefit, Contribution and Financial years (paragraphs 174 to 185).
- (4) The limitation of cash benefits payable to insured persons whilst resident abroad (paragraphs 186 to 194).
- (5) The abolition of record cards (paragraphs 195 to 206).
- (6) The amendment of the regulations to provide some measure of finality in regard to evidence of incapacity (paragraphs 207 to 214).
- (7) The abolition of the dissection of statistics between the respective countries by Approved Societies not nationally valued (paragraphs 215 to 221).
- (8) The amendment of the existing procedure relating to transfers of membership between societies (paragraphs 222 to 226).
- (9) The amendment of the present procedure relating to contributions paid during sickness; adjustments of contributions, and the preparation of contribution returns (paragraphs 227 to 239).

V.—Content of Medical Benefit. Other "Treatment" Benefits.

Witnesses will advocate:—

- (1) The inclusion, as a part of the existing "General Practitioner" Service, of medical attention and treatment at confinements and all illnesses arising therefrom (paragraphs 240 to 249).
- (2) The inclusion of a "Specialist" Medical Service as a part of the medical benefit provided by the Act (paragraphs 250 to 254).

- (3) The inclusion of dental benefit as a statutory benefit under the Act (paragraphs 255 to 284).

VI.—Administration of Medical Benefit. Insurance Committees.

Witnesses will advocate:—

- (1) The retention of Insurance Committees (paragraphs 285 to 293).
- (2) The administration by Insurance Committees of the benefits applicable to insured persons attaining the age of 70 years (paragraphs 294 to 297).
- (3) The retention and extension of the Central Index Committees (paragraphs 298 to 306).

VII.—Finance. Audit. Valuation.

Witnesses will advocate:—

- (1) The amendment of the Act relating to monies available for investment (paragraphs 307 to 319).
- (2) The diversion to hospitals of that portion of the General Medical Benefit Fund applicable to insured persons who fail to select a panel doctor within a reasonable period (paragraphs 320 to 326).
- (3) The retention by each society of any surplus disclosed upon a valuation except in certain specified instances (paragraphs 327 to 332).
- (4) The retention of the existing waiting period for qualification to participate in "additional" benefits (paragraphs 333 to 339).
- (5) The amendment of the Regulations to provide for the capitalisation of administration expenses (paragraphs 340 to 344).

VIII.—Miscellaneous.

Witnesses will advocate:—

- (1) The extension of the powers of the Minister of Health to deal with mal-administered societies (paragraphs 345 to 346).
- (2) The standardisation of the procedure relating to appeals by insured persons (paragraphs 347 to 351).

EVIDENCE.

I.—PROVISION OF MEDICAL BENEFIT TO THE DEPENDENTS OF INSURED PERSONS.

13. In order to maintain, or improve, the general health conditions applicable to a community of over 40,000,000 individuals, it is contended that there must, of necessity, be some measure of co-operation between all concerned for making the necessary provision in the event of sickness or invalidity. Otherwise any efforts made in this direction by one section alone can only be nullified by the inaction or inability of the other section to do likewise.

14. Prior to 1911 it was entirely optional among the whole population as to whether or not this provision should be made; and it is suggested that by reason of the fact that a considerable proportion of the population showed either apathy or inability in this direction some measure of compulsion was introduced to meet the case of those persons who either could not, or would not, take the necessary precautions of their own free will. This measure of compulsion was accordingly embodied in the National Health Insurance Act of 1911, which, it is important to note, provided not only for periodical payments during sickness, but was also designed as a measure for the prevention of sickness. Although there can be no doubt that the disbursement of periodical sums to persons who are sick must materially assist in the amelioration of suffering and a recovery to health, it is suggested that the other object—and in the opinion of the Witnesses the major object—for which the National Health Insurance Act was brought into being, viz., the prevention of sickness, has not, unfortunately, received that measure of consideration during the past 10 years which it deserved.

15. A study of the National Health Insurance Act will clearly show that the promoters of the measure drew a clear line of demarcation between:—

- (1) Those persons who were exposed to abnormal risks of sickness by reason of their occupation.
- (2) Those persons whose financial position was such as to enable them to make provision themselves in case of sickness.
- (3) Those persons who were financially unable to take the necessary precautions.

16. The first class referred to above has reference to manual workers, in respect of whom the Act stipulates that they should be parties to a compulsory scheme, irrespective of their earning capacity.

17. With regard to the last two classes, it was apparently considered in 1911 that, in the case of non-manual workers, an income of £160 per annum or more was sufficient to enable the average individual to make the necessary provision against loss of health, without being brought within the confines of a compulsory scheme. Owing, however, to the general increase in prices as a result of the Great War, a special enactment was passed in 1919 increasing the income limit from £160 to £250 per annum, at which figure it stands to-day.

18. In these circumstances, therefore, it is contended that a reasonable interpretation of the National Health Insurance Act in its existing form is that whilst the non-manual worker in receipt of more than £250 per annum is regarded as being in a position which should enable him to make his own provision in case of sickness, the individual with a lesser income is unable to take this course, and consequently needs the financial assistance of his employer and the State to attain this end.

19. Had this line of demarcation in respect of non-manual workers been carried out to the letter, the objects of a national scheme of insurance would undoubtedly have been attained, but it is submitted that unfortunately such is not the case. Whilst on the one hand those who are regarded as being in a position to make their own provision are definitely prohibited from coming under the scheme, only a portion of those who are regarded as being unable to make the necessary provision are brought within the confines of the National Health Insurance Act.

20. It is contended that the Act in its present form makes three separate distinctions in regard to the latter class of persons, viz.:—

- (1) Those who are earning less than £250 per annum, but in addition are the recipients of a private income, or mainly dependent upon others.
- (2) Those who are earning less than £250 per annum, not supplemented by private income, and not dependent upon others.
- (3) Those who are not earning at all, and absolutely dependent upon the earnings of others.

21. In order that the true position may be fully realised, it is considered that the position of the individuals coming under the above headings respectively should be carefully analysed in so far as their position is concerned regarding their ability or inability to make provision against sickness.

22. With regard to the first class, the Act provides that if an individual is earning a salary of, say, £240 per annum, in addition to which he is in receipt of a private income of 10s. per week or more, such an one may claim to be exempted from the provisions of the Act, presumably on the ground that he is not financially unable to make his own provision against sickness.

23. It is admitted that there are other circumstances in which an individual may claim to remain outside the provisions of the Act, and according to the Fifth Annual Report of the Ministry of Health for the years 1923-1924, there were, on the 1st April, 1924, 33,225 such persons holding certificates of exemption.

24. It is desired to emphasise at this stage the following facts. Firstly, notwithstanding that for

one reason or another such individuals are considered to be in a position to provide for their own medical treatment if required, and secondly that they themselves have expressed a definite desire not to participate in the benefits under the National Insurance Act, yet the law deliberately thrusts medical attention and treatment upon them free of cost.

25. With regard to the second class referred to above, viz., the person who is earning, say, £200 per annum, not supplemented by a private income, such an individual was not given the option of remaining outside the Act if he so desired, but is required to make some payment towards the cost of providing medical treatment and attention if, and when, desired.

26. Concerning the last class of person, i.e., the individual who is in receipt of no income whatever, but is entirely dependent upon others, notwithstanding that such a person is absolutely powerless to make any financial provision towards the cost of medical treatment, no assistance whatever is forthcoming in such a case under the provisions of the National Health Insurance Act.

27. It is contended that it is difficult to justify—in fact, it is impossible to justify—any measure which has for its primary object the prevention of sickness, but which provides firstly, that the individual in the best financial position is entitled to medical benefit free of cost; secondly, that the individual with a lesser income is required to bear a proportion of the cost of treatment; and thirdly, the person with no income whatever, and entirely dependent upon others, is required to provide the whole cost of any medical attention and treatment that may be required.

28. If it be conceded that the imposition of an income limit of £250 per annum is the line of demarcation between those who can and those who cannot provide their own medical attention, it is contended that if the individual in receipt of less than £250 per annum needs the financial support of his employer and the State to provide for his own needs, then it is difficult to see how such a person can possibly be expected to bear the whole cost of treatment rendered to those who are dependent upon him.

29. The inability on the part of the insured person to provide the necessary financial assistance for the proper medical attention of his dependents (which must be the case if such a person requires the assistance of his employer and the State to provide for himself), coupled with the absence of means on the part of the dependent, can only lead to one end—the lack of proper and sufficient medical attention, which in its trail must bring about the protraction or intensification of the disease (or even both), and consequently a continuance and accentuation of the suffering by the patient.

30. There can be no doubt that a considerable amount of unnecessary sickness and suffering exists among the dependents of insured persons owing to the services of a medical practitioner not being sought in the early stages of the complaint, due to financial reasons.

31. This state of affairs must necessarily result in worry, anxiety and even malnutrition to the insured person, and nullify to no small degree any benefits he himself may have derived under the provisions of the Act.

32. Further it is suggested that the extension of the existing medical service to the dependents of insured persons would have a far-reaching and beneficial effect upon the future financial aspect of National Health Insurance. The children of insured persons are to a very large extent the insured persons of the future, and securing for them efficient medical attention from birth would undoubtedly result in their reaching the age of employment and insurance in a much improved standard of physical efficiency, with a subsequent favourable influence upon the disbursement of sickness and other benefits in the future.

33. Again, the inclusion of the children of insured persons within the scope of the medical service would undoubtedly prevent many a serious error in the choice of occupation. It must be admitted that many a boy or girl has been handicapped throughout life by entering into work for which they are physically unfitted, and in the opinion of the Witnesses a thoroughly efficient and wisely administered medical service would, by judicious counsel, enable parents to decide more fittingly such matters, especially in the case of permanent physical disability.

34. Not only the injustice, but the inconsistency in regard to the existing medical service provided under the National Health Insurance Act, will be all the more apparent when it is remembered that although the scheme laid down by the Act is alleged to be a national one in regard to persons coming under a defined wage limit, in actual practice it only affects approximately 15,000,000, and fails to touch 20,000,000, leaving the majority dependent upon the minority, who, as pointed out above, are themselves unable to provide for their own welfare.

35. Witnesses are of the opinion that the matter is one which calls for serious reflection, in view of the fact that in any national scheme designed to prevent and cure sickness, due consideration must be given to the preservation of, and improvement in, the health of the whole of the population who are unable to provide for themselves, and not confined to 15,000,000 only out of a possible total of 35,000,000.

36. For the above reasons, therefore, Witnesses advocate that the "General Practitioner" service now available to insured persons should be extended to embrace the dependents of such persons.

37. In this connection it is desired to point out that the fact has not been lost sight of that such a benefit may be given by Approved Societies in the form of an "additional" benefit under the Act.

38. If it be agreed that the dependents of insured persons (both men and women) number approximately 20,000,000, and that the cost of medical benefit is approximately 2½d. per week, on a basis of 48 weeks in the year, the cost of providing this benefit will amount to approximately £10,000,000 per annum. As, however, the total disposable surplus of all societies as a result of the valuations at 31st December, 1918, amounted to only £9,000,000, it will be apparent that the inclusion of such a benefit under the Act in the category of an "additional" benefit is impracticable. For this reason, therefore, if such a benefit is to be conceded, it must of necessity be included as one of the statutory benefits of the Act.

39. In advocating the adoption of such a measure, it may be argued that such a course is foreign to the principles of the existing National Health Insurance scheme, but it is contended that such is not the case; in fact a precedent can be cited in support of the proposition. In accordance with Sub-section 6 of Section 14 of the National Health Insurance Act, 1924, it is provided that "Maternity benefit shall in every case be the mother's benefit. . . ." If, therefore, the payment of maternity benefit out of the National Health Insurance Fund is made in respect of the insurance of an insured man, but is to be regarded as the benefit of the wife, who may not herself be insured, it is contended that such a course establishes the principle of making the benefits of the Act available not only to the insured person, as would be the case if the woman herself were an insured person, but also to the dependents of an insured person, as would be the case if the woman were not insurable under the Act, but received the benefit in respect of her husband's insurance.

40. Accordingly, if the Act in its present form acknowledges the principle of maternity benefit to the dependents of insured persons, then there seems little justification for withholding the provision of proper and sufficient medical treatment and attention to the same individuals.

41. Whilst advocating the extension of the "General Practitioner" service on the lines sug-

gested, Witnesses fully appreciate that due consideration must be given to the financial aspect of the case.

42. As stated above, it is suggested that to carry out the proposals put forward would entail an annual expenditure of a sum in the vicinity of £10,000,000, which, in the opinion of the Witnesses, could only be obtained from the following sources:—

- (1) Surpluses disclosed upon valuations of Approved Societies.
- (2) A contribution payable by the dependents of insured persons themselves.
- (3) An increased contribution payable by the existing insured persons.

43. With regard to the first method, it is considered that the appropriation of surpluses of Approved Societies for this purpose could not be utilised in any better form if it were possible to provide the whole of the cost required. If, however, the utilisation of surpluses will not dispense with the imposition of a contribution either on the dependent or the insured person, then, in the opinion of the Witnesses, it is considered that it would be a better policy to raise the whole of the funds required by means of contributions, and retain the surpluses in their entirety for the provision of such "additional" benefits in kind as may be required for the general betterment of the health of the community, e.g., nursing, dental, optical, convalescent homes, &c., and which could be provided without an increased contribution.

44. In view of the fact, however, that the whole of the surpluses of Approved Societies at the last valuation were insufficient to provide the benefit advocated for a period of even one year, there appears to be no alternative but to raise the funds required by one or other of the remaining methods set out above.

45. With regard to the proposal to impose a contribution upon the dependents themselves for the provision of medical benefit, it is submitted that a weekly contribution of 2½d. would be necessary for this purpose, on an average number of 48 contributions per year.

46. In view of the fact that the persons concerned are at present required to be treated by the doctor in the capacity of a private patient when necessary, it is urged that the sum of 10s. per annum cannot under existing conditions go very far to meet the charges of the doctor in the case of a serious or protracted illness of an insured person's wife or family. If, therefore, free medical attention for the insured person's wife could be obtained by the payment of 10s. per annum, it is suggested that little or no opposition would be forthcoming to the payment of such a sum in view of the doctor's charges for attendance upon the individual as a private patient.

47. Against the above, however, due weight must be given to the administrative difficulties which are likely to arise from the payment of different contributions by the insured person and his dependents respectively, in return for which medical benefit only is provided in one case, whilst medical benefit and cash benefits are provided in the other.

48. Whilst Witnesses fully recognise that such difficulties will undoubtedly arise in the direction quoted above and also as to who is to be deemed to be a dependent, they are of the opinion that such will not be of an insurmountable character.

49. With regard to the last source of obtaining the necessary revenue, i.e., an increase in the existing rates of contribution applicable to insured persons, in view of the fact that in the majority of cases the cost of the contribution, whichever method be applied, will require to be borne by the insured person, it is recommended that it would be preferable to adopt a uniform increase in contributions applicable to all at present within the scope of the National Health Insurance Act, which would undoubtedly overcome the administrative difficulties outlined above.

50. At first sight it may appear that such a course would be inequitable to the insured person who has

no dependents, and that objections would be raised from this source if such a one were called upon to contribute towards the dependents of his neighbour. Witnesses desire to state, however, that such a measure is already adopted in regard to the provision of maternity benefit inasmuch as the funds required for the provision of this benefit are derived from the contributions of all insured persons, and not restricted to those to whom the benefit applies.

51. With regard to the financial aspect of the question, therefore, Witnesses are of the opinion that the necessary funds should be obtained from a uniform increase of contributions of all insured persons rather than the institution of a contribution payable only by the dependents of insured persons. Further, it is urged, that as the surpluses of Approved Societies cannot possibly prevent the imposition of a contribution in some shape or form, no part of this fund should be used for a purpose which can only result in diminishing the provision of other benefits which are urgently needed for the health of the insured population.

SUMMARY OF CONCLUSIONS.

52. Witnesses are accordingly of the opinion:—

- (1) That the inclusion of the dependents of insured persons under the National Health Insurance Act, in so far as medical benefit is concerned, is a necessity for the betterment of the health of the community as a whole.
- (2) That an increase should be made in the contributions payable by insured persons for the provision of this benefit.
- (3) That a person who is unable to make the necessary provision against sickness and invalidity for his own need cannot possibly make the necessary provision for his wife and family.
- (4) That it is unjustifiable to offer free medical attention to an individual who has deliberately asked to be relieved of the benefits of the Act, and debar the benefit to an individual who is dependent upon another, and in urgent need of it.
- (5) That it is against the interests of public health to provide medical treatment for 15,000,000 persons, whilst leaving 20,000,000 persons who are in a worse financial position to their own devices.
- (6) That medical benefit should not be available to persons who have applied for, and obtained, a certificate of exemption from the provisions of the Act, but that the contributions paid in respect of such persons by their employers should be applied towards the cost of providing medical benefit to the dependents of insured persons.

II.—(1) THE CONTINUANCE OF THE EXISTING SCHEME OF ARREARS SUBJECT TO A REDUCTION IN THE NUMBER OF SCALES NOW IN FORCE.

53. Regulations have been made providing for the reduction or suspension of sickness, disablement and maternity benefits in the case of insured persons who incur arrears of contributions, and for the necessary payments to enable such persons to become qualified for normal benefits.

54. At the present time the principle of the scheme is to regulate the benefits payable in a benefit year upon the contributions and arrears paid in respect of the preceding contribution year, and although Witnesses are of the opinion that such a scheme presents no great difficulty in its application as a whole, they nevertheless consider that some modification is desired in regard to the various categories in which insured persons in arrears are placed.

55. The existing arrears scales provide for different rates of benefit applicable to employed and voluntary contributors respectively. Under each of these heads, varying scales are again provided for men and women.

Again, it is necessary to subdivide those persons who are, and those who are not, entitled to any additional cash benefits provided by the society, whilst finally each of these divisions is again required to be subdivided in regard to persons who have paid either less, or more, than 104 contributions.

56. Excluding the normal rates of benefits, the result of the creation of all the subdivisions above referred to necessitates in the case of the Society which Witnesses represent, no less than 144 classes applicable to the various circumstances in respect of insured persons who are in arrear. Notwithstanding the creation of 144 categories, as stated above, there are only 36 different amounts involved in the case of this Society.

57. It will be appreciated, therefore, that one rate of benefit can apply to varying types of insured persons in arrear. In this connection it is desired to point out that although the rate of 17s. can only apply to one type of contributor, the rate of 7s. 6d. is made applicable in no less than 13 different circumstances. In order that this point may be fully appreciated, the following shows the varying circumstances which apply to the members of this Society, each of whom is entitled to receive benefit at the rate of 7s. 6d.:—

- (1) Disablement benefit to an employed contributor (man) who has paid between 39 and 41 contributions and is entitled to additional benefits.
- (2) Sickness benefit to an employed contributor (man) who has paid between 17 and 25 contributions, resident in Ireland, entitled to additional benefits, and has paid less than 104 contributions in total.
- (3) Sickness benefit to an employed contributor (man) who has paid between 39 and 41 contributions, not entitled to additional benefits, and has paid less than 104 contributions in total.
- (4) Disablement benefit to a man who has paid between 48 and 52 contributions and not entitled to additional benefits.
- (5) Sickness benefit to an employed contributor (woman) who has paid between 17 and 25 contributions, is resident in Ireland, entitled to additional benefits and has made more than 104 contributions in total.
- (6) Sickness benefit to an employed contributor (woman) who has paid between 33 and 35 contributions, entitled to additional benefits, and has paid less than 104 contributions in total.
- (7) Sickness benefit to an employed contributor (woman) who has paid between 48 and 52 contributions, not entitled to additional benefits, and has paid less than 104 contributions in total.
- (8) Disablement benefit to an employed contributor (woman) who has paid between 48 and 52 contributions, and not entitled to additional benefits.
- (9) Disablement benefit to a voluntary contributor (man) who has paid 46 or 47 contributions, and entitled to additional benefits.
- (10) Sickness benefit to a voluntary contributor (man) who has paid between 39 and 41 contributions and not entitled to additional benefits.
- (11) Disablement benefit to a voluntary contributor (man) who has paid between 50 and 52 contributions and not entitled to additional benefits.
- (12) Sickness benefit to a voluntary contributor (woman) who has paid between 34 and 38 contributions, resident in Ireland, and entitled to additional benefits.
- (13) Disablement benefit to a voluntary contributor (woman) who has paid between 50 and 52 contributions and not entitled to additional benefits.

58. Having regard to the above, it is necessary for the position of every claimant for benefit to be

carefully reviewed before the rate of benefit can be assessed, and in view of the meticulous methods adopted by the Government Auditors in the examination of benefit claims, Witnesses are of the opinion that the scale of arrears should be materially modified so as to provide a considerably smaller number of rates of benefit, and a greater degree of uniformity in those rates, which will have the effect of considerably reducing the work thrown upon Approved Societies in the assessing of benefit claims, and adding in no little measure to the degree of efficiency.

II.—(2) THE AMENDMENT OF THE EXISTING PENALTY APPLICABLE TO THE LATE SURRENDER OF CONTRIBUTION CARDS.

59. Section 15, Sub-section (1) of the National Health Insurance Act, 1924, empowers the Minister of Health to make regulations in respect of the recalculation of arrears, and the subsequent readjustment of the rate of benefit, where a stamped contribution card in respect of any contribution year is surrendered after the expiration of the period of grace.

60. Under the Arrears Amendment Regulations, 1923, the Minister may exercise special powers given him thereunder to vary the operation of Article 17 of the Arrears Regulations, which provides that the rate of benefit shall not be adjusted until after the expiration of four weeks from the receipt of a belated contribution card.

61. This period of four weeks may involve a possible loss of maternity benefit of £2, which in the opinion of the Witnesses is too severe a penalty for the offence. Such a loss, however, would not occur unless the date of confinement occurred before the expiration of the four weeks after the surrender of the card.

62. In these circumstances, it will be seen that if the woman herself is not an insured person she will be the sufferer by reason of her husband's omission to surrender a contribution card, and it is contended that this is inconsistent with the provisions of Section 14 (6) of the National Health Insurance Act, 1924, which provides that maternity benefit shall in every case be the mother's benefit.

63. With regard to the loss of sickness or disablement benefit, it is desired to state that this is not proportionate in all cases, but is dependent according to the amount of benefit to which the member would otherwise have been entitled.

64. Whilst it is admitted that there should be some penalty imposed for the omission, it is nevertheless contended that it is inequitable to make a greater penalty in the case of a member receiving sickness benefit than that applicable to a member entitled to disablement benefit only.

65. It has been pointed out that the Minister of Health may, if he so desires, allow the revision of the rate of benefit to take effect from a date earlier than four weeks from the date of the surrender of the card. This provision, although allowing of special treatment in necessitous cases, also permits of that type of insured person whose practice it is to appeal to the Minister of Health against all decisions of his Approved Society, who are acting strictly in accordance with the regulations, to obtain preferential treatment over the insured person who is willing to abide loyally by the decision of his society.

66. Witnesses therefore contend that where a claim is the first intimation of the loss of a stamped card, or is instrumental in the surrender of a late card, a uniform penalty of 10s. shall be imposed by way of a penalty for the offence. Further, subject to the verification of the card having been legitimately stamped, and subject to the contributions thereon permitting of reinstatement to benefit, the suspension of maternity benefit should be removed to enable Approved Societies to pay the claim, and in other cases for reinstatement to sickness or disablement benefit being effected from the date the contribution card is surrendered to the Approved Society or the Minister of Health.

67. Witnesses are further of the opinion that the fine of 10s. referred to above should not be one deductible by the society from the member, but should be recoverable out of any benefit payable to the member during the current benefit year.

II.—(3) THE AMENDMENT OF THE REGULATIONS APPLICABLE TO THE GRANTING OF "FREE CREDIT" OF CONTRIBUTIONS.

68. In determining the rates of benefit payable under the Act due regard was undoubtedly had to the fact that a certain loss of revenue would occur in consequence of the non-payment of contributions arising through unemployment, but such a calculation must have been based on normal conditions.

69. Owing to the acute and prolonged state of unemployment among the insured population, measures were introduced in 1921, and periodically renewed since that date, for the crediting of free contributions to those insured persons whose contributions have been depleted on account of trade depression. The effect of such regulations is to regard an employed contributor who has paid less than 26 contributions in a contribution year as though 26 contributions had been paid for the purpose of calculating his arrears, subject to certain qualifying tests. The fact of desmising 26 contributions as having been paid obviously has the effect of removing any suspension from benefits, and providing title to the insured person concerned to the minimum benefits of the Act during the succeeding benefit year, at the same time reserving to the member his right, if he so desires, to establish his title to full benefits by the payment of the remainder of the arrears penalty himself.

70. In respect of each person who comes under these provisions, societies are recouped by the Minister of Health to the extent of 5s. for a man and 4s. for a woman. The position, therefore, is that, whilst for the payment quoted above, societies are accepting liability for the payment of the minimum benefits of the Act, they are normally losing contributions to the extent of £1 1s. 8d. for a man, and 19s. 6d. for a woman, which was undoubtedly not allowed for in the original actuarial calculations.

71. By reason of the fact that this provision has been in operation for the last four years, there are cases in the Society which Witnesses represent where no contributions whatever have been paid by an insured person for some years, but such persons have been entitled to receive—in fact do receive—the minimum benefits of the Act in return for a payment of 5s. or 4s. per annum by the Minister of Health.

72. It is contended that as the original calculations in determining the rate of contributions payable by an insured person only provided for normal conditions of unemployment, the granting of free contributions to insured persons for a protracted period, although beneficial to the individuals concerned, must have an adverse effect upon the finances of Approved Societies. Consequently Witnesses are of the opinion that the time has arrived when this aspect of this question should receive careful consideration.

73. A condition to the granting of free contributions is that the insured person should satisfy a contribution test. These tests are not only varied according to the date of entry of the insured person, but are also of a complicated nature, and in view of the fact that they have reference to the insured person's position in the year 1918, it is claimed that they are also antiquated.

74. Witnesses are therefore of the opinion that whilst some measure of relief should be extended to insured persons during the continued industrial depression, a simplification is required in the contribution tests now in operation, and that in view of the continued liability which societies have borne in this direction since 1921, serious consideration should be given to the financial aspect of the question.

II.—(4) THE AMENDMENT OF THE PROVISIONS OF THE PROLONGATION OF INSURANCE ACT.

75. This subject is closely allied to that applicable to the granting of "Free Credit" of contributions, and upon which evidence has already been tendered.

76. The Prolongation of Insurance Act provides that a person who is unemployed shall be kept in insurance beyond the normal period of 12 months provided he has not been unemployed by reason of having entered upon a non-insurable occupation. His title to remain in insurance is also dependent upon a certain number of contributions having been paid as under:—

- (1) 80 contributions in respect of the two years ending 4th July, 1920; or
- (2) if the date of entry was after 1st July, 1918:—
 - (a) three-quarters of the possible number of contributions from date of entry to 31st December, 1920; or
 - (b) three-quarters of the possible number of contributions from date of entry to date of ceasing to be employed.

77. The Act was originally to operate from 31st December, 1920, until 31st December, 1922, but its life has been extended annually under the Expiring Laws Continuance Act until 31st December, 1925.

78. Notwithstanding the extension of the operation of the Prolongation of Insurance Act, the contribution test remains unaltered, with the result that a person who has not made any contributions since the week commencing 5th January, 1920, is still regarded as an insured person and entitled to benefits provided he has not taken up non-insurable employment in the interval.

79. The contribution test which has been imposed, however, is considered to be antiquated, and if a contribution test is considered necessary, it is urged that it should be materially simplified, and be one which can be applied to all contributors, irrespective of their dates of entry into insurance.

80. The test at present is one which may, and in fact does, act unfairly as between various insured persons.

81. With regard to a person who has contributed each week to National Health Insurance from 15th July, 1912, to November, 1919, and had a period of unemployment from November, 1919, to August, 1920, but resumes insurable employment in August, 1920, and contributes regularly until July, 1923, when he again becomes unemployed, such a person is not entitled to prolongation of insurance by reason of his not having made the required 80 contributions in respect of the two years ending 4th July, 1920.

82. In the case, however, of a person who enters insurance on 4th July, 1921, and continues in employment until 10th July, 1922 only, such a member is entitled to the privileges of the Prolongation of Insurance Act, as three-quarters of the possible number of contributions have been received from the date of his entry into insurance to the date of ceasing to be employed.

83. It will be seen from the above that whilst the individual who has contributed less than 60 contributions under the National Health Insurance Act becomes entitled to the special provisions applicable to prolongation of insurance, the individual who has paid contributions in the vicinity of 500 is debarred from receiving any benefit in this direction by reason of not being able to fulfil the necessary contribution test.

84. With regard to its application to married women, under the National Health Insurance Act, a woman who marries, and, within 12 months of the date of marriage has eight consecutive weeks of unemployment, is suspended from the ordinary benefits of the Act, and becomes entitled to special lower rates of benefit. The operation of the Prolongation of Insurance Act, however, nullifies this transfer from the ordinary to the special rates of benefit in the case of a woman who can show that she did not

voluntarily cease work, and has been available for, but unable to obtain, employment. In such cases there is no contribution test, with the result that a newly-married woman who, under the National Health Insurance Act would normally be entitled only to the special lower rates of benefit, is empowered under the provisions of the Prolongation of Insurance Act to remain entitled to the ordinary benefits of the Act. In these circumstances it then becomes necessary to regard her as an ordinary insured person, entitled to receive advantage from the Prolongation of Insurance Act by an extension of the free year of insurance, and the contribution test referred to previously has to be applied.

85. As, however, the conditions relating to the employment of married women differ from those applicable to unmarried women, it is the experience of this Society that a married woman who remains subject to the normal conditions of the Act instead of the special provisions applicable to married women, is not infrequently unable to fulfil the contribution test applicable to an ordinary employed contributor through lack of employment. This being the case, the insurance of such a woman will naturally cease at the expiration of the normal free year of insurance.

86. It will be seen, therefore, that the application of the Prolongation of Insurance Act in regard to newly-married women is not only complicated in its application, but may also mean that a woman will be entitled to receive sickness benefit at the rate of 12s. a week without any limitation during her free year of insurance instead of the special rate of 7s. 6d. per week for six weeks; but, on the other hand, would only be entitled to maternity benefit until the expiration of her free year instead of during the two years after marriage if she had been transferred in the ordinary way.

87. Witnesses desire to suggest that although some measure of consideration should be given to persons whose contributions are materially depleted on account of unemployment, nevertheless in view of the fact that it is possible for a person's insurance to have already been extended four years under these provisions, some maximum should be placed upon the length of time that benefit can be obtained thereunder.

88. Witnesses are accordingly of the opinion:—

- (1) That the Prolongation of Insurance Act should be amended to provide for the extension of the insurance of an insured person by not more than one year after the termination of the normal free year.
- (2) That if it be considered necessary to institute a contribution test, such test should be made applicable to all contributors, irrespective of the date of entry into insurance, and brought up to date.
- (3) That the Act should be amended to provide for simplification in its application to married women.

III.—(1) THE ABOLITION OF DEPOSIT CONTRIBUTORS.

89. In any scheme of National Health Insurance it is admitted that there must be a certain percentage of individuals who, whilst complying with the law in so far as it affects them, possess objections, either real or imaginary, to the scheme itself, and refuse to take advantage of any benefits to which they may be entitled. Such a state of affairs was apparently anticipated in the introduction of the National Health Insurance Act, inasmuch as special provisions were made for dealing with this class of person.

90. On the other hand, it was apparently anticipated that the creation of the provisions dealing with deposit contributors would only be of a temporary nature, by reason of the fact that it was designed to operate only until 1st January, 1915. No action, however, has been taken to terminate definitely this class of insured person, but on the contrary, the special conditions applicable thereto have, from time to time, been extended under the Expiring Laws Continuance Act, whilst under

Section 54 of the National Health Insurance Act, 1924, the preservation of this class of insured person is assured until 31st December, 1925.

91. Whilst there may have been good grounds in the initial stages for making special provisions for persons who either could not, or would not, join an Approved Society within the prescribed time, Witnesses are of the opinion that the time has now arrived for the abolition of provisions which were only intended in 1911 to be of a temporary character.

92. In the Fifth Annual Report of the Ministry of Health it is stated that for the year 1923 there were 237,000 persons coming within this category, as compared with 272,000 for the year 1914, from which it will be seen that over a period of ten years a reduction of only approximately 13 per cent. has been made in this direction.

93. It is contended that if the law permits of no less than a quarter of a million insured persons remaining outside the principal provisions of a National Scheme of Insurance, then it is equally just for the remaining persons who have joined an Approved Society to do likewise if they so desire.

94. For the year 1923 there were 12,000,000 insured persons resident in England who had joined Approved Societies, and 237,000 persons who had elected to become deposit contributors. Consequently under the law in its present form it is quite possible for the positions to be reversed, and it is difficult to see how any scheme of insurance can be maintained if the majority exercise their right not to be subject to the principles of insurance, but choose to become deposit contributors, and draw upon their own contributions in the event of sickness.

95. It is quite admitted that the insured person would be acting detrimentally to his own interests by adopting such a course, but it is desired to point out that although the Act is designed to be one for effecting a form of insurance among 15,000,000 persons, there is beyond doubt a provision which enables those who are compulsorily brought under its provisions entirely to defeat the objects for which the Act was designed.

96. It is suggested that the deposit contributor class is comprised of three distinct types of individuals, viz. :—

- (1) Those who have not joined an Approved Society within the prescribed time through genuine inadvertence or ignorance.
- (2) Those who have been refused admission to an Approved Society by reason of bad health.
- (3) Those who have deliberately refrained from endeavouring to become members of an Approved Society, and are antagonistic to the Act itself.

97. With regard to the person who is placed in such a position through inadvertence or ignorance, every opportunity is given him to transfer to an Approved Society of his choice; in fact, the experience of this society shows that for the year 1923 approximately 2,000 members took this course.

98. It will be seen, therefore, that such persons can, and in fact do, join Approved Societies when they become cognisant of their error.

99. With regard to the other two classes, however, the position is somewhat different, inasmuch as the individual with a bad life may possibly be required to remain a member of the Deposit Contributors' Fund through no fault of his own, whilst the individual who is opposed to the scheme as a whole remains a deposit contributor by design.

100. It has been stated on more than one occasion that the deposit contributor class consists largely of the individual who cannot gain admission to an Approved Society; but Witnesses contend that such is a fallacy, and in their opinion the majority of the deposit contributor class comprise those individuals who have not taken, and do not intend to take, any steps to become members of Approved Societies, and consequently parties to a general scheme of insurance. In support of this contention Witnesses desire to quote from the National Health Insurance Fund

Accounts for the year ended 31st December, 1922, in conjunction with the Fifth Annual Report of the Ministry of Health. For the period quoted there were 245,000 deposit contributors, of which 163,000 were men and 82,000 were women. For the corresponding period such individuals contributed, by way of contributions under the Act, a sum of £397,271 11s. (exclusive of Exchequer grants), whilst the amount disbursed to them by way of sickness and disablement benefits amounted to £30,847 17s. 8d.

101. It is accordingly contended that if the Deposit Contributors' Fund is composed of individuals who have been refused admission to Approved Societies by reason of bad health the amount of sickness benefit drawn by such individuals would amount to considerably more than 10 per cent. of the contribution income. In this connection it is desired to state that out of 245,000 deposit contributors the total amount disbursed in disablement benefit for the year 1922 amounted to only £3 15s. 10d. The smallness in the amount of disablement benefit paid may be due to the fact that the accounts applicable to those in receipt of benefit were not in such a position to allow of disablement benefit being paid. If this be the case, then in the opinion of the Witnesses it goes to prove that the enormous surplus of contributions over sickness benefit paid, viz., £357,000, must be standing to the credit of the accounts of those individuals who have either not had occasion to draw sickness benefit or have deliberately refrained from doing so.

102. If the condition of the health of such individuals is so bad that they could not gain admission to an Approved Society, it is hardly conceivable that they would deliberately refrain from drawing upon the contributions standing to their credit in the Deposit Contributors' Fund. Therefore, the only conclusion which can be arrived at is that 90 per cent. of the contribution income in respect of deposit contributors is being credited to individuals who do not desire either to be members of Approved Societies or claim sickness benefit if occasion should arise.

103. It is contended, therefore, that the contributions paid in respect of such individuals should not be allowed to stand to their credit and eventually be disbursed to their dependents in the form of death benefit, but that they should become part of the general pool applicable to the insured population as a whole, and go towards providing the benefits of another insured person who is in necessitous circumstances and in genuine need of the benefit.

104. Witnesses accordingly advocate that the provisions permitting an individual deliberately to remain outside the general scheme of insurance should be abolished, and that all insured persons who have failed to select an Approved Society of their own free choice within a reasonable period, should be allocated to a society by an authoritative body. Such an action, it is contended, would not only be to the advantage of the individual who has failed to join an Approved Society through genuine inadvertence, or has been refused admission by reason of bad health, but would also tend to bring the contributions paid in respect of the indifferent or antagonistic insured person into the common pool to be used for the benefit of insured persons as a whole.

105. It is desired to point out that powers are given to Insurance Committees to take similar action in regard to insured persons who have failed to select a panel doctor within the prescribed time, and it is therefore urged that as the principle of allocation has already been created, it should be applied to the case of a deposit contributor.

106. Witnesses fully appreciate that if such action were taken it must automatically mean the abolition of the society's right to expel a member as it exists to-day, and that in the scheme of allocation due regard must be had to the peculiar circumstances appertaining either to a society or an insured person, and that an individual of the Catholic faith should

not be required to join a society consisting of persons of the Protestant religion, or non-abstainers allocated to a temperance society. It is agreed that matters of this description cannot be investigated by those responsible for the allocation, but the individuals concerned would have the right of transferring to a suitable society in the event of the insured person or the Approved Society showing good and sufficient cause for objecting to the allocation.

SUMMARY OF CONCLUSIONS.

107. Witnesses are accordingly of the opinion:—

- (1) That the deposit contributor class of insured person should be abolished.
- (2) That the persons at present comprising the deposit contributor class should be allocated among Approved Societies by an authoritative body.
- (3) That similar action should be taken with regard to all insured persons who, in the future, fail to select an Approved Society within the prescribed time.
- (4) That due consideration to the peculiar circumstances applicable to the individual and the society should be had when carrying the allocation scheme into effect.

III.—(2) THE AMENDMENT OF THE ACT IN ITS APPLICATION TO MARRIED WOMEN.

108. The position of an insured woman who marries is one which has given rise to many complications under the National Health Insurance Act, and although the position was undoubtedly much improved as a result of the amendments instituted in 1918, the fact still remains that a single insured woman who marries is treated in a different manner from the woman who is married before entering insurance.

109. Witnesses are fully alive to the fact that there may be good actuarial grounds upon which such a distinction is based, and although they are not qualified to tender evidence on matters of an actuarial character, they nevertheless desire to put forward the following proposals for due consideration.

110. Originally, when an insured woman married, her position was determined upon her "intentions" in the future, and it will be appreciated that societies found no little difficulty in coming to a definite conclusion in this respect. Under the law as it at present stands the position of such a woman is not dependent upon her possible actions in the future, but is decided upon her actions in the past. If, on the one hand, certain conditions appertain within a prescribed period after the date of her marriage she remains in the same category as an ordinary insured person, whilst if other conditions exist she is suspended from the ordinary benefits of the Act, and offered a special rate of benefit applicable to married women only.

111. The institution of a special reduced rate of sickness benefit to an insured woman who married was probably due to the heavy liability for sickness benefit arising among this class of insured person, but Witnesses fail to see any differentiation in sickness liability between a woman who marries on a given date and enters insurable employment on the following day, and a woman who enters insurable employment on a given date and marries on a subsequent day.

112. In respect of the first class quoted, such an insured person is treated in all respects like any other insured person, that is to say, she is entitled to the normal rates of benefit and is subject to the application of the Prolongation of Insurance Act. Her right to participate in the benefits of the Act terminates at the expiration of the normal free year of insurance.

113. In the case of the second woman, however, by reason of the fact that she married after entry into insurance, if eight consecutive weeks of unemployment occur during the first 12 months after marriage she is transferred to a special class, and her rate

of sickness benefit not only reduced but considerably curtailed, although the right to maternity benefit extends for two years after the date of marriage.

114. Again, in the case of the woman who was married at entry into insurance, a society receives the reserve value applicable to a married woman in respect of such an individual, whilst in the case of the woman who married after entry into insurance, a lesser reserve value is credited to the society unless insurable employment is maintained for 12 months after the date of marriage.

115. If it be maintained that the sickness experience among married women as a whole is heavier than that applicable to single women, it is submitted in the opinion of the Witnesses that because a woman marries and then enters insurable employment she cannot have a lesser rate of sickness than the woman who enters insurable employment and marries, which would appear to be the principle upon which the operation of the National Health Insurance Act applies in its present form to this class of contributor.

116. Although it is admitted, as stated above, that this subject is a highly actuarial one, Witnesses desire to put forward the suggestion that such an individual should be placed in all respects in the same position as an insured woman who is already married, and to meet any higher rate, and extension, of sickness benefit, the society should be credited with a married woman's reserve value in respect of such a person as from the date of marriage, and not from the end of 12 months from the date of marriage as at present.

117. Witnesses fully appreciate that in these circumstances a woman who married after entry into insurance and ceased work immediately on marriage, would automatically become disentitled to all benefits 12 months thereafter, which would have the effect of depriving her of any maternity benefit in the event of a confinement occurring during the second year of marriage.

118. It is admitted that under existing conditions a woman is more favourably treated in this respect, but against this it is desired to state that under the suggestion put forward above, she would be receiving the normal rates of sickness benefit for the whole of her free year of insurance instead of a reduced rate of benefit for a maximum period of six weeks.

119. As an alternative to the above, if the sickness experience applicable to insured women who marry is of such an abnormal character as to warrant the special provisions at present in operation, it is suggested that the proposal of making a lump sum payment (according to length of insurance) to a woman who does not continue in insurable employment after marriage, and terminating her insurance, is one for consideration.

120. Witnesses desire to state that there are many points for and against such a proposition. Such a course would undoubtedly simplify the administration of the insurance of such women, and enable a clear-cut policy to be adopted. On the other hand it would debar a woman from receiving any sickness benefit after marriage, or any maternity benefit as at present, but it is thought that in the majority of cases, at least where an insured woman definitely ceases work on marriage, sickness benefit is one which her husband is capable of providing, whilst a maternity benefit would also be payable if he were an insured person. If, however, the husband were in such a position as to be outside the provisions of the National Health Insurance Act, then it may be assumed that, in normal circumstances, he would be in a position to provide any benefits that may be needed, applicable to sickness or confinement in respect of his wife.

121. A further point in connection with the payment of a marriage dowry arises by reason of the fact that, if the insurance of a woman who presumably need not continue employment, is terminated, and a cash payment made in lieu thereof, there appears to be some justification for the individual whose insurance is terminated by reason of

his salary extending beyond £250 per annum making a similar claim.

122. It has already been pointed out that both the proposals outlined above are actuarial matters, and are merely put forward in the nature of suggestions with a view to dispensing, if possible, with any special form of treatment of this type of insured person.

123. If it be considered that the suggestions are impracticable, and that special treatment is necessary, then Witnesses are of the opinion that, generally speaking, the existing machinery applicable to married women should be retained, as it does not give rise to serious administrative difficulties.

124. Reference is, however, desired to be made concerning the application of the Prolongation of Insurance Act in regard to married women. This aspect has already been dealt with in the previous part of this evidence, wherein it was shown that, whilst the National Health Insurance Act transferred such women to a special class in certain circumstances, the operation of Section 2 of the Prolongation of Insurance Act nullified this action.

125. In dealing with the application of this Act to married women administrative difficulties are again being experienced of a similar nature to those which existed under the original Act of 1911, and which necessitated amendment in 1918.

126. It is, however, considered that if it is not possible to exclude definitely from the operation of the Prolongation of Insurance Act women who marry after entry into insurance, the existing conditions of the labour market justify extension of the eight weeks of unemployment, and Witnesses therefore desire to submit that the period of unemployment as stated in Section 56 (2) of the 1924 Act should be retained, but should be extended to 16 weeks where the Prolongation of Insurance Act applies.

127. A further suggestion is put forward that instead of crediting one rate of reserve value for a single woman and a different rate for a married woman either at marriage or twelve months thereafter, a uniform reserve value should be instituted for all women, irrespective of whether they be single or married, and that the normal provisions of the Act should apply to such persons.

128. Witnesses are accordingly of the opinion that, failing the introduction of a system enabling the insurance of married women to be put on the same footing as that of other insured persons, the existing system, subject to certain modifications, should be retained.

III.—(3) THE AMENDMENT OF THE ACT RELATING TO THE REQUALIFICATION FOR DISABLEMENT BENEFIT OF DISCHARGED SAILORS, SOLDIERS AND AIRMEN IN RECEIPT OF A 100 PER CENT. PENSION.

129. Under Section 60 of the National Health Insurance Act, 1924, it is provided that an insured person in receipt of a 100 per cent. pension in respect of disability due to the War is subject to a reduction of 7s. 6d. per week in respect of both sickness and disablement benefits.

130. In order to requalify for the full rate of benefit such a person is required to have been insurably employed since his discharge from the Forces for a period of 26 weeks for sickness benefit and 104 weeks for disablement benefit.

131. Whilst this qualification can be, and is in many instances, fulfilled by men discharged from the Forces, it is no uncommon occurrence to find that it is quite impossible for such an individual to comply with the conditions laid down by reason of the nature of his disability. The person concerned may have been able to secure regular employment, but through the nature of his injuries he is unable to work full time each day or week, as a consequence of which it frequently happens that he loses his employment. The state of the health of the insured person, however, is such that he is not totally unable to perform some sort of work, with the result that he decides

to undertake work on his own account in order that he may rest if the condition of his health should demand it.

132. As, however, an Ex-Service man is required to make 104 contributions as an employed contributor after the date of his discharge to requalify for disablement benefit, it will be apparent that the discharged soldier in receipt of a 100 per cent. pension who is forced to undertake work on his own account by reason of his health before the completion of 104 weeks, is debarred from ever qualifying for the full rate of disablement benefit. Such a person may, however, continue to pay National Health Insurance contributions for years as a voluntary contributor, and yet only be entitled to receive sickness benefit.

133. In view of the above circumstances, therefore, Witnesses desire to advocate that in order to enable such persons who have been incapacitated through war service to requalify for disablement benefit, any contributions paid by them whilst undertaking work on their own account should be regarded as requalifying contributions for this purpose.

III.—(4) THE AMENDMENT OF THE ACT RELATING TO THE INSURANCE OF MEMBERS OF APPROVED SOCIETIES WHO JOIN HIS MAJESTY'S FORCES.

134. Under the National Health Insurance Act, 1924, it is provided that the contributions in respect of persons serving in the Forces of the Crown shall be paid by the Admiralty, the Army Council or the Air Force, which entitle the insured person to maternity benefit only during the period of service with the Forces, but immediately on discharge such persons become entitled to all the benefits provided by the Act.

135. Machinery is also provided for periodically crediting to Approved Societies sums in respect of their members, to cover the liability referred to in the preceding paragraph, and the cost of administration.

136. Upon the enlistment of a member of an Approved Society the latter is entitled to receive from the Minister of Health an official notification (Form 634 A.G.D.), notifying the particulars of service, and such notification is sufficient evidence for the society to prove insurability during the time that the member was serving in the Forces.

137. A corresponding notification (i.e., Army Form O. 1845A), is also issued by the Minister of Health to Approved Societies on discharge, desertion or death of the member, and, except in the case of death, the member is then reinstated to the position of an ordinary insured person, and becomes entitled to full benefits.

138. Experience has shown, however, that although notification of enlistment is forwarded by the Minister to Approved Societies in cases where the membership of an Approved Society is known, there are frequent instances where Approved Societies have to apply for the form owing to the member not disclosing his membership of his Approved Society on enlistment.

139. Whilst it is appreciated that the issue of these notices on enlistment cannot be made by the Minister to Approved Societies by reason of the member not disclosing his membership, or even the name of his Approved Society when enlisting, societies likewise are not always able to apply for the form in question. It not infrequently happens that a member of an Approved Society who enlists, supplies no information of any character to his Approved Society concerning his regiment, etc., with the result that the society loses touch with the member, and his membership automatically terminates.

140. Again, where it is possible to maintain the membership during service, difficulty is experienced in connection with the settlement of claims for maternity benefit owing to the service man being resident in distant parts of the world, and the inability of his wife to give the necessary particulars to his Approved Society when a claim is made.

141. There can be little doubt that the continuance of the insurance of members of Approved Societies during their term of service with His Majesty's Forces gives rise to complications, and Witnesses are of the opinion that, upon enlistment, the insured person should be treated as if he had ceased to be insurably employed, and that his membership of his Approved Society should terminate accordingly.

142. Witnesses are, however, of the opinion that some provision should be made for the reinstatement of such a member to his old society if he so desires, on discharge from the Forces, and it is accordingly suggested that, although his membership with the Approved Society should temporarily cease during service, the member should be entitled to full benefits immediately on discharge, the sums necessary to give effect thereto being obtained from the Reserve Suspense as a new entrant into insurance, and the balance to provide immediate full benefits from the Army Council or other competent authority in lieu of the contributions formerly paid. That authority should also be responsible for the payment of maternity benefit during service.

143. In the event of the discharged soldier rejoining his former society within a prescribed time after discharge, the reserve value then credited should be sufficient to enable him forthwith to be entitled to additional benefits.

IV.—(1) THE LIMITATION OF ADDITIONAL CASH BENEFITS.

144. In connection with the valuations of Approved Societies, which are required to be made quinquennially, it is provided that in the event of the Valuer certifying a surplus as being available for distribution among insured persons in the form of additional benefits, a society is required to formulate, and submit for the approval of the Minister, a scheme for the distribution of such sum in one or other of the additional benefits laid down by the Act.

145. Although the schemes are required to receive the sanction of the Minister of Health before they can be put into operation, it will be appreciated that the selection of additional benefits rests very largely with the Approved Societies themselves.

146. In connection with the valuations at 31st December, 1918, the actual process of deciding as to the best means of utilising surpluses for the benefit of insured persons presented no little difficulty to those responsible for this task. In view of this being the first valuation made under the provisions of the National Health Insurance Act, it was necessary that due precaution should be exercised in the selection of additional benefits to avoid the institution of any benefit which could not be maintained under subsequent valuations.

147. Further, it should be pointed out that in discriminating between cash and non-cash benefits, whilst a society had not only the necessary experience, but also the required machinery for dealing with the first type of benefit, it was totally devoid of both in regard to the latter. This fact, therefore, coupled with the above circumstances, no doubt had great influence in guiding societies to recommend the utilisation of disposable surpluses for additional cash benefits in preference to benefits in kind.

148. At this juncture it is thought advisable to state that while 96 per cent. of the valuations made disclosed disposable surpluses, no less than 81 per cent. of such schemes made no provision in any shape or form for the inclusion of additional benefits in kind.

149. The experience gained in the administration of additional benefits over a period of five years has led the Witnesses to come to very definite conclusions in regard to the matter. In the first place, they are of the opinion that the insured population as a whole do not fully realise, or appreciate, the granting of additional cash benefits, as they have reason to believe that whether an insured person receives the statutory benefit of 15s., or the sum of, say, 13s.

(including additional benefit of 3s.), the recipient is of the opinion that he is only receiving the normal benefit of the Act, and not any additional benefit for which he has not been called upon to pay a corresponding additional contribution. If, on the other hand, he only receives 15s., but also free dental treatment, it leaves no doubt in his mind that he is receiving a benefit under the Act which was not provided for when the scheme first came into operation. Secondly, experience has shown without question that there is a growing demand on the part of the insured person to receive treatment benefits rather than cash benefits. Thirdly, the existence of a multitude of varying schemes of additional benefits among insured persons does undoubtedly give rise to dissatisfaction among such individuals, which in the opinion of the Witnesses is not altogether unjustifiable.

150. Whilst those who are responsible for the making of a valuation, and those whose duty it is to discriminate as to the best manner in which any disposable surplus should be distributed, are fully aware of all the circumstances connected therewith, it is unreasonable to expect the average insured person to look at the matter from the same point of view. Consequently, if it be assumed that the provision of 50 per cent. of the cost of dental benefit is equivalent to an additional weekly cash payment of, say, 1s., the insured person who belongs to an Approved Society which has decided to give dental benefit will not unnaturally be very surprised when he receives a weekly payment of 1s. less than his neighbour, who is a member of an Approved Society which has decided to give additional cash benefits and not dental benefit. Again, the same position will arise with regard to the individual whose society provides no additional cash benefits, but offers additional benefits in kind in the nature of convalescent homes or optical treatment.

151. In the opinion of the Witnesses, therefore, it is contended that the construction which an insured person puts upon the granting of additional benefits is entirely dependent upon his personal needs at any particular time. That is to say, if he needs dental treatment, and his society provides optical treatment instead, he naturally becomes dissatisfied, whilst the individual who prefers an additional cash payment and happens to belong to a society which has decided to give dental benefit instead, considers that he has a legitimate grievance against his society.

152. Reviewing the position from the point of view of the insured population as a whole, Witnesses desire to emphasise that, in their opinion, a definite proportion of any disposable surplus certified by the Government Valuer should be distributed in the form of additional benefits in kind, which must automatically act in arresting incapacity among insured persons, and consequently conserve the benefit funds of Approved Societies generally.

153. There is, however, another side of the question which needs consideration. It will be admitted, in fact it has been stated by the Government Actuary on more than one occasion, "that the surplus of an Approved Society is the property of the members of that Society." Consequently in distributing any surplus which may be disclosed, the necessary precaution must be taken to preserve to the insured person any advantage which he may have gained through his choice of an Approved Society. That is to say, any additional benefits which might accrue to the members of a particular society through careful and efficient management, or sound judgment in the selection of its members, should not be utilised for the benefit of the members of another society which is less prudently administered. Such a measure can only mean the pooling of funds of Approved Societies.

154. Whilst Witnesses desire to state most emphatically that they are entirely opposed to any proposition which might entail the pooling of funds of Approved Societies in whole or in part for the equalisation of cash benefits, they are nevertheless strongly of the opinion that a more uniform method of distributing disposable surpluses of Approved Societies resulting from valuations should be adopted.

155. It is accordingly advocated that no society should be permitted to utilise more than 50 per cent. of its disposable surplus for the provision of additional cash benefits, the balance being set aside for the provision of benefits in kind. It is contended that such a course would not only meet with the general approval of the insured population who are to-day anxious to obtain this type of benefit, but will also:—

- (1) Still enable the efficient society to offer a higher additional benefit in cash than the maladministered society.
- (2) Assist materially in preserving the health of the insured person.
- (3) Conserve the benefit funds of Approved Societies.
- (4) Abolish, to a great extent, grievances, which are not altogether unjustifiable, existing among insured persons in the matter of the granting of additional benefits.

156. In addition to the above it is contended that a more uniform system should also be instituted with regard to the administration of benefits in kind. At the present time those societies which are administering this type of benefit are operating schemes which vary considerably in their procedure. Such a state of affairs was not overlooked in official circles, for the Third Annual Report of the Ministry of Health 1921-1922, states that:—

“Model schemes for the guidance of societies were prepared by the Department, and general information was issued to them in July, 1921. It was realised that there were very inadequate data available upon which schemes could be framed with precision on matters of detail, and, therefore, considerable discretion was left in the hands of the committees of management of societies. Further experience will be acquired from the actual operation of the various schemes, and the results will be carefully scrutinised in order that Approved Societies and their members may reap the advantage of such modifications as may be shown to be advisable.”

157. Witnesses are therefore of the opinion:—

- (1) That not more than 50 per cent. of a society's disposable surplus should be used for the provision of additional cash benefits.

- (2) That the balance should be used solely for the provision of additional benefits in kind.
- (3) That the administration of additional benefits in kind should be placed on a more uniform basis.

IV.—(2) THE AMENDMENT OF THE ACT RELATING TO THE PAYMENT OF BENEFITS TO PERSONS WHILST IN-PATIENTS OF HOSPITALS.

158. Under the terms of Section 17 of the National Health Insurance Act, 1924, any benefit payable to an insured person who is an inmate of a private hospital may be paid to such person in the usual way. Where such person is in a rate-aided institution, the benefit accumulates unless payable in respect of dependents or in defraying expenses other than to the institution for the benefit of the insured person.

159. At the end of 1923, excluding in-patients for less than six months, there were 320 members of this society in rate-aided institutions who had no dependents, who may be regarded as representing chronic or permanent in-patient cases. Although the necessary enquiries had been made, it was ascertained that there was no way in which the benefit due to them could be applied to their advantage. Consequently, practically the whole of the benefit due to these persons is accumulating, and is only payable to such persons on discharge from the institution.

160. In respect of the 320 persons referred to, the total amount of accumulated benefit is no less than £14,500. This benefit is not only accumulating at the rate of 7s. 6d. per week in respect of disablement benefit, but it will be further augmented as the majority of the individuals concerned will be entitled to participate in the scheme of additional benefits disclosed at the 1923 and successive valuations.

161. The greatest amounts of benefit thus accumulated in *individual* cases are shown below:—

	£	s.	d.	£	s.	d.	£	s.	d.
Men ...	159	9	1	145	16	7	145	12	11
Women ...	159	1	6	150	18	7	140	19	0

whilst the following statement shows the number of cases in various age groups and the largest *individual* amount in each group:—

Ages.	MEN.			WOMEN.		
	Nos.	Largest Individual Amount.	Earliest Date In-patient.	Nos.	Largest Individual Amount.	Earliest Date In-patient.
16 to 20 ...	6	£ 50 5 0	1.6.21	2	£ 11 12 6	30.5.23
21 " 25 ...	17	90 19 7	11.5.18	11	84 5 6	20.3.18
26 " 30 ...	27	145 12 11	29.6.15	26	111 16 6	14.12.16
31 " 35 ...	26	159 9 1	1.10.14	22	146 19 0	31.5.15
36 " 40 ...	16	143 2 5	30.7.15	23	130 16 11	16.8.13
41 " 45 ...	14	109 17 7	8.7.16	16	150 18 7	20.1.15
46 " 50 ...	15	124 0 1	15.2.17	18	124 16 4	31.5.15
51 " 55 ...	9	130 18 7	22.6.16	16	90 12 4	24.7.19
56 " 60 ...	7	145 16 7	27.8.15	5	121 12 4	5.7.17
61 " 65 ...	12	74 11 9	15.3.19	9	159 1 6	25.6.14
66 " 70 and over ...	14	136 4 3	27.3.16	9	54 10 2	8.7.19

162. It will be seen from the above that in one instance the member concerned was admitted as an in-patient in August, 1913, and has remained there up to the present time, over 11 years. Further, it should be observed that over 40 per cent. of the individuals concerned are under the age of 35 years.

163. It is estimated that approximately 80 per cent. of the cases in question are mental cases, and there is only a remote chance that the members concerned will ever be permitted to leave the institution. Bearing this point in mind it will be obvious that the amount of benefit which will ultimately

accumulate in respect of any one individual will amount to a considerable sum.

164. As the unfortunate individuals concerned are likely to remain in the institution until their death, the accumulation of benefit at that time will fall to be dealt with as a part of their estate in accordance with the provisions of the Act. Consequently, although such individuals cannot themselves make use of the benefit which is accumulating, and there are no dependents to whom it could be paid, the benefit in question will eventually be required to be paid over to the member's next-of-kin,

who may not have contributed in any way to the comfort of the member during his lifetime, or even visited him in the institution.

165. Under the original National Health Insurance Act, it was provided that in respect of a State insured person who was an in-patient of a rate-aided hospital, etc., without dependent relatives, no sickness benefit whatever became due for the period that the insured person remained in the institution.

166. Subsequently, however, this position was amended, and any benefit accumulated as from 1913 and not expended as stated above becomes payable to the insured person on discharge, or is deemed to form part of his estate.

167. Doubtless there was good reason for amendment of the original Act, but it is an open question whether it was ever anticipated that really large sums would accumulate.

168. It is accordingly contended that further amendment in the Act in this direction is badly needed. Whatever reform may be suggested it should be borne in mind that due consideration should be had to the 20 per cent. who may eventually be discharged, as well as the 80 per cent. who remain in-patients for life.

169. Witnesses, therefore, suggest that benefit should accumulate on the present lines up to a maximum of £50 in order that any individual who is fortunate enough to be subsequently discharged from the institution may not find himself destitute, but no benefit should accumulate and become payable to the insured person's estate.

170. It is suggested that that portion of the benefit which would otherwise be payable to the member in excess of the £50 referred to, shall remain a part of the benefit fund of the member's Approved Society.

171. With regard to the proposal, although it is admitted that the in-patient will not benefit under this scheme any more than under the existing law, it is contended that it would be preferable and more equitable for any sum which cannot be paid to an insured person to go to the relief of other insured persons instead of an unknown individual who may not be in need of the money.

172. It is desired to point out that in the event of an insured person dying in a rate-supported institution without having made a nomination or will, and leaving no next-of-kin, the guardians appear to have power under Section 16 of the Poor Law Act, 1849, to claim from the estate funeral expenses and the cost of maintenance during 12 months previous to the decease.

173. In view of the present position, therefore, being not only undesirable but also obscure, Witnesses are of the opinion that the amount of benefit which may accumulate in respect of an insured person whilst resident in any institution, in any circumstances should not exceed the sum of £50.

IV.—(3) THE ADJUSTMENT AND REALLOCATION OF THE EXISTING BENEFIT, CONTRIBUTION AND FINANCIAL YEARS.

174. The various regulations instituted under the Act provide for three separate "years" as follows:—

Benefit Year.—From the first Monday in January in one year to the Sunday immediately before the first Monday in January in the following year.

Contribution Year.—The period comprising two consecutive half-yearly contribution cards commencing in June or July.

Financial Year.—From the 1st January to the 31st December.

It is submitted that considerable relief could be obtained in the work thrown upon Approved Societies if a readjustment could be effected between these periods.

175. It will be seen that the benefit and contribution years respectively are movable periods, whilst the financial year is always stationary.

176. At the end of each financial year it is necessary that all claims in respect of persons on the funds at that time should be balanced for the purpose of arriving at a figure for inclusion in the annual accounts. In view of the fact that this work has to be undertaken as at 31st December, it will be appreciated that, whatever form of register is in use by a society, whether it be the orthodox benefit register or a special system for which permission has been obtained by the Minister, the work of balancing is required to be undertaken at a time when the sickness experience of any society is approaching its zenith, and incidentally when the normal business of the society is considerably interrupted on account of the Christmas vacation.

177. The above will indicate briefly the work in connection with the claims of insured persons which has to be undertaken for the preparation of the final accounts.

178. With regard to the benefit year, however, in view of the fact that the new year commences within a few days after the termination of the financial year, the claims in respect of members then on the fund are required to be re-assessed for the purpose of ascertaining the new rates of benefit, and the necessary entries brought forward into the new benefit register. Here again it is desired to point out that this necessitates no little work upon the part of the staff of Approved Societies when it is remembered that in the case of this society it has to be undertaken in respect of 30,000 members at the one time, and, as in the case of the balancing of accounts, at a time when the sickness experience is at its height.

179. Apart from the matters referred to above, the differentiation in the dates between benefit and financial years results firstly in the payment of benefit at varying rates during the same financial period, and, secondly, the calculation of two different rates of benefit in the first week of the new year.

180. Whatever period may be fixed as the benefit year, it is appreciated that the latter is bound to exist, but in the opinion of the Witnesses it is considered that it would be more desirable if this work could be undertaken at a time when the benefit experience of the society is at its minimum instead of its maximum, and when there is no loss of time arising through public holidays.

181. Again, in view of the fact that the new benefit year may commence on, say, 3rd January, no little difficulty is experienced by the society in endeavouring to explain to an insured person why his rate of benefit should be affected at an odd date, and not at a period which is recognisable by the ordinary individual.

182. It is accordingly considered that as the balances of benefit claims are required to be made for the preparation of the annual accounts, it would be an advantage if one normal rate of benefit were applied to a financial year instead of two varying rates, which are bound to exist if the financial year does not correspond with the benefit year. This, it is contended, could be brought about by making the period applicable to the financial year coincide with that relating to the benefit year.

183. Witnesses accordingly advocate that in order to bring about the above condition, and to lessen the strain upon the staffs of Approved Societies when their sickness experience is at its height, the benefit and financial years should coincide, and that this period should commence on the 1st July.

184. If the above were carried into effect, it will be apparent that an alteration must necessarily be made in the existing period applicable to the contribution year and period of grace, and Witnesses accordingly suggest that the contribution year should run from the first Monday in January to the first Sunday in the following January. With regard to the period of grace, this could be made to operate from the end of the contribution year to the 31st May instead of the 30th November as at present.

185. Witnesses are accordingly of the opinion:—

- (1) That the periods covered by the benefit year and financial year should coincide.
- (2) That this period should be from the 1st July to the 30th June.
- (3) That the contribution year should run from the first Monday in January to the Sunday preceding the first Monday in the following January.
- (4) That the period of grace should be the period from the end of the contribution year to the 31st May.
- (5) That the readjustment on the lines indicated above would enable societies to undertake the work of balancing benefit claims, and the bringing forward of entries into the new benefit registers at a time when their sickness experience was at its minimum instead of its maximum, and thereby materially reduce the risk of error connected therewith.
- (6) That the readjustment of a benefit claim at a recognised date would be more easily understood by the insured person than at an odd and movable date as at present.

IV.—(4) THE LIMITATION OF CASH BENEFITS PAYABLE TO INSURED PERSONS WHILST RESIDENT ABROAD.

186. Under Section 19 of the National Health Insurance Act, 1924, the insured person is entitled to sickness and disablement benefit whilst temporarily resident in the Irish Free State, the Isle of Man, and the Channel Islands, whilst an insured person may receive such benefits whilst temporarily resident abroad with the permission of his Approved Society.

187. It will be seen that in the first case the title to benefit is established by law, whilst in the latter instance the payment of benefit is left to the discretion of the Approved Society.

188. It not infrequently happens that through the generosity of employers insured persons are sent to foreign spas and institutions for the benefit of their health, whilst others themselves seek a change of air in the Isle of Man and the Channel Islands.

189. It is quite admitted that when these persons take up such residence they honestly believe that it will only be of a temporary nature, and a similar attitude is adopted by Approved Societies when authorising the payment of sickness and disablement benefit to their members whilst resident abroad. After the necessary permission, however, has been given, it frequently occurs that the circumstances change, and that the insured person concerned resides "as a temporary resident" for a number of years in foreign countries, with the result that a society may be involved in payment of benefit extending over a period of years to a member resident outside the country and over whom it has no jurisdiction beyond the production of medical certificates.

190. It may be said that as the society is given discretion in the granting of benefit it has the right of discontinuing it when it thinks fit, but it is submitted that if permission were given when the insured person was entitled to sickness benefit, there is little justification for withholding payment if the incapacity has been prolonged to such an extent as to reduce the person to disablement benefit.

191. It is therefore submitted that once authority has been given for the payment of benefit to such persons, Approved Societies are under a moral obligation to continue it until the person is restored to health.

192. It has already been pointed out that, under the existing law, there is a differentiation between an insured person who takes up temporary residence in the Irish Free State, the Isle of Man or the Channel Islands, and the individual who becomes temporarily resident in a foreign country, inasmuch as the former is given a statutory right to benefit which is denied to the latter, but no limitation as

to benefit is provided for under the Act in either case.

193. As the original Act undoubtedly only contemplated the payment of benefit in these circumstances for a reasonable period of convalescence or special treatment, Witnesses desire to advocate that some limitation should be made in respect of both classes of persons, which in their opinion should be twelve months, but that the same distinction should be kept as at present, having regard to the provisions of Section 19 (1) (b) of the National Health Insurance Act, 1924.

194. Witnesses are accordingly of the opinion:—

- (1) That a person who becomes a temporary resident in the Irish Free State, the Isle of Man or the Channel Islands should have the right to benefit for a period not exceeding twelve months.
- (2) That a person who becomes a temporary resident in a foreign country should not have any statutory right to benefit, but that discretion should be left with the Approved Society as at present, with the proviso that benefit, if granted, should not be paid for a period exceeding twelve months.

IV.—(5) THE ABOLITION OF RECORD CARDS.

195. Under Article 35 of the Collection of Contributions Consolidated Regulations (1918) an Approved Society is required to issue to its members a record card showing the member's record of contributions, arrears payments, and such other matters as the Minister of Health may from time to time think fit, and to issue a duplicate card if required in the event of the original being lost.

196. The issue of record cards under this Regulation entails upon Approved Societies generally a considerable amount of labour and expense, which is further increased by the receipting and returning of record cards to members at the expiration of each half-year at a time when the staffs of Approved Societies are experiencing great pressure by the receiving of expired contribution cards and the work in connection therewith. This pressure is obviously much greater at the July half-year than at the January half-year in consequence of the necessity of promptly crediting to the respective accounts the contributions represented by the stamped contribution cards to enable the relative accounts to be balanced and arrears notices issued in accordance with the Arrears Regulations.

197. Experience shows that frequently record cards are not surrendered regularly with the expired contribution cards owing to their not being readily accessible to the insured person. This results in the cards being sent separately from the contribution cards, and not infrequently at irregular intervals, both actions necessitating reference to the insured person's account and the completion of the record cards in respect of many periods at the one time.

198. It is submitted that the record card serves no useful purpose to the insured person, and certainly not to Approved Societies, and could therefore with material advantage be abolished. In point of fact the Minister of Health practically admits the possibility of dispensing with record cards, as the proviso to Article 35 (2) of the Collection of Contributions Consolidated Regulations gives the Minister power to exempt a society from issuing such cards should they think it desirable, but such a course has not been taken to the knowledge of the Witnesses.

199. The record card may serve one useful purpose as it bears the name and address of the Approved Society and also the insured person's membership number therein. Such information is undoubtedly of assistance in cases where the insured person loses touch with the Approved Society, but the information could be obtained from the medical card, which is of course of much more value to the insured person.

200. It may possibly be suggested that the record card is necessary for the insured person to enable

title to benefits to be determined. It is, however, not the practice of this Society to pay benefits on entries contained on record cards, as reference is invariably made to the official accounts to determine title or otherwise to benefits. Further, in the event of arrears being outstanding which adversely affect title to benefit, an Approved Society is required each year to give notice of such arrears in the prescribed form, which notice also contains information as to the manner in which the arrears may be discharged and the adverse effect on benefits removed.

201. It would certainly be effective if Approved Societies sent notice to all members each half-year instead of annually, in cases where the contribution card for the preceding half-year has not been surrendered in due time. Such notice would serve a much more useful purpose than the title of an insured person to hold a record card, it being in the nature of a prompt reminder of his omission to surrender his contribution card and a forceful means of indicating the effect on benefit unless the omission be remedied.

202. The substitution of a regulation to this effect in lieu of the one requiring record cards to be issued is therefore desirable from many aspects, including efficiency, reduction of labour and cost.

203. It may be argued that the insured person is entitled to some form of receipt for contributions paid under the Act, but it is maintained that this end is accomplished by the issue of the arrears notice before any reduction is made in the rate of benefit. If an insured person receives the full rate of benefit during incapacity it is submitted that it is immaterial from his point of view whether such benefit is the result of the payment of 1 or 48 contributions.

204. Further, any right which it is claimed exists to an insured person for a receipt of contributions paid, must equally exist in the case of employers; therefore, if the record cards are designed to meet this right on the part of the former, corresponding notifications should be sent to the latter.

205. If, however, it is not admitted that a case has been established for the discontinuance of record cards, it is urged that future cards should cover a longer period than the present issue (which is 3 years), and should also be designed to enable them to be despatched to the insured person under postal conditions similar to those applying to the contribution cards.

206. Witnesses are therefore of the opinion:—

- (1) That the existing regulations providing for the issue of record cards should be abolished.
- (2) That, if thought desirable, notices should be issued half-yearly instead of yearly as at present.
- (3) That, in the absence of the above, the cards should be made available for a longer period than at present, and subject to the same postal conditions as the contribution cards.

IV.—(6) THE AMENDMENT OF THE REGULATIONS TO PROVIDE SOME MEASURE OF FINALITY IN REGARD TO EVIDENCE OF INCAPACITY.

207. The onus of deciding the admissibility or inadmissibility of a claim for sickness benefit is left in the hands of the Approved Society of which the insured person happens to be a member, and in coming to a decision on this point naturally considerable weight is given to the medical evidence of incapacity produced by the applicant for benefit, although other circumstances are also taken into account in arriving at a decision.

208. Witnesses desire to point out that although in the majority of cases little difficulty was experienced in this direction in the early days of National Health Insurance, it often happened that the society desired to have an opportunity of confirming the

panel doctor's opinion by that of another practitioner, instead of being placed in the invidious position of having to decide between the evidence submitted by the panel doctor and its own sick visitor. It was consequent upon this difficulty that a system was introduced in October, 1920, which provided for the appointment of regional medical officers throughout the kingdom to assist societies in determining whether or not incapacity continued to exist.

209. The practice of this society is only to employ the regional medical officer where genuine doubt exists as to the insured person's incapacity for work, and not as a lever to stop the payment of benefit without justification. To the 31st August, 1924, 2,905 cases were thus referred, and in every case the member was at the time producing medical evidence from his panel doctor to the effect that he was totally incapable of work. The results of the reports furnished by the regional medical officers in these cases are analysed hereunder:—

Certified unfit for work ...	1,518=52·26 per cent.
Certified capable of light work ...	339=11·67 per cent.
Certified capable of work without reservation ...	301=10·36 per cent.
Members declared off before examination ...	645=22·20 per cent.
Members did not attend ...	102= 3·51 per cent.
	<hr/>
	2,905 100·00 per cent.

210. Witnesses desire to draw attention to the fact that whilst the regional medical officer was in entire agreement with the panel doctor in 52 per cent. of the cases, 22 per cent. of the cases showed that in the opinion of the regional medical officer the member was not totally incapable of work, whilst no less than a further 22 per cent. of the members failed to attend the examination and immediately declared off the funds.

211. It will be seen from the above that whilst the threat of a medical examination by the regional medical officer had the effect of obtaining a final certificate from the panel doctor in 22 per cent. of the cases, in a further 22 per cent. of the cases the society received contradictory evidence from the regional medical officer. It may be stated that the society has had experience of cases where the insured person continued to produce weekly medical evidence from his panel doctor after the regional medical officer had certified to the society that he was not totally incapable of work.

212. It will be seen from the above, therefore, that whilst in many instances the regional medical officers' reports are of considerable value to the Approved Society, it often happens that instead of assisting societies in coming to a decision on the matter they result in the existence of two medical certificates bearing diverse opinion which must of necessity increase the society's difficulty in coming to a decision.

213. If on the one hand the society decides to accept the evidence furnished by the panel doctor, it will be appreciated that they have derived no benefit by referring the case to the regional medical officer, whilst if, on the other hand, they decide to accept the report of the regional medical officer as against the panel doctor, they are at once brought into conflict with the insured person, who considers he has a legitimate grievance against the society for refusing to pay benefit. Incidentally the disregarding of medical evidence furnished by a panel practitioner cannot tend to maintain that good relationship which should exist between the medical profession and Approved Societies.

214. Witnesses therefore desire to advocate that steps be taken to institute a system whereby some measure of finality may be arrived at in regard to medical evidence submitted, which will enable societies to come to a decision as to whether disability does or does not exist, without creating dissatisfaction among either the insured persons or the medical profession.

IV.—(7) THE ABOLITION OF THE DISSECTION OF STATISTICS BETWEEN THE RESPECTIVE COUNTRIES BY APPROVED SOCIETIES NOT NATIONALLY VALUED.

215. It is provided under Section 72, Sub-section (1), paragraph (a) of the National Health Insurance Act, 1924, that a Society shall keep its books and accounts in such form as may be prescribed. It is further provided under Article 39, Sub-section (2), paragraph (b) of the Approved Societies' Consolidated Regulations, 1918, that in the case of a society approved for more than one part of the United Kingdom, and having members resident in any two or more parts of the United Kingdom, separate records are required to be kept of the benefits administered in each part of the United Kingdom, notwithstanding the fact that the society is regarded for valuation purposes as a single unit.

216. Witnesses desire to point out that the society which they represent transacts State insurance business in England, Scotland, Wales and Northern Ireland in respect of both men and women. It will be seen, therefore, that to give effect to the above provisions it is necessary to keep elaborate and detailed records of all benefits disbursed under eight separate categories, and to keep similar detailed records in regard to all investments made by the society, and any interest and dividend arising therefrom.

217. If, however, the society is not to be nationally valued, there appears to be no justification for the imposition of such detailed work, which must of necessity be ultimately amalgamated for the purpose of arriving at a valuation result.

218. It would seem that the only purpose which such an analysis can possibly serve is to enable the society to complete the orthodox requisition for the issue of the necessary funds required for the payment of the benefits provided by the Act, and the cost of administration thereof.

219. In order to obtain such funds, societies are required to complete monthly, in respect of each country for which approval is given, a recognised form of application for the issue of funds. The requisition in question requires a society to estimate its requirements in respect of sickness, disablement and maternity benefits for one month in advance, divided between men and women respectively.

220. Witnesses desire to point out that whilst they fully appreciate the necessity for the central authorities instituting some measure of check upon the issue of funds to Approved Societies, the details required necessitate a considerable amount of unnecessary work and expense in the administration of the Act. In their opinion, the requirements concerning the maintenance of elaborate details as to expenditure between countries when the society is not nationally valued is not justified, particularly in view of the fact that any misappropriation or malversation of funds is duly guarded against by the society giving the necessary form of security to the Minister as provided by Section 35 of the National Health Insurance Act, 1924, as a contributing party to the Approved Societies' (Officers) Guarantee Fund.

221. Witnesses therefore strongly advocate the abolition of the existing details required in regard to the dissection of benefit expenditure and other items connected with investments between the respective countries in the case of international societies valued as a whole, and that the segregation of accounts and statistics by a society should only be such as are necessary to enable a proper valuation of the society's assets and liabilities to be made, and not as a means of check upon the issue of monies required from the various central authorities.

IV.—(8) THE AMENDMENT OF THE EXISTING PROCEDURE RELATING TO TRANSFERS OF MEMBERSHIP BETWEEN SOCIETIES.

222. It is an accepted principle of the scheme of National Health Insurance that an insured person shall have an absolutely free choice among Approved Societies.

223. Although Witnesses are entirely in agreement with this principle, they nevertheless contend that some amendment is desirable in the existing procedure relating to the transfer by an insured person from one society to another. This procedure is prescribed in regulations made by the Minister, wherein the onus of showing why effect should not be given to a member's desire to transfer is placed upon Approved Societies.

224. Generally speaking a society is required to show that, if effect were given to the transfer in question, it would seriously prejudice the administration of the affairs of that society, which is, in the majority of cases, an impossibility.

225. Witnesses have had experience of instances where the procedure on a certain matter adopted by this Society is not in agreement with the procedure adopted by another society, with the result that if a claim for benefit be disallowed on absolutely legitimate lines, such a course is apt to cause annoyance to the insured person, who at once makes application for transfer. Although the Society cannot possibly show that the transfer of this member would prejudicially affect its administration, it is nevertheless indirectly prejudiced by reason of the fact that it would probably not have lost the membership of the insured person if it had not acted strictly in accordance with the letter and spirit of the Regulations.

226. Witnesses are accordingly of the opinion that, whilst maintaining the principle of free choice of society among insured persons, it should be the duty of an insured person, subject to the right of appeal, to satisfy his society that he has a real and legitimate reason for desiring to terminate his membership.

IV.—(9) THE AMENDMENT OF THE PRESENT PROCEDURE RELATING TO CONTRIBUTIONS PAID DURING SICKNESS; ADJUSTMENTS OF CONTRIBUTIONS, AND THE PREPARATION OF CONTRIBUTION RETURNS.

227. Under this heading Witnesses desire to make reference to certain minor matters connected with the existing procedure laid down for the crediting to Approved Societies of contributions paid under the Act.

228. It is provided under the Act that contributions can only be paid by an employed contributor in respect of weeks of sickness or unemployment, provided that a total of 104 contributions has not been already paid for the purpose of qualifying for the full rate of sickness benefit or disablement benefit. Although, after this number has been paid, an employed contributor is not entitled to stamp his own card when incapacitated or unemployed, many contributors do nevertheless do so under the erroneous impression that they will thereby avoid arrears.

229. The Regulations of the Minister of Health debar societies from claiming credit for contributions which have thus been incorrectly paid, and consequently they fall to be credited to the "Unclaimed Stamps Account." In the opinion of the Witnesses credit for these contributions should be given to the societies of which the contributors concerned are members, on the grounds that, firstly, neither the Acts nor the Regulations prescribe that contributions incorrectly paid shall not be credited to societies; and secondly, having regard to the fact that the member has paid the contributions, and does not receive any credit therefor, either by way of a refund or otherwise, he should receive benefit indirectly by the amount of the erroneous payment being credited to his Approved Society.

230. A further point to which attention is directed is the necessity for constant adjustments in the contributions which have already been credited to the Approved Society. It not infrequently happens that credit is claimed by an Approved Society for contributions which subsequent events show to have been irregularly paid, such as adjustment of date of birth or belated notification of sickness or unemployment. Under the existing instructions it is necessary to notify all such adjustments and for the society's

account to be eventually amended by means of advices of debit or credit.

231. The amount of work involved in notifying these adjustments and recording the subsequent advices is often out of all proportion to the value of the contributions involved, and Witnesses desire, therefore, to submit that a considerable amount of unnecessary labour could be avoided if such adjustments could be discontinued, at any rate under a defined amount, by reason of, firstly, the smallness of the amount which is frequently involved; and, secondly, as the advices relate to both debits and credits to Approved Societies, many of such advices become ineffective from the financial point of view.

232. Lastly, Witnesses desire to refer to the issue to Approved Societies of the necessary forms to enable them to claim credit for contributions paid.

233. With regard to the contribution cards relating to the first half of the contribution year, i.e., the period from July to January, the forms in question are issued to Approved Societies in ample time to allow them to commence the necessary work involved in their compilation immediately on the termination of the half-year.

234. As regards the returns relating to the second half of the contribution year, however, i.e., January to July, the forms in question are not available to the Approved Societies until late in the Period of Grace, which normally expires at the end of October. The result of such action is that not only is a delay of a period approaching four months involved before the returns can be commenced, but further the whole of the work is required to be undertaken in a restricted time of approximately two months instead of six months, as in the case of the first half of the contribution year, and when the sickness experience is on the increase.

235. It will be apparent that such action causes considerable disorganisation in the office machinery of an Approved Society. Apart, however, from such dislocation of work, it is desired to point out that contribution cards commence being received by the society immediately on the termination of the half-year.

236. In this connection Witnesses desire to state that so far as the current half-year is concerned, although cards have been continuously received by the Society which they represent since 7th July last, the necessary returns for dealing with such cards were not received until 22nd October—a period of 15½ weeks.

237. This has necessitated the accumulation between the dates mentioned of no less than 375,000 stamped contribution cards, equivalent to over £900,000, in respect of which no action could be taken for despatching them to the Ministry of Health.

238. It is consequently contended that such a state of affairs is not only undesirable but also unnecessary.

239. In the matter of the crediting of contributions to Approved Societies, therefore, Witnesses are of the opinion:—

- (1) That any contributions erroneously paid by an insured person during sickness or unemployment should remain to the credit of the Approved Society.
- (2) That the issue of advices of adjustments in contributions as a result of subsequent events necessitates an amount of work out of all proportion to the value involved, and that such advices should be discontinued, at any rate in respect of sums under a specified amount.
- (3) That Approved Societies should be in possession of the requisite returns for claiming credit of contributions immediately after the expiration of the half-year, thereby avoiding the accumulation of many thousands of contribution cards which represent no inconsiderable amount of money.

V.—(1) THE INCLUSION, AS A PART OF THE EXISTING GENERAL PRACTITIONER SERVICE, OF MEDICAL ATTENTION AND TREATMENT AT CONFINEMENTS AND ALL ILLNESSES ARISING THEREFROM.

240. In accordance with the range of service which a general practitioner is required to give as laid down in Article 8 of the First Schedule of the National Health Insurance Medical Benefit Regulations, 1924, the service available to the insured person comprises 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.

241. Whilst sub-section (2) of section 10 of the National Health Insurance Act, 1924, specifically excludes from the range of service of the general practitioner attendance in respect of a confinement, the Regulations above quoted define attendance in respect of a confinement as being attendance within ten days after labour in respect of any condition resulting therefrom. It will be seen, therefore, that the operation of the Act, in conjunction with the Medical Benefit Regulations made thereunder, debar a woman from receiving medical treatment, not only in respect of the confinement itself, but also for a period of ten days thereafter, in respect of any incapacity arising out of the confinement.

242. It must be admitted that in determining the standard of any service to be rendered under a scheme of the magnitude of the National Health Insurance Act by a body of professional men, due regard must be had to the services which can be reasonably expected from an individual of average competence and skill, and for this reason, therefore, no exception can be taken to the exclusion from such a service of the abilities of a medical practitioner which have only been obtained either by a specialised knowledge or abnormal skill.

243. It is suggested, however, that whilst the performance of a major operation could not reasonably be regarded as within the skill of an average practitioner, it seems inconceivable that the general practitioner is not regarded as possessing that amount of skill to enable him to undertake the normal duties connected with a confinement.

244. Stress has already been laid upon the fact, in the preceding pages of this Evidence, that the spirit of the National Health Insurance Act was not only to make periodical payments to persons while incapacitated, but also designed as a measure for the prevention of sickness, and if the above be conceded, it is contended that if ever there were an occasion for adequate and proper medical attention to prevent sickness, such an occasion exists at a confinement.

245. Under Sub-section 4 of Section 14 of the National Health Insurance Act, 1924, it is prescribed that every Approved Society shall make rules requiring any insured married woman in respect of whom maternity benefit is payable in respect of her own insurance to abstain from remunerative work during a period of four weeks after her confinement.

246. It is reasonable to suppose that the object of imposing such a restriction is to ensure that due precaution is taken to safeguard the health of the woman which must be prejudicially affected if work of a remunerative character be undertaken prematurely.

247. Witnesses are entirely in agreement with such a measure, but at the same time it cannot be understood why a woman should, on the one hand, be debarred from undertaking work on account of the condition of her health, whilst, on the other, she is debarred from adequate medical attention. It seems reasonable to suppose that if her state of health for the first ten days after the confinement does not justify proper medical attention, then the woman must surely be fit to undertake remunerative work before the expiration of a period of four weeks after the confinement.

248. It may be argued, however, that such is not the case, and that her condition of health for the first ten days does justify medical attention, but for some reason or another such attention cannot be included as a part of the medical benefit of the Act. If this be the contention then it is submitted that no useful purpose can possibly be served by offering to an insured woman an alleged benefit of £4 at a confinement (the whole, or the majority of which, must be used for the payment of the medical fee), prohibiting the woman from undertaking remunerative work for a period of four weeks on the ground that such a course would prejudice her health, and at the same time leaving her to her own devices to obtain any medical attention that may be required.

249. It is contended that the fact of an insured married woman being prohibited from undertaking remunerative work for four weeks after a confinement on the ground that such a course would prejudice her health cannot be reconciled with the exclusion of medical attention for the first ten days; and whilst Witnesses are entirely in agreement with the provision relating to the abstention from work, they advocate most strongly that there are justifiable grounds for including free medical attention to women in respect of confinements and all illnesses arising therefrom.

V.—(2) THE INCLUSION OF A SPECIALIST MEDICAL SERVICE AS A PART OF THE MEDICAL BENEFIT PROVIDED BY THE ACT.

250. It has already been conceded that in determining the extent of medical treatment which can reasonably be expected from a general practitioner, those services which can only emerge from exceptional knowledge and skill must obviously be omitted therefrom. Notwithstanding this fact, however, it is nevertheless contended that if the state of an insured person's health is such as to warrant extraordinary skill, and such skill does in fact exist, then an endeavour should be made to bring the individual who requires that skill into contact with the individual who is in a position to render it.

251. Prominence has already been given to the unquestionable fact that the National Health Insurance Act is, in the main, a statutory measure for assisting that branch of the community which is itself unable to provide adequate medical attention. If, therefore, such individuals require assistance to provide the everyday needs of medical science, it must be admitted that they have little hope of obtaining, if necessary, that extraordinary competence and skill not possessed by the average general practitioner. Such a state of affairs cannot therefore be regarded in the opinion of the Witnesses, as a step in the direction for the "prevention and cure of sickness" among the insured population.

252. Whilst, on the one hand, it is contended that the inclusion of a specialist service in the range of service available to insured persons would undoubtedly arrest a considerable amount of sickness now prevalent, it is admitted, on the other hand, that it is unreasonable to expect a combined general and specialist medical service in return for a contribution which was only designed to provide for the former. If, however, such a service is available—and it is reasonable to suppose that it is—but is precluded from the patient on the grounds of cost, it is urged that serious consideration should be given to the reconstitution of the finances of the Act to provide for its availability.

253. Although it would be premature to put forward definite statistics indicating the sources from which the necessary funds could be obtained before the actual cost has been determined by the responsible authority, it is suggested that if necessary the cost of the provision of a specialist service should be a first charge upon that proportion of a society's disposable surplus which it has already been advocated should be devoted solely in connection with treatment benefits. As an alternative, or in addition, to the above, it is maintained that the measure is of sufficient importance to the health of 15,000,000 persons even to warrant its substitution

for a proportion of the disposable surpluses required for the provision of additional benefits in cash.

254. Witnesses are accordingly of the opinion:—

- (1) That the inclusion of a specialist medical service as a part of the medical benefit conferred by the Act is necessary in the interests of the insured population.
- (2) That the finances of the Act should be amended to provide for the cost of such service.
- (3) That, if necessary, the whole, or a portion, of such cost should be derived from the proportion of the disposable surpluses of Approved Societies which it has previously been advocated should be used solely for the provision of treatment benefits.
- (4) That, if necessary, a further limitation than that already advocated should be placed upon disposable surpluses for the provision of additional cash benefits for this purpose.

V.—(3) THE INCLUSION OF DENTAL BENEFIT AS A STATUTORY BENEFIT UNDER THE ACT.

255. There can be little doubt that for generations past insufficient attention has been paid by the population as a whole to the preservation of the teeth, and few will question the statement that a considerable percentage of the illnesses arising to-day can be attributed either directly or indirectly to this cause. Although at one time the lack of attention in this direction was undoubtedly due to genuine fear, it is submitted that the modern methods of dentistry have done much to remove this state of affairs, and that the major cause for neglect at the present time is due to financial reasons. Witnesses accordingly advocate that in view of the important part which the teeth play in the general health conditions of the community, the provision of this benefit should be embodied as a statutory benefit of the National Health Insurance Act, and not left in the category of additional benefits which may, or may not become available to the insured person.

256. That such a benefit is in great demand is evidenced by the fact that although this Society did not originally include dental treatment as one of its additional benefits, it was found necessary at a later date to diminish the additional cash benefits in order to meet the demands of its members for dental assistance.

257. It is only to be expected at the institution of any new form of benefit that applications for assistance will be received in abundant numbers, but in the course of time such applications should gradually diminish. In regard to the provision of dental benefit, however, the experience of this Society is that time has not brought about a reduction of applications, but on the contrary increased numbers, which in the opinion of the Witnesses is proof that the benefit is in real demand.

258. Owing to the fact that little consideration has been paid to this aspect of national health in the past it is difficult to formulate any reliable estimate as to the normal needs of the average insured person in this respect, but it is suggested that the demand for this benefit is swiftly approaching its zenith, and should in the near future drop to its normal requirements.

259. The inclusion of dental benefit among the list of additional benefits has resulted in one section of the insured population receiving 50 per cent. of the cost of treatment; others 33½ per cent.; whilst others obtain no relief whatsoever.

260. Further, as each society operating this type of benefit makes its own arrangements concerning its administration, a multitude of varying systems have sprung into being, each with a common object, which can only tend to bring about confusion among the dental profession.

261. It is accordingly suggested that the time has arrived when not only should this benefit be made available to the whole of the insured population

instead of a part (subject to the institution of qualifying tests as to contributions paid and periods of insurance), but also some measure of uniformity introduced respecting the extent of the benefit, and defining the methods of its administration.

262. It is urged that the administration of the benefit should be undertaken by a central authority representative of the Minister of Health, the dental profession and Approved Societies, and that suitable safeguards be introduced to deal with complaints respecting unsatisfactory treatment and matters incidental thereto.

263. With regard to the extent of treatment, it is suggested that the insured person should continue to be liable for some part of the cost, but that a reasonable proportion thereof should be borne by the funds of Approved Societies, subject to the addition of the statutory State Grant in respect of benefits paid.

264. With regard to the question of finance, it is proposed that the necessary funds for providing the societies' share should be obtained by diverting to the existing Central Fund—or a separate fund created for the purpose—a specified proportion of each contribution paid in respect of an insured person.

265. It is fully realised that such a course must necessarily affect the amount which would otherwise be available for additional benefits in one of the following ways:—

- (a) Reducing the amount of disposable surplus.
- (b) Converting a surplus into a deficiency.
- (c) Increasing an existing deficiency.

266. If the effect of the proposition put forward will still enable societies to maintain disposable surpluses to any degree, there can be little objection to its adoption, but due consideration should be given as to whether or not valuations of the majority of Approved Societies will result in deficiencies as a consequence, and in order that such a contingency may be clearly reviewed it is desired to analyse the results of the valuations as at 1918.

267. At that date no less than 96 per cent. of the units valued disclosed surpluses amounting in the aggregate to £17,273,887, equivalent to £1 1s. 7d. per member. Of this amount the sum of £9,184,087, or 55 per cent. of the total, was retained by the Valuer to provide for future contingencies. Although the remaining 4 per cent. of the units represented 407 societies and branches with deficiencies, it was only necessary for recourse to be made for assistance from the Central Fund in four such instances.

268. A certain proportion of the gross surpluses among 96 per cent. of Approved Societies and branches was apparently attributed to "War Profits" which are not likely to recur in future valuations, and on this point it is thought advisable to quote from the Government Actuary's Report to the Chairman of the National Health Insurance Joint Committee dated 31st March, 1922, as follows:—

"... it was evident to myself and to my professional assistants that, apart from the general question of the prudent treatment of surplus which would arise under normal conditions) the position at the end of 1918 was so uncertain that in addition to reserving the Societies' Contingencies Funds, as required by the Act, measures must be adopted which in their results would carry forward at least the greater part of what we estimated to be the fortuitous 'War Profits' included in the surpluses."

269. It will be seen from the above quotation that in arriving at the amount to be released to Approved Societies for the provision of additional benefits, due regard was had by the valuers not only to prudent reserves under normal conditions, but also to the elimination of the major portion of the "War Profits." If this be the case, therefore, the amount eventually released as disposable for additional

benefits was not inflated in any way through abnormal conditions, and could reasonably be taken as a basis for future valuations.

270. It is admitted that, in connection with the second valuations, circumstances have arisen which will bring about both losses and profits to Approved Societies' funds which did not exist in 1918.

271. With regard to the former, the finances of Approved Societies will undoubtedly be adversely affected by reason of:—

- (a) The loss of contribution income through unemployment.
- (b) The increase in sickness benefits through acute unemployment.
- (c) The protracted operation of the Prolongation of Insurance Act.

272. It will be noticed that no reference has been made to a heavier rate of sickness (other than that due to unemployment) by reason of the fact that the profit derived from the extraordinarily light sickness to 1918 was regarded by the Government Actuary as a "War Profit," and the majority carried forward.

273. With regard to the question of profits, it is submitted that societies will reap an advantage in this direction from two sources. In the first place it is contended that societies who have invested wisely will reap material advantage in the direction of excess interest over the valuation rate of 3 per cent. Although this source of revenue existed to a certain extent in 1918, and was classified (and incidentally carried forward) by the Government Actuary among the "War Profits," Witnesses desire to point out that in the case of the Society which they represent, the average rate of interest at 31st December, 1923, on investments made in the names of the trustees was no less than £5 2s. 2d. per cent. Further, as by far the greater proportion of the investments yielding this rate are irredeemable, the rate can be assured for practically all time.

274. So far as this society is concerned therefore, the excess interest of £2 2s. 2d. per cent. on practically £1,600,000, equivalent to £32,000 per annum in perpetuity, can hardly fall in the Government Actuary's category of "War Profits."

275. Secondly, the Government Actuary attributes no small proportion of the surpluses disclosed at 1918 to careful and efficient management by Approved Societies.

276. If during the initial stages of administering a scheme of the magnitude and complexity of the National Health Insurance Act, and in spite of the abnormal conditions which existed during the Great War, Approved Societies were able to contribute materially to the valuation surplus by prudent and careful administration, it is contended that greater advantages must be derived from this source during the second valuation period by reason of the fact that a further five years' experience has been gained and the scheme has been administered under more favourable conditions.

277. In view of the above, therefore, it is contended that if due reserve was made in 1918 to provide for normal contingencies, and the majority of the "War Profits" were carried forward, coupled with the possibility of increased revenue being derived by societies through excess interest and more efficient management, the disposable surpluses among all Approved Societies at the second valuation should not be materially less than those disclosed formerly.

278. Under Section 76 of the National Health Insurance Act, 1924, it is provided that any part of a society's Contingency Fund not required for the purpose of making good a deficiency is to be carried to the Benefit Fund of the society, but must not be treated for the purpose of arriving at any surplus until the following valuation.

279. This being the case it will be seen that 96 per cent. of societies and branches which showed surpluses at 1918 will at 1923 have their Benefit Funds augmented to the extent of the Contingencies Funds at 1918, which amounted to no less than approximately £6,500,000.

280. If, therefore, the disposable surpluses at 1923 can reasonably be expected to equal those at 1918 as set out above, at which date societies did not have a Contingencies Fund to bring forward, it follows that at 1923 the disposable surpluses must be augmented by the Contingencies Funds amounting to £6,500,000 which fell into the Benefit Funds on 1st January, 1919.

281. Apart from this any deficiency which may arise in 1923 will have the support of the second Contingencies Fund which accumulated from the 1st January, 1919, to 31st December, 1923. Bearing this in mind, therefore, it is contended that there is ample margin to provide for the part payment of the cost of dental treatment necessary to insured persons without resulting in serious deficiencies among 96 per cent. of the units which showed surpluses at 1918. Should, however, such a course result in a deficiency, a society is always protected by the Central Fund, but in order to obtain assistance from this source it must first not only have actuarially exhausted its Benefit Fund, but also the Contingencies Fund at 31st December, 1918, and its Contingencies Fund at 31st December, 1923. Further, as the Central Fund is at present in credit to the extent of approximately £1,500,000, this sum would go no little way to meeting deficiencies arising among Approved Societies whose deficiencies were of such extraordinary dimensions as to need the support of the Central Fund in addition to the various funds referred to above.

282. It has already been stated that owing to the instability of dental benefit at the present time it is difficult to obtain a standard figure upon which to base that proportion of the weekly contribution required to provide a reasonable share of the cost of treatment, but Witnesses desire to state that the experience of the Society which they represent shows that to provide the whole cost of treatment would be equivalent to approximately 5s. per member per annum. As, however, it is only the intention to provide a reasonable share of the cost, say 50 per cent., this will amount to the sum of 2s. 6d. per member per annum.

283. On the assumption that the average number of contributions paid in respect of an insured person is 48 per annum, the deduction required to provide the sum of 2s. 6d. would amount to just over $\frac{1}{2}$ d. per week. If, therefore, a deduction of this sum were made from each weekly contribution it would create a fund of £1,500,000 per annum, or £7,500,000 in five years. As, however, it has already been pointed out that Approved Societies can reasonably be expected to maintain the disposable surpluses at 1923 without the assistance of the Contingencies Funds accumulated at 1918, it will be seen that this sum, viz., £6,500,000, would be available to meet no less than 86 per cent. of the cost of providing half the cost of dental treatment under existing conditions.

284. In view of the whole of the circumstances set out above, it is contended that a deduction of $\frac{1}{2}$ d. per week from each contribution would not, on the whole, seriously jeopardise the result of future valuations of Approved Societies, and Witnesses accordingly advocate:—

- (1) That the provision of at least 50 per cent. of the cost of dental treatment to insured persons should be provided as a statutory benefit of the Act.
- (2) That the qualification for such benefit should be the payment of at least 26 contributions, and that the persons should have been insured for at least 26 weeks.
- (3) That any society should still be enabled to augment this amount in the nature of additional benefits, if it so desires.
- (4) That the necessary deduction be made out of each weekly contribution paid in respect of an insured person to meet the cost of this benefit.
- (5) That the benefit should be administered on more uniform lines than at present.

VI.—(1) THE RETENTION OF INSURANCE COMMITTEES.

285. In view of the fact that the benefits provided by the Act are of two distinct characters, viz., benefits in cash and benefits in kind, it is apparent that the most appropriate form of machinery should be introduced for dealing with their respective administration.

286. The administration of cash benefits through the medium of Approved Societies is simply a continuation of the methods adopted in connection with such benefits before the advent of National Health Insurance, and it is contended that as the Act gives the insured person a free choice of society, there are many reasons why he would desire to receive his benefit through his society instead of through another channel.

287. With regard to medical benefit, however, the position is somewhat different, inasmuch as the position must be reviewed firstly, from the point of view of efficient supervision; secondly, from the point of view of the insured person; and thirdly, from the point of view of the medical practitioner.

288. Whilst the insured person is given a free choice of doctor in the same way that he is afforded a free choice of society, it will be obvious that in the former case his selection must to a certain extent be limited to those practitioners resident reasonably near him, whereas in the case of the Approved Society it is not so imperative that his society should be located in the immediate vicinity of his residence.

289. If, therefore, both the patient and the doctor are resident in the same locality, the supervision of any benefit which is closely associated with these individuals can be better undertaken by a body also resident in the same vicinity rather than one which is situated many miles away. From the point of view of supervision, therefore, it will be seen that medical benefit is one which should be administered on a territorial basis.

290. With regard to the insured person, the institution of a local body entrusted with the proper administration of medical benefit affords to him a channel through which grievances can be aired concerning unsatisfactory treatment, and matters relating thereto. In view of the fact that a local body is fully cognisant of local conditions which must play an important part in such matters, it must obviously be in a better position to adjudicate as to whether or not the medical practitioner is complying with the terms of service than an organisation situated outside the vicinity.

291. Reviewing the position from the point of view of the medical practitioner, it will be apparent that whilst such a person can take no exception to being under the jurisdiction of one properly constituted body, he would appear to have a legitimate grievance if he were called upon to deal with a multitude of different organisations, as would be the case if medical benefit were administered by Approved Societies, by reason of the fact that the insured persons on his panel would in all probability be members of different Approved Societies.

292. It would appear, therefore, that the provision in the Act for the constitution of Insurance Committees is one which not only gives due representation thereon to all parties concerned, but is a measure which is necessary to ensure proper supervision of the administration of medical benefit, and provides for the needs of both the insured person and medical practitioner alike.

293. In view of the above, therefore, and the fact that the administration of medical benefit is one which necessitates local administration, Witnesses are of the opinion that the existing local Insurance Committees are performing beneficial work in this direction, and accordingly should be retained. Further their abolition can only mean the transfer of the work now undertaken to another organisation (either in being or to be created) and the loss of 12½ years' experience in matters relating to medical benefit.

VI.—(2) THE ADMINISTRATION BY INSURANCE COMMITTEES OF THE BENEFITS APPLICABLE TO INSURED PERSONS ATTAINING THE AGE OF 70 YEARS.

294. It is provided under the National Health Insurance Act that contributions shall cease when a person attains age 70, and that sickness and disablement benefits shall also terminate.

295. Medical benefit, however, continues throughout life, and notwithstanding the fact of such a person's disqualification to participate in the major cash benefits of the Acts, he remains a member of his Approved Society throughout life. Approved Societies are not permitted to regard such persons as members for the purposes of administration appropriation, but nevertheless are required to keep in touch with them for the purpose of notifying the Insurance Committee when title to medical benefit ceases in consequence of death. Further, if the society fails to trace any of these members it is required to issue a specially endorsed notification terminating medical benefit.

296. In view of the fact, therefore, that when an insured person reaches the age of 70 he ceases to have an active interest in his Approved Society and that in normal circumstances the only benefit to which he is entitled is one which is administered by the respective Insurance Committees, Witnesses are of the opinion that membership of Approved Societies should cease at age 70, and that subsequently the whole of the affairs of such a person should be dealt with by the local Insurance Committee who would be notified by the Approved Society that age 70 had been attained.

297. It should not be a difficult matter for the Insurance Committee to be notified by the doctors or other local bodies when a person over age 70 dies, or alternatively the work at present performed by Approved Societies of regularly communicating with its members over age 70 for the purpose of determining continued title to medical benefit could with equal facility be undertaken by the Insurance Committee.

VI.—(3) THE RETENTION AND EXTENSION OF THE CENTRAL INDEX COMMITTEES.

298. In view of the fact that the actual administration of medical benefit is undertaken by the respective local Insurance Committees, and that the necessary title to, or disqualification from, this benefit is determinable by Approved Societies, it will be apparent that there must be some medium through which the necessary particulars can be conveyed to the appropriate bodies.

299. For many years it was the procedure for an Approved Society to notify the appropriate Insurance Committee of an insured person's title to benefit direct, and to take a similar course when for any reason the insured person ceased to be entitled to this benefit. This was effected by the issue of various forms of index slips by Approved Societies.

300. This procedure of direct communication between Approved Societies and Insurance Committees for this purpose led to endless confusion and caused considerable expense to all concerned, which will be illustrated by the following:—

301. An insured person entered insurance whilst resident at Birmingham. He subsequently removed to Edinburgh, and at a later date to Cardiff, where he became disentitled to medical benefit. In these circumstances the Approved Society notified the Birmingham Insurance Committee of the insured person's title to medical benefit. If, on his removal to Edinburgh, he desired the services of a panel doctor, the index slip originally prepared by his Approved Society would be forwarded to this quarter from Birmingham. If, however, he did not require treatment, the index slip would remain with the Birmingham Insurance Committee. When the society became aware that the insured person ceased to be entitled to medical benefit, he was then resident in Cardiff, and accordingly the necessary notification for discontinuing medical benefit was despatched to the Insurance Committee for that area. As the insured

person had probably not claimed benefit whilst resident in Cardiff, that committee would not un-naturally be a little surprised on receiving a notification from the Approved Society discontinuing the member's title to medical benefit, as it would be in total ignorance of the existence of such a person. This naturally resulted in correspondence between the Insurance Committee, the Approved Society and the insured person, which may, or may not, have resulted in discontinuing the insured person's title to medical benefit.

302. It will be apparent that such a state of affairs led to endless confusion, as a result of which the Central Index Committees for England and Wales respectively were brought into being for the purpose of acting as a clearing house between Insurance Committees and Approved Societies.

303. Under the revised procedure all notifications, whether establishing or discontinuing title to medical benefit, are sent by Approved Societies to the Central Index Committee, who notify the respective committees and are enabled to locate readily any particular individual in respect of whom they receive intimation that his title to medical benefit has ceased, and to take the necessary action for its termination.

304. Witnesses desire to state that the experience of the Society which they represent is that the establishment of such bodies has more than justified itself, and although this society's contribution to their upkeep amounts to approximately £1,200 per annum, it is strongly urged that no steps should be taken to bring about their discontinuance and thus revert to the former method of direct communication between Approved Societies and Insurance Committees.

305. Unfortunately the old procedure still exists in the case of Scotland and Northern Ireland, which results in two systems being in operation for dealing with the same branch of National Health Insurance.

306. Witnesses are therefore of the opinion:—

- (1) That the creation of Central Index Committees for England and Wales respectively has been fully justified.
- (2) That one Central Index Committee only, however, should be established with jurisdiction over all countries, failing which additional organisations should be established for Scotland and Northern Ireland instead of continuing the former system in respect of these countries, thus avoiding the existence of two separate systems for dealing with a similar type of work.

VII.—(1) THE AMENDMENT OF THE ACT RELATING TO MONIES AVAILABLE FOR INVESTMENT.

307. Under Section 70 of the National Health Insurance Act, 1924, the Minister of Health is required to ascertain periodically the sums standing to the credit of Approved Societies which are available for investment, whilst under Section 71 a society has the right, if it so desires, of requesting that one half of such sums shall be paid to it for the purpose of being invested in the names of the trustees of the society.

308. The remaining half is required by law to be retained by the Minister of Health on behalf of the Approved Society, and credited to an investment account, at a rate of interest to be prescribed. This rate of interest is at the present time fixed at 4½ per cent.

309. Although the reasons for such a provision are probably due to the fact that the total sum found available for investment has not been contributed solely by the insured person, but also by his employer and the State, it is nevertheless contended that inasmuch as a society is restricted in its choice of investments to trustee securities, it should be given the opportunity, if it so desires, of investing on its own behalf, the whole of the sums released for the purpose.

310. It is fully realised that a society is relieved of all anxiety concerning depreciation in respect of

money standing to its credit in the investment account, and is receiving a fixed rate of interest, but on the other hand it is also practically deprived of any interest which the society itself could earn on such sums over and above the rate prescribed by regulation.

311. Witnesses desire to point out that at 31st December, 1923, there was standing to the credit of the society which they represent, in the investment account, the sum of £1,345,984, and approximately an equivalent sum had from time to time been handed over to the society for investment in the names of its trustees.

312. With regard to that portion retained by the Minister of Health in the investment account, the society has not at any time received interest in excess of 4½ per cent. (although for a considerable period the rate was below this figure), nor has it been credited with any realised profit due to capital appreciation thereon.

313. With regard to a similar amount, however, which has been invested by the Society itself, not only has a capital appreciation of £95,954 accrued, of which figure £50,000 has actually been realised, but in addition, the average rate of interest earned on such investments at 31st December, 1923, was £5 2s. 2d. per cent., or an increase of over ¼ per cent. over the rate earned by a similar amount in the investment account, which makes a considerable addition to the benefit fund on a capital approaching £2,000,000.

314. It is further desired to point out that this rate of interest is by no means of a temporary character, by reason of the fact that as the investments made by this Society, or a greater proportion thereof, are irredeemable, the rate above quoted is assured for practically all time to come.

315. It will be seen, therefore, that if the whole of the sums available had been handed over to the society for investment, the benefit fund would have been materially increased, and consequently reacted to the benefit of the insured members.

316. Witnesses are accordingly of the opinion that in view of the safeguard which sub-section 2 of section 71 of the National Health Insurance Act, 1924, imposes by prescribing that all investments made by a society shall be such as trustees are for the time being, by law, empowered to undertake, there appears to be ample justification for allowing the 50 per cent. of the funds withheld from Approved Societies to be invested by the trustees.

317. Witnesses also desire to put forward the suggestion that provision should be made for advancing to a society a limited proportion of the amount standing to its credit in its current account with the Minister of Health, in advance of the ascertainment of the sums available for investment.

318. It often occurs that a society may be enabled to make a sound and profitable investment, but through lack of funds, this can only be effected by realising an existing investment.

319. Witnesses are accordingly of the opinion that a sum equivalent to 10 per cent. of the last amount released for investment should be available to the society, if it so desires, and be deducted from the next succeeding amount released for investment.

VII.—(2) THE DIVERSION TO HOSPITALS OF THAT PORTION OF THE GENERAL MEDICAL BENEFIT FUND APPLICABLE TO INSURED PERSONS WHO FAIL TO SELECT A PANEL DOCTOR WITHIN A REASONABLE PERIOD.

320. In spite of the fact that when an individual becomes liable to the provisions of National Health Insurance every possible means is taken of informing him of his rights in regard to obtaining medical treatment, there is a substantial proportion of such individuals who, through ignorance or apathy, take no action whatever in this connection. At the inception of the scheme such an occurrence could not be regarded as extraordinary, but when it is remembered that National Health Insurance has now been

in operation for 12½ years, if the cause were due to ignorance the number of insured persons who have failed to select a panel doctor should be comparatively negligible. Although no definite information is available on the point, it is believed that the number of such persons is by no means negligible, but on the contrary is a considerable figure, which in the opinion of the Witnesses is due to the fact that such persons do not desire to take advantage of the medical benefit provided by the Act.

321. Notwithstanding this fact, however, special provisions are made for the purpose of assisting such persons to obtain medical benefit, inasmuch as not only are members of the medical profession under an obligation to treat such persons, if required, but a special scheme of allocation has been instituted for the use of the respective Insurance Committees.

322. If, on the one hand, the medical profession are liable to render treatment to an individual who has not troubled to be included on his panel, there is a clear justification on the other hand for the capitation fee of such an insured person being paid into the General Medical Benefit Fund, but in the opinion of the Witnesses the time has arrived when, if an insured person clearly indicates that he does not desire the benefit for which he has paid in accordance with the law, then effect should be given to his wishes in this direction instead of establishing elaborate machinery for providing for such a person in case of emergency.

323. It is admitted that there may be a number of insured persons whose failure to select a panel doctor can be reasonably accounted for, and in such cases it is contended that due provision should be made.

324. It is suggested that if an insured person, after receiving proper notification, fails to select a panel doctor within a reasonable time, say six months after the date of his entry into insurance, the medical profession should be relieved of any liability to treat such a person, and that the capitation fee in respect of him should cease to form part of the General Medical Benefit Fund as at present.

325. In regard to the payment of sickness and disablement benefits an insured person is required by regulation to comply with certain conditions before he becomes entitled to this benefit, and any neglect on his part in this direction will render him disqualified to receive such benefits. If, therefore, an insured person is debarred from receiving the cash benefits through non-compliance with the conditions of the Act, there seems no justification for making any exception in this direction in regard to medical benefit.

326. With regard to the fund which would be built up as a result of the diversion from the General Medical Benefit Fund of the capitation fees in respect of persons who fail to select a panel doctor, there are many ways in which such a fund could be used with advantage; but in the opinion of the Witnesses as the calls upon the hospitals of the country are increasing daily in respect of treatment required by insured persons, it is advocated that the fund in question could not be used for any better purpose than for the assistance of such bodies.

VII.—(3) THE RETENTION BY EACH SOCIETY OF ANY SURPLUS DISCLOSED UPON A VALUATION, EXCEPT IN CERTAIN SPECIFIED INSTANCES.

327. The fact that an insured person is given the right of joining any Approved Society he may desire is one of the underlying principles upon which the existing scheme of National Health Insurance is based, and there is no doubt that this right of the insured person is not infrequently exercised. In coming to a decision on the point the insured person may have various reasons for selecting the society to which he is ultimately admitted. It may be, firstly, that it is a trade society; secondly, that it is a society with which he is already associated in a private capacity; and thirdly, that the additional benefits provided by the society of his choice are greater than those provided by other societies.

328. In his Report on the Valuation of Approved Societies at 31st December, 1918, the Government Actuary was very definite that careful and efficient management of an Approved Society had contributed its due share to the accumulation of surpluses among Approved Societies of no less than £17,000,000. Further, in the Report mentioned it is clearly stated that in nearly all cases where deficiencies had been found upon valuation, such deficiencies occurred in those societies where the Insurance Commissioners were led to believe that the methods of administration were defective and had taken appropriate action in connection therewith.

329. From the above, therefore, Witnesses submit that as the question of prudent and careful management plays an important part in the result of the valuation, and, in its turn, upon the benefits available to insured persons, it would be unjustifiable to institute any measures which would tend to prejudice prudent administration.

330. Witnesses have already pointed out in the previous part of this evidence, that they are strongly opposed to any form of pooling of funds of Approved Societies for the equalisation of cash payments, and they again desire to emphasise their opinions in this direction.

331. If such a state of affairs were brought into being it is submitted that the maladministered society would benefit at the expense of the society which was managed on prudent and economical lines, and which, in the words of the Government Actuary, has played no little part in bringing about increased benefits to its members.

332. Witnesses desire, therefore, to advocate most emphatically that any surplus disclosed at the valuation of a society, should normally be retained in its entirety by that society, and should not be subject to any measure of pooling with the surplus or deficiency disclosed by another society.

VII.—(4) THE RETENTION OF THE EXISTING WAITING PERIOD FOR QUALIFICATION TO PARTICIPATE IN ADDITIONAL BENEFITS.

333. With regard to any additional benefits which may become available as a result of the second valuation, it has been determined that an insured person will normally only become entitled to participate therein as from the beginning of January in the calendar year in which he will have completed a period of five years' membership in the society.

334. It has been suggested on more than one occasion that this waiting period is too long, and should be materially reduced.

335. There can be little doubt that this period was fixed in view of the fact that valuations are required to be made normally quinquennially.

336. It will be apparent that if a valuation be made on a given date, this must be based upon a given number of individuals, and if, after having arrived at a disposable surplus to be distributed among this number of individuals, it is ultimately decided that the participants in the surplus should be increased, then the basis of the original calculations must obviously be seriously affected.

337. In the opinion of the Witnesses, therefore, it is contended that any waiting period for additional benefits disclosed as a result of the second and subsequent valuations must of necessity be dependent upon the interval between the respective valuations, and any reduction in the waiting period must automatically bring about more frequent valuations.

338. Witnesses appreciate that the amount of work involved in a valuation of over 10,000 units is of no little magnitude, and accordingly it would be unreasonable to expect such a task to be undertaken at lesser intervals than five years.

339. In view of the above, therefore, Witnesses are of the opinion that no alteration should be made in the existing regulations governing the waiting period for participation in the second and subsequent valuations.

VII.—(5) THE AMENDMENT OF THE REGULATIONS TO PROVIDE FOR THE CAPITALISATION OF ADMINISTRATION EXPENSES.

340. Under Section 73 of the National Health Insurance Act, 1924, it is provided that the amount which a society is entitled to appropriate out of contributions for the purposes of administration shall be limited by regulation, and in the event of such an amount being exceeded, a special levy is required to be made upon all members of the society to the extent of the deficiency, unless such deficiency is made good otherwise than out of contributions payable under the Act.

341. The regulations prescribed in accordance with the above, provide that all expenditure incurred by an Approved Society in each year shall be debited against the amount allowed to be carried to the Administration Account in that year, and in the event of a deficiency in excess of 6d. per member being disclosed, the required levy is to be made on the members of that society. There are, however, special provisions made for dealing with a deficiency in excess of 6d. per member which arose out of the conditions connected with the War, and was such as could not reasonably have been prevented without prejudicing the efficiency or welfare of the society.

342. Although the above Regulations make provision for deficiencies occurring in abnormal circumstances, Witnesses desire to point out that a society's Administration Account may show a deficiency in excess of the amount allowed by reason of the fact that the initial cost of instituting any big scheme of re-organisation is required to be charged against one year's administration allowance, instead of being written off over a period of years as is the custom in such cases in the commercial world.

343. It will be seen, therefore, that whilst a society may make drastic re-organisations, and introduce fresh schemes which will tend to effect greater efficiency and economy in the future, such a measure may lead to that society being placed in the same category as the society which is maladministered, and required to levy its members as a consequence.

344. Witnesses are accordingly of the opinion that the Administration Account of an Approved Society should not be called upon necessarily to bear the whole of the expenses incurred in any one year, but that any expenditure of a capital or quasi-capital nature which has been incurred for the purpose of effecting administrative efficiency and economy, should, with the permission of the Minister, be allowed to be written off to the Administration Account over a term of years.

VIII.—(1) THE EXTENSION OF THE POWERS OF THE MINISTER OF HEALTH TO DEAL WITH MALADMINISTERED SOCIETIES.

345. In view of the fact that there are upwards of 10,000 Approved Societies and Branches administering National Health Insurance it will be apparent that there must of necessity be a sprinkling of units whose methods of administration are not all that could be desired.

346. The action of a few maladministered societies and branches must obviously have the effect of bringing disrepute upon the administration of National Health Insurance by Approved Societies generally in view of the fact that the only redress that the Minister of Health has at the present time against such a body is the withdrawal of approval. There are many offences committed which do not warrant such drastic action, such as the non-surrender of returns, etc., and Witnesses are accordingly of the opinion that additional powers should be granted to the Minister of Health for dealing with offences by Approved Societies and Branches in cases where the offence does not justify the withdrawal of approval.

VIII.—(2) THE STANDARDISATION OF THE PROCEDURE RELATING TO APPEALS BY INSURED PERSONS.

347. Although the administration of the cash benefits of the Act are left in the hands of Approved Societies, provisions require to be made in the rules of each society for dealing with appeals by insured persons.

348. In the case of the Society which Witnesses represent, members have the right of appeal to a properly constituted Appeals Committee, thence to a Board of Arbitrators, and finally to the Minister of Health. The only deposit which is required to be made by the insured person is a sum of 5s. in the event of his taking the matter to the Board of Arbitrators after it has been through the Appeals Committee. If the member is then dissatisfied with the decision of the Arbitrators, he has the right of appeal to the Minister of Health.

349. There are, however, societies whose procedure relating to appeals necessitates not only a deposit of a much larger sum than 5s., but also requires the insured person to appeal through several channels before he has the right of final appeal to the Minister of Health.

350. In the opinion of the Witnesses it is undesirable that any obstruction should be placed in the way of an insured person's right of appeal to the Minister of Health against the decision of his society, whilst the institution of a large deposit, and the necessity of appealing through many channels can only lead to the insured person abstaining from his right in this direction.

351. Witnesses are therefore of the opinion that some measure of standardisation should be introduced relating to the question of appeals by insured persons against the decision of their society.

CONCLUSION OF EVIDENCE.

352. We hereby certify the foregoing to be the evidence we tender on behalf of the Hearts of Oak Benefit Society before the Royal Commission on National Health Insurance.

(Signed) HEZEKIAH DUDLEY,
(Chairman, Executive Council).

(Signed) JAMES PRITCHARD LEWIS,
(Secretary).

APPENDIX V.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE ANCIENT ORDER OF FORESTERS FRIENDLY SOCIETY, APPROVED SOCIETY No. 152, BY MR. W. J. TORRANCE, HIGH CHIEF RANGER, AND MR. STANLEY L. DUFF, SECRETARY. See Minutes of Evidence of the Eighth and Ninth Days, Questions 3788 to 4424.

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PREFATORY NOTE BY THE SECRETARY OF THE ANCIENT ORDER OF FORESTERS FRIENDLY SOCIETY, UPON THE SUBMISSION MADE ON BEHALF OF THAT SOCIETY.

The central body of an Approved Society operating through branches, although the body approved under the National Insurance Act, is not itself a benefit unit.

The insured person deals only with the branch of the society of which he is a member, and benefits under the Act are administered by the branch officials only.

Contribution returns and cards are submitted to the appropriate Department of the Ministry of Health or the Board of Health, direct from the branches.

For these reasons the subjects included in the subjoined Submission made on behalf of the Executive Council of the Ancient Order of Foresters are, in the main, general in character.

Matters of administrative detail will doubtless be submitted by societies, whose centralised records provide greater facilities for assembly, and no attempt has been made herein exhaustively to deal with such details.

SUBMISSION ON BEHALF OF THE ANCIENT ORDER OF FORESTERS APPROVED SOCIETY, No. 152.

I.—PRELIMINARY OBSERVATIONS.

1. The Ancient Order of Foresters is a society registered under the Friendly Societies Act and operating through the medium of 3,524 branches in Great Britain and Northern Ireland, 2,430 of which are utilised for the purpose of administering the benefits provided under the National Insurance Acts.

2. The Order is an international society and is the fourth largest society approved under the National Insurance Act. At the date of the first valuation there were 737,577 members, 592,852 of whom were men, and 144,725 were women.

3. In Approved Societies with branches the branch is the financial unit, each unit (in the case of the Foresters called a Court) being valued as a separate entity. The Contingencies Fund of a branch society is, however, common to all units within the society and must be exhausted before recourse can be had to the Central Fund provided for the assistance of deficiency societies.

4. The gross surplus revealed throughout the branches of the Society at the first valuation was £1,054,267 of which the sum of £629,804 was declared to be disposable for the provision of additional benefits under Section 37 of the Act of 1911. Deficiencies were revealed in eighty-eight branches, amounting in total to £5,931, and this sum was discharged from the Society's Contingencies Fund which at the valuation date amounted to £336,365.

5. When the National Insurance Bill was being drafted in the years 1910 and 1911, the experience and procedure of the branch Friendly Societies were to a considerable extent utilised by the Government of that day and their advisers, as the basis for their proposals.

6. Prior to the inception of the National Insurance Act very little provision of sickness benefit, disablement or maternity benefit, was made by any organisa-

tions in the country other than the Friendly Societies. The provision of medical benefit likewise was available mainly through the instrumentality of those societies or of institutions formed locally by representatives of the societies.

7. In administering the National Insurance Acts this Society, in common with others of like nature, has succeeded in retaining the humane personal touch which was characteristic of its operations prior to the institution of the National Insurance Act.

II.—GOVERNMENT.

8. The government of the Ancient Order of Foresters in each branch by the members themselves, permits the freest display of the democratic control of the affairs of the Society, which was intended to be a prominent factor in Approved Society administration by the sponsors of the original Act. Generally speaking, the branches meet fortnightly, although in some instances, monthly. The chairman of a branch, in the case of the Foresters styled the Chief Ranger of the Court, seldom holds that office for more than twelve months.

9. There is direct representation from nearly every Court to a district meeting, held either half-yearly or annually, and direct representation is available from every Court to the High Court of the Order, which constitutes the annual meeting of the Approved Society.

10. The Executive Council is elected at each High Court for a period of twelve months, and normally no one person can continue a member of the Executive Council for more than five years in succession. The President of the High Court known as the High Chief Ranger presides over the meetings of the Executive Council held monthly.

11. In the actual administration of the benefits of the National Insurance Act a large number of the members participate. There is a Committee of Management numbering eight in each Court responsible for controlling the work associated with the administration of benefits.

12. Officers known as Woodwards are elected annually to visit sick members and to pay benefits. The Woodwards are authorised to pay up to and including a certain day in the week, selected by the Court as the end of the benefit week, or to the date of the final certificate should the member be certified as recovered. By this means, delays in payment of benefit properly due are avoided, and the payments themselves are made in the most sympathetic manner possible.

13. A member has the right of appeal against any decision of the Committee of his Court, firstly to the Arbitration Committee of the Court elected annually, secondly to the Arbitration Committee of the District elected annually at the district meeting, and thirdly to the Final Arbitration Committee in connection with which certain members of the Society are elected annually to act as chairmen as occasion arises.

14. The procedure explained above results in a large number of members taking part in the administration of a complex scheme of insurance against sickness and the consequences of ill-health, developing thereby in the members themselves a responsible-minded outlook upon their duties and their privileges. The flow of additional benefits as the result of the first valuation has instilled an additional degree of reality in the work of the branches and of their officers.

15. It is submitted that the method of administration employed by the Ancient Order of Foresters and similar branch societies permits the operation of the National Insurance Act most nearly in accord with the principles upon which the Act was founded.

III.—STANDARD OF ADMINISTRATION.

16. Successive Annual Reports of the Ministry of Health indicate that the standard of administration in the case both of societies and branches shows progressive improvement. So far as the accounting

work is concerned, this is amply confirmed by the Annual Reports of the Chief Auditor.

17. In the early days of administration of benefits under the National Insurance Act defects in administration of varying degrees of seriousness were found in most Approved Societies. In the case of the Foresters as with other Friendly Societies there was evidence of a tendency to regard National Insurance work as the extension of something with which the branches were familiar, and their previous experience frequently had the effect of misleading, rather than assisting, officers of the branches.

18. The percentage of clear audit certificates in respect of the branches of the Ancient Order of Foresters during recent years is in excess of the figure which represents the percentage of all Insurance units. The head office accounts have recently been certified without reservation or comment.

19. Throughout the branches of the Society there now exists a correct attitude of mind towards National Insurance, and a true appreciation of the responsibilities attaching to the duties of branch secretaries and of other branch officers.

IV.—FINANCIAL BASIS OF APPROVED SOCIETIES.

20. The Approved Society system as operating to-day is inherently associated with the procedure whereby the funds of each society or branch, except for the contribution to the Central Fund, are devoted solely to the provision of benefits for the members of that particular society or branch.

21. Such being the case the first valuation of Approved Societies inevitably produced dissimilar results with consequent dissimilar future benefits. Such conditions, however, must always arise where varying liabilities are borne by different societies, and where the cost or the standard of administration is not identical.

22. The admission to a society of members known by reason of their occupation, or for some other cause, to bring liabilities beyond the normal is certain to react unfavourably upon the financial prosperity of a society.

23. With regard to the cost of administration, there is a limit to the amount which by regulation, societies may expend in administering their affairs, and in so far as that limit is not reached, which is the case in a very large number of societies and branches, a larger proportion of the funds is left available for benefits, or for surplus as the case may be, in some societies than in others.

24. The safeguarding of benefit funds by proper supervision of sickness claims and of members in receipt of benefit, likewise results in a conservation of benefit funds, which has the effect of improving results upon valuation, producing thereby greater additional benefits.

25. Any departure from a system whereby careful administration of the benefit funds would cease directly to affect the future prosperity of the society would, in the opinion of this Society, be highly undesirable if not indeed absolutely dangerous.

V.—POOLING OF FUNDS.

26. It may be contended that a scheme requiring like contributions from all insured persons according to sex, should necessarily involve the provision of like benefits in respect of those contributions.

27. This contention, however, disregards the factors mentioned in the above paragraphs, and although in the view of this society every reasonable effort should be made to maintain standard benefits for standard contributions, no material departure from the existing principle would be warrantable, providing as that does, the most powerful incentive to a high standard of administration.

28. It is, nevertheless, realised that diverse valuation results have arisen and will continue to arise from circumstances not entirely within the control of the less favoured societies. To meet this development and with a view to guaranteeing standard benefits,

including the proposed addition contained in paragraph 48 to all insured persons, an extension of the existing Central Fund is recommended by increasing the contribution payable to that Fund by each Approved Society.

29. This society is entirely opposed to any complete scheme of pooling of funds, and is of opinion that such an arrangement would result in lowering the standard of administration and in consequence lead to a greatly increased drain upon National Insurance benefit funds.

30. It should be borne in mind that the Act was framed upon an insurance basis, and apart from other undesirable factors any considerable degree of pooling of funds would quickly remove the scheme from a basis of true insurance to one of irregular benevolence.

VI.—SMALL UNITS.

31. In any general consideration of the existing scheme of National Insurance, the question of the retention of the small society will inevitably be brought under review. This will apply equally to small branches of Approved Societies which operate through branches. Any arbitrary figure or solution to be applied in respect of small societies should not necessarily apply in the case of branches.

32. In a small society a deficiency revealed upon valuation to an extent sufficient to absorb that society's own Contingencies Fund, would bring it within the purview of the Ministry's officials for consideration as to the discharge of the remaining deficiency from the Central Fund.

33. Such would not be the case of a small branch similarly situated in respect of a valuation deficiency. The branch after absorbing its own branch share in the Contingencies Fund of the society would have recourse to the balance of the Contingencies Fund, which in effect is the share of the Contingencies Fund contributed by other branches of the same society, and until the Contingencies Fund as a whole was exhausted the branch would have no recourse to the Central Fund.

34. In view of the operation of this common Contingencies Fund within a society with branches, there is less reason for keeping the minimum number which should constitute a branch at a relatively high figure. The Government Actuary declined to certify any portion of the surplus revealed at the first valuation as disposable in respect of branches having a membership of less than 30, and regulations made by the Minister of Health empowered the governing bodies of Approved Societies with branches to transfer the engagements of a branch having a membership of less than 50, solely on numerical grounds, and notwithstanding the fact that there existed no evidence of mal-administration.

35. No exception has been or will be taken by this Society to the Government Actuary's action referred to above, nor indeed would objection be taken if it were found desirable to include similar treatment of branches having a small membership but in excess of the number utilised in respect of this restriction upon the last occasion.

36. As a practical policy the Society's governing body, except where exceptional circumstances have existed, have transferred the engagements of every branch below 50 in number, under the powers vested in them in the regulations to which reference has already been made.

VII.—MEDICAL BENEFIT.

37. In the view of those within this Society most competent to express an opinion, it is generally agreed that the service rendered under the present panel system of insurance practitioners is an improving one.

38. Under the regulations in force prior to the current year the treatment which a practitioner was required to give to his insured patient comprised "such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a general practitioner of ordinary professional competence and skill."

39. Under the 1924 regulations the treatment which a practitioner is required to give to his patients comprises "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."

40. From each of the foregoing definitions it will be observed that the insured person is not entitled under the Act to service of a specialised character, notwithstanding that an individual general practitioner may, in point of fact, be competent to perform such service.

41. Many cases occur daily where something more is required. It is submitted that provision should be included for specialists' and consultants' services for every insured person. In view of the fact that restoration to health of an insured person at the earliest stage possible is of supreme importance, the cost of such additional services should be met by setting aside for medical purposes an increased proportion of the contributions paid in respect of insured persons.

42. Apart from the limitation in the range of service at present available, it is apparent from the alterations made in the Medical Benefit Regulations of 1924 that serious doubts existed as the result of experience, as to the appreciation by certain practitioners of their ordinary professional responsibilities to their insured patients.

43. Such is a fair deduction to make from the obvious necessity shown by the new regulations to provide more effectively for adequate surgery accommodation, for the provision of deputies, for employment of assistants, for arrangements for practice, for certification, for the limitation of lists, and in respect of medical records, etc.

44. It is too early definitely to demonstrate whether or not the defects in the panel practitioners' service have been eliminated by the more stringent regulations.

VIII.—LOSS OF MEDICAL BENEFIT UPON LEAVING INSURABLE EMPLOYMENT.

45. The loss of medical benefit at present incurred by insured persons going out of insurance prior to reaching seventy years of age calls for remedy by legislation. Many insured persons are compelled to cease work by the terms of their employment at sixty or sixty-five years of age, thus forfeiting title to medical benefit which would have been sustained throughout life, had they continued work until seventy years of age. The recommended continuance of medical benefit should, of course, be dependent upon the completion of a specified period of insurance and the payment of a specified number of contributions.

IX.—DENTAL BENEFIT.

46. The direct relationship between defective teeth and ill-health has been very definitely established, and is now universally acknowledged. In any comprehensive National Health Insurance scheme, therefore, it is essential that dental treatment should occupy a prominent place.

47. In the view of this Society the provision of dental treatment should be made one of the statutory benefits of the Act at as early a date as possible, instead of leaving its provision to flow only as a result of a favourable valuation report.

48. It is suggested that dental benefit should be treated as a cash benefit, and that expenditure rightly incurred by insured members of Approved Societies, say up to £1 should be met in full by the society; and that the expenditure involved beyond that sum should require authorisation by the society after the submission of an estimate, and the cost thereof in respect of all sums beyond £1 be met from the society's funds to the extent of 50 per cent.

49. It is highly probable that the inclusion of such a benefit would do much to absorb the valuation surpluses anticipated in the future, but it is submitted that the disbursement of funds in this direction would

be more beneficial to the health of the nation than adding varying amounts to the statutory sickness or disablement benefits. The provision of dental benefit, probably more than the provision of any other treatment benefit, would have the effect of conserving benefit funds so far as the drain due to sickness and disablement benefit is concerned.

X.—ADDITIONAL BENEFITS.

50. In Part II of the Fourth Schedule to the Act of 1911 appeared a list of additional benefits which may be provided from surpluses revealed upon valuation. This Schedule was added to subsequently. Additional benefit No. 3 permits an increase of the sickness or disablement benefit of members of the society.

51. In the view of the Ancient Order of Foresters it would be an advantage if a definite limit were imposed upon the extent by which normal cash benefits can be augmented from surpluses, as it is considered that the full benefit of preventive services will never be forthcoming, until a substantial proportion of the sums available by way of surplus is devoted to the provision of treatment benefits.

52. During the year 1923 the total sum expended on benefits of all kinds under the National Insurance Acts amounted to upwards of £20,000,000 of which the sum expended on additional benefits other than cash amounted to £555,000 only, and that sum was greatly in excess of the amount which had been so expended in any previous year.

53. The provision to insured persons by Approved Societies of the services of dentists as a statutory benefit, and of some of the other treatment benefits from surpluses is regarded by this Society as essential if the full potentialities of the National Insurance Acts are to be made effective.

XI.—MARRIED WOMEN.

54. The administration of National Insurance benefits to married women has always presented difficulties which the improvements effected by the Act of 1918 did not wholly remove. Subsequently the difficulties were accentuated by the introduction of the Prolongation of Insurance Act and the placing upon Approved Societies the onus of deciding whether or not an insured woman member had or had not definitely ceased to be employed upon marriage.

55. It is suggested that considerable simplification would be effected if upon the marriage of all insured women, a bonus of, say, £1 or £2, were made payable at the termination of 52 weeks from marriage, the whole of the provisions relating to Class K being abolished.

56. If such were done insured women ceasing to be insurably employed upon marriage could remain entitled to ordinary benefits for a period of 52 weeks only, in addition to the bonus referred to in the preceding paragraph.

XII.—INSURANCE COMMITTEES.

57. Insurance Committees are at present charged with the duty of administering medical benefit, to which all insured persons are entitled.

58. The provision of such additional benefits as will continue and which will be dependent upon surpluses (a condition which it is claimed should be maintained) can never be available to the same area of insured persons as medical benefit. Authority for their provision must always issue from, and the degree to which they should be provided must be determined by, the Approved Society in whose hands the members' records lie. The administration of additional benefits must therefore remain in the hands of Approved Societies.

XIII.—RESEARCH WORK.

59. In any revision in the allocation of contributions payable in respect of insured persons, it is suggested that a margin should be allowed for provision of adequate sums for scientific research work having for its object the prevention or cure of sickness, or the restoration of sick persons to health.

XIV.—SUMMARY.

60. We have, therefore, to submit on behalf of the Ancient Order of Foresters, for the consideration of the Royal Commission, the following summarised conclusions:—

- (a) That the existing branch Approved Society system of administering the National Health Insurance Acts, authorised by the original Act of 1911, be continued.
- (b) That such method of administration, maintaining as it does a humane personal touch, operates the National Insurance Act most nearly in accord with the principles upon which the original Act was founded.
- (c) That the principle should be maintained whereby careful administration becomes reflected in the future prosperity of an Approved Society.
- (d) That no departure should be made in the existing system which would have the effect of lifting the National Insurance Scheme from a basis of true insurance.
- (e) That no pooling of funds beyond that foreshadowed in (f) would be either beneficial or justifiable.
- (f) That an extension of the operation of the Central Fund be made with a view to rendering a greater degree of assistance to societies found deficient upon valuation.
- (g) That in dealing with the problem of small units, distinctive treatment be afforded to small branches of an Approved Society.
- (h) That in connection with medical benefit, specialists' and consultants' services should be available for all insured persons, and that the cost of such additional services be met by setting aside an increased proportion of the contributions paid in respect of insured persons.
- (i) That the provisions whereby title to medical benefit is forfeited upon leaving insurable employment, be modified.
- (j) That dental benefit be made one of the primary statutory benefits and operated upon a cash basis.
- (k) That a definite limit be imposed upon the extent by which sickness and disablement cash benefits can be augmented from valuation surpluses.
- (l) That the provisions relating to Class K insured married women be abolished, and that a small bonus be paid to all insured women at the expiry of 52 weeks after marriage.
- (m) That the administration of additional benefits continue in the hands of Approved Societies.
- (n) That in any revision of contributions a margin be allowed for the provision of adequate sums for research work.

W. J. TORRANCE,
High Chief Ranger.
STANLEY L. DUFF,
Secretary.

22nd October, 1924.
17, Russell Square,
London, W.C.1.

APPENDIX VI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL CONFERENCE OF INDUSTRIAL ASSURANCE APPROVED SOCIETIES BY SIR THOMAS NEILL, J.P., CHAIRMAN OF THE EXECUTIVE COMMITTEE, MR. E. F. SPURGEON, F.I.A., AND MR. E. T. PALMER, MEMBERS OF THE COMMITTEE. See Minutes of Evidence of the Ninth, Tenth and Eleventh Days Questions 4425 to 5460.

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1. The following evidence is submitted on behalf of the National Conference of Industrial Assurance Approved Societies, consisting of the Societies referred to hereunder, approved under Section 23 of the National Insurance Act, 1911, who are associated in the National Conference for the single purpose of co-operation and interchange of experience in the administration of the National Health Insurance Acts:—

- Blackburn Philanthropic Approved Society (International—one Valuation).
- Blackburn Philanthropic Mutual Approved Society (England only).
- City of Glasgow Approved Society (International—one Valuation).
- Liverpool Victoria Approved Society (International—one Valuation).
- London and Provincial Approved Society (International—one Valuation).
- Leigh Friendly Collecting Approved Society (England only).
- National Amalgamated Approved Society (International—separate Valuations for Scotland and Wales).
- Prudential Approved Societies (International—separate Valuations for Scotland and Wales).
- Royal Liver Friendly Society (National Health Section) (International—one Valuation).
- Royal Co-operative Approved Society (International—one Valuation).
- Scottish United Reform Approved Society for Men and Women (Scotland only).

2. The number of insured persons who were members of the various societies within the Conference at the date of the first Valuation was 6,697,504, of whom 3,550,474 were men and 3,147,030 women, the latter figure representing 56 per cent. of the female membership of all societies at that date.

3. The amount of benefits paid by these societies since the Act came into operation up to the 31st December, 1923, is as follows:—

	£
Sickness Benefit	27,784,845
Disablement Benefit	8,048,834
Maternity Benefit	6,601,842
Total	£42,435,521

4. Considerable sums have also been paid by way of additional benefits. During 1923, £193,758 was contributed by these societies to hospitals and convalescent homes throughout the country, and £198,185 was expended in providing dental treatment for members.

5. The benefits are paid and the contribution cards distributed and collected by means of the Agency Staffs of the various societies within the Conference, constituting an organisation which effectively covers practically every town and village in the United Kingdom.

6. The people brought into compulsory insurance by the original Act were, in the main, of two distinct types. Firstly, the members of the then existing Sickness Benefit Societies who were familiar with the practice and rules of such societies. Secondly, the very large majority who had no such experience, had never voluntarily associated themselves with any such movement and were unacquainted with the principles and practice of sickness insurance.

7. It was mainly this latter class which depended upon the Industrial Assurance Organisations as the medium through which to obtain the benefits of the Act, and the enrolment of this class into Approved Society membership was only made possible by the extensive organisation of the Industrial Assurance Offices, whose agents, entering as they did, into practically every industrial home in the Kingdom, explained the potential benefits of National Health Insurance and disseminated information which alone made possible the degree of success with which the Act commenced to function.

8. While much has been done since 1912 to educate the insured population as to their rights and privileges under National Health Insurance, it is submitted that an organisation such as the Industrial Assurance Societies alone can provide, is still necessary for the smooth working of a compulsory system of insurance among that class to which reference has been made. The "home service" which it provides is the only means by which vast numbers of the insured population are maintained in effective insurance, and thereby entitled to claim the benefits of the Acts. This is illustrated by the fact that very great difficulty is still experienced in collecting contribution cards. Repeated calls have to be made upon a considerable proportion of members before the card is obtained, and without such persistency large numbers of insured persons would, either through their own default or the default of their employers, fail to surrender their cards, and thereby be disqualified for benefits. The same considerations apply to the vast number of notices of marriage, death and alterations which are required to maintain accurate valuation data. In the opinion of the Conference it would be quite impossible to obtain this essential information in respect of this type of insured person without the personal service given by the Industrial Assurance agents, and it is submitted that it would not be in the interests of National Health Insurance generally that a large body of insured persons should, through ignorance of a somewhat complicated procedure, be deprived of the benefits for which compulsory deductions have been made from their wages.

9. In reviewing the question of the cost of administration, special consideration must be given to the needs of this class of insured person, and it should therefore be remembered that in addition to the statutory benefits to which they are entitled under the provisions of the Acts, they are receiving a most valuable and (to them) necessary additional benefit in the shape of the "home service" which is provided through the staffs of the Industrial Assurance organisations.

10. If the case for a "home service" in the distribution of National Health Insurance benefits is admitted to be sound, it would be equally sound in regard to the extension of cash benefits in any form. It is the most effective method in the circumstances, investing the society with a personality, in the person of the agent, which is so helpful in the administration of a compulsory insurance scheme and so necessary to its willing acceptance by the population.

ARREARS OF UNEMPLOYED MEMBERS AND PROLONGATION OF INSURANCE.

11. Holding, as the Conference does, the opinion that the National Health Insurance scheme should be based on strict insurance principles, it can only regard as a temporary measure the present special arrangements for maintaining in insurance, and providing minimum cash benefits for, those members who are unemployed in consequence of the existing trade depression.

12. As a temporary measure, however, it regards the present arrangement as inadequate, providing as it does only minimum benefits. It is, therefore, suggested—as a temporary measure and until a permanent solution can be devised—that the cost of maintaining such members in full benefit should be met out of the non-disposable surplus standing to the credit of societies. Failing this, the schedule of Additional Benefits should include "the remission of arrears whenever such arrears are due to genuine unemployment" with the proviso that in the event of a society having no disposable surplus, the non-disposable surplus should be available for this particular purpose. Such an extension to the schedule of Additional Benefits would involve the deletion of all words after "distress" in Additional Benefit No. 11.

13. The Conference would cordially welcome any suitable proposal, subject to its being based on insurance principles, which had for its object the maintenance of the title to full sickness benefit of insured persons genuinely unemployed, and, as a permanent solution, it suggests that this should be done by the payment of the necessary contributions from some source.

DEPOSIT CONTRIBUTORS.

14. The Conference is of the opinion that the time has arrived for the elimination of the Deposit Contributor class and that a scheme should be devised under which Approved Societies should assume responsibility for their absorption.

MARRIED WOMEN.

15. The existing provisions as regards insured women who marry are admittedly complicated and from the point of view of simplicity alone, the Commission are asked to consider whether a marriage bonus should not be substituted for the contingent rights under Class K. The proposal for a marriage bonus was accepted by the Committee under the Chairmanship of Sir Gerald Ryan in 1916, and was incorporated in the Bill subsequently submitted to Parliament. In its passage through the House of Lords, however, the present benefits were substituted.

16. The complex nature of the existing provisions has been accentuated by the Prolongation Act, but even under normal circumstances their administration is troublesome and expensive to societies and out of proportion to any advantages they may possess. If the proposal for the substitution of a marriage bonus is accepted, the Commission are asked to consider the following suggestions:—

(a) An insured woman on marriage to be entitled to select one of two options—

(i) A bonus on marriage, the payment of the bonus to terminate the contract of insurance, a fresh contract being set up (with fresh waiting periods, &c.) in the event of the member continuing in employment or re-entering employment; or

(ii) To have her insurance treated as continuous, subject to the ordinary conditions as regards "Free Year," &c.

(b) The option should be open for four weeks from the date of marriage, and where it is not exercised within that period (whether or not this is due to the marriage not having been notified) the insurance should automatically be treated as continuous, that is, as if (a) (ii) had been selected by the member.

EXTENSION OF BENEFITS.

17. While the Conference sympathises profoundly with the need for the extension of benefits generally, it holds the view that any extension or readjustment of National Health Insurance benefits should be within the existing contribution.

MEDICAL BENEFIT.

18. It is recommended that attendance at confinements, if so required by the insured person, and at illnesses arising therefrom, be included in the contract of service of insurance practitioners, a prescribed sum for such service being paid to the practitioner from the maternity benefit due to the insured person from his or her society.

19. In the event of any material change in the character or cost of medical benefit being recommended to the Royal Commission, the Conference respectfully asks to be allowed to submit its views thereon.

ADDITIONAL BENEFITS.

20. The Conference holds the view that the future development of National Health Insurance should be in the direction of treatment benefits rather than increasing cash benefits, and for this reason it is suggested that the amount which may be devoted to increasing cash benefits should be restricted to not more than two-thirds of the number of complete units of disposable surplus with a maximum of five units. Subject to this restriction, societies should be allowed to retain the right of devoting their disposable surplus to any of the prescribed additional benefits.

21. An alternative recommendation has already been made in paragraph 12 to the effect that the schedule of Additional Benefits should include power to remit arrears in respect of periods of genuine unemployment. It is further recommended that societies should be allowed to provide, as an Additional Benefit, treatment and training for blind members.

DENTAL TREATMENT.

22. The Conference accepts the view, so widely held, that it is desirable that a measure of dental treatment should be available to all members of Approved Societies, and while still adhering to its opinion that societies should retain the full control of all disposable surplus funds arising out of the contributions of their own members, it desires to make the following suggestions:—

(a) Out of every contribution one halfpenny be credited to the Central Fund.

(b) That valuation deficiencies, in so far as the Contingencies Fund of each society is inadequate, be first liquidated from the Central Fund, provided no part of such deficiency is due to maladministration.

(c) That the Central Fund be maintained at a minimum figure of £1,500,000.

(d) The balance remaining in the Central Fund to be distributed to societies on the basis of membership for the specific purpose of providing treatment benefits (with dental treatment as a first charge) of a character uniform throughout the country.

(e) All payment from the Central Fund for treatment benefits to carry the State grant.

- (f) That the scale of fees and the character of the dental service be negotiated by a committee representing the Ministry and Approved Societies on the one hand and the Dental Profession on the other. In this connection it may be mentioned that a Joint Committee of representatives of certain Approved Societies and of the Public Dental Service Association already exists for the purpose of administering a national scheme for societies who are already giving dental treatment to their members.
- (g) That the contribution to the Central Fund on the above basis should be retrospective as from the 1st January, 1919.
- (h) That the qualification for dental assistance under this scheme be 104 contributions and 104 weeks of insurance.
- (i) There should be only one Central Fund for all countries.

23. It is estimated, as far as it is possible to estimate on the available data, that on the present scale of fees in operation under the scheme referred to in paragraph 22 (f), a halfpenny per contribution would support a benefit of 100 per cent. of the first pound, and 50 per cent. of the remainder, subject to safeguards against abuse. It would, however be necessarily introduced on an experimental basis, but the retrospective nature of the proposal contained in paragraph 22 (g) above, would provide a considerable fund as a reserve, and this would sufficiently support the above benefit until such times as more reliable data are available.

24. Until the results of the Second Valuation are known it is difficult to estimate what effect the foregoing proposals would have on individual societies, but it is believed that the National Health Insurance funds in the aggregate will be able to meet this new charge.

25. The scheme would be uniform in its operation and would still leave unimpaired the relationship of societies one to the other and would not destroy that incentive to good management which results from a society retaining any surplus for the benefit

of its own members, i.e., for the provision of other additional benefits.

INSURANCE COMMITTEES.

26. The Conference is in favour of maintaining Insurance Committees as at present constituted, and with their existing duties. With its representative constitution the Insurance Committee fulfils an important function in maintaining contact between the insured person and the administration of medical benefit. It forms a tribunal to which insured persons may appeal, and in the opinion of the Conference the value of the committees cannot be measured by the number of complaints investigated by them, but rather by the fact that the existence of such a tribunal has the effect of maintaining a higher standard of medical service than would otherwise be the case. The Conference regards the continued existence of the committees as necessary to the proper administration of medical benefit and any modification of its representative character or the substitution of another body lacking equivalent representation of insured persons would be a retrograde step.

CENTRAL INDEX COMMITTEES.

27. It is recommended that there shall be only one Central Index Committee for England, Scotland, and Wales.

VALUATION.

28. It is recommended that the option to combine into one valuation unit those countries which have hitherto been valued separately, be again granted to International Societies provided that, in order to take effect at any particular valuation, notice shall be given to the Ministry not later than twelve months before the valuation date, the option to remain open indefinitely.

2, Pump Court,
Temple, E.C.,

2nd December, 1924.

APPENDIX VII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INDEPENDENT ORDER OF ODDFELLOWS, MANCHESTER UNITY FRIENDLY SOCIETY, APPROVED SOCIETY No. 123, BY MR. EDWIN HEATHER, DIRECTOR. See Minutes of Evidence of the Eleventh and Twelfth Days, Questions 5461 to 6098.

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I.—PERSON GIVING EVIDENCE.

1. Evidence will be given on behalf of the Society by Edwin Heather, 474, Commercial Road, Portsmouth, Director of the Independent Order of Odd-

fellows, Manchester Unity Friendly Society—Approved Society No. 123—who has been a Director of the Society for the last four and half years, a member of the Portsmouth Insurance Committee since its formation to October, 1924, and has been actively engaged in the administration of National Health Insurance since the inception of the Act.

II.—PARTICULARS OF SOCIETY.

2. The Independent Order of Oddfellows, Manchester Unity Friendly Society was established in 1810. It is a registered Friendly Society. At a specially convened Conference of Deputies in February, 1912, it was decided to become an Approved Society under the National Insurance Act which came into operation on 15th July, 1912.

3. The Society was duly approved and operates as Approved Society No. 123.

4. The Society is an International Society and is the largest of the Affiliated Orders in the Kingdom administering National Health Insurance. The National Health Insurance Acts are administered through the medium of 3,527 Lodges grouped in 257 Districts.

III.—GOVERNMENT.

5. The Manchester Unity is governed by the members themselves formed into branches called Lodges.

6. Members have the right to attend, vote and take part in the business of their Lodge on each occasion it meets.

7. Each Lodge meets either weekly, fortnightly or monthly. The Chairman of the Lodge is designated "The Noble Grand," and presides at its meetings.

8. A Committee of Management is set up in each Lodge, consisting of at least 13 members, who are elected annually. Any action they may take requires confirmation at a subsequent meeting of the Lodge.

9. Lodges are formed into Districts, each District consisting of the number of Lodges within its area, and each Lodge has direct representation at the meetings of the District which are held quarterly or half-yearly, according to the rules of each particular District.

10. These meetings are presided over by a Provincial Grand Master.

11. Each District appoints representatives to the Annual Meeting of the Society, which is termed the Annual Moveable Conference. This Conference meets during Whit-week in each year at such place as may be decided upon according to the rules of the Society.

12. The Board of Directors constitute the Committee of Management of the Society and are appointed at each Annual Moveable Conference and remain in office for a period of twelve months, and are eligible for re-election.

13. All Districts and Lodges are under the supervision and control of the Board of Directors.

14. The President of the Annual Moveable Conference is known as the Grand Master of the Order, and he presides at all meetings of the Board of Directors.

15. The Head Office of the Society is situated in Manchester.

16. The system outlined above permits of all members coming into close personal touch with each other and the officers through whom their National Health Insurance is conducted and tends to a better dissemination of knowledge amongst insured persons.

17. It creates and encourages interest in National Health Insurance work amongst the members.

18. Every member has an opportunity of taking part in the administration of the affairs of Lodge, District and Order.

19. He may pass through the various offices of Lodge and District, he may be a Deputy to the Annual Moveable Conference, and has opportunities of attaining the highest position in the Society.

20. The system creates self-dependence, builds up character, teaches mutual responsibility, fosters the cultivation of fraternal principles, and is therefore a great national asset. It is working well and efficiently.

21. It is also claimed that the present system has given general satisfaction to the insured persons who are members and who are visited by the sick visitors, and so treated as to ensure the provisions of the Act being carried out in a just and sympathetic manner.

22. The system also secures prompt payment of benefits due.

23. For these reasons it is strongly urged that the existing Lodge system authorised by the original Act of 1911 be continued.

IV.—ADMINISTRATION.

24. The administration of National Health Insurance by Lodges of the Society has shown a consistent and marked improvement each year since the inception of the original Act.

25. A better understanding of the provisions of the Act and the regulations and circulars of the Ministry is in a great measure accountable for this improvement.

26. Such improvement is also evidenced by the reduction in the number of reservations in the Government Auditors' Reports on the accounts of Lodges.

27. Membership, contribution and benefit registers and cash books are kept by the secretaries of Lodges.

28. Contribution cards are issued and collected by the various Lodges and accounted for in the contribution registers, and the half-yearly returns prepared and transmitted to the Ministry.

29. All benefits and payments regarding the administration are made by individual Lodges and accounted for in the cash book, the money necessary being remitted from the Head Office through Districts monthly, based on the average expenditure of the preceding year.

30. All books, returns, forms and documents necessary for audit purposes are prepared by the Lodge Secretaries.

31. Districts receive contribution cards and returns from Lodges which are examined and checked to ensure accuracy before transmission to the Ministry.

32. All financial accounts as between the Society and the Ministry are wholly prepared and completed by Head Office from the advices received from the Ministry.

33. The sums received from the Ministry from time to time for investment are invested by the Trustees of the Society in accordance with its rules as the Directors may decide.

34. To improve administration transfers of engagements to District State Insurance Lodges have, in some instances, taken place, where the administration is faulty. No pressure is brought to bear in this connection where the management is satisfactory.

35. It is considered that the administration by Lodges is an incentive to efficiency.

36. That the system is economical is proved by the fact that whereas there is a fixed allowance for all types of Approved Societies yet the gross surplus of all Lodges in the Manchester Unity at the end of the year 1922 amounted to £81,101 7s. 11d., and the deficiencies were only £4,617 5s. 11d.

37. Lodges are constantly under review by the Directors and in cases of inefficiency prompt action is taken to remedy the same.

V.—VALUATIONS.

38. At the date of the First Valuation under the National Health Insurance Acts (31st December, 1918), the Society comprised 965,462 Insured persons, of whom 751,825 were men, and 213,637 women. Included in the latter were 173,212 spinsters and widows, and 40,425 married women.

39. Each Lodge is treated as a separate unit for valuation purposes. Where a Lodge discloses a deficiency, this deficiency is made good from the Contingencies Fund of the Society. This Fund, during the First Valuation, was credited with the amount of £431,993, from which deficiencies were liquidated to the extent of £11,222, the balance, £420,771, being distributed between the Lodges of the Society. For the Second Valuation period from 1919 to 1923 inclusive, the amount of £443,597 has been credited to the Fund.

40. The gross surplus disclosed throughout the Society in Great Britain at the First Valuation was £1,268,939 and £758,735 of this amount was available for the provision of additional benefits under section 37 of the 1911 Act, and the regulations made by the Minister.

41. The method of disposal of surplus is decided in each Lodge by the members at a meeting convened for the purpose.

42. Out of 3,710 Lodges only 164 Lodges revealed deficiencies amounting in total to £11,222, which

sum was discharged from the Society's Contingencies Fund.

43. The following is a summary of the results of the First Valuation:—

—	Membership.	Surplus.	Deficiencies.	Reserve.	Disposable Surplus.
		£	£	£	£
England	879,613	1,177,348	7,619	468,786	708,562
Wales	62,488	54,832	3,268	28,210	26,622
Scotland	22,408	35,454	335	12,794	22,660
Ireland	953	1,305	—	414	891
	965,462	1,268,939	11,222	510,204	758,735

VI.—ADDITIONAL BENEFITS.

44. On the declaration of the results of the First Valuation many Lodges availed themselves of the opportunity provided by the Act of increasing their sickness, disablement and maternity benefits, in many cases to the limit of the amount available, and these have been in operation since the results of the First Valuation were revealed.

45. Having once had the opportunity of increasing their cash benefits from surplus, it is assumed that many Lodges will again take advantage of this method of disposing of their surplus when the results of the Second Valuation are made known.

46. We are of opinion that there should be a statutory limitation of sickness and disablement benefits.

47. The present payment of statutory cash benefits to which are added such additional sickness cash benefits as the Lodge may be entitled to pay from its surplus, has a tendency to destroy the incentive to personal thrift.

48. When the First Valuation was completed very little information was available as to the cost of non-cash benefits and in the absence of such information many of the Lodges adopted the system of using the disposable surplus entirely for the provision of additional cash benefits (sickness, disablement and maternity).

49. With the realisation that the first essential is early recovery to good health, there is a growing feeling that future surplus should be used in a greater degree for the provision of non-cash benefits rather than be applied to an additional few shillings per week as an additional sickness benefit which does not to any degree reflect itself in the restoration to good health.

50. There are instances throughout the Unity where Lodges have set aside part of their surplus for a particular additional treatment benefit, but few applications have been received from members for the treatment benefit adopted, whilst applications for other forms of treatment have been made. Consequently the money so set aside has not been used for the purpose originally intended, and applications have had to be made to vary schemes.

51. It would therefore be of advantage to allocate a total sum for all such purposes, so as to permit of the provision of all the benefits according to varying requirements and not earmark specific sums for special benefits, provided the total amount allocated is not exceeded.

52. Surpluses are contingent on a light sickness experience and careful administration by Society and Lodge. It is therefore necessary so as to ensure careful administration and the continued interest of members, that the administration of additional benefits brought about by valuation surplus should be administered by the unit responsible for the surplus and not handed over to any other body, especially in view of the fact that all information in respect of them is in the possession of the Society or Lodge. Further, the Society or Lodge, having the right of choosing the particular benefit desired, and

the extent to which it shall be provided, is, in all respects, the best source of administration.

VII.—DENTAL TREATMENT.

53. The demand for dental treatment as one of the additional treatment benefits raises the question as to whether the time has not now arrived when consideration should be given to the possibility of incorporating dental treatment as one of the prescribed benefits of the Acts.

54. There has been a considerable demand for this benefit, and realising that defective teeth are a predisposing cause of many diseases it is considered that dental treatment should be made one of the statutory benefits of the Act.

55. We are of opinion that this benefit should be a cash benefit with certain safeguards as to period of insurance and the number of contributions paid.

56. The introduction of dental treatment to insured persons as a right under the Act would undoubtedly have a tendency to lessen the claims for sickness and disablement benefits.

57. It is difficult to form any reliable estimate of the cost of this benefit, but it is suggested that if it is not actuarially possible to make this a statutory benefit under the Act, an examination of the matter should be made as to the extent to which dental treatment could be given to insured persons from surpluses, bearing in mind that the member should be liable for some proportion of the cost.

58. It is realised that difficulty would be experienced in cases of societies and branches in deficiency or with no disposable surplus on valuation. It might be possible in these cases to make provision from a central fund in the case of societies with branches, or from the societies' Contingencies Funds; and in the case of other societies from a central fund, to which all such societies should contribute.

VIII.—MEDICAL BENEFIT.

59. We are of the opinion that the present system of providing medical benefit through panel practitioners should be continued.

60. It may be observed, however, that cases are continually arising where insured persons require treatment of a more efficient and specialist character than that provided by the regulations, and this fact leads us to the conclusion that the present system may be improved by extending the benefits to include consultant and specialist services.

61. It is suggested that the additional cost of such services could be met by setting aside an increased proportion of the contributions paid in respect of insured persons for this purpose.

62. We are of opinion that many cases of hardship occur through insured persons ceasing insurable employment between the ages of 60 and 70, and thereby ceasing insurance with consequent loss of medical benefit. We recommend medical benefit throughout life to such persons who may be

desirous of availing themselves of this privilege, contingent upon the insured person having been in continuous insurance for a specified period and on payment of a specified number of contributions, subject to such persons paying until the age of 70 the proportionate contribution cost of such benefit. We suggest that this system, if adopted, could be worked through Insurance Committees.

IX.—CLASS K MEMBERS.

63. The administration of National Health Insurance as regards married women has always presented difficulties and requires simplification. It is therefore recommended that the ordinary conditions applicable to insured persons, viz.:—one year's free insurance on ceasing insurable employment, should obtain in the case of all insured women, and that Class K members should be abolished.

X.—DEPOSIT CONTRIBUTORS.

64. The position of deposit contributors is unsatisfactory, and we are of opinion that the present system of individual accounts should be abolished.

65. We suggest that a Deposit Contributors Approved Society be set up and worked upon the mutual system of insurance on the same principle as at present appertains in all other Approved Societies.

66. That the existing deposit contributors be advised to join an Approved Society forthwith; failing this, they be transferred to the Deposit Contributors Society within a stated period.

XI.—SICKNESS BENEFIT.

67. We are of opinion that the statutory rates of sickness and disablement benefit laid down in the Act should not be increased.

68. We are, however, of the opinion that payment of sickness benefit should be made the first day of incapacity.

69. In support of this opinion we desire to submit that—

- (a) The payment from the first day would enable insured persons to cease employment in the early stages of an illness and would therefore in many cases prevent a prolonged period of incapacity.
- (b) It would tend largely to the simplification of accounts.
- (c) We think the additional payment for the first three days would to a great extent be counterbalanced by the prevention of many serious illnesses and the earlier restoration to good health, observing that under the present system insured persons in many cases do not return to work after three days' incapacity when they receive no sickness benefit, but remain on the sick funds to complete a longer term.

XII.—MEMBERS IN INSTITUTIONS.

70. We are of opinion that sub-section 3 of section 17 of the National Health Insurance Act, 1924, should be amended, to provide for a limitation of payment of benefits to in-patients of institutions.

71. There are cases of insured persons without dependents, who have been inmates of institutions for many years and large sums of money are accruing in the books of Approved Societies as liabilities to such persons, and instances have occurred where considerable sums have been paid on the death of the member to the next of kin who probably have taken no interest in the member and have not in any way contributed to his comfort whilst alive.

72. We suggest a limit should be set up in the above cases, beyond which there should be no liability to Approved Societies.

XIII.—EXEMPT PERSONS.

73. We are of opinion that paragraph (a) of sub-section (1) of section 2 of the National Health Insurance Act, 1924, whereby any employed person in receipt of any pension or income of the annual value of £26 or upwards, not dependent on his own personal exertions, may claim exemption from the provisions of the Act, should be amended. Such persons should be brought into insurance under the ordinary conditions applicable to employed persons.

74. Cases have occurred within our knowledge of ex-service men with pensions exceeding £26 per annum who have claimed exemption within a short time of their discharge from the Forces and on subsequently applying for employment have been refused such employment owing to the fact of their holding exemption certificates.

XIV.—DISCHARGED SAILORS AND SOLDIERS IN RECEIPT OF 100 PER CENT. PENSION.

75. Difficulties are experienced by Approved Societies in dealing with this class of member, due to considerable sums being overpaid in respect of sickness and disablement benefits owing to the non or belated receipt of the notification from the Ministry of Pensions of the award of such pensions. It is suggested that steps should be taken to insure in all cases that prompt notification be made to Approved Societies of these awards, and thus relieve societies of the difficulties they are experiencing in this direction.

XV.—CLASS B INSURED PERSONS.

76. We are of opinion that the present system of insurance of this class of member works satisfactorily, and no difficulties are being experienced by Approved Societies. We therefore submit that the present system should be continued. Many of these men are insured on the voluntary side of their society, and any alteration that would have a tendency to break the continuity of their interest in the society would be undesirable.

XVI.—SUMMARY.

77. In continuation of the foregoing Statement, the Manchester Unity Independent Order of Oddfellows submits for the consideration of the Royal Commission the following summarised conclusions:—

- (a) That the existing Branch System authorised by the original Act of 1911 be continued.
- (b) That this is desirable if the principles advocated by the founders of the Act are to be carried into effect.
- (c) The system of branches as organised and maintained in the Manchester Unity creates and encourages interest in National Health Insurance amongst the members and ensures prompt payment of benefits.
- (d) The system creates self-dependence, builds up character, teaches mutual responsibility, fosters the cultivation of fraternal principles and is, therefore, a great national asset.
- (e) That a definite unit be fixed for sickness and disablement benefits.
- (f) That encouragement be given to societies to allocate a larger proportion of surplus declared on valuation, to additional non-cash benefits.
- (g) That the sums allocated from surplus for non-cash benefits be placed in one fund in each Society or Lodge, and any of the additional non-cash benefits be paid therefrom, provided the total sum allocated is not exceeded.
- (h) That dental benefit be made a statutory benefit under the Act.
- (i) That no alteration be made in the present method of administering additional benefits through Approved Societies.
- (j) That the present system of providing medical benefit through panel practitioners be

- continued and extended to include specialist and consultant services, the adjustments necessary to meet the increased cost being made from contributions under the Act.
- (k) That medical benefit be extended throughout life to insured persons ceasing insurable employment after 60 years and prior to 70 years of age.
- (l) That the provisions governing Class K members be amended.
- (m) That the present deposit contributors system be abolished and a Deposit Contributors Society set up in lieu thereof, upon the Approved Societies principle.
- (n) That provision be made for the payment of sickness benefit from the first day of sickness.
- (o) That the system of accumulation of sickness and disablement benefit to members, without dependants in institutions, be modified.
- (p) That para. (a) of sub-section (1) of section 2 of the 1924 Act whereby any person employed within the meaning of the Act may

claim exemption if in receipt of any pension or income of the annual value of twenty-six pounds or upwards should be abolished.

- (q) That arrangements be made for the prompt notification to Approved Societies of the Awards of 100 per cent. Disability Pensions to insured persons.
- (r) That the present system of insurance of Class B Members through Approved Societies be continued.
- (s) The Manchester Unity is prepared to continue to place its machinery at the disposal of the Government in regard to the administration of National Health Insurance and the carrying out of such recommendations as may be submitted by your Commission and embodied in any future legislation compatible with the principles of the Society.

EDWIN HEATHER.

Board Room, Manchester.
20th November, 1924.

APPENDIX VIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INDEPENDENT ORDER OF RECHABITES BY MR. JOSEPH CAVE, HIGH CHIEF RULER, AND MR. JONAS P. ILLINGWORTH, DIRECTOR. See Minutes of Evidence of the Thirteenth Day, Questions 6099 to 6397.

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I.—PRELIMINARY.

1. The Independent Order of Rechabites is a Registered Friendly Society established in 1835. Membership in the Society is open to both sexes subject to the condition that all members must be abstainers from intoxicants. Membership in the Approved Society is open to all abstainers who are qualified for insurance and is not restricted to persons who are or may become contributors to the funds of the Society on the private side, and *vice versa*. Members can thus be admitted to the Order as "State members"—those who are insured under the National Health Insurance Acts; or as "Order members"—those who insure in the private or voluntary side of the Order for selected benefits. Members may be in either of these classes or both.

II.—SOURCE OF INCOME.

2. The adequacy of contributions and proportions paid by employer, employed, and Exchequer, are matters left to the Actuary. The fact that practically all our branches show surpluses would appear to indicate that the present rate of contributions for men is adequate for the present rate of benefits according to our experience. The amount of contributions paid for and on behalf of women members is not adequate for the benefits now paid. An adjustment could be made by a reduction in the rate of benefit, but we suggest that the contribution should be increased and that women should pay the same rate as men.

3. The system of payment by stamps on cards has now become established and presents no difficulties in working. Cases occasionally occur where a card is genuinely lost and unless the member supplies a duplicate card stamped similarly to the one which has been lost there is a distinct loss both to the member and to the Society. We are of opinion that where satisfactory evidence is produced and proper safeguards are provided Societies should be reimbursed for a lost card as is now done in the case of a card which has been destroyed.

4. We find that frequently contribution cards issued by the Society to members and handed by them to their employers are lost during the currency of the half-year, necessitating the use of emergency cards to a far greater extent than was intended. Many of these cards bear the name of the person only, there being an entire absence of the particulars necessary to establish the identity of the person to whom it belongs, or indicate the society of which he is a member. We are of opinion that the system adopted for filing the cards by employers can in many instances be improved upon. The use of emergency cards should be reduced to a minimum, and when used, such card should contain, as far as can be ascertained the same particulars as the card issued by the society.

III.—MONEY BENEFITS.

5. We are not favourable to the present rates of payment for sickness and disablement benefits being increased. Voluntary societies make ample provision for any person who requires a larger amount of benefit than is provided under National Health Insurance.

6. The maternity benefit might advantageously be increased to £3 provided the rate of contributions is adequate for such increase and provided also that adequate safeguards can be introduced to ensure that the mother actually receives the increased benefit and that it is not used as a reason for increased charges by doctors or midwives.

7. In our view, the double maternity benefit now payable where the husband of an insured woman is not qualified for maternity benefit, should be abolished.

8. We consider that the present scale of penalty arrears is not unfavourable to insured persons and does not inflict hardship on any one, and should be maintained. To abolish penalties for arrears would doubtless lead to carelessness in return of stamped cards to Approved Societies. If the period of grace were permanently fixed for 30th November, insured persons would have five months in which to pay arrears. It would not be advisable to extend the period of grace later than the end of November.

IV.—PARTICULAR CLASSES OF INSURED PERSONS.

9. *Married Women.*—The Order has a good proportion of women members, and consequently a large number of members who transfer to Class K. The present method of dealing with married women is much simpler than the methods adopted in the earlier days of the Act. The greatest difficulty at present is in connection with the termination of the eight weeks of unemployment, especially in cases of early resumption of employment after that date. The application of the Prolongation of Insurance Act to married women presents more difficulties than its application to ordinary insured persons.

10. It would doubtless tend to simplification if no distinction were made between married women and other insured persons, and women who cease work on or after marriage were allowed the ordinary benefits during the "free year."

11. An alternative would be to transfer every woman member on marriage to Class K, any employment after that date, whatever the interval, if any, being treated as a new entry into insurance. The sickness and disablement benefits for Class K members might then be increased.

12. *Deposit Contributors.*—The time has now arrived when this class should be abolished and all deposit contributors be compelled to join some Approved Society by a certain date either voluntarily or by allocation. As a society we would take our portion of allocated members on the understanding that all such are prepared to comply with our conditions of membership. At the present time the Deposit Contributors Fund provides for continuance in insurance of a member expelled from a society for breach of rules who has failed to join another

society. If deposit contributors are abolished, power should be given to compel such expelled members to join a society within a definite period from the date of expulsion.

V.—ADMINISTRATION.

13. The members of this Society resident in one locality are grouped together in branches named "tents," with periodical meetings, usually fortnightly or monthly. For funeral benefits and other purposes the tents are grouped into districts. In some cases the district covers a county, in others a group of counties. In the more populous parts of the country there are two or more districts in one county, with a county borough or other large town as a centre. All districts are under the control of the High Moveable Conference of the Order, which meets biennially, and of the Board of Directors elected by this Conference. The head offices of the Order are situated in Manchester.

14. When the National Health Insurance Act became law in 1911-12, the Order became an Approved Society, and the districts were made the "units" for the purposes of the Act. Experience has shown that this arrangement was wise, and that it was a very practical method of working, being both efficient and economical.

15. The districts vary in membership from 332 to 41,970 (1923 figures), the average being 4,030. The Order is approved for all countries and comprises 75 districts in England, 17 in Wales, 11 in Scotland, and 1 in Ireland. The total membership at the end of 1923 was 281,085 men and 138,111 women, a total of 419,196. All districts admit both men and women members.

16. The constitution of the Order provides for its government by the members on a representative and democratic basis. All officers of tents are elected by a majority vote of members present at a tent meeting open to all members, whether "State" or "Order." Each tent appoints a representative to attend the "District Council" meeting for the election of the officers of the district and the Committee of Management (termed "District Executive"), and the transaction of business connected with the district. Each District Council appoints representatives to attend the High Movable Conference for the election of the Officers and the Board of Directors (the Committee of Management of the Order) and for the transaction of business affecting the Order generally. All districts and tents are under the supervision and control of the Board of Directors. All official returns are made through the Head Office.

17. The Tent Secretary is the medium of communication between the member and the district. All insurance cards and notices to members are supplied from the district to the member by or through the Tent Secretary. All claims for benefit by the member are given to the Tent Secretary for transmission to the District Secretary. The District Secretary gives instructions as to benefit payments, keeps all official records and registers, receives and distributes all moneys connected with National Health Insurance. The system thus provides personal touch and personal intercourse with the insured person through the Tent Secretary, which is a great benefit to the insured person, and at the same time secures economical administration. All routine work at the district office is carried out by staffs of full time employees under the control and direction of the District Secretary and the District Executive. The Executives meet regularly at stated periods, and specially when necessary. Full details of the cash transactions are submitted, and questions relating to membership, benefits and other matters are decided upon.

18. In the private side of the Order there has been in existence almost from the beginning a system of "clearance" whereby a member removing from one town to another may be transferred to a branch nearer his new residence. This system has been

adopted to a very large extent in the State Section, and members removing are allowed to transfer from one district to another without the payment of a transfer fee. The only requirement is to sign a form intimating a desire to join the district in whose area they reside. All necessary adjustments are then carried out by the district and head offices. Such transfers are optional on the part of the member and not compulsory.

19. In cases where a member who has removed and has not transferred makes a claim for benefit, it frequently happens that the payment of benefit and supervision are undertaken by the district in whose area he resides on behalf of the district of which he is a member.

20. The payment of benefits is carried out by Tent officers, but no benefit can be paid or recognised which has not been authorised by the district. Under this method the only accounts which are required to be kept by a Tent Secretary are the returns of benefits paid on the instruction of the district. These are usually weekly. In a few cases they are fortnightly or monthly, but in no case are they less frequent than monthly. Members receive benefits due to them promptly and complaints of delay are practically nil. Any claim made up to a Wednesday receives attention the same week and payments are made regularly afterwards until recovery. A member is thus certain of receiving his first payment in the same week or in the week following the commencement of illness.

21. All communications from the Ministry or the Head Office are sent to the district, which in turn forwards, where necessary, to the members. For audit purposes all books are at the office of the district with the exception of books dealing with financial transactions between the Ministry and the Society. In these matters, as well as in others, the system is conducive to economy and efficiency.

22. New methods of working and administration have from time to time been introduced as found necessary, based on the combined experience of responsible officials in all parts of the country, and the requirements or suggestions from the Commissioners and Ministry of Health have been readily complied with.

23. A survey of the past 11 years, and a full knowledge of all the developments, confirms the view taken at the beginning, that the administration of the National Health Insurance through the Order as the Approved Society and the districts as the branches is one of the most—if not the most—satisfactory methods for its successful, economical and efficient administration.

24. *Additional Benefits.*—At the first valuation of Approved Societies, the Order showed satisfactory results. Each district, being a separate unit, had a separate valuation. In a few districts the surplus available, after the proportion reserved, was not sufficiently large to allow of additional cash benefits. In all these cases, it was noted that the majority of the members insured were engaged in occupations of a hazardous nature. In all other districts there was a disposable surplus of varying amount. The following table gives the particulars for the various countries:—

—	Liabilities.	Assets.	Surplus.	Deficiency.
	£	£	£ ^D	£
England ...	7,881,844	8,100,492	218,865	217
Scotland ...	2,425,354	2,492,891	67,537	—
Wales ...	1,482,404	1,501,676	19,560	288
Ireland ...	119,788	121,572	1,784	—
	11,909,390	12,216,631	307,746	505

VI.—MEDICAL TREATMENT AND ADDITIONAL BENEFITS.

25. *Medical benefits.*—It can almost unreservedly be said that our relations with the medical profession have been most cordial, and recorded cases of complaint have been very few indeed. Occasional cases of difference have been found to be due to misunderstanding either by the member or the doctor, and have been generally satisfactorily settled.

26. As a society, we are entirely favourable to an extension of the range of medical service, so as to include consultant and specialist services. We hold the view that whilst a cash benefit to an incapacitated insured person is essential, and should be adequate for immediate necessities, his restoration to health is of greater importance, and if medical attendance beyond that now provided in the contract of service is necessary, some portion of the contribution should be set aside for such additional attendance and advice to be provided; this additional service to be applicable to all insured persons entitled to the ordinary medical service.

27. We are also of opinion that the present schedule of surgical appliances should be extended.

28. We are favourable also to provision being made for the medical benefit to be continued to persons over 65 years of age who cease to be insured on account of ceasing to be employed, as it is now provided for persons attaining the age of 70 years. Cases frequently occur where insured persons over 60 years of age have to cease employment on account of partial incapacity, who are not sufficiently incapacitated to claim benefit. The only method at present whereby such persons can continue in insurance is by becoming voluntary contributors, but not many adopt this method. If the right to medical benefit could be continued after the expiration of their "free year" up to the end of life, such extension would be a national as well as an individual benefit. It would be necessary to attach to this extended benefit the condition that there had been a continuous insurance for a stated number of years, and the payment of a stated number of qualifying contributions.

29. As a society, we would also favourably support a proposal that medical benefit should be given by medical institutes on the same terms and conditions as by panel doctors, it being understood that only fully qualified medical practitioners would be engaged. The present embargo should be removed to permit the setting up of new medical institutes where such are desired and where circumstances appear to warrant such action.

30. The question of the provision of medical benefit for dependants of insured persons has received our attention at various times. In the interests of public health we believe such a provision would be a distinct advantage and would tend to remove much of the overlapping which now obtains in medical services. In view, however, of the many difficulties which immediately present themselves when this question is considered, we make no further comments beyond expressing a general approval of the scheme prepared by the National Conference of Friendly Societies.

31. *Additional Benefits.*—In the districts where the valuation revealed a disposable surplus, the method of using such surplus was decided by a meeting of the representatives of all the members of the district. Generally the method adopted was an addition to the cash payments for sickness, disablement and maternity benefits. Some districts apportioned a part of the surplus to non-cash benefits, whilst a few used all the surplus in this way. The absence of definite information as to the cost and effect of non-cash benefits doubtless led many to adopt what was certainly the easier method of additional cash benefits. There is, however, a rapidly growing feeling in favour of limiting the amount which may be added to the cash payments, and using the surplus for benefits which have a distinct tendency to aid in a more rapid recovery or in increasing the general health.

32. In the former class, the sending of members recovering from illness to a convalescent home has been proved to be a much more valuable help to a member than the addition of a few shillings per week to his benefit payment. The change of air and environment and in many cases the better food, have not only helped a member to recover from the illness from which he was then suffering, but have enabled him to more successfully resist further attacks. This is a benefit which may be more generally adopted when the next valuation surpluses come up for consideration.

33. To the second class belong dental and optical treatment. Where dental treatment has been adopted as one of the additional benefits, it has proved the most popular, not excluding the districts where a portion only of the cost is borne by the district, the member being responsible for the other portion. This benefit is not restricted to members incapacitated from following employment, and has undoubtedly, by prevention of illness, reduced the number of claims for benefit for sickness or disablement. Until some comprehensive scheme of national medical service is established, we consider that dental and convalescent treatment should be granted as additional benefits administered by Approved Societies and not form part of the ordinary medical treatment. The same observations, but to a much smaller degree, apply to optical treatment.

34. As these additional benefits are dependent upon the surpluses shown at valuation—and these surpluses are dependent upon the favourable sickness experience and general good management of the society or branch—it follows that they cannot be provided for all insured persons on the same terms as medical or sickness benefits. It also follows, in the opinion of the Order, that their administration can only be carried out by the societies which have provided the surplus by which the additional benefits are made available, and cannot be handed over to Insurance Committees as has been suggested in some quarters.

35. After the first valuation a society devoting its surplus or part of its surplus to non-cash benefits had to decide the amount which should be allocated

to each of the benefits adopted, though a slight variation from these amounts was allowed in the actual expenditure. In the opinion of the Order it would be an advantage to decide only the total amount to be used for all such benefits. This would allow for the benefits to be provided in accordance with the varying requirements of the members without exceeding in any way the amount allocated.

36. Under present arrangements an insured person is not entitled to additional benefits until the expiration of five years from the date of joining a society. Whilst this may be accepted in the case of a new member or in transfers between societies, we are of opinion that a society should be allowed to modify the arrangement in cases of transfer between its own branches.

VII.—MEDICAL CERTIFICATION.

37. Complaints respecting medical certification have occasionally been reported to the Board of Directors, and other complaints have been dealt with by the various District Executives. They are, however, relatively very few, and do not call for any alteration in the present arrangements.

38. There have at times been reports of difficulty in obtaining certificates required under the Act for the Society, and subsequently for the auditors by members who are not entitled to cash benefits under section 11, and by other members claiming one of the non-cash additional benefits. All certificates required for benefits under the Act should be issued free. The regulations in this matter do not appear to be always strictly adhered to by some doctors.

39. Cases have been more numerous where there has been an apparent delay in the furnishing of a medical card to an insured member entitled to medical benefit, and it would probably obviate delays in this direction if the first medical card was issued by the society to the member. This would not interfere with the necessary notification to the Index Clearance House, and would be a distinct advantage to the new member. Nor would it materially interfere with the registration system worked by the Insurance Committees if a continuation of such registration is found necessary.

APPENDIX IX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL ASSOCIATION FRIENDLY SOCIETY, APPROVED SOCIETY No. 138, BY MR. JONATHAN DUNCAN, GENERAL SECRETARY, AND MR. HARRY BAILEY, ASSISTANT SECRETARY. See Minutes of Evidence of the Thirteenth Day, Questions 6398 to 6680.

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GOVERNMENT OF THE SOCIETY.

1. The National Association Friendly Society was established in 1837 and has carried on the work of a Friendly Society continuously since that date, catering for the needs of the lowest to the highest wage earners for the purpose of providing benefits

during sickness and at death. Prior to the National Health Insurance Act the Society also provided for Medical Benefits.

2. The Society is what is termed a Centralised Society, that is to say, the branches are not separately registered. All the money not required for immediate use is remitted by the branches to the Chief Office and invested by Trustees for the benefit of the whole Society. This applies to the private side only.

3. Delegate meetings are held triennially for the purpose of amending or making new Rules; the Delegates to represent the members are elected by the members in 44 approximately equal electoral districts.

4. The society is governed by one code of rules, the executive body being called a Board of Management, which meets three times a year or oftener if required.

5. The business between Board meetings is relegated to a Sub-Committee of the Board comprised of the three Trustees, the Treasurer and the Board Representative for the Lancashire and Cheshire District. This Sub-Committee meets every fortnight, or oftener if required, for the transaction of ordinary business and for investment of funds.

6. The members are grouped into branches (unregistered) which may be termed agencies. These branches are in various parts of the country and meet monthly for the transaction of business.

7. The society is essentially democratic, as the Board of Management, Trustees, and Treasurer are all elected by the members.

The officials of a branch or agency comprise a Secretary, Chairman, and as many sick visitors as are required by rule according to the membership of the branch.

The Branch Secretary is elected by the members of the branch, and appointed by the Board. The Chairman and sickness visitors are also elected by the members.

In addition to the branch officers mentioned previously, each branch is entitled to form a Committee of its members to assist in conducting the branch.

STATE DEPARTMENT.

8. This Society became approved for National Health Insurance work immediately it was possible to do so, and conducts its business through the agencies or branches, in the same manner as for the voluntary or private side of the Society.

9. At 7th July, 1924, the society had—

768	Branches for Men in England.	
738	" Women in England.	
84	" Men in Wales.	
76	" Women in Wales.	
1	Branch in Scotland for Men.	
1	" " Women.	
<hr/>		
1,668	Total.	

The membership comprises—

92,457	Men—effective members.
1,513	" Navy and Army members.
3,523	" over 70 years of age.
22,607	Women—effective members.
843	" Class K—first year.
267	" over 70 years of age.
811	" Class K—second year.

122,021

a total of 117,430 effective members in respect of whom administration is allowed, and 4,601 members for whom administration is not allowed.

10. The method, or system, of working National Health Insurance through the branches makes it possible for the Registered Office to exercise strict supervision and jurisdiction over the accounts of each branch, as accounts are rendered monthly to the Registered Office along with all vouchers for payments. To enable the Branch Secretary to make payments of benefits to his members he is supplied with application forms for money upon which he applies periodically to the Registered Office for the money required to meet benefit claims and administration expenses. These forms have to be signed by the Branch Secretary and Chairman.

11. The Branch Secretary issues and collects the stamped cards for the members of his branch, and he is supplied with a list of his members upon which he is requested to enter the number of stamps on each member's card.

The list of members is forwarded to the Registered Office each half-year for checking purposes, and the completion of members' yearly record. This completed list gives a Branch Secretary sufficient information to enable him to inform his members of their contribution record.

12. The Branch Secretary is also supplied with sufficient information to enable him to pay ordinary benefits to which the members may be entitled, except in certain cases which he has to refer to the Registered Office. All claims for maternity benefit, however, are submitted to the Registered Office, also all cases of accident or industrial disease for which compensation may be payable. All claims submitted to the Registered Office are dealt with the same day as received, and thus all claims receive prompt attention.

13. In cases of dispute the member has a right of appeal to arbitration in accordance with the rules of the Society.

14. All the recording and accounting work required by the Ministry and Treasury is done at the Registered Office.

We feel it a duty to say, that in consequence of a simplification in the accounting, including an improved Contribution Register, the forms for the half-yearly return of stamped cards, and the advice notes of debit and credit, the work of Approved Societies is now much less complicated, and so far as this Society is concerned no difficulty is experienced.

15. The same system of centralisation of funds applies to National Health Insurance as applies to the private side, which means that the branches are not valued separately, but all men members are valued in one section and all women members in another section. By this system no branch is richer or poorer than another.

16. At the first valuation the membership comprised 100,148 men and 25,149 women, and as the accounts for men and women are kept separate, the valuation was also kept separate, and the surplus shown was:

£127,605 for men.
£14,318 " women.

The disposable surplus for men was £68,869, and £58,636 carried forward.

The disposable surplus for women was £4,197, and £10,121 carried forward.

17. A scheme was adopted for allocating the disposable surplus as follows:—

The Sickness Benefit of men members was increased by 2s. per week;
the Disablement Benefit of men members was increased by 1s. per week;
and the Maternity Benefit was increased by 4s.

For the women members a scheme for additional benefits was adopted for making grants for—

2. Dental treatment.
11. Members in distress.
13. Payments for suspension from work on account of infection.
15. Members in hospitals and convalescent homes.
16. Medical and surgical appliances.
17. Optical treatment.

18. All the members who came under the scheme adopted for the disposable surplus on the valuation are entitled to these additional cash or treatment benefits irrespective of the branch to which they may be attached. Transfer from one branch to another does not affect the rate of benefit.

This society is not prepared to agree to the pooling of surpluses, as it carries its own risks. Moreover insured persons had and have a free choice of joining any Approved Society.

19. It is submitted that the system of government and management generally is one which harmonises with the main idea of National Health Insurance, as the registered office is in constant touch with the branches. Moreover, being governed by one code of rules and each member being entitled to share equally in any disposable surplus, any distinction between one branch or locality and another is obviated. For instance, the Society has a large number of branches in mining districts where sickness is rather heavier than in the agricultural and similar districts, and thus it brings into its experience, for sickness and other benefits, an average of all classes of the community.

20. It seems necessary to point out that under the whole organisation there are over 4,000 persons who are brought into direct contact with the work of the Society, and also into contact with the membership of the Society, thus showing that there must be a real live interest in the work which is carried on for mutual good. The humane personal touch is maintained, such as characterised the Society's work prior

to the advent of National Health Insurance, yet, at the same time great care is exercised in administering the benefits.

21. It is assumed, according to the Government Auditors' Reports, that the Society has always conducted its business efficiently.

22. The experience of the Rational Association Friendly Society justifies the statement that Friendly Societies generally are specially adapted and quite capable of continuing to carry on National Health Insurance work upon the principles laid down in the Act of 1911.

RECOMMENDATIONS FOR MAINTAINING PRESENT PROVISIONS OR FOR AMENDMENT AND EXTENSION OF NATIONAL HEALTH INSURANCE.

AGE LIMITS FOR INSURED PERSONS.

23. It is submitted that the present age limits be maintained, viz., 16 to 70.

The suggestion that young persons who commence employment at age 14 shall be compulsorily insurable is not considered advisable, as a large majority of young persons under 16 years of age are not in settled employment.

In regard to continuing insurance for sickness and disablement benefits after age 70 the cost would be tremendous. When the Act of 1911 was being prepared this problem was fully considered, and it was decided to allow only medical and maternity benefits after age 70 when the old age pension commenced.

Whilst there is nothing to prevent a capable man of 70 from working and earning more than sick pay or old age pension, there would be great difficulty in determining whether such person at that age or over was capable of work.

THAT CLASS K BE ABOLISHED

24. At present women members who marry and cease insurance are entitled to receive sickness benefit of 7s. 6d. per week for not more than six weeks during the first 12 months and eight weeks after ceasing employment, and a maternity benefit within two years after marriage.

In lieu thereof it is recommended that such persons be entitled to the ordinary free year's insurance after ceasing insurable employment.

For the information of the Royal Commission a test of the Society's experience is submitted as follows:—

ENGLAND (Women).

Particulars re Class E and Class K—1919-1923 inclusive.

Year.	Mean Membership, Class E.	Number who Married.	Number who became Class K.	Percentage of those who married who became Class K.
1919	24,187	1,249	1,182	94
1920	22,779	1,271	1,030	81
1921	22,143	1,123	989	88
1922	21,763	1,093	881	80
1923	21,687	988	830	84

Benefits Paid to Class K Members.

Year.	Number of Class K Members.	Claims for Sick Benefit.	Periods for which Benefit was paid.		Amount Paid.	Maternity Claims.		Amount Paid.
						1st Year after Marriage.	2nd Year after Marriage.	
			Weeks.	Days.	£ s. d.			£ s. d.
1919	1,182	98	168	1	41 5 10	247	—	354 11 6
1920	1,030	73	323	5	109 0 10	632	—	1,067 0 0
1921	989	99	429	2	161 0 0	428	194	1,172 1 9
1922	841	106	465	1	174 8 0	371	164	986 19 3
1923	830	108	466	5	178 17 7	327	169	916 12 9
	2,700	313	1,361	2	514 5 7	1,126	527	3,075 13 9

For the purposes of this test the years 1919-1920 are ignored as Class K had not become normal, but, taking the years 1921-1923 as a fair criterion, the sickness periods averaged 4.34 weeks per claim and the amount paid averaged £1 12s. 10d. per person.

Maternity Benefit.—Taking the years 1921-1923 as a criterion, the average payment per claim was £1 17s. 2½d.

In connection with Class K claims it must be noted that maternity benefit is reduced, by arrears of contributions, but not to less than £1.

The total amount paid for the three years 1921-1923 was—

£	s.	d.
514	5	7
for sickness.		
3,075	13	9
for maternity.		
3,589	19	4
total both claims.		

N.B.—The sickness benefit of an employed woman contributor is 7s. 6d. per week until she has been insured for two years and paid 104 contributions. After being insured for two years and having paid 104 contributions she is entitled to 12s. per week. A maternity benefit of £2 is payable after 42 weeks' insurance and 42 contributions have been paid.

If the same members included in the test had been entitled to a free year's insurance after ceasing to be employed contributors, the approximate cost of payments would be as follows:—

It is assumed that the mean average weekly payment to women members in this test would have been 10s. 6d. per week, and if they had been entitled to a free year's insurance from ceasing employment there is every probability that the periods of claims for sickness would have been increased by 50 per cent., and the amount paid would have been:—

	£	s.	d.
1,361 weeks, plus 50 per cent.—			
2,041 weeks at 10s. 6d.	1,071	10	6
1,126 maternity claims (1st year) at £2	2,252	0	0
	<hr/>		
	£3,323	10	6

There is a suggestion made that a bonus shall be given to a woman member on marriage on the same lines as the former Class H, and also allow a free year's insurance, but this Society is not in agreement with that suggestion, as it appears to be too costly and unfair between one contributor and another.

There is a great amount of work required in dealing with Class K. After notice of marriage the Society issues:—

1. A special form for particulars of marriage.
2. If case is transferred to Class K the following operations are necessary:—

- (a) Completion of marriage register.
- (b) Alteration of contribution register—change of name, date of marriage, date of unemployment. Special arrears calculation.
- (c) Membership register. Change of name and class.
- (d) For alteration schedules.
Alteration, Card D.5., to give particulars of marriage.
Alteration, Card D.6., to give particulars of transfer to Class K.
- (e) Notification of marriage to be sent by a removal slip to Insurance Committee.
- (f) Change of alphabetical index to show membership in married name.
- (g) To control cessation of titles to benefits, a date index is prepared and kept, as dates of cessation arise nearly every day.
- (h) Notification to branch secretary and member as to position and title to benefit in Class K.

If the person returns to insurable employment within a year after becoming Class K, further attention to details is necessary.

If, on the other hand, the member remained in insurance and entitled to benefits for a free year from date of last stamp, the only work required would be to amend the name in the registers, inform the Insurance Committee of change of name, write out an alteration Card D.6., and forward to the Department.

NON-MANUAL WORKERS CEASING COMPULSORY INSURANCE BY REASON OF INCOME LIMIT.

25. There are many non-manual workers who cease to be compulsorily insurable by reason of the income limit. They are allowed to be voluntary contributors for the first 12 months at the full rate of contribution of 10d. a week (men), 9d. a week (women). After 12 months their contributions should be reduced by 2d. per week and they cease to be entitled to medical benefit.

In many cases persons who may have been insured for 10 years or more decline to become voluntary contributors, probably because medical benefit is cut off after 12 months; to act fairly to all persons who would continue insurance as voluntary contributors, if medical benefit was provided, the following suggestion is made:—

That any person (except married women) having been compulsorily insured for two or more years be allowed the option of becoming a voluntary contributor, and to pay the full rate of contributions irrespective of the income limit and to be entitled to all the benefits of the Act.

LOSS OF MEDICAL BENEFIT ON CEASING TO BE INSURABLY EMPLOYED.

26. Inasmuch as many persons are discharged from employment at age 60 or 65 (thus losing their right to medical benefit, after their free term has expired), who would otherwise have been entitled to medical benefit throughout life had they continued employment until 70 years of age, it is considered that such persons suffer hardship. It is, therefore, recommended that legislation should be promoted to enable such persons to pay up to the age of 70 an equivalent sum (to include cost of administration) to that paid by insured persons, and after age 70 to be entitled to free medical treatment.

It is suggested that a condition of continuance of medical benefit on the above lines should be dependent upon a specified period of insurance prior to attaining age 60 or 65.

This Society is particularly anxious that such persons should be fairly treated. The majority cannot afford to become voluntary contributors and the "Private Side" of their Approved Society is unable to make local arrangements except at an exorbitant figure.

ACCIDENTS AND INDUSTRIAL DISEASES.

27. There is great difficulty in dealing with claims arising in consequence of accidents and industrial diseases. The majority of insured persons have to wait prolonged periods before their claims are acknowledged by employers and Insurance Companies. For these reasons, and because many employers do not insure their workpeople under the Workmen's Compensation Act, it is suggested that the time has arrived to seriously consider the advisability of payment of such claims being made to their members by the Approved Societies.

The payment of premiums to be made by the employer by stamps of additional value to cover the liability and in that way every insured person would be covered.

It may be argued that Approved Societies are not adapted for this class of work, but they are at present obliged to be in contact with claims for accidents and industrial diseases, so that it is not new to them.

The method of claiming and the amount of compensation would remain the same as now; in fact, there is no suggestion to alter the principles of the Workmen's Compensation Act.

In regard to premiums payable, the argument will be that there is a great differentiation of risks. That is quite true, and there is a similar difference in risks for sickness experience. It is, therefore, suggested that one flat rate be paid for men and one flat rate for women.

That the income be pooled and the claims and expenses be drawn from the pool.

DEPOSIT CONTRIBUTORS.

28. This society does not favour abolishing this class entirely, as it appears that the Fund must be kept open for persons expelled by the Approved Societies and other persons who are not acceptable by Approved Societies.

With the above exceptions it is suggested that all other persons who have been in the Deposit Contributors Fund for twelve months be given notice to join an Approved Society within three months, failing to do so to be allotted by the Ministry to a society operating conveniently to the person's residence.

SMALL SOCIETIES.

29. As a matter of economy and efficiency it is suggested that societies with a less number of members than 5,000 be amalgamated with other societies, and that the unit for an Approved Society be not less than 5,000.

COLLECTION AND ADEQUACY OF CONTRIBUTIONS.

30. The present system of half-yearly cards appears to be adequate and convenient to all parties concerned.

Cards for longer periods than six months would cause difficulties, as the insured person and the Approved Society would be out of touch with the position in insurance. Further, unless arrangements were made to the contrary, societies would lose interest on their income by only returning the cards yearly to the Ministry.

The present contributions appear to be adequate for the present benefits under the Act, and in fact seem to allow a margin for an extension of benefits as disclosed by surplus on valuation.

EXTENSION OF BENEFITS.

31. It is suggested that without an increase of contributions there is sufficient money available for specialist's consultation, massage and electrical treatment, also:—

Dental Treatment.—This is of great importance for the health of the insured person, and should be a statutory benefit instead of an additional benefit payable out of a surplus on valuation. If it were a statutory benefit all societies would pay a like amount. This would reduce surpluses on valuation of those societies which have a favourable experience, and any society which had a deficiency would have such deficiency made good from the contingencies fund or central fund, so that the members would in any case receive the statutory benefits.

A person must have been insured for two years and have paid 104 contributions before becoming entitled to dental benefit.

As it would probably be too expensive for the Approved Societies to provide the whole cost of dental benefit, it is suggested that the statutory benefit be 50 per cent. of the cost, but not exceeding a maximum of £3 10s.

This, however, in an actuarial question, as the above are suggestions without actual data.

Special regulations would be required to govern the frequency of claims for this proposed benefit.

MONEY BENEFITS.

32. The amount of cash benefits for sickness and disablement supplemented by benefits from other sources appears to be adequate, and if increased it is liable to cause over-insurance and malingering.

That a limit be placed upon the amount of additional cash benefits payable out of surplus on valuation.

ARREARS OF CONTRIBUTIONS.

33. Some concern is felt in regard to the loss of stamps through unemployment and the parlous position of some members who cannot even pay the reduced penalty arrears after allowing "free contributions" under the provisions of the Prolongation of Insurance Act.

Whilst regretting the present position of unemployed insured persons, the view is expressed that the present provisions be maintained until trade becomes more normal, as the difficulties of amending the present scheme, in fairness to all concerned, seem very complicated.

This Society would favourably consider a scheme to assist insured persons if the financial position was not jeopardised, and it was assured that only the genuinely unemployed person received assistance.

MEDICAL BENEFIT.

34. This society is entirely opposed to any curtailment of the right of insured persons to a free choice of doctor or of facilities to lodge complaints in regard to inattention and the like.

For this reason it is considered necessary that Insurance Committees shall continue their work.

The number of representatives of insured persons serving upon these committees is not expensive. The insured person has a right to be represented for the protection of his interests, as he is the mainspring of the whole concern.

This Society is opposed to any demarcation of streets into areas in any large centre for the purposes of Medical Benefit, as such an idea savours of pauperism.

It is suggested that the provisions of section 50 of the Consolidation Act, 1924 (Section 60 of the 1911 Act) should be carried out by the Insurance Committees.

MEDICAL CERTIFICATION.

35. This is a difficult subject for laymen to pronounce judgment upon, but according to the evidence of cases submitted to the Ministry (*vide Reports*) and the experience of this Society, a large number of medical men are either deceived by the detailed symptoms of the insured person or they do not diagnose cases correctly, and hence a number of persons are treated and take drugs for diseases from which they do not suffer.

From 1st January, 1913, to 31st December, 1920, this Society paid an average fee of 5s. per case for examination and report in all doubtful cases of incapacity, with the following result:—

England and Wales.—145 cases referred; 10 declared off before examination; 64 declared off after examination; 71 remained incapable of work. This showed that over 50 per cent. of those examined were not incapable of work.

Cases referred to the Regional Medical Officers—January, 1921, to November, 1924.—England and Wales.—897 cases referred; 177 declared off before examination; 184 declared off after examination; 536 remained incapable of work. This period shows 40 per cent. of those examined who were not incapable of work.

This Society is anxious that all insured persons shall have proper remedial and curative treatment, but as the doctors are the great spending department of National Health Insurance, errors on their part are costly, and it is earnestly hoped that greater care will be exercised before certifying insured persons as incapacitated from work.

APPENDIX X.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SCOTTISH MINERS FEDERATION APPROVED SOCIETY (No. 23), By Mr. JAMES GOLD, Secretary. See Minutes of Evidence of the Fourteenth Day, Questions 6681 to 6959.

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CONSTITUTION AND MANAGEMENT.

1. The Society was formed at the initiation of the National Health Insurance Act and is constituted almost exclusively of miners and their immediate relatives. The latter represents but a small proportion of the actual membership and is composed chiefly of females employed either about the pithead or engaged in domestic service. The Society is centralised. The Head Office is situated in Glasgow, with branches extending to the respective mining areas in Scotland. The number of branches is in the vicinity of 200.

2. The operations of the Society are confined exclusively to the administration of National Health Insurance. The branch agents are part-time employees. They serve simply as the medium of collection and distribution of cards and benefits and their work is literally circumscribed by the limits which these functions impose. All the work is carried through at the Head Office. The membership of the Society in 1913 was 42,187; of which 39,715 were males and 2,472 females; at the present moment it is 46,500; of which 42,096 are males and 4,404

females. There is a full-time staff of fifteen—two juniors and thirteen adults. Twelve members of the staff are responsible for the preparation and issue of the blank cards and arrears notices; entering the stamped cards and preparing the half-yearly return, and advising weekly, up to the date on the medical certificates presented, the benefit to which each applicant is entitled. The work of the other three embraces correspondence, accounts, and miscellaneous matters. The average assessment for cards, claims, &c, in respect of each of those members of the staff whose energies are confined to this class of work is 3,874 members; or 3,321 members distributed over the whole staff. Experience demonstrates that the work involved by this assessment is not strenuously exacting. The Society has availed itself of the services of a medical man of wide experience who purges the benefits registers regularly each week and has at its disposal the professional skill of other four part-time medical referees. In addition it has utilised to the utmost the services of the medical referees appointed under the medical refereeing scheme established by the Scottish Board of Health.

3. The claims presented weekly are carefully and critically inspected and a number of the staff have been specially allocated the work of testing and supervising each first claim and are responsible for the issue of authority to pay. The staff's efforts are supplemented, as I have already indicated, by the doctor who purges the benefits registers and selects for refereeing those cases where, judging by the nature of the illness, the duration of incapacity is longer than is warranted. I have referred in the previous paragraph to the settled practice of the Society in taking full advantage of the medical refereeing scheme, and the following figures represent the result of the number examined for the last three years:—

	1.	2.	3.	4.	5.	6.	7.
1921	1021 less 304 = 717			147	302	148	120
	Approximate per cent. ...			20.50	42.12	20.64	16.74
1922	1093 less 318 = 775			178	372	127	98
	Approximate per cent. ...			22.97	48.00	16.39	12.64
1923	859 less 304 = 555			121	300	85	49
	Approximate per cent. ...			21.80	54.05	15.32	8.83

1. Number selected by our doctor.
2. ,, not cited (unfit to travel).
3. ,, cited for examination.

4. Number certified fit.
5. ,, certified unfit.
6. ,, that failed to appear for examination.

7. Number that declared off prior to citation.

A small proportion of the ramshackle cases certified fit for light work were, on appeal to the independent referee, either confirmed or rehabilitated. Benefit was suspended in respect of those who failed to appear for examination, and no systematic effort was made to find out what happened in the remaining cases. In spite of these precautionary measures it is impossible, where the members are severely segregated and engaged in a highly dangerous and hazardous occupation, to control the sickness experience and regulate the flow of expenditure to closely correspond to the general average experience of the whole insured population; or to the figure of expected sickness, determined by the Actuary in relation to the respective ages of the members of the Society.

4. The men and women are valued separately. At the close of the valuation in the year 1918 there was a surplus of £18,718 on the men's account and a deficit of £128 on the women's account. A sum equal to the loss was liberated from the Women's Contingency Fund. There was no disposable surplus. It is a safe and cautious prediction to say that there never will be any disposable surplus in a society similarly constituted.

SPECIAL FEATURES OF A MINERS' SOCIETY.

5. Coal mining is, as was pointed out by the Sankey Commission, "a national key industry upon which nearly all other industries depend . . . a cheap supply of coal is essential to the maintenance

of the trade of the country. It occupies a unique and exceptional place in our national life . . . There is no other industry with which it can be compared." The prosperity of the mining industry, as has been authoritatively stated, vitally depends on the provision of a supply of cheap coal to other industries and, owing to this immutable interdependence, a depression in any one, or a number, of the dependent industries operates against the steady employment of those engaged in the "key" industry. The result is reflected, quite apart from the loss which the risks of the "key" industry itself inflict, in an impaired annual revenue. The depreciation in the number of contributions paid annually is fluctuatingly revealed over a series of years. The loss is undeniably substantial. The average number of contributions actually received is materially less than the expected average (48), and the following analysis of the last five years' income places the question beyond the region of uncertainty:—

AVERAGE CONTRIBUTIONS.

	1919.	1920.	1921.	1922.	1923.
Males	44	43	32	38	43
Females	40	38	32	37	39

The number of contributions paid is consistently sub-normal. The precipitate diminution of the number in the year 1921 was due to an internal dispute and in 1922 to unemployment in the industry. A factor to which due emphasis should be attached is that the lengthened sickness of the miners, engaged as they are in a heavy risk occupation, stands out in striking contrast to the experience of those engaged in selected professions and has a pronounced effect in influencing unfavourably the contributory annual income. It is obvious that an insured person who is engaged in an occupation of a less exacting character continues at work for a longer interval at the inception of an illness and invariably resumes at a certain stage of recovery which does not represent his normal degree of physical fitness; whereas the miner, owing to the strenuous nature of his life, is inevitably compelled to relinquish his work at the onset of the disease and does not resume until he feels thoroughly well equipped to undertake the arduous task of coal getting. In this respect the society, which is constituted entirely of miners, sustains a greater loss in contributions and has a far heavier sickness liability at the inception and termination of an illness than is common to those societies whose members are more fortunately placed. The short period claim, compared to the claim extending over a longer period affords less opportunity, owing to its limited duration, for the exercise of careful supervision. For the year ended 31st December, 1923, practically one-fifth of the membership of the society was at one time or another during this period in receipt of benefit. The following figures confirm that the greater part of the burden was in respect of illnesses of short duration:—

Members in receipt of benefit for one month or less	5,537
Members in receipt of benefit from one month to two months	1,303
Members in receipt of benefit from two months to three months	596
Members in receipt of benefit from three months to four months	326
Members in receipt of benefit from four months to five months	225
Members in receipt of benefit from five months to six months	147
Members in receipt of benefit from six months to twelve months	435
Members in receipt of benefit for over twelve months	675
	<hr/> 9,244 <hr/>

In 1919 the average sickness experience was 2.78; in 1920, 2.37 for the first half and 2.80 for the second half; in 1921, 3.62; in 1922, 3.32; and in 1923, 2.79.

6. The industry is productive of a considerable number of derelicts, and when physical deterioration has set in they rapidly become chronic and constitute a permanent charge on the funds of the Society. On account of their physical condition and age, it is an uncommon experience to find any of these chronic cases recovering sufficient vitality to graduate for some other form of suitable light employment. There is therefore less fluctuation in the disablement benefit. It has been maintained throughout the last five years at a fairly constant altitude. In 1919 the disablement average was .93; in 1920, .80 for the first half and 1.32 for the second half; in 1921, 1.49; in 1922, 1.79; and in 1923, 1.92. Similarly the benefit paid in respect of maternity is far in excess of the general average, and, as is obvious, the greater the liability in respect of this class of benefit the less there must be available for sickness and disablement. The Society has not only an abnormally high rate of sickness and disablement liability to face, but also an abnormally high maternity rate. Of these three, I cannot conceive that under present conditions sickness may be further diminished; chronic disablement may be regarded as insusceptible to control and the inroads made on the funds by maternity are uncontrollable and irremediable. The coincidence of these heavy risks stamps the miners as a distinctive class of the insured population, requiring special consideration and treatment. Provision was made in section 20 of the 1911 Act for the reinsurance of the maternity benefit, but, owing presumably to the low average general experience, there was no universal demand for its adoption. The average annual experience of the Society for the last five years was: 1919, .74; 1920, .94 for the first half and 1.04 for the second half; 1921, 1.07; 1922, .92; and .90 in 1923. It was intended that the double maternity benefit would meet the special expenses inevitably associated with confinement, but it is now generally recognised that the extra sum has been diverted from this object to meeting a concurrent rise in doctors' and midwives' fees. The doctors' fees range from 10s. to 60s., and the midwives' from 10s. to 42s. In general, the maternity benefit is 40s. The double maternity benefit is the exception. Out of either the single or double maternity benefit there is rarely any balance available to provide nourishment for the mother and comforts for the child, or to defray the expenses of a domestic help. The necessity for domestic help is, in the circumstances, as essential as the services of either the doctor or midwife. It is desirable that the fees of these three should be covered by the maternity benefit. The weekly wage is frequently inadequate to maintain the normal standards of comfort, and there is all the greater need to preserve it from invasion, in the hope that part of it may be diverted to purchase nourishment and comforts for mother and child.

7. There is also a heavy liability and loss in revenue in respect of injuries sustained by the miners in the course of their employment. The magnitude of this factor is not generally recognised. It grows in volume annually. For the year ended 1st July, 1923, there were 30,697 weeks in respect of which no contributions were payable on account of the fact that the members (2,020 in number) were in receipt of compensation, and 35,010 weeks, representing 2,113 members, for the year ended 5th July, 1924. There is a high percentage of permanently disabled compensation cases, in respect of whom contributions may not have been paid over a series of years, but who are entitled to both maternity benefit and medical benefit. On account of the hazardous character of mining the casualties in the industry, employing over one million persons, are relatively far greater than they are in the factories, where over five million are employed. The following comparative analysis brings into relief the striking contrast of the industries concerned:

	1.	2.	3.	4.	5.	6.
		£			s. d.	Per cent.
Factories	5,318,311	2,463,782	135,584	844	9 5	1.41
Mines	1,109,023	2,257,511	103,784	833	40 9	3.88

1. Persons employed.
2. Total compensation paid.
3. Disablement cases.

4. Fatal cases.
5. Charge per employee.
6. Incapacity lasting over 26 weeks.

It may be urged that these figures have no practical bearing on the problems of National Health Insurance. But they have a very direct bearing, particularly in those types of cases where the employee has accepted a lump sum and granted a final discharge to the employer. The physical condition of the injured person is permanently impaired, and where work of a suitable light character has been secured, it can only be intermittently pursued. The interrupted intervals represent a constantly recurring charge on the funds of the Society. The burden of medical evidence points to the fact that the primary cause of these recurring periods of incapacity is either closely allied to the seat of injury or directly attributable to the original accident. It can be reasonably argued that the incapacity which the mining industry inflicts is generally of a more serious character than that inflicted by ordinary industry. The miner labours under a dual disability. Owing to the isolated nature of the industry and the fact that he has to undergo a special training to fit him for the peculiar requirements of mining life, it is more difficult to find suitable light employment, and his choice is unquestionably limited. There are other typically expensive cases; it is a not infrequent occurrence that the injured person is unable to establish his title to compensation on account of his inability to prove accidental circumstances (e.g., gas poisoning); in certain instances legal opinion recommends that an action would be unsuccessful; while in contested cases, owing to a technical weakness, the Courts frequently decide against the claimant. It should be understood that where a member has, through personal neglect, prejudiced his title to compensation, he simultaneously forfeits his title to benefit. The occupational risks common to the mining industry are responsible for a high percentage of minor accidents lasting less than two weeks, and if the official figures in the White Paper issued by the Government are exact, the burden up to December, 1923, placed on the Approved Society was in the vicinity of 6.54 per cent.; but this liability has been modified by the introduction of the Workmen's Compensation Act, 1923.

CONDITIONS IN THE COAL MINING INDUSTRY.

8. It was contemplated under section 63 of the National Health Insurance Act, 1911, that where excessive sickness in a locality was proved to be due to the default of some person or authority, a claim might be made against such person or authority for the extra expenditure incurred in sickness. The Act, it was thought, would make unhealthy houses and unhealthy mines a bad investment on account of the fact that the excessive sickness caused by unhealthy conditions would be charged against the owners or employers who were responsible. The cause of excessive sickness is presumably too elusive to assess, as the section has remained a dead letter. Efforts have been made within the last two decades to improve the housing conditions in the mining localities. It has been publicly stated that between 1899 and 1918—20 years—the Scottish Mineowners have spent £1,280,000 on new houses, £141,000 on reconstruction, and £771,000 on repairs; amounting in all to the sum of £2,192,000. If the output of the Scottish Coal Mines for the year 1923 (37,039,097 tons) is taken as the basis of calculation and spread over the period of years referred to, the expenditure on improved housing figures out at .710 of a penny, or a little less than three farthings per ton. Public

attention was directed during the current year to a part of the dark continent of the mining area. As a means of measuring the progress made during the last eleven years, it is well, when dealing with one of the plague spots (referred to in the publication "Coal and Power"), which in 1924 received so much publicity, to redigest the terms of the report prepared in 1913 and presented to the Royal Commission on Housing:—"The area enclosed by the houses is more like a ploughed field than the entrance to dwellings . . . open middens are the only means of disposing of refuse . . . but at the time of our visit were not accessible unless one were wearing water-tight boots." There is manifestly scope in part for improvement. It may not be easy to assess the incidence of sickness occasioned by the housing conditions, but there would appear to be liberal ground to warrant the view that it is one amongst a number of other factors contributing to the dissipation of the Society's funds.

9. It is, however, long since the question of the miners' high sickness experience excited public attention and criticism. At the Social Science Congress held in 1860 statistics were presented which proved, that the average sickness of miners was greatly in excess of the sickness experience of the general public. At the end of each decade the miners' sickness experience was stated to be 46 per cent. more than that of the general public at the age of 20; 70 per cent. at 30; 78 per cent. at 40; 76 per cent. at 50, and 53 per cent. at 60. In the intervening years attempts have been made to measure the effect of occupational sickness and determine its exact incidence. In a series of lectures delivered in 1911 and 1912, under the auspices of the Institute of Actuaries, by the present Government Actuary, Sir Alfred Watson, it was pointed out that "the average weeks of sick pay of colliers were 1.62 per member per annum taking all ages, while the average weeks of sick pay of all other classes were 1.20. I satisfied myself," he states, "that the age distribution was practically the same in both groups. The colliers had a great amount of sickness liability due to compensated accident cases, the average being 1.29 weeks per annum, while the other classes had an average of only .21 of a week. The purely sickness experience thus showed an excess in the case of the miner of about 35 per cent., whilst his industrial accident liability was about six times the average of the other classes . . . There is more sickness proper among the heavier risk occupations than among the normal grades and this illustrates the fallacy . . . that if the industrial accident liability is eliminated everybody is brought to the normal condition, justifying equality of financial treatment." Dealing on another occasion with the same subject, he has placed on record the experience of particular groups in the increasing order of their incidence:—

	Weeks.
1. General occupations, at age 30 ...	.918
2. Outdoor building trade, at age 30...	1.073
3. Quarry workers, iron, steel, etc., at age 30	1.736

At the age of 40 the miners' sickness experience, he pointed out, increased to 2.523 weeks; at 50 to 4.391; at 60 to 9.076, and at 69 to 20.934; while all other classes at age of 69 fluctuated between 9.155 and 17.546 weeks. It should be remembered that these statements and calculations were made prior to the National Health Insurance Act coming into operation

and were the statistics now reviewed in the light of the last eleven years' experience they in all likelihood, would not disclose any material modification. In the recent enquiry conducted by the Medical Research Council into the problem of "The Nutrition of Miners and their Families" it is recognised that the evidence upon which the report is based would not justify any sweeping conclusions, but they are of opinion that in four out of the five districts which were subjected to the test "the children measured were, in respect of weight, slightly below the county average," and of the assessed number of calories which they fixed as representing the required number to enable the miner to do a strenuous day's work they report that "in none of the districts is this figure attained." The condition of the children represents a future rather than an immediately increased liability. Where the children are underfed it is practically certain that the adults will be in a more grievous physical condition and the consequences on the funds of the society will be immediate rather than remote. The sickness and disablement experience of the society during the years of depression (1921, 1922 and 1923) not only corroborates their deductions, but significantly elaborates and confirms the influence which underfeeding in the main exerts over the available funds.

10. Following up their recent enquiry, the Medical Research Council is at the moment conducting an investigation into the Sickness Experience of Miners. The purpose of the investigation is "not merely to establish the fact that the sickness among miners is excessive," as the Council are of opinion that "that may be taken to be proved by past investigations"; it is their intention to select "a number of pits in which the rate of sickness is high and a further number in which the rate of sickness is low and by contrasting the conditions in the two classes of pits . . . it is hoped that it will be possible to ascertain the actual causes from which the excessive sickness arises."

EFFECTS OF SEGREGATION ON BENEFIT RATES.

11. Segregation may prove either advantageous or detrimental. It is obvious from the evidence advanced that in the heavier risk occupations the evil effects will on the one hand be perpetuated, while, on the other, in the lighter risk occupations the excellent results will be maintained. It is fallacious to urge, as has frequently been urged, that the difference in the rates of supplementary benefits is the measure of the difference between intelligent and profligate administration. The critics who argue thus reconnoitre mentally on the surface in preference to exploring the problem to its genesis. There is considerably more in the problem than is represented by these two extremes. Where the sickness and disablement experience is abnormally high on account of segregation, the administration of the society is far more exacting than it is in a society whose experience is sub-normal. There is at least a *prima facie* argument that the society with the heavier risk is driven by force of circumstances to work efficiently and economically, while the light risk society lends itself to greater administrative elasticity. But to whatever causes the differences may be attributed, we put forward the claim that a flat rate of contribution implies a universally flat rate of benefit. It is an iniquitous system which directs that the insured person whose sickness record is highest should be paid the lowest rate of benefit and *vice versa*. These anomalies are inseparable from the present system. The architectural nature of the structure is wholly responsible for the angularities which to-day characterise National Health Insurance. The prevailing disparities, which must of necessity grow as the years advance, cannot be better exemplified than by taking the following figures:—There were 10,162 societies and branches valued at 1918, which represented a total of 16,250,778 insured persons; 10,683,101 of whom were males and 5,567,677 were women. The following rates of additional benefits have been in operation since 1st July 1921, and the percentage of the insured population who are entitled to participate is set opposite the varying rates:—

Sickness.	Disablement.	Maternity.	Per cent.
Per week. s. d.	Per week. s. d.	s. d.	
Nil.	Nil.	Nil.	28·95
1 0	0 6	2 0	19·77
1 6	0 9	3 0	5·74
2 0	1 0	4 0	6·19
2 6	1 3	5 0	15·37
3 0	1 6	6 0	9·71
3 6	1 9	7 0	5·30
4 0	2 0	8 0	2·73
4 6	2 3	9 0	2·32
5 0	2 6	10 0	3·92
			100·00

It is revealed in the preceding table that 71·05 per cent. of the whole insured population are in receipt of varying rates of additional benefits, and the small percentage of 28·95 are not entitled to more than the bare statutory rates. No doubt administrative efficiency is a factor which contributes its quota to these favourable results, but it cannot conceivably be argued that this single factor in itself covers the whole case: obviously it does not. If the rates of additional benefits are to be accepted as determining the quality of administrative efficiency, it is evident that efficient management is as variable in degree as the benefits themselves. The additional benefits are responsible for a considerable number of transfers, and the little restrictive snags which have been set up in the way of fees and waiting periods have not had the effect of keeping them within reasonable proportions. *The Society's losses in transfers are equal to nine weeks' recruiting.*

12. The inexplicable eccentricities of National Health Insurance is further illustrated by taking the Glasgow Insurance Committee as typical of the others. There is an insured population of 492,042 in the Glasgow area, whose membership is unevenly distributed over 384 Approved Societies:

There are 98 societies with a membership of 1 each.

There are 92 societies with a membership of between 2 and 10 each.

There are 71 societies with a membership of between 11 and 100 each.

There are 65 societies with a membership of between 101 and 1,000 each.

There are 44 societies with a membership of between 1,001 and 9,000 each.

There are 14 societies with a membership of between 11,000 and 53,000 each.

13. These examples illustrate to the unbiased critic more forcibly than any argument can the unintelligible structure of National Health Insurance as it is organised and administered to-day. Were the Glasgow area treated as a single unit in preference to having approved units studded all over like a cluster of nebulae it would be possible to administer the area at an enormous economic saving to the insured population.

14. No one marvels at the volume of pardonable misunderstanding and personal resentment of the insured person regarding the provision of additional benefits. He never can grasp the justice of an arrangement that gives 15s. worth of sickness benefit per week in one society and 20s. per week in some other society for the flat contribution of 10d. per week. "Why," he asks, "should one society pay 15s. and another 20s. per week in sickness benefit; one 7s. 6d. and another 10s. in disablement benefit; and one 40s. and another 50s. for maternity benefit?" He regards the question as incapable of intelligent explanation and despairingly concludes that these disparities are nothing more or less than the product of an invisible evil genius entertainingly piling up an insoluble insurance puzzle. These anomalies abound throughout the whole scheme: they are common to the society whose registered branches are

valued separately, and apply to the insured members of the same household. Similar peculiarities characterise additional benefits in kind. To find an exact parallel to National Health Insurance one has only to visualise a group of insured persons purchasing their weekly supply of domestic necessities

from their grocer and each being supplied, for exactly the same payment, with a gradually increasing or decreasing quantity of goods.

15. Under the present scheme it costs roughly in administration 5s. for every 20s. paid out in benefit. The latest official returns available reveal that:

	1.	2.	3.	4.	5.
	s. d.	s. d.	s. d.	s. d.	s. d.
In England it costs	5 0.45	5 5.85	5 4.57	4 9.91	4 2.16
In Scotland it costs	5 0.37	4 10.39	5 4.54	4 8.65	5 10.37
In Wales it costs	4 8.66	4 3.99	4 4.26	5 0.92	4 4.88

1. Friendly societies with branches.
2. Friendly societies without branches.
3. Industrial and collecting societies.

4. Trade unions.
5. Employers' funds.

From the point of view of the insured person the analysis reveals that at present out of every 20s. distributed annually he gets less than 16s. It may be argued that certain funds are being accumulated for his benefit, which will eventually alter this proportion, but, assuming that only a necessary amount is being put aside for future contingencies, this argument does not appear to materially affect the inference of disproportionate expenditure on administration which must be drawn from the facts of the existing circumstances.

ADMINISTRATION OF NATIONAL HEALTH INSURANCE ON A TERRITORIAL BASIS-

16. We are of opinion that the perpetuation of the present Scheme militates against the best interests of the whole insured population, and we suggest that, as the Royal Commission is an instrument of reform, it should set itself the task of introducing architectural readjustments to redress the inequalities identified with National Health Insurance and make the benefit universally fair, irrespective of occupation or profession. The most effective arrangement would be to reorganise the Scheme on a purely territorial basis. The approved units would be absorbed in the territorial areas, and their anomalies would subside with them. Reconstruction on this basis would make for considerable administrative saving. A greater volume of work at much less cost would be produced by concentrated effort, needless waste eliminated, and the energy dissipated in answering the never-ending and increasing stream of enquiries regarding additional benefits in cash and in kind would be diverted into more profitable channels. Other economies, substantial in the aggregate, would as a natural sequence follow, and, taken in combination with the accumulations standing to the credit of the "Stamps Sold Account" (£3,378,655 at 1920 and £5,484,519 at 1922)—ignoring for convenience other similar accumulations—a sum of 2s. 6d. might be added to disablement benefit, thus raising it to the same level as the maximum rate paid for Old Age Pensions. A saving of a sixpence per insured person on administration alone would represent, basing the calculation on the disablement benefit paid in 1921, an additional 1s. 6d. per week, and another shilling could be secured by taking £400,000 from the "Stamps Sold Account," which increases at the rate of £1,000,000 per annum.

17. Examined as a National Scheme the surfeit of accumulations suggest great possibilities for exploration, but these fundamental changes are doubtless too far-reaching to be readily popularised.

SPECIAL GRANTS FOR HAZARDOUS INDUSTRY SOCIETIES.

18. As a practical proposition we suggest that the present Scheme should be brought more into line with sound insurance principles. At present the employer presumably contributes because of the sickness risks incidental to employment. These undoubtedly vary between industries and as a consequence the industry in which occupational sickness is high contributes less than a fair proportion of the cost of sickness compared to the industry in which occupational sickness is low. The contribution paid by the industry in which occupational sickness is high has its final incidence in the lower rates of benefit and where the employees are segregated the effects are primarily upon them. In the industry where occupational sickness is high the risk of unemployment and high sickness go largely together; consequently the contribution paid by the heavy risk industry is actually lower than the contribution paid by the light risk industry, when, on account of the greater risk, it should be in fact higher. It cannot be denied that the heavy risk industry and the light risk industry both serve the community as a whole. Each pays the same flat rate of contribution, which in the one case inadequately covers the risk and in the other is more than ample. The convenience of the flat rate of contribution for purposes of collection is obvious. But the same argument cannot be urged in support of the State's contribution. The heavy risk industry and the State each pay a contribution which would appear to cover only "ordinary risks" when, as a matter of fact, it should be an increased contribution to cover "hazardous risk." The result is that the insured person's benefit is prostituted in the process to the mutual advantage of the employer and the State. The inequality in benefits, if not redressed by the heavy risk industry, should be met by a generous increase in the State grant. If a society with a high occupational sickness is free from maladministration and is as efficiently managed as a society where the occupational sickness is low, there seems no sound reason why the former should not be placed in an exactly similar position to the latter and be able to pay the highest rates of additional benefits regardless of whether these benefits are regulated by the 17 million surplus of 1918 or the 37 million contemplated surplus of 1923.

JAMES GOLD,
Secretary.

Scottish Miners' Federation,
62, Robertson Street,
Glasgow.

17th November, 1924.

APPENDIX XI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE LANCASHIRE AND CHESHIRE MINERS' PERMANENT APPROVED SOCIETY (No. 1169) BY Mr. E. HIBBERT, CHAIRMAN, AND Mr. D. SHAW, SECRETARY. See Minutes of Evidence of the Fourteenth Day, Questions 6960 to 7186.

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CONSTITUTION AND MEMBERSHIP.

1. This Approved Society, No. 1169, became approved under the National Health Insurance Acts, 1911, the Certificate of Approval bearing the date 8th July, 1912.

2. At the 31st December, 1912, the number of members in Class A was 13,962, whilst at the same date the number of members in Class E was 917. At the 31st December, 1923, the number of members in Class A was 15,995, whilst at the same date the number of members in Class E was 1,231.

3. In the early years of the Society's work, probably 95 per cent. of its members were engaged in work at the coal mines either on the surface or underground, but in recent years the basis of membership has been much broadened, and probably now the members engaged in coal mining might be put at from 80 to 85 per cent. This change in the basis of membership has been due to the efforts made by the Board of Management and its officers to bring in new members engaged in occupations other than coal mining with the object of achieving a more favourable sickness experience.

AGE OF ENTRY INTO INSURANCE.

4. We suggest that the present age of 16 on entry into National Health Insurance shall be reduced to 14 years of age, or whatever may be the school-leaving age, either now or in the future. As a matter of fact the school-leaving age is at present about 14 years 3 months on the average so far as regards the Elementary Schools. The addition of three months or thereabouts continuation at school being due to the requirement of the Education Act, 1918, that children attending Elementary Schools may only be permitted to leave at the end of the school term—Easter, Midsummer, or Christmas. We have often been approached by the parents of young people under 16 years of age, and occasionally by these young people themselves for permission to allow them to join our Approved Society.

The young persons of 14 to 16 years of age should be treated as half members, paying half the weekly contribution paid by full insured persons, and should receive sickness and disablement benefit in proportion.

FINANCIAL BASIS OF THE ACT.

5. We venture to suggest that careful consideration might be given to the method of approaching the financial aspect of the National Health Insurance Acts. By this we mean that every care should be taken to avoid if possible increasing the contributions of insured persons or employers. And on the other hand equally great care might be taken to

develop the possibilities of making more fruitful the inherent financial resources of the Approved Societies under the Act.

6. We venture respectfully to submit for consideration of the Commissioners the attached Appendix A, which shows what actually has been accomplished by the members of our Accident Society in increasing benefits without increase in contributions of members. In what follows in this Statement of Evidence there will be found here and there various points which arise in connection with this matter.

TRANSMISSION OF STAMPED CARDS.

7. In connection with these two subjects, our principal suggestion is that consideration might be given to the question of devising some method by which stamped cards should not pass through the hands of members themselves, but might conceivably be sent in bulk by employers to the District Offices of the National Health Insurance Inspectors there to be sorted under the Identity Number of each Approved Society, and the latter would then receive their respective stamped cards from the District Inspector's Office.

8. On the ground of economy and simplicity of method it would be very desirable that the District Inspector's Office should be fixed at the Labour Exchange. So far as our own experience is concerned, we have reason to believe that we suffer fairly substantial loss of revenue, and of members also, owing to the loss of stamped cards from various causes. If such a scheme as is suggested could be devised, we think that employers should be remunerated for the trouble involved in preparing lists of the details of the stamped cards they would send in to the District Inspector's Office. The stamped cards would be signed by the members before being sent by the employer to the District Inspector's Office.

9. But it is realised that one of the principal difficulties arising in connection with the above scheme might be increased expenditure, and as economy of administration will be referred to in the course of this Statement of Evidence, we should regard the scheme as undesirable if it meant increased expenditure. But the absence of stamped cards is the cause of so much profitless work in the administration of Approved Societies, as well as of serious increase in administration expenses, that it would be to the advantage of all concerned if some better method than at present existing could be devised of ensuring the rapid and safe transmission of stamped cards into the hands of Approved Societies. See Appendix D.

THE CASH BENEFITS.

10. With regard to the cash benefits paid under the National Health Insurance Acts, we suggest that a higher rate of sickness and disablement benefit should be paid to married men members whose wives are alive. Such increased benefits might be made according to a graduated scale, having regard to the number of children under 14 years of age. Under the head of married men members we would include a young single man who may be the sole support of young sisters and brothers and of a widowed mother.

11. We are satisfied from our experience that there is great distress existing amongst our married men members when they are sick, especially where there are families of young children, none of whom may be wage-earners. And as illustrating the difficult position of the families of married men members, we beg respectfully to refer the Commissioners to Part 3 of the attached letter, Appendix B, sent to the Ministry of Health on 29th June, 1923.

12. It may indeed be necessary to make some slight increase in the contribution of insured Class A persons in order to provide these extra sickness and disablement benefits for married men members, but in connection with this point we again beg respectfully to refer the Commissioners to Appendix A and also to the suggestions which follow in reference to finance and economy generally. (See also Appendix E.)

ARREARS OF CONTRIBUTIONS.

13. We suggest that arrears should be paid in the ordinary manner by insured persons who may have been in receipt of compensation under the Workmen's Compensation Act or in receipt of unemployment benefit under the Government Unemployment Insurance Act. The present arrangement seems to us to be inequitable and not sound insurance, and we would remind the Commissioners that persons in receipt of compensation and unemployment benefit periodically make claims for maternity benefit, whilst continuously the Approved Society is liable for the cost of medical benefit and other expenses.

14. Further, if sickness and disablement benefits to married men members are increased it would appear that they would be expected to pay arrears accruing during periods of incapacity. We think the arrears card should be simplified, and made more useful and effective than it is at present. In order to do so we suggest that the reverse side of the card should be left blank for the member's name and address for postal purposes, and it is needless to point out that this course would help to reduce postage and stationery expenses of Approved Societies. Again, on the front side of the card on which appears the member's name and membership number the present arrangement of printed matter should be abbreviated and simplified. As at present printed the card is simply a source of mystery and trouble to insured persons who can seldom take the mental trouble involved in reading a closely printed and fairly long document. In Appendix C we have drafted our idea of what an arrears notice might be.

15. We suggest that the regulations as to arrears should be strengthened; and that under no circumstances should questions as to amendment of arrears notices or applications to pay penalty arrears after November 30th be entertained. Members occasionally make application some months after the period of grace has elapsed for permission to pay their arrears on the plea that they had not received an arrears notice, or that they did not know they were in arrears. We regard all such statements as actually untrue, and all insured persons are now fairly well acquainted with the position as regards National Health Insurance and have a perfectly clear idea as to whether they are getting into arrears with their contributions or not. We consider that the present dates of September 30th and November 30th be retained for the issue and return of arrears notices.

TRANSFERS.

16. We suggest that transfers should operate only on January 1st of each year; and that the transfer fee should operate in all cases no matter what might be the date of entry into insurance.

SPECIAL CLASSES OF INSURED PERSONS.

17. *Class E Members.*—We feel obliged to call the attention of the Commissioners to the heavy drain on our sickness funds as the result of numerous and continuous cases of misconduct (pregnancy) of unmarried Class E members. We do not know what may be the experience of other societies in this respect but in our own society our experience is painful. Numerous cases of unmarried Class E members at all ages from 17 to 35 frequently declare on our sickness funds and certify to be suffering probably from gastritis or anaemia, or even influenza, and after some weeks' benefit has been paid under one of these heads another complaint will appear on the medical certificate, and finally the

case then becomes one of pregnancy: cases arise in which the misconduct has occurred some weeks after the member declares on the funds.

18. We therefore suggest that the contribution of insured persons in Class E in all societies should be increased by one penny per week as the only means of meeting the excessive claims of Class E members generally.

19. *Class K Members.*—We suggest that the period of two years within which claims for maternity benefit for the first confinement after marriage may be made by Class K members shall be reduced by one year in order to coincide with the period of one year within which claims may be made for sickness and disablement benefit.

We believe it would be desirable if Class K could be abolished, and would suggest that a sum of about £3 be paid to each case in full settlement on becoming Class K, it being understood that they cannot re-enter insurance except in the event of widowhood.

20. *Class B Members.*—We think it was unfortunate that the Recoupment Scheme should have ceased on 21st December, 1920. Many of our ex-Army members still continue to make claims for sickness and disablement benefit in respect of wounds or sickness sustained on War service, and we think that the liability for these cases should be borne by the Ministry of Pensions.

MATERNITY BENEFIT.

21. We very strongly recommend that maternity benefit should not be paid to the wives of married men members in respect of children whose father is not the woman's husband. We have had several cases of this kind recently where the women have been living in adultery, and yet under present laws we are obliged to pay maternity benefit, and in such cases the husband has strongly protested against the maternity benefit being paid in respect of his insurance. The injustice of the present unsound insurance position is seen in the fact that the Approved Society of which the adulterous father is the member escapes all liability for the benefit, whilst the married man and his society suffer all the injustice and liability. We think that the law should be altered in this respect without delay.

TREATMENT BENEFITS.

22. Concerning this subject we would respectfully refer the Commissioners to the accompanying statement marked A, and in connection with the position therein indicated, we beg to suggest that the following should form part of the ordinary benefits provided by the National Health Insurance Acts and should not be dependent upon any favourable valuation results.

1. Dental treatment.
2. Trusses.
3. Spectacles.
4. Knee-caps.

We consider dental treatment and the appliances referred to should be supplied on the understanding— if it is possible to lay down such a condition—that as a result of their provision the members will be enabled to resume work.

23. The cost of a truss, or a pair of spectacles, or of a knee-cap is very slight. A good pair of spectacles after proper testing can be obtained for about 15s. 6d., and in our private Society we supply many of these spectacles in the course of each year. A good truss can be supplied from 8s. to 18s. 6d., and again in our private side we are supplying these articles every week, whilst a knee-cap only costs from 4s. 6d. to 5s. 9d. At this moment we have several members who would return immediately to work if we could provide them with one of those useful surgical appliances.

DENTAL BENEFIT.

24. But with regard to dental treatment we would desire respectfully to press upon the Commissioners

the urgent necessity of making dental treatment an ordinary benefit under the National Health Insurance Acts. We do not think there should be any proposal to pay only a small portion of the cost of this treatment, as we are convinced that but few members are in a position to provide funds to pay even half the cost of dental treatment especially in cases where two complete dentures are required at a total cost of £6, £9 or £10. We believe that the provision of complete dental treatment as an ordinary benefit would certainly transform in the most favourable sense our present unfavourable sickness experience. As a result of this unfavourable sickness experience, the surplus at the first Valuation on 31st December, 1918, was not sufficiently large to enable the Society to grant extra benefits. (See Appendix G attached.) But a constant study of sickness experience revealed the obvious fact that a large percentage of it might be prevented by the provision of dental treatment, and accordingly some 12 months or so ago, we asked the regional medical officers to refer in their reports to the condition of the teeth of sick members referred to them for examination. The regional medical officers have very kindly complied with this request. It is quite obvious from those reports—and they confirm our previous impressions formed as laymen of the position of this subject—that a considerable proportion of our excessive sickness experience is due to this preventable cause. Realising as we have done the urgent necessity of dental treatment, and knowing that it was improbable we could hope to achieve a disposable surplus in the benefit fund under present conditions, we have endeavoured by close attention to our Administration Account to secure therein as large a surplus as possible with a view to a start being made in the provision of dental treatment. At 31st December, 1922, the surplus in the Administration Account was £640 0s. 0d., whilst at 31st December, 1923, we believe the figure will be slightly over £1,000 0s. 0d.

25. Members themselves have frequently sent us letters pleading for dental treatment to be provided for them or have called upon us with the same object in view. And the following are quotations from some of those letters or statements:—

“ Off work several times as the result of dental effects, and treatment would indirectly benefit the Society.”

“ Off work two days a week for the last two months, and doctor told him to get teeth out.”

“ Very bad health for over 12 months, only able to work two or three days a week. Bad stomach.”

“ Suffers from recurrence of septic poisoning through bad teeth.”

“ Lost many days' work through bad stomach through bad teeth.”

“ Troubled with bad stomach. Instead of improving with medicine gradually getting worse. Doctor says teeth have a lot to do with the cause.”

From many of these letters may be quoted cases of bad teeth causing indigestion, rheumatism, tonsillitis, dyspepsia, and catarrh.

So recently as 21st October, 1924, we received the following striking report from the regional medical officer in the case of our member No. 11880:

“ Gums are extensively ulcerated. Teeth are loose and septic. Patient is anæmic. Stomach is dilated. Nutrition poor. Urgent case for dental treatment.”

26. The beneficial effects that would follow from the provision of dental treatment are surely plain. We have always thought it unfortunate that the surplus of over £6,000 at the 1918 valuation was not boldly applied to the provision of dental treatment, as we believe the Society would have been amply repaid by a transformed sickness experience. We realise that the cost in the first instance would be heavy, and we have considered various ways of assisting Approved Societies, on the one hand, and insured persons, on the other hand, to meet the cost. We are reluctant to suggest that the contributions of

members should be increased to meet this benefit, but it may even be necessary to do so. But as an alternative the expenditure might be met from the Society's present funds in the firm belief that in a short time the funds would be reimbursed by a reduced sickness rate. In connection with this suggestion it is desirable to bear in mind that Approved Societies with a compulsory membership are in a much more favourable position to deal with a problem of this kind than are Voluntary Societies whose members may leave at a moment's notice. Another suggestion is that the society might pay 50 or 75 per cent. of the cost of dental treatment, and the insured person pay the remaining proportion in the form of a special arrears contribution payable each November. But whatever method is adopted it is urgently necessary that complete dental treatment should be provided for insured persons without delay. To our afflicted members it would mean new life and health; to the society a contented membership, growing in numbers and financial strength. (See Appendix E.)

INSURANCE COMMITTEES.

27. In order to economise the funds of Approved Societies and thus enable larger benefits to be given without increase in contributions, we suggest as one means to this end that Insurance Committees should be abolished. We consider them to be entirely useless and a drain upon the funds of Approved Societies. The administration of medical benefit might be left with Approved Societies, or with District Inspectors.

FINANCE.

28. We suggest that the fees for regional medical officers should be charged to the Benefit Fund Account and not to the Administration Account as at present.

29. We suggest that the Contribution Registers should be designed to cover a valuation period of five years and thus assist in securing further simplicity and economy in administration.

In our opinion it would be desirable if before the next issue of Benefit Registers provision were made for inclusion of payment of maternity benefit. At present Approved Societies have to use separate books for these payments, which means additional cost in administration. The necessary space for four columns (one for each quarter) for payments made in respect of maternity could be saved from columns 8, 10 and 11 (shillings and pence columns), and 21.

30. In the case of an Approved Society having a heavy sickness rate and unable to achieve a disposable surplus at the valuation, any surplus arising in the Administration Account should be available for providing the increased benefits such as dental treatment, etc.

INVESTMENTS.

31. We think that section 56 (2) of the National Health Insurance Act, 1911, relating to powers of investment should be amended in order to allow Approved Societies much larger powers of investment.

32. As already stated, there should be considerable hesitation in increasing the contributions of insured persons, and, on the other hand, every part or section of the procedure of Approved Societies, of the Ministry of Health, of Insurance Committees, or any other body occupied with work in connection with National Health Insurance should be closely scrutinised with a view to reducing expenditure and thus rendering available for benefit funds that are now wasted on useless administration.

33. In our private side we have registered under the Friendly Societies' Act the following rule relating to investments:

“ So much of the Society's Funds as may not be wanted for immediate use or to meet the usual accruing liabilities, shall, with the consent of the Board of Management or of a majority of the members present and entitled to vote at the General Meeting, be invested by the Trustees in such of the following ways as such Board or

General Meeting shall direct, namely, in any Savings Bank, in the Public Funds, or with the Commissioners for the Reduction of the National Debt, or upon Government or real securities in Great Britain or Ireland, or upon Debentures, Mortgages or Securities of any Company, incorporated by Charter or Act of Parliament and paying a dividend upon its Ordinary Share Capital or in any Investment in which Trustees are for the time being by law authorised to invest Trust Funds, or upon the Security of any County, Borough or other Rates Authorised to be levied and Mortgaged by Act of Parliament, or in the purchase of Land, or in the erection or alteration of Offices or other Buildings thereon as aftermentioned.

"The Board of Management, with the consent of a Special Meeting of the Society called for the purpose, may, in the name of the Society purchase, or take or lease in the names of the Trustees any land, and may sell, exchange, mortgage, lease, or build upon the same (with power to alter and pull down buildings and again re-build), and no purchaser, assignee, mortgagee, or tenant shall be bound to enquire as to the authority for any sale, exchange, mortgage, or lease by the Trustees, and the receipt of the Trustees shall be a discharge for all moneys arising from or in connection with such sale, exchange, mortgage, or lease." (See Appendix F.)

34. We suggest that it is very necessary that the section 56 (2) of the Act of 1911 should be largely amended on the lines of the rule quoted above, and thus permit Approved Societies to make the most advantageous investment of their surplus funds. It should also be understood that any amendment should include powers to invest funds in such authorities as the Mersey Docks and Harbour Board, Port of London Authority, Manchester Ship Canal Bonds, or any similar well-established authority.

35. With the economy of administration on the one hand, and profitable investment of funds on the other hand it is possible that much could be done in providing larger benefits with little or no increase in contributions.

D. SHAW,
Secretary.

Old Permanent Buildings,
22, Hope Street,
Wigan.
6th November, 1924.

APPENDIX A.

THE LANCASHIRE AND CHESHIRE MINERS' PERMANENT RELIEF SOCIETY.

At the Annual Meetings of the Society held during recent years, certain representatives of Local Agencies have made remarks which appears to indicate some misapprehension of the work which has been accomplished by the Board of Management in the interests of the members generally, as well as of the widows and children.

The Board of Management have accordingly thought it desirable to issue this brief record of the progress made by the Society, especially during the last ten years.

In issuing the record, the Board desire to explain that their object has always been to ask members for as small a contribution as possible, and on the other hand to give benefits as large as possible consistent with financial solvency.

The Record of Contributions.

1. *Surface Members.*—The contributions of full surface members is 4d. per week, and of half members 2d., and these figures have remained unchanged since February, 1901—a period of over 23 years, and yet all surface members have been entitled to participate in the numerous increased benefits which have been made since the year 1901.

2. *Underground Members.*—The contribution of underground members is 5d. per week, and of half members 2½d., and these rates have continued in operation since February, 1901, with the exception of the two years July, 1920, to July, 1922, when an extra 1d. and ½d. were paid respectively in order to meet the cost of paying relief to members suffering from industrial diseases.

3. Again, notwithstanding the increased cost of management, as a result of the economic conditions arising out of the War, no call has been made upon the members for any extra contribution.

Deficits.

4. From its formation in the year 1872 until 1916 the Society was engaged in a constant struggle to attain solvency. At every valuation between 1872 and 1916 the Actuary had reported a deficit, and on several occasions the deficit exceeded £50,000.

At no time between the years 1872-1916 had any increased benefit been made without also increasing contributions.

The First Surplus.

5. But at the valuation as at 31st December, 1916, the Actuary reported a surplus of £2,513. This was the first surplus to be attained in the history of the Society, and in his report Mr. R. Todhunter, the Actuary, said, "The consistent efforts which have been made with the loyal co-operation of the members to attain the goal of 20s. in the £ have now been crowned with well-deserved success. I congratulate the Society most sincerely on the result of the investigation."

The Record as to Benefits.

6. Immediately after the above Valuation Report was received a Special General Meeting was held on 16th June, 1917, when the following numerous increases of benefit were made:—

- (a) The 80 cases of disabled members who came on the funds previous to 1898 had their present allowance increased from 7s. to their original rate of 10s. per week.
- (b) Rule 29a was rescinded, and the disabled members coming on the funds since 1898 were paid at the ordinary rate of 7s., and were not reduced to 5s. per week.
- (c) The grant of £15 to the parents or next-of-kin on the death by accident of single members or widowers leaving no dependent relatives was increased to £20.
- (d) The widows receiving 4s. per week had this sum increased to 5s. per week.
- (e) The weekly allowance of 2s. paid to children was increased to 2s. 6d.
- (f) Cases similar to that of Joseph Jackson (deceased) were included in the rules and paid for.
- (g) Illegitimate children of married members were recognised under the rules of the Society, and were paid as in the case of other children.
- (h) The Board of Management were empowered to provide for disabled members treatment by specialists, massage and other similar treatment, artificial and other surgical appliances, on the understanding that as a result the injured members would be enabled to return to work.

The Board were also empowered to arrange for disabled members to attend technical and other schools, learn trades, on the understanding that the members will be enabled to return to work at some trade or business.

The foregoing increases of benefits as set out from (a) to (h) above were estimated by the Actuary to cost £4,000 per annum, with a capitalised value of £31,642. But members were not asked for a single penny of extra contribution to pay for these benefits.

7. At the 31st December, 1917, the Board of Management transferred the large sum of £17,500 from the Management Fund to the credit of the Benefit Fund. This course was made possible after many years of efficient and economical management.

8. Again, in order to enable disabled members and widows to cope with the increased cost of living, the Special General Meeting, held on 24th May, 1919, made the following increases of benefits:

- (a) The 5s. paid weekly to widows (including all cases on the funds) was increased to 6s.
- (b) The 7s. paid weekly to disabled members (including all cases on the funds) as from the second week was increased to 8s.

These two increases of benefit were estimated by the Actuary to cost £3,073 per annum, with a capitalised value of £26,250. And again members were not asked for a penny extra contribution to pay for these benefits.

9. In the next valuation report as at 31st December, 1921, the Actuary stated that these increased benefits together with the surplus at the 1921 valuation had been made possible owing to the surplus of £17,000 saved on the Management Fund Account (see paragraph 7 above), and to the high rate of interest earned on the invested funds.

Industrial Diseases.

10. With regard to industrial diseases, relief has been paid to all these cases since 1st July, 1920, and as the extent of the liability was then unknown the contribution of underground members was increased at that date by 1d. per week for full members and ½d. per week for half members; but these increased contributions were taken off as from June, 1922, and thus the payment of relief in cases of industrial diseases is now being accomplished without the members paying any contribution for the benefit, although it is now costing the Society over £3,000 per annum.

Surgical Appliances.

11. For about ten years or more the Board of Management have been supplying surgical appliances to disabled members in order to enable them to resume work. Such articles include artificial legs and hands, trusses, knee-caps, new artificial teeth to replace those broken by accident at work, spectacles, and other smaller appliances. These cases are very numerous and costly. For the year 1923 there were about 300 cases dealt with and the cost was about £900. All these surgical appliances are granted without the members paying any extra contribution.

Travelling Expenses of Disabled Members attending Hospitals.

12. Disabled members attending hospitals have their travelling expenses paid by the Society. Each month there is a large number of these cases, and the cost is very heavy. Members do not pay any extra contribution to meet these expenses.

The Board of Management do not know of any Friendly Society possessing a similar record of benefits provided for their members on the basis of a contribution fixed almost a quarter of a century ago. The Board have stretched the rules to their utmost in their efforts to include every case as far as possible. But the limit has been reached, and with the warning uttered by the Actuary at the 1921 valuation, together with the disastrous accident experience of the last two years, and in view also of the decline in the rates of interest on investments, it is unlikely that any further benefits can be provided without also increasing contributions.

In closing this record of the work accomplished during the last few years, the Board of Management hope and believe that members generally will now appreciate better the disinterested efforts made to advance their well-being. Similar efforts will be

continued in the future, and members may rest assured that the utmost care will be taken to make the best possible use of their contributions to the Society.

The Board trust also that they may continue to receive the support of the general body of representatives of Local Agencies to the Annual General Meetings of the Society. For that loyal support in the past the Board of Management have always felt profoundly grateful and the hope is expressed that representatives themselves may feel that their confidence has not been misplaced.

(Signed) T. G. DOBB,
Chairman of the Board of
Management.

D. SHAW,
General Secretary.

Old Permanent Buildings,
21a, Hope Street,
Wigan.

30th June, 1924.

APPENDIX B.

COPY LETTER FROM THE LANCASHIRE AND CHESHIRE MINERS' PERMANENT APPROVED SOCIETY TO THE MINISTRY OF HEALTH.

Old Permanent Buildings,
22, Hope Street,
Wigan.
29th June, 1923.

Sir,

In reference to the valuation of this Approved Society as at 31st December, 1922, I am instructed by the Board of Management at their Meeting to-day to place before you some reasons in explanation of the Society's excessive sickness experience during the last two years or so, a problem which the Board have frequently had under their consideration.

The Board desire to point out that the causes as given for the Society's excessive sickness experience are quite beyond the control of the Board and at the same time have almost daily manifested themselves in dealing with the Society's sickness claims. Taken together the causes appear to account for a very substantial proportion of the Society's unfavourable experience as regards sickness.

(1) The effects upon the constitution and health of our members of their War Service during the years 1914-1919 is one reason of our excessive sickness experience. The effects of this service have been shown in two ways (a) the direct effects of such service in disability caused by wounds, or of such distinctive service diseases as malaria; (b) less direct effects such as tuberculosis, heart trouble, which may have been revealed after the members have returned to work, and in cases in which, so far as we can judge had, previous to 1914, a comparatively clear record of such diseases.

(2) The second cause of our excessive sickness experience is to be found in the condition of the teeth of many of our members. During the last few months we have asked the regional medical officer to refer in their reports to the condition of members' teeth, and they have very kindly done so. It is quite obvious from these reports, and they confirm our previous impressions of the position of this subject—that a considerable proportion of our excessive sickness experience is due to this preventable cause. Realising as we have done the urgent necessity for dental treatment, we have endeavoured by attention to our Administration Account to secure therein such a surplus as would enable the Board to justify their application to you for the provision of dental treatment. The amount of the surplus in the Administration Account at 31st December, 1922, is £640, whilst we expect a further increase in this surplus during the year 1923.

The Board therefore desire formally to make application that this surplus may be definitely applied to dental treatment and thus remove one of the most glaring causes of the Society's excessive sickness experience. The Board are hopeful that if this dental treatment could be brought into operation immediately there would very shortly result a substantial improvement in our sickness experience.

(3) A third and more serious cause of our excessive sickness experience is due to the terrible social and economic condition existing in the families of our members owing to the low wages and the high cost of food still prevailing. This is a very grave matter and the Board desire urgently to bring before your serious attention the appalling suffering and actual starvation prevailing in the families due to the low wages and the high price of food. A very common phrase in the reports of the regional medical officer is, "This member is emaciated," another phrase is, "Member is debilitated and badly nourished," whilst the realistic phrase, "I fear the member's recovery is retarded by want of food," had actually been used by the regional medical officer.

All this confirms our daily experience with our sick members either directly or through our visitors. Our visitors' report that in some cases the families are so poor that on the day benefit is paid there has been no fire in the house and no food obtainable by the family until our visitor has arrived probably in the afternoon with the few shillings sickness benefit. Again, members of our office staff have all personally come in contact with such cases, and on Tuesday, the 5th instant, the secretary personally met with a most typical case—namely, that of Thomas Goulding, Mem. No. 2785. On Saturday, the 2nd June, the member was in bed suffering from influenza, and unable to get up and go to the doctor for a signing-off certificate. In reply to our inquiry as to why he wanted a signing-off certificate when he was ill in bed, he replied that he has a wife and seven children, and only one of the latter was doing some work, and he could not stop at home as he was obliged to work in order to get more money than sickness benefit of 15s. per week. When seen on the 5th June on his return from work in his black face he said he had not the strength of a kitten, and that day at the colliery he had only two pieces of bread

and butter to eat. He had called with regard to the payment of benefit for the two days for which he had no doctor's certificate, and, of course, benefit was paid.

We could illuminate this third cause of our excessive sickness experience by many instances of a similar kind, and it is, of course, the married members with children who are suffering most. An obvious danger in cases such as that of Thomas Goulding is that the member continues at work whilst actually seriously ill, with the very strong possibility that his health will become permanently undermined, and by the time he is 50 years of age—he is actually only 40—he becomes a chronic case of illness.

4. In conclusion, the Board would remind you of the nature of the occupation of the great majority of the Society's members. Probably quite 95 per cent. of them are engaged in coal-mining, which is not only an arduous and dangerous occupation, but in its ordinary course leads to extremes of great heat, cold and wet; the men come out of the pits very heated, have frequently long waits on the roads and stations for cars and trains (large numbers live three, five and even ten miles from their collieries), and on wet days only get home after getting wet through. All these adverse conditions lead to unusually heavy sickness, such as influenza, rheumatism and bronchitis.

Finally, the Board of Management express their earnest hope that you may grant this application for the provision of dental treatment out of the surplus in the Administrative Account, and thus remove one cause of the Society's excessive sickness experience.

I am, Sir,
Your obedient servant,
(Signed) D. SHAW,
Secretary.

The Controller,
Ministry of Health,
Insurance Department,
Whitehall, London, S.W.1.

P.S.—The Board asked me to state that they believe the surplus in the Administration Account at 31st December, 1923, will be not less than £1,000

APPENDIX C.

THE LANCASHIRE AND CHESHIRE MINERS' PERMANENT APPROVED SOCIETY, No. 1169.											
				22, Hope Street, Wigan.							
Name: JOHN ROBINSON.			Mem. No. 1234.								
The number of stamps credited to you for the year ended 6th July, 1925, is 40, and you are 3s. in arrears.											
To avoid reduction of benefit it is important that Health Insurance stamps to the amount of 3s. should be put on this card and returned in an envelope to the above address by 30th November.											
<table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>											
Signature of Insured person.....											
Address.....											

NATIONAL HEALTH INSURANCE—NOTICE OF ARREARS OF CONTRIBUTIONS.

Stamp.

POST CARD.

MR. JOHN ROBINSON.

14. EXETER STREET,

WIGAN.

APPENDIX D.

NOTE ON THE SUGGESTION THAT STAMPED CARDS SHOULD BE SENT BY EMPLOYERS TO THE DISTRICT INSPECTOR'S OFFICE, AND AT THE LATTER PLACE APPROVED SOCIETIES WOULD RECEIVE THEIR OWN STAMPED CARDS.

1. The employer would not accept any new card from a work-person unless the card bore the identity number of the Approved Society.

2. At the close of the half-year the employer's clerk would arrange the stamped cards according to the identity number of the societies. The clerk would then prepare a typed list, including a duplicate copy, giving the following details of the cards:—

Mem. No.	Name.	No. of stamps.
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One of these lists would be prepared by the clerk for each society.

3. The lists, with the respective bundles of cards, would then be taken by the employer's clerk to the District Inspector's Office, and there a receipt would be given for the cards.

The District Inspector would then communicate with the Approved Societies concerned, and the latter would send a clerk to the Inspector's Office to check and receive the stamped cards, and would give a receipt for them.

4. In certain cases it may be necessary for the District Inspector to send some stamped cards by post to the head offices of Approved Societies, if the latter happen to be some distance away from the Inspector's Office. In such cases the societies would send an acknowledgment by post.

5. The employer should be paid for the clerk's time occupied in sorting the stamped cards and in preparing the typewritten lists of the cards for each Approved Society concerned. In a staff of, say, 100 workpeople, there might be, say, 20 societies represented, but a good typist would sort the cards and type the lists within an hour. The employer might be paid at the rate of 2s. per 100 cards sent to the District Inspector's Office, and this sum should be paid out of the present administration allowance of the Approved Societies.

6. It does seem necessary that societies should secure the more rapid and safer receipt of their stamped cards than is the case at present. It is in the hope of helping towards the solution of this difficulty that the above suggestion is made.

NATIONAL HEALTH INSURANCE.

Name of Employer:—
Messrs. A. Brown and Co.,
London Colliery,
London.

Details of stamped insurance cards sent to the District Inspector's Office, at London, for the 2/1924 period, in respect of the Approved Society bearing identity number 3915.

Membership Number.	Name.	Number of Stamps.

Total number of stamped cards sent in.....

.....
On behalf of above firm.

Date.....

.....
Signature of official receiving cards at District Inspector's office.

Date.....

.....
Acknowledgment of receipt of above stamped cards by representative of Approved Society No. 3915.

APPENDIX E.

The Board of Management of this society venture to submit the following points in a scheme designed to provide the necessary funds with which to extend the benefits provided by the National Health Insurance Acts. The scheme is a moderate one, yet a wide experience shows that it would be a great step in advance and of immense value to insured persons of all societies.

(A) Sources of revenue to provide funds for granting increased benefits under (B):—

(1) Continued efforts to be made in simplification and economy of administration.

- (2) Wider powers of investment.
- (3) Improvement in sickness experience as the result of the provision of dental benefit.
- (4) Increase of, say, one penny in the weekly contribution paid by insured persons.

(B) Suggested increased benefits as the result of (A):

- (1) The provision of dental treatment for all insured persons: the amount payable in respect of any person not to exceed £8 8s. (the average cost of complete upper and lower dentures). The Approved Society to pay the entire cost of the treatment.
- (2) The increase of sickness or disablement benefit for married members living with their wives and having children under 14 years of age.
- (3) The provision of small surgical appliances, such as spectacles, trusses, knee-caps, etc., for sick members, on the understanding that the provision of the article will enable the member to return to work.

APPENDIX F. INVESTMENTS.

We are surprised that the Committee of the National Conference of Friendly Societies have not referred to the question of the powers of investment. As we consider it of great importance to develop the inherent financial resources of Approved Societies, without increasing contributions, with the object of providing larger benefits, we consider that the present section 56 (2) of the National Health Insurance Act, 1911, is restricted in its limitation of the powers of investment. We strongly advocate a substantial amendment of section 56 (2) of the 1911 Act. On our private side we have the following rule relating to investments, but as it was adopted in the year 1872 we regard this rule also to be considerably out of date, and we suggest that whilst everything in it should be included in an amendment of section 56 (2) of the National Health Insurance Act, 1911, powers to invest funds in the following securities should also be given:—

1. The debentures or bonds of public utility companies providing:
 - (a) Gas light.
 - (b) Electric light.
 - (c) Water.
 - (d) Sewage.
2. The debentures or bonds of great corporations chartered by special Acts of Parliament, including—
 - (a) Port of London Authority.
 - (b) Manchester Ship Canal.
 - (c) Mersey Docks and Harbour Board.
3. The securities of urban district councils, without limit as regards population.

The following is the rule of our private side relating to investments:—

“So much of the Society's Funds as may not be wanted for immediate use, or to meet the usual accruing liabilities, shall, with the consent of the Board of Management or of a majority of members of the Society present and entitled to vote at a General Meeting, be invested by the Trustees in such of the following ways, as such Board or General Meeting shall direct, namely, in any Savings Bank, in the Public Funds, or with the Commissioners for the Reduction of the National Debt, or upon Government or real securities in Great Britain or Ireland, or upon debentures, mortgages or securities of any company, incorporated by Charter or Act of Parliament, and paying a dividend on its ordinary share capital, or in any investment in which trustees are for the time being by law authorised to invest trust funds, or upon the security of any County, Borough, or other rates authorised to be levied and mortgaged by Act of Parliament, or in the purchase of land, or in the erection or alteration of offices or other buildings thereon as after mentioned.

“The Board of Management, with the consent of a Special Meeting of the Society called for the purpose may in the name of the Society purchase, or take on lease in the names of the trustees any land,

and may sell, exchange, mortgage, lease, or build upon the same (with power to alter and pull down buildings and again rebuild), and no purchaser, assignee, mortgagee, or tenant shall be bound to enquire as to the authority for any sale, exchange, mortgage, or lease by the trustees, and the receipt of the trustees shall be a discharge for all moneys arising from or in connection with such sale, exchange, mortgage, or lease.”

APPENDIX G.

THE VALUATION OF APPROVED SOCIETIES: “FAVOURABLE SICKNESS EXPERIENCE” AND “UNFAVOURABLE SICKNESS EXPERIENCE.”

The Board of Management respectfully desire to invite the attention of the Commission to the position of so-called “favourable sickness experience” and “unfavourable sickness experience” of Approved Societies.

At the first valuation of this Approved Society, No. 1169, the Actuary recorded a surplus of £6,324, and stated that no portion of this surplus was available for additional benefits, and pointed out that this position was to some extent due to the “unfavourable sickness experience of the Society.”

We wish to state that, in our opinion, these sickness rates depend a good deal upon the difference of method of administration of sickness benefit.

1st. Some societies only pay benefits as from the date of receipt of the claim, and not from the date of the doctor's first certificate. We regard this method as not only unjust to the sick member, but as contrary to the spirit of consideration in which a National Health Insurance Scheme should be carried out.

There are various reasons why sick members cannot send their claims in early. But whatever the reasons may be, the method adopted only succeeds in adding to the domestic misery and mental distress of sick members. In cases where there are children under working age, the shortness of food, want of the most ordinary domestic necessaries, and nourishment for the sick father, all become acute.

It follows that certain societies, by following this practice, have shown a spurious “sickness experience” and succeeded in getting a large surplus.

If our Society had or were to follow this practice, we estimate that we could reduce our payments of sickness benefits by about 10 per cent.—or £2,500 per annum.

2nd. Certain societies unduly delay payment of sickness and other benefits; and thus the prolonged absence of the cash benefits often compels the sick member (especially if married with young children) to return to work earlier than he should, and thus there follows another “shortening” of the claim and again “a false but favourable sickness experience.”

3rd. Again, certain societies fine members 2s. 6d. each if they fail to produce a signing-off certificate. If this fine is applied to the reduction of the sickness benefit the latter is again made into a “favourable sickness experience.”

Disciplinary measures of the kind indicated above appear to us to be entirely out of place so far as they concern the insured persons of Approved Societies. So far as our experience goes, the great majority of insured persons are already too poor and suffer too greatly from want of food and nourishment in times of sickness to make it desirable that fines of any kind should be imposed upon them.

Thus, the Ministry of Health actuaries and others responsible for the study of problems affecting the life and family conditions of the insured persons are seriously misled where supplied by “statistics” prepared upon methods of administration described above.

We suggest that the three points referred to should be dealt with by statutory measures; and if they are made impossible, we imagine that certain societies will show in the future a substantially higher “sickness experience” than that which they have shown in the past.

APPENDIX XII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE LANCASHIRE AND CHESHIRE MINERS' FEDERATION APPROVED SOCIETY (No. 2,778), BY MR. LEE SHAW, SECRETARY.

See Minutes of Evidence of the Fourteenth Day, Questions 7187 to 7393.

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RESULTS OF VALUATION.

1. We desire to submit before the Royal Commission our views regarding the operation of the National Health Insurance Act regarding certain defects which involve hardship and which gives rise to a feeling that a measure of injustice is experienced by insured persons belonging to certain types of societies.

2. In connection with the first valuation a large number of Approved Societies showed substantial surpluses. This enabled such societies to provide additional benefits in cash and in kind, which no doubt have been of considerable value to the recipients. On the other hand, there were a substantial number of societies which had no surpluses available, in consequence of which their members have received the statutory rates of cash benefits only.

3. Approved Societies similar to ours, consisting of miners only, are almost without exception in the unfortunate position of not being able to provide additional benefits. The fact that a heavy sickness experience, and invariably a high maternity rate experience, in connection with such societies, has prevented the accumulation of funds to provide additional benefits, in itself suggests that the need is equally as great for the provision of additional benefits, and possibly greater.

4. The valuation of our society as at the 31st December, 1918, showed that we began with a membership of 13,903, and at the end of the period we had a membership of 16,086, giving a net increase of 2,183. There was paid the sum of £43,844 7s. 8d. for sickness benefits, £6,606 15s. 5d. for disablement benefits, and £12,123 9s. 2d. for maternity benefits, and after other items of expenditure had been taken into account, there was a surplus of £3,982 only, which was not available for additional benefits.

SPECIAL POSITION OF MINERS' SOCIETIES.

5. Our unfavourable experience is unquestionably the result of the laborious and uncongenial conditions of the occupation in which our members are engaged, and also bad housing. The character of the work is such that a high degree of physical efficiency must be maintained for the purpose of continuing at work. This means that for similar complaints those engaged in the mining industry are compelled to cease work earlier and remain off work longer than those following occupations which are less laborious and more congenial in character.

HIGH MATERNITY RATES.

6. The adverse experience is further accentuated by the fact that the maternity rate experience is much above the average. This applies in a considerable degree to societies consisting of miners. For the purpose of ascertaining the maternity rate experience of societies affiliated to the National Association of Trade Union Approved Societies, each society was asked to furnish particulars of the number of claims and the amount paid for maternity benefits for the years 1913, 1914, 1915, 1916, 1917 and 1918. There were 36 male societies which supplied the information, and the society with the lowest experience had an average payment of £5 10s. per annum for each 100 members, whilst the society with the highest

experience paid £19 13s. 1½d. per annum for each 100 members. It will be seen from these figures there is a very wide disparity in the experience of societies in this connection, and is sufficient to indicate the necessity for the re-insurance of maternity benefit in accordance with section 25 of the National Health Insurance Act, 1924.

7. It is a lamentable defect of the National Health Insurance Act that a section of the insured population, who through the nature of their employment are exposed to greater sickness risks, should receive less rates of benefits than another section. We suggest that it is a great hardship, and is indefensible, for the position of such insured persons to be aggravated through an excessive maternity rate experience.

8. Since the National Health Insurance Act came into operation there are societies, as in our case, which have continually experienced excessive sickness and maternity claim rates, and on the other hand societies that have experienced comparatively light sickness and maternity claim rates. Although societies with excessive sickness claim rates may have to abide by that experience, we very strongly express the view that their unfavourable position should not be intensified by a high maternity claim rate. No society should be in a better position in the amount available for sickness benefits through a low maternity rate experience, and at the same time societies worse off through the amount available for sickness benefits being impaired by a higher maternity rate experience.

ADMINISTRATION.

9. We are a centralised society, and all payments of benefits are authorised from the Head Office. There are five adults and two juniors employed at the Head Office, and one sick visitor. We may add that two of the Head Office staff undertake sick visiting also as circumstances permit. Every precaution is taken to prevent improper expenditure. In 1915 we engaged the services of a medical practitioner to examine members whose claims were considered doubtful, and this arrangement continued until the appointment of regional medical officers. It is our practice to have each member visited and if the sick-visitor suggests that certain members should be examined, the regional medical officer is notified of the cases. When the reports are received suitable action is taken where necessary.

10. It has been our experience to receive numerous enquiries from members for assistance towards the payment of dental treatment and dentures, purchase of glasses, trusses, convalescent home treatment, etc. It is an unpleasant duty, we may assure you, to inform the enquirers that we are unable to assist them. We are conscious that this must have a depressing effect and retarding influence in the progress toward recovery. In a scheme of National Insurance it is undesirable and unsatisfactory. It is not the fault of such insured persons; but is due to the system of administration in operation in connection with the Act.

PARTICULARS OF SICKNESS AND DISABLEMENT BENEFITS.

11. Below we give particulars of sickness and disablement benefits paid by our Society for the years 1919, 1920, 1921, 1922, and 1923, which indicate a serious progressive increase in the amounts paid for disablement benefits when compared with those paid for sickness benefits.

	Sickness Benefit.			Disablement Benefit.		
	£	s.	d.	£	s.	d.
1919	8,224	1	8	2,250	16	11
1920	8,549	1	2	3,067	6	1
1921	11,392	5	4	4,513	2	7
1922	11,143	16	3	5,203	10	3
1923	12,788	6	2	6,298	17	11

12. For the year 1919 the rates of sickness and disablement benefits were 10s. and 5s. per week respectively, and for the first half-year of 1920 benefits were paid at these rates, and the second half-year at 15s. and 7s. 6d. per week respectively. The subsequent years the rates were 15s. per week and 7s. 6d. per week for sickness and disablement benefits.

13. In 1919 it will be seen that the amount paid for both benefits bore a relation, approximately four-fifths for sickness benefits, and one-fifth for disablement benefits. For the year 1923 the proportion, approximately, is two-thirds paid for sickness benefits and one-third disablement benefits. Year by year the number of members is increasing who are becoming a burden to the Society, and this is very marked amongst the members who are 50 years of age and over.

14. On the 9th February of this year we ascertained the number of members receiving benefits between certain ages, which we submit below.

Number of members on the 9th February, 1924, 16,353.

	Mem- bers.	In receipt Sick Benefits.	Average.
16½ years and under 30 years	6,460	99	% 1.53
30 " " 40 "	3,438	88	2.56
40 " " 50 "	3,065	135	4.40
50 " " 60 "	2,309	200	8.65
60 " " 70 "	1,081	203	18.78
	16,353	725	—

ADVERSE EFFECTS OF SEGREGATION.

15. It is reasonable to suggest on reviewing these figures that serious physical impairment takes place after the attainment of 50 years of age, which is largely due to the character of the occupation followed by our members, the effect of which is to load the funds with a liability which must always tend to the payment of benefits at the lowest rates. Circumstances have now arisen by which it is clearly indicated that societies with members following what are described as healthy and congenial occupations will receive substantially better benefits, both in cash and in kind, thus hastening recovery, whilst members of societies following hazardous occupations will continue in receipt of benefits at the lowest level, which must have a serious retarding effect in the progress of recovery.

EQUAL RATES OF BENEFITS FOR ALL SOCIETIES.

16. In submitting this statement for your consideration we respectfully suggest that the National Health Insurance Act requires to be so amended that the flat rate of contribution shall provide for all insured persons equal and similar benefits, in cash and in kind, throughout the country.

17. We have purposely refrained from expressing our view on other questions to be considered by the Royal Commission, as these will be dealt with by the National Association of Trades Union Approved Societies with which our Society is affiliated.

Miners' Offices,
Bridgman Place, Bolton.
23rd December, 1924.

APPENDIX XIII.

STATEMENT OF EVIDENCE SUBMITTED BY MR. ALBAN GORDON. See Minutes of Evidence of the Fifteenth Day, Questions 7450 to 8009.

For summary of contents, see below, paragraph 3.

1. I am Secretary of the United Women's Insurance Society, an Approved Society under the National Insurance Act, but am not tendering evidence on that Society's behalf. The following statement should accordingly not be considered as representing the views of the Committee of Management of that Society, but solely as arising from my personal experience in National Health Insurance, in which I have been engaged since January, 1912.

2. Such experience has been gained in the following capacities:—

In the service of the National Health Insurance Commission, January to July, 1912.

Clerk to the Coventry Insurance Committee, 1912.

Organising Secretary, Yorkshire Rural Friendly Society, 1912

Secretary, United Women's Insurance Society, 1912 to present date.

Member of London Insurance Committee, 1913-1921.

Member of Brighton Insurance Committee, 1924-5.

I am a Bachelor of Science, a member of the Brighton Town Council, and have twice been a Parliamentary candidate.

3. I would desire to tender in general evidence such portions of my book, "Social Insurance" (George Allen & Unwin, 1924), as may be considered to fall within the terms of reference of the Com-

mission. The following statement is to a considerable extent based on that book, but supplemented and amplified, in various directions.

SUMMARY OF MATTERS UPON WHICH EVIDENCE IS TENDERED.

- That the present system of administration through Approved Societies and Insurance Committees is open to grave objections. (Paragraphs 4-22.)
- That the variation in rates of benefit paid to insured persons for the same contribution is inequitable, and contrary to public policy. (Paragraphs 23-24.)
- That the present state of 'non-cash' additional benefits (benefits of a treatment character) is chaotic and unsatisfactory. (Paragraphs 25-30.)
- That medical benefit as at present established is entirely inadequate in scope, and in its present form, a hindrance to a national development of preventive medicine. (Paragraphs 31-56.)
- That the present financial system of 'reserve values' needs reconsideration. (Paragraph 57.)

SYSTEM OF ADMINISTRATION THROUGH APPROVED SOCIETIES.

4. The primary object of administering a national scheme of this character through semi-private organisations such as Approved Societies was doubt-

less to ensure the successful commencement of so vast a scheme by utilising existing machinery. In the first instance such an argument would counterbalance many otherwise valid objections, but with the passage of time the advantage has served its purpose and ceased to exist, whilst the drawbacks have steadily grown in importance.

These drawback fall under two headings:—

1. The administrative weakness of the system.
2. Its undesirability from the standpoint of public policy.

THE ADMINISTRATIVE WEAKNESS OF THE APPROVED SOCIETY SYSTEM.

5. The administrative weakness of the Approved Society system lies, firstly, in the enormous number of Approved Societies (now 8,427 separate administrative units) with their consequent overlapping and duplication of machinery, and in the small size and membership distribution of many of them.

Whatever may be the ideal membership for an Approved Society it is obviously difficult for a unit of much less than 1,000 to be or to remain sound, actuarially or administratively, and probably a minimum more nearly approaching 5,000 would be better, taking all things into consideration. In any case the proviso should be made that the membership should be concentrated within a geographical area or areas of not too large dimensions, so that sickness claims, for example, could be supervised by the services of a health visitor, whose services would be fully utilised in a reasonably compact district.

6. In actual practice not only is there a large number* of Approved Societies considerably less in membership than any reasonable minimum, but even those societies which 12 years ago started under satisfactory conditions (i.e., with a sufficiently large number of members in a given geographical area) have, by the effluxion of time, diffused their membership over the whole country in such a way as to render a high standard of efficiency in the administration of their benefits impossible.

Economically the excessive number of small societies with their multiplication of establishment charges cannot fail to be an expensive method of administration.

7. If any area is analysed it will be found to contain a large number of societies possessing a ludicrously small membership in that district. For example, in Dundee (which is an illustration chosen at random) there are 217 separate societies (ignoring branches), of which 99 have less than 10 members in the town, 52 of these having only one member. These societies have their Head Offices at London, Manchester, Glasgow, Aberdeen, Edinburgh, Leeds, Portsmouth, Newcastle, Tunbridge Wells, etc. The tables handed in in evidence by Sir James Leishman on the 18th of November, 1924, illustrate this in summary form.

8. In considering the minimum number of members that constitutes a satisfactory unit it must be borne in mind that under the present system each Approved Society is in direct competition with every other, and the recruitment of new members in the face of such competition is a matter of vital importance to good administration. Some small societies are perhaps exceptionally fortunate in the propagandist zeal of their members and officials, but in the main such societies are terribly handicapped as against large societies with their staffs of paid agents or other officials, and their financial ability to pay procuration fees in respect of new memberships secured.

The success of an insurance society is not established by its assets exceeding its liabilities at a given moment. A further factor of vital importance is

* See paras. 36 and 37 of the official Statement. 65 per cent. of the total number of societies have only 2 per cent. of the total of insured members between them.

that there should be a steady inflow of new members, since a society that fails to recruit its proportion of young and healthy lives is faced with consequences likely to lead to disaster in the future. It would be interesting to see a record of the membership statistics of a batch of small societies to determine whether or no their membership shows a progressive increase or a diminution.

9. The competition between Approved Societies is in itself a feature far from desirable in a scheme such as the present, administered under State auspices, and financed partly by State funds. It is true that there is but little formal transfer of members between societies, since this has been checked by provisions depriving a transferring insured person of his right to additional benefits for a period of years. But competition for new members is acute, and undoubtedly leads to insured persons whose membership of their old society has not strictly lapsed, being induced to abandon it, and sign an application for admission to another society as a new entrant into insurance. This, I have reason to believe, goes on to a very considerable extent, and in the case of the United Women's Insurance Society the committee were forced to spend large sums in press and other advertising, and finally to offer a procuration fee of 2s. 6d. to members of the society in respect of new members introduced, in order to counterbalance the activities of agents of other Approved Societies, and only in this way was a steady decline in membership checked.

10. The multiplicity of societies already referred to leads to much overlapping and wasted effort, and results in widely differing standards of administration, even within the same society. For example, a society possessing 1,000 members in a given area, and another 1,000 scattered over a wider area will be able to give much more efficient supervision to the 1,000 concentrated, rather than to the 1,000 diffused members. In the case of the former, therefore, malingering could readily be checked; in the case of the latter it would be impossible to do so.

11. An inherent defect in the present system whereby practically any body of persons could constitute themselves an Approved Society, is that it necessitates a more elaborate scrutiny over the doings of Approved Societies by Government Departments than would otherwise be necessary; and in general a greater expenditure of national effort to achieve a given result than would be the case if fewer and more carefully selected units were engaged in the administration.

12. As evidence before the Commission has already shown, elaborate machinery has been set up by the Ministry of Health and the Treasury for the guidance, supervision and audit of the heterogeneous collection of societies, large and small. A great deal of this machinery would be rendered superfluous if, for example, approved societies were so reorganised that there was only one society for each administrative county or county borough.

It is equally obvious that it is more difficult to teach the intricacies of the Acts, regulations and amendments, to thousands of part-time secretaries and officials, than to train a smaller number of full-time officers. An important corollary of this is that conditions of employment amongst those engaged in administering the Act would be far more satisfactory in the circumstances I have envisaged, when it would become easy to initiate, for example, a superannuation fund for all the employees in the service.

THE POLITICAL DANGER OF THE SYSTEM.

13. Even more important, however, are the objections to the Approved Society system from the standpoint of public policy. In practice, instead of forming a democratic machinery of government, the Approved Societies have very largely developed into a close caucus of interested persons, and the political power attaching to the officials of Approved Societies constitutes a distinct menace.

14. In theory every Approved Society is governed by its members, but the farcical nature of this has been demonstrated to the full by table 3 on page 58 of the Statements prepared by certain Government Departments and confirmed by oral evidence before the Commission. In the case of those societies therein referred to, and others in a similar position, the ludicrous nature of the "self government" is obvious, and probably half of the insured population are members of societies which are, in actual fact, close oligarchies.

15. In the case of the Friendly Societies and Trade Unions, democratic government is far more real, but even here in the case of their State insurance business much less interest is taken by the rank and file of the membership than is the case with their private business, and speaking as a member both of a Friendly Society and a Trade Union, and from a somewhat intimate knowledge of the government of both types of bodies, I have no hesitation in saying that even in their case the ordinary insured person takes little, if any, interest, in the government of his Approved Society *qua* Approved Society.

It is, therefore, not untrue to say that the insured population on the whole takes in actual practice but little interest in the administration of the Insurance Act.

16. Directly concerned in the administration of the Insurance Act are nearly 75,000 officials (including 45,000 trained canvassers) in the employment of the various Approved Societies, controlled in their turn by a body of perhaps 100 or 200 men, who may properly be said to be the Approved Societies so far as wielding their influence is concerned. It is no reflection on the character of Approved Society officials to state that their vested interests either in their posts, or in the maintenance of their own organisations, colour their views on the Insurance Act. Such a vested interest is common to any body of men in similar circumstances, and were the conditions similar to those under which, for example, Unemployment Insurance is administered, no harm could result. But when it is recollected that National Health Insurance is intimately linked up with various forms of profit-making enterprises, such as, for example, Industrial Assurance and Workmen's Compensation Act Insurance, it will be realised that there are the gravest possible objections to the existing system. Under it the political power derived from the representation of 15,000,000 insured persons is exercised throughout the country by means of an army of thousands of skilled, trained, and interested persons, under the direction of what is virtually a close corporation of a handful of superior officials, most of whom are closely allied with various financial or political interests.

17. As an illustration of the potential strength of this machine one may instance what happened in the General Election of 1923. It will be within the recollection of the Commission that in the autumn of 1923 a bitter dispute was in progress between the medical profession and the Approved Societies on the one hand, and the Approved Societies and the Ministry of Health on the other hand as to:

- (a) what should be the panel doctors' capitation fee, and
- (b) how much of it should be taken from Approved Society funds.

A number of Approved Society officials—of whom I was one—constituted themselves into an 'Emergency Committee' on the initiative of the secretary of the largest group of Approved Societies. This Emergency Committee in its turn called a Conference of Executives of the different groups of Approved Societies, and it was determined to use all possible means to influence the decision of the questions in dispute in a direction favourable to the Approved Societies. When the conflict was at its height a General Election unexpectedly occurred, and such was the power of the Approved Society organisation that every Parliamentary candidate was subjected to the strongest imaginable pressure to pledge himself in favour of the Approved Societies' point of view, and,

in fact, a House of Commons was returned pledged in support of this point of view to a remarkable degree, on the strength of the alleged voice of fifteen million insured persons. In point of fact, probably fourteen and three quarter of these fifteen million had not even the knowledge that the controversy was taking place, still less as to the true merits of it. The 'Emergency Committee' had not the slightest vestige of claim to represent anybody, yet by virtue of the mock-democracy of the Approved Society system it wielded the political authority of fifteen million persons, largely electors.

18. It is not contended in the foregoing that there was anything improper in the Approved Societies' case, but the instance serves to illustrate the enormous and quite undemocratic power, exercised on that occasion by a small body of individuals, a power which may easily be wielded again in a less innocuous cause. What is contended is that a system which places so much political power in such circumstances in the hands of an unrepresentative body of men, is an exceedingly dangerous one, particularly bearing in mind that the financial interests with which many of them are so intimately connected may yet come to be the subject of legislation in which National Insurance is involved.

19. A further objection to the present system of Approved Societies, although one which I hesitate to elaborate for fear of straying beyond the terms of reference of your Honourable Commission, is that in the event of it being found desirable to unify the various forms of social insurance now in existence or hereafter created, the present Approved Society system is not suitable for administering any other form of insurance benefit, nor does it seem capable of being co-ordinated with any other system of administration.

20. It is suggested that all the foregoing objections to the present system of Approved Society administration would be met by re-grouping Approved Societies on a territorial basis, and setting up one Approved Society for each County or County Borough, or other local unit, with or without the possibility of local occupational societies where the number of persons engaged in the same occupation in any given locality was sufficiently numerous for a special society to be set up for the employees in that industry in the locality should they so desire.

INSURANCE COMMITTEES.

21. The continued existence of Insurance Committees with their present limitations is, except for one single function, a pure farce. That exception is the Medical Service Sub-Committee, which performs useful work. Apart from this, however, it is impossible to see anything whatever for the Insurance Committees to do that could not be equally well accomplished by a subordinate official in the local Public Health Office.

On the other hand, these bodies being on a territorial basis, command a great deal of public-spirited service which could well be utilised to better purpose, and the suggestion comes naturally to mind that the machinery of Insurance Committees might form the basis of a new type of Approved Society such as is referred to in the previous paragraph.

If, however, it is deemed desirable that Insurance Committees should continue to exist in their present form, there is no reason why, as the Insurance Act definitely contemplates, and, indeed, enacts, those benefits which are of the nature of medical benefit should not be administered by them.

It must be borne in mind that the removal of the administration of these 'additional benefits' from Approved Societies would deprive the latter of an important part of their functions and render much of their machinery superfluous. It would be robbing Peter of a job to find work for Paul.

22. As will be seen hereafter, I suggest that medical benefit (including the ancillary benefits) should be removed from the Insurance Act altogether, and united with the other medical services already in existence.

I would then amalgamate Approved Societies with Insurance Committees by re-constituting the former on a local territorial basis. These new Approved Societies would then be available for administering any other branch of social insurance that might properly be intrusted to them.

VARIATIONS IN THE RATES OF BENEFIT.

23. It was obvious from the inception of National Insurance that the flat rate of contribution, combined with the free choice of Approved Society, would result in the segregation of good lives in some societies, with the natural corollary of inferior risks predominating in others. This has proved true in practice, and the first valuation disclosed disposable surpluses varying from nil to 33s. or 34s. per head. In view of the fact that the surpluses at the current valuation are expected to be more than twice as much as at the first valuation, the discrepancy will be even more marked in the near future. Even at the present moment the benefits given by different societies (for the same contribution) vary by as much as 5s. per week in cash, with a corresponding discrepancy in non-cash benefits. These differences will become acute when, in the course of another year or so, revised rates of benefit in accordance with the second valuation fall due to be paid.

A complete system of pooling of surpluses and deficiencies between Approved Societies as at present constituted would be difficult, not only in view of the resistance which might be expected from many Approved Societies, but also by removing the incentive to good management, which would lay the system open to objections. No such objections however, could be urged to a system of partial pooling between territorial Approved Societies, if indeed such proved necessary, which is exceedingly unlikely.

24. In the event of the present Approved Society system being adhered to, it is submitted that in spite of objections in principle to the pooling of funds, some system of this sort must necessarily be resorted to in order to provide new statutory benefits, *e.g.*, dentistry, in replacement of the ill-regulated additional benefits given at the present moment by some societies. It is against the public interest that a member of society A should receive far greater benefits than his next door neighbour who pays the same contribution, but is unfortunate enough to be a member of society B, which gives little or no additional benefits. Grave and increasing discontent will be caused if this distinction is continued or intensified.

Apart from this, the interests of public health demand that dentistry, at any rate, should take its place as a benefit conferred on *all* persons insured under the National Insurance Act, instead of only a few. Societies possessing little or no surplus are unable to give this benefit at the present moment, and to enable them to do so would need either an extra contribution or State grant, or else a very considerable measure of pooling between Approved Societies. It would be impossible to substantiate a demand for either of the former two in view of the enormous surpluses (which I understand are expected to aggregate anything up to fifty million sterling) within the Insurance funds.

ADDITIONAL BENEFITS.

25. The present position with regard to additional benefits is one of extraordinary chaos, and the existing arrangements under which benefits of a 'treatment' character are provided are thoroughly unsatisfactory. As the Commission are aware, the disposable surpluses possessed as at December 31st, 1918, by the 10,162 separately valued societies and branches vary from nil to nearly £2 per head, very few societies actually showing a deficiency. Amongst all these societies scarcely any two have utilised their surplus in exactly the same way, and every conceivable form of scheme exists, subject only to the few general limitations imposed by the Ministry of Health.

With regard to additional cash, this merely results in a difference in the rates paid by different societies, but in the case of non-cash or 'treatment' benefits not merely do different societies give different benefits, but the definition of benefits themselves differs from society to society. With regard to dentistry, for example, some Approved Societies pay the entire cost of dentistry and of dentures, others pay only 25 per cent. of the cost, and in between these two extremes there are various gradations. The actual administrative procedure varies very widely between different societies, some even possessing dental clinics of their own.

26. The divergencies are even greater in the case of other additional benefits, such as optical treatment. Some societies pay an ophthalmic surgeon's fee while others do not: some have private agreements with opticians; others merely make a grant towards an optician's bill; some retain the services of Harley Street specialists; others provide a 'clinic' at which members are required to attend; some pay the whole cost, others a variable fraction. The result is that the insured person is quite unable to know in advance what are his rights, or even if he has any rights, and the cost of the different benefits is often unnecessarily high by reason of the fact that in many cases the insured person is treated as an ordinary private patient with the added disadvantage of the practitioner or dealer knowing that the patient or customer will receive a subsidy towards the bill, which is not likely to be any the less on that account.

From the point of view of the society administering the benefits the position is equally unsatisfactory, as it has little or no check on the standard of professional or other services rendered, and it is placed in an invidious position in regard to its members in seeking to enforce regulations which are only of its own private making, and have not the same weight as those, for example, attached to sickness benefit, which are of legislative origin.

27. It is abundantly clear that it is desirable to regularise both the title to, and the administration of, additional benefits. With regard to the former it is contended that some of these benefits, being in the main of a preventive character, are as important as the palliative cash benefits, and that dentistry at any rate should forthwith be established as part of the normal benefits of the Act; indeed, it is not evident how it can be contended that care of the teeth does not fall within the "adequate medical attendance and treatment" envisaged by the framers of the 1911 Act, and dentistry should therefore be considered as being an integral part of medical benefit. The same holds true of the other forms of treatment benefit, the whole completing with consultants' and other specialists' services and institutional treatment of various kinds, the "adequate medical service" so urgently required for the health of the population.

This being so it would seem clear that in view of the undoubted fact that benefits such as dentistry, optical treatment, etc., are "in the nature of medical benefit," they should already, strictly speaking, be administered by and through the Insurance Committees by virtue of section 75 (5) of the National Health Insurance Act, 1924, so long as medical benefit is administered by them. It has been firmly established that Approved Societies are not a suitable organisation for the purpose of controlling medical practitioners, and from eleven years of practical experience in administering dentistry as a benefit under the National Insurance Act, it is clear to me that the same applies to the control of dental practitioners.

28. As the evidence tendered by the United Women's Insurance Society will show, that Society has every reason to be satisfied with the results of its 11 years of dental benefit, administered, however, through the medium of an *ad hoc* charitable organisation; but throughout the whole of this time the difficulties of such a private venture have made themselves felt in the lack of guarantee of uniformity. For example, some dentists would have nothing to

do with the scheme and would refuse to accept the Society's vouchers. Others (including some of the best men in the profession) would accept the vouchers and give the holders treatment identical with that rendered to their most paying patients. Others, again, would accept the vouchers but haggle over the scale of fees or the nature of services to be rendered, or demand supplementary payments from the members. The only period during which complete satisfaction could be felt by those responsible was a period of several years during which the scheme was administered in the provinces by a panel of dentists, one or more in every town, with each of whom the Society entered into a definite and binding contract as a condition of the inclusion of his name in the panel. This arrangement, however, satisfactory as it was from the Society's point of view, was naturally the object of strong hostility on the part of dentists in general, more particularly since the 1921 Dentists' Act, as the panel in question included none but fully qualified dentists. In order to promote peaceful relations between the dental profession and Approved Societies, and for the sake of uniformity, the Society finally decided in 1922 to abandon its own closed panel. Since then, however, the service has steadily deteriorated, and it is extremely unsatisfactory that the Society can no longer be certain of the reception its member will receive from the dentist to whom the voucher may happen to be presented, the standard of work that will be rendered, or whether supplementary fees will not be required.

The only way in which the difficulties concerning the title to and the administration of dental benefit can be overcome is for it to be incorporated with medical benefit as a normal benefit of the Insurance Act, and administered by the same body that administers medical benefit. With the finance of this statutory medical benefit I propose to deal in that section of my evidence relating to medical benefit.

29. With regard to other benefits in kind, such as optical treatment and appliances, surgical appliances, nursing, etc., it is submitted that it is highly desirable that the title to, and administration of, these benefits too should be put on a more uniform footing.

The present loss of rights to additional benefits suffered by an insured person on transfer should be altered, as regards the 'treatment' benefits at any rate, since it cannot be to the ultimate advantage either of the insurance funds or of the community to hinder a person from obtaining treatment that will prevent his falling ill.

In any event, however, statutory provision should be made for defining these benefits more precisely, and for setting up the machinery for administering them. For example, in the case of the additional benefit "ophthalmic treatment and the provision of spectacles," it would be preferable for this to be defined more exactly, *e.g.*, as to whether it should include the services of an ophthalmic surgeon, or whether refraction by an optician; as to whether the whole of the cost of spectacles should be defrayed, or only part. It is obviously most undesirable that there should be a dozen or 20 different schemes of additional benefit all purporting to be the same benefit. The definition should be standardised so that insured persons may know the extent of benefit to which they are entitled and, if the administration of it is left in the hands of the Approved Society, the society should either give it or not give it, but should not be allowed to give it partially.

If it should be decided that the administration is not to be entrusted to the same hands as administer medical benefit, but is to be left to Approved Societies, the organisation should be facilitated by the setting up of official bodies such as a statutory Dental or Ophthalmic Council to settle terms of service, fees, specification of goods and price list, and to vary such from time to time. At the present moment there is no representative body on either side capable of even entering into negotiations on such points, still less of making the result of such negotiations effective.

30. In connection with additional benefits I may perhaps venture to tender an opinion with regard to section 20 of the National Health Insurance Act, 1924 (section 21 of the old Act), since I was the person responsible for first making use of the section in the direction which has now been so widely followed.

The United Women's Insurance Society, acting on my advice, has contributed from 1914 to 1924 no less than £51,510 under section 21 to the United Women's Benevolent Association, the *ad hoc* charitable organisation referred to above, and there is no possibility of doubt that these payments have been extraordinarily beneficial to the members of the society, and that nothing but good has resulted from them. At the same time, however, it seems clear that the payment of such sums under this section was not contemplated by the framers of the original Act, and it is not easy to substantiate a logical case for the retention of the section in its present form, particularly in view of the fact that it might lend itself, in the hands of an unscrupulous, or even an injudicious committee, to possibilities of abuse.

On the other hand, I would most strongly urge the Commission not to recommend the total repeal of the section, or any direct statutory limitation of powers under it. In a scheme involving such enormous expenditure as does the National Health Insurance Act, it is naturally essential that it should be so drafted that all contributions and benefits are defined as precisely as is humanly possible. On the other hand, in an Act dealing with so many persons, many of them belonging to the poorest orders of society, it is equally desirable that there should exist a loophole, which wisely and judiciously used, will allow governing bodies administering the Act a certain amount of latitude in an indefinite direction, to meet minor contingencies that cannot be otherwise dealt with. Innumerable minor hardships and distressing cases that could not have been dealt with in any other way have been assisted in some form or another by the benevolent facilities afforded under section 21 in addition to the major schemes of, *e.g.*, dentistry. The outlay has been relatively insignificant, while the benefits derived have, humanly speaking, been very large. I submit that it would be a harsh thing to repeal this section altogether, and thus to deprive the administrators of the Insurance Act of any possible elasticity in a human and benevolent direction.

At the same time, however, there is no reason why, if there is any strong desire, the section should not be so amended as to provide that payments made under it should be subject to the approval of the Ministry of Health.

MEDICAL BENEFIT.

31. The question that must first of all be answered is, can medical benefit be considered as a fit subject for insurance? Insurance, properly speaking, is the collective sharing of a risk of uncertain incidence, but bearing in mind that in accordance with the calculations of the Ministry of Health, every insured person sees his doctor on the average seven times in two years, it is evident that medical benefit is scarcely an insurance benefit at all, but is more in the nature of a compulsory and collective form of saving for a definitely recurring event. Scarcely any element of uncertainty enters into its financial side, other than the mild risk of epidemics and other unusual calls upon his services which may affect the individual doctor. It would seem, therefore, that it is a misuse of terms to consider medical benefit as a logical part of an 'insurance' scheme, at any rate in so far as general practitioner treatment is concerned, which is the only form of treatment granted as medical benefit under the Insurance Act.

32. With regard to the nature of the services now rendered within the existing scope of medical benefit, I do not propose to offer any evidence, as although in the course of my connection with National Insurance I encounter a not inconsiderable number of complaints against panel doctors, and the service in general, yet I am not prepared to contend that it

does not possess as high a standard of efficiency as can reasonably be expected within the bounds at present set.

33. The grave defect of medical benefit—so grave as almost to merit the description tragic—are:

1. The narrow limits assigned to the range of services to be rendered as medical benefit; and
2. the entire absence of any co-ordination between medical benefit and other branches of medical or public health services.

In addition, the present system possesses the considerable fault of being unduly expensive.

34. I do not propose to weary the Commission with details of the many individual cases that have come to my knowledge in the past 12 years, in which these defects have been displayed, but I cannot refrain from citing one individual case now under my observation, which is so tragic and so typical as to warrant attention.

35. M. is a member of the United Women's Insurance Society, living in the north of Scotland, a domestic servant, who on March 3rd, 1921, was operated upon for appendicitis, such an operation, of course, not coming within the scope of medical benefit. She commenced to claim sickness benefit from the society on the 24th of February, 1921, and has been receiving sickness benefit and, subsequently, disablement benefit, continuously ever since. During the whole of this time—practically four years—the member has received a monthly examination by a general practitioner, and no other treatment. The society, becoming dissatisfied with the vague diagnosis of "anæmia" for so protracted a disability, has at various dates referred the case for examination by the regional medical officers. As far back as December, 1922, and at periodical intervals ever since, the regional medical officers have expressed the opinion that the symptoms in her case indicate a need for the attention of specialists and for institutional treatment.

In June, 1924, the district medical officer summarised the position as follows:—

"The girl has been nearly three and a half years at home, and has apparently gone steadily downhill. There is no doubt that a change is absolutely essential. . . . She must be removed from her present environment if improvement is to be looked for."

Again in October, 1924, the examining officer reported:—

"This patient has remained month after month in much the same condition, and so far as I see will continue to do so, or get worse, if she is not removed from her present home surroundings and treatment obtained in a suitable institution. With this done—and she will readily accept such treatment—she might be then expected to return to her usual employment."

There is, however, no provision under the Insurance Act for the appropriate treatment of such a case; a special kind of treatment is clearly and obviously indicated, but it is nobody's business to do anything more than "advise" the unfortunate person to obtain it.

As an act of personal kindness, the district medical officer of the Scottish Board of Health has interested himself in the case, but says:—

"I have made enquiries as to possible institutions where residence might assist in checking the retrograde progress in this case. Unfortunately, owing to individual restrictions as to admission in some cases, and to the presence of long waiting lists in others, I have so far failed to find a suitable institution."

The patient's own efforts, and those of her Approved Society (the latter handicapped by operating at a distance of hundreds of miles) have proved equally unavailing. At the present rate of progress the member seems doomed to go steadily downhill and the insurance funds to be mulcted in long drawn out payment of benefit, because of the defects alleged above, viz., the narrow range of the present medical benefit, and its lack of co-ordination with other branches of medical service.

RELATION OF MEDICAL BENEFIT TO EXISTING MEDICAL SERVICES.

36. It is possible to consider the cash benefits of National Insurance as subjects by themselves, and to decide as to their amount and conditions uninfluenced by anything save the actuarial considerations involved.

On the other hand it is impossible to consider medical benefit solely from the point of view of National Insurance, since it impinges at so many points on so many other features of the daily life of the community. It would, for example, be ridiculous to say that medical benefit under the Insurance Act should contain provision for the building and maintenance of isolation hospitals against smallpox since these are adequately provided under an existing form of medical service. Conversely it should be equally impossible from the point of view of the "prevention and cure of illness" to exclude essential forms of medical treatment from medical benefit, without making certain that such services are already provided in a manner fully as adequate as that in which the insurance medical benefit scheme would provide them, did it undertake to do so.

Medical benefits, therefore, ought to be considered in relation not only to the Insurance Act, but to the many other medical services now existing, and equally to the gaps where medical service is desirable but is not at present provided, or only in an exiguous form.

37. The unification of central control which took place when the Ministry of Health was established was unaccompanied by any corresponding unification or co-ordination of existing medical services locally, with the result that there exists to-day a large number of different branches of medical service, financed wholly or partly out of public funds, and controlled by different public authorities. These include the Poor Law Medical Service, the Public Health Service, and the Education Medical Service, with their many ramifications in various specialised ways, such as venereal disease clinics (usually in conjunction with local hospitals), tuberculosis services, smallpox and other isolation hospitals, general municipal hospitals, maternity and infant welfare centres, vaccination officers, mental deficiency service, including hospitals and asylums.

In addition to the foregoing there are minor services, such as those afforded by the police surgeons and the certifying surgeons under the Home Office, and semi-private services such as the Post Office Medical Service.

Side by side with these there exist a number of medical clubs, often run by the doctors themselves, and the network of voluntary hospitals and allied institutions, vast in extent, but yet unequal to the needs of the population, together with various provident schemes and other financial devices in connection with them.

It is impossible to calculate in terms of money the total annual cost of all forms of medical service other than those privately paid for, but the aggregate must be a figure of startling dimensions, considerably exceeding the nine millions spent from Insurance Act funds on medical benefit.

38. At every stage medical benefit overlaps with one or other of the large number of existing forms of medical service. For example, an insured married woman during pregnancy can either call in her panel doctor, or can avail herself of the advice of the local maternity clinic; a man requiring vaccination can go to his panel doctor or to the local vaccination officer; a girl suffering from incipient tuberculosis may attend her panel doctor or the local tuberculosis dispensary; the infirm pauper who has not yet exhausted his rights to medical benefit under the Insurance Act may alternate between his panel doctor, or the workhouse infirmary, or the Poor Law medical officer. These are but a few elementary instances of an overlapping which goes on in so many different directions. It is highly extravagant and inefficient to maintain two or three separate agencies to deal with the same contingency, and this duplication of effort between the Insurance Act and

existing medical services is a grave source of weakness and expense.

39. But it is not only with the panel service that the various existing medical services overlap; they compete vigorously and wastefully among themselves, as was clearly set out in the report of the Royal Commission on the Poor Law.

Equally the panel service under the Insurance Act is, from the financial point of view, extremely wasteful, in that it operates through a large number of individual units (general practitioners) totally uncoordinated with each other or with the higher or more specialised forms of medical treatment which constitute the line of attack against illness. Each of these practitioners is remunerated on a part-time basis, in itself an expensive method.

In calculating the remuneration of panel practitioners, regard had to be taken of the establishment and overhead charges of as many surgeries as there were practitioners. Every separate doctor, or partnership of doctors, maintains his separate waiting room or rooms, often crowded, inconvenient, and even insanitary, his own consulting room, his own filing and clerical system, his own means of transport. This may be the only system in country districts where one doctor is separated by miles from his neighbours, but in the urban areas which account for the great majority of insured persons it seems ludicrous, in this age of specialisation and division of labour, that the first rudiments of these are largely inapplicable to the medical profession.

The capitation fee is, therefore, inflated by the necessity of providing for these superfluous overhead charges, which are not only a wasteful extravagance in themselves, but reflect a definite inefficiency in the service.

40. Apart altogether from any statutory reforms it would surely be a great step forward if general practitioners could be linked up together in groups, so that instead of every man providing his own waiting room, consulting room, &c., and employing perhaps one dresser-nurse-attendant-secretary, the group of doctors might work in well-designed, well-built, and equipped suites of waiting and consulting rooms, with specialised attendants, nurses, clerical assistants, &c. An arrangement of this sort would have other advantages, too. It would permit of a minor degree of specialisation within the group, it would provide for one doctor at least to be practically always in attendance, and it would facilitate holidays, periods of study, &c., among the doctors concerned, while the patients would receive quicker and more effective attention in more convenient and hygienic conditions.

This conception is, of course, based to a considerable extent on the primary health centre referred to in the report of the Consultative Council on Medical Service (Cmd. 693, 1920).

41. The study and experience of existing conditions have, however, long convinced me of the need for consolidating all existing forms of medical treatment into one comprehensive service, and I would urge upon the Commission to the utmost of my ability the desirability of bringing to an end the present tangle of medical services, redundant at one point, lacking altogether at another, costly, inefficient, and unprogressive; and of merging medical benefit in a National Medical Service.

A NATIONAL MEDICAL SERVICE.

42. Before developing proposals as to changes in the system of medical benefit under the Insurance Act, I should like to call attention to the prejudice caused by the use of the phrase "State Medical Service" to signify a "soulless" organisation, rigid and stereotyped in form, bound in red tape, and incapable of all elasticity or humanity.

This conception is quite unnecessarily biased, and the type of organisation which I have in mind when I refer to a National Medical Service would be open to none of these objections; further, I do not wish to advocate under this name any definite cut-and-dried form of organisation. For example, although as a matter of personal conviction I should favour

a service largely staffed by full-time salaried medical officers, yet there is no reason why such a service should not be composed principally of practitioners working under conditions of remuneration somewhat similar to those now obtaining in the Insurance Act Medical Service, although such a service must necessarily be more costly and less efficient than a fully organised system. As a guide to envisaging such an organisation we have the admirable sketch drawn up by Lord Dawson of Penn's Committee referred to above (Cmd. 693, 1920).

The paramount virtue of a co-ordinated national service is that for the first time the two great branches of medicine, preventive and curative, could be linked up in the fullest liaison with each other, whilst the service itself would be all-inclusive, that is to say, it would provide the services not only of general practitioners, but also of consultants and medical and surgical specialists, including dentists and ophthalmologists, and institutional treatment, including both convalescent homes and hospitals, and chiefest of all, complete modern diagnostic facilities to the fullest extent.

43. Again, touching hospitals, it has been assumed in many quarters, quite unnecessarily, that a national medical service in which was co-ordinated adequate institutional provision, must necessarily mean the death of voluntary hospital effort. This is by no means the case, and I would particularly draw the attention of the Commission to the special conference of hospital, medical, and kindred societies and members of the Labour Party held at Caxton Hall, Westminster, on April 28th and 29th, 1924. At this conference the following resolutions were agreed to unanimously:—

- (1) "The accommodation, equipment, and finance of hospitals generally are inadequate and must be supplemented."
- (2) "The geographical distribution of hospitals is uneven, leading to overlapping and the lack of co-ordination. The unit of co-ordination should be such as to include a sufficiently large population to constitute a satisfactory unit."
- (3) "There should be closer relationship between voluntary hospitals themselves; between the voluntary hospitals and the various hospitals provided by local authorities; between the curative and preventive medical services; and between the hospitals and the private medical practitioner."
- (4) "Some form of public assistance is essential if a complete and adequate hospital system is to be maintained, and the development and maintenance of an adequate hospital system should be provided in such fashion as will preserve the best features of the present voluntary system."
- (5) "The infirmaries at present under the Poor Law should be thrown open to all citizens and removed from all taint of the Poor Law."

These resolutions gain remarkable force from their unanimity when it is recollected that the organisations represented include the great majority of those representing the medical profession, dental profession, nursing profession, hospital associations, friendly and approved societies and many social and philanthropic organisations. It is clear that the policy of these resolutions could be so developed that the hospital services of the country could be augmented, improved, and brought into close relationship with a National Medical Service without derogation of the magnificent amount of voluntary work that for many years past has been such an admirable feature of British hospitals.

44. Many persons well qualified to advise have expressed an opinion in favour of extending the medical benefit of the Insurance Act to the dependants of insured persons. This would, in all probability, add something like twenty-two million persons to the fifteen million now insured, making a total of thirty-seven million,* or more than three-fourths of the

* I use these in the following argument as convenient but of course quite empirical figures.

whole population. The question immediately occurs, is it worth while to incur so vast an additional expenditure and to create such an enormous organisation whilst at the same time there remain—

- (a) the various overlapping forms of medical service already referred to; and
- (b) a small residue of a million or two* persons who are neither insured under the Insurance Act nor are dependants of an insured person, but who are in an economic position no better or even worse than that of the thirty-seven million.

It must be borne in mind that an 'insurance' form of medical service necessitates each person proving and maintaining a title to the benefit, which necessitates keeping up an elaborate and costly organisation for the purpose of seeing that no one who is not entitled to the benefit gets it. If the medical benefit were extended to dependants, it would mean that the country would be spending something like a million of money annually merely to prevent the small residue referred to in (b) above, from getting the advantage of a medical service of which they undoubtedly stand in need.

Weighty as this argument is, there is an even more cogent one. By consolidating all the overlapping services, and by wedding preventive medicine to the curative branch, the very greatest gain would accrue to the community in general. It, therefore, seems that instead of setting up a service available only for thirty-seven million, it would be far wiser, and in the long run actually more economical, to extend the service to the whole thirty-nine million, and wipe out the existing overlapping of function and duplication of machinery.

45. It may be asked why, on this reasoning, the service thus established for thirty-nine million should not be open to the whole population, and indeed the question is unanswerable in direct logic. From the point of view of expediency, however, Parliament has long laid down various income limits in various Acts of Parliament (e.g., Finance Acts, Workmen's Compensation Act, National Insurance Act) to differentiate from the whole population certain sections of it needing special consideration. The income limits already adopted in the Insurance Act, arbitrary as they are, and unreasonable though they may be in many cases, have, notwithstanding, set a precedent which is easy to follow if it is thought fit that a National Medical Service, if brought into existence, should be confined to the poorer members of the community.

At the same time, however, although I do not press this point, the wiser precedent would in my opinion be that established in public elementary education, which is in theory equally open to the son of a millionaire or the son of a pauper. In practice some sort of income limit settles itself through the working of human nature, below which persons send their children to the free public elementary schools, and above which persons, although paying for the education service, prefer to pay over again to send their children to schools of their own selection. If a National Medical Service were created, and if the "elementary" side of it at any rate were freely opened to the whole population, a similar state of affairs would very probably eventuate.

46. My own personal predilection would therefore be in favour of abandoning altogether any attempt to base a National Medical Service on insurance funds, to abolish medical benefit altogether, relieving the Insurance Act contributions proportionately, and to finance a National Medical Service out of taxation, national and local. The incidence of such taxation would, in the long run, be very much the same as that of the contributions under the National Insurance Act, the remitted or substituted portion of which would, therefore, counterbalance that increase in general taxation.

47. At the same time it cannot be denied, from the point of view of political expediency, that it might be unwise to hand back to the insured persons and their employers a sum of eight million a year, which they are now paying without complaint, only to

re-levy the same sum in the form of increased taxation in some other direction which might be strongly resented. Furthermore, the insurance funds now contain an exceedingly large sum of money by way of accrued surpluses on the first two quinquennia, a large portion of which is proper to be used for medical and allied purposes. Some of this might well be utilised as a capital sum to defray in whole or in part such expenses consequent upon the inauguration of the National Medical Service as are of a capital nature, e.g., primary health centres, such as are contemplated in the Dawson Report, additional hospital accommodation, and conversion and improvement of existing hospital buildings, etc.

48. The analogy already referred to between medicine and education lends itself to a consideration of a National Medical Service. Public elementary education is universally free. Public secondary education is not free, those who can afford to do so being required to pay fees for children sent to municipal secondary schools. These are, however, largely subsidised out of public funds, and by the device of scholarships and free places the advantages of secondary education are greatly facilitated to the poorer classes.

Here is a precedent which gives a rough indication of the limitations which might well be imposed on a National Medical Service. Elementary medicine, i.e., a general practitioner service and such allied services as nursing which it might be thought fit to treat as under this heading, would be universally free either (preferably) to the whole population or, if thought fit, to all under a given income limit. "Higher" medicine, including the services of consultants and specialists of all kinds, dentists, ophthalmologists, etc., and institutional treatment, might be available on payment by the patient of some portion of the cost, such cost being levied on him by the principles of chargeability already in use. Incidentally this portion of the charge might well become a subject for voluntary insurance through Friendly Societies or other similar bodies, or alternatively, might be paid on an individual's behalf by his Approved Society as an additional benefit.

It would be idle for me to attempt to offer any detailed suggestions of how co-ordination with the other existing public medical services should be brought about, but no great difficulty need be feared, provided always that the co-ordinated service is based upon suitable areas, in which connection considerable importance will attach to the findings of the Royal Commission on Local Government Areas now sitting. Speaking of present conditions, the administrative counties and county boroughs would be the most obvious areas of administration, but what would be the position of the existing small sanitary authorities within the counties is a matter in which guidance would be looked for from the findings of the Commission referred to.

Considering at any rate the county and the county borough as the unit which will embrace the larger portion of the population, all forms of medical service within the area would be brought under the control of a local governing body, which could be either a committee of the nature of existing Education Committees, i.e., partly constituted of members of the local authority, and partly of co-opted members representing the various interests concerned; or it could, if so desired, be a new *ad hoc* body directly elected or otherwise appointed. The decision on this point would doubtless be influenced by the probable future of Boards of Guardians.

FINANCE.

49. With regard to the all-important question of finance; I have already stated that whilst preferring to see the cost of the service met entirely from public funds, I recognise strong considerations of expediency that suggest the utilisation of that part of insurance funds now earmarked to medical benefit, and possibly other portions of insurance funds corresponding to the surpluses now utilised, or to be utilised, in respect of additional benefits of a medical nature.

Assuming that the latter consideration prevails, I would suggest that the funds of the National Medical Service would be built up from four sources:—

- (1) From insurance funds in respect of insured persons and their dependants.
- (2) From public funds in respect of non-insured persons who are at present obtaining, or would obtain, medical attention from the Poor Law Medical Service.
- (3) In respect of the small residue coming within the income limit, but not included in either of the two foregoing classes, a direct contribution would have to be levied annually on each person concerned, possibly in the form of an annual demand, in much the same way in which various forms of licence are now purchased at the Post Office.
- (4) A subsidy from State funds equivalent to demands now made in respect of various public medical services to be taken over by the national service.

50. The subsidy from insurance funds would have two sources:

- (a) from realised surpluses.
- (b) from current contributions.

It would be idle to overlook the fact that objections can be brought against both forms of contribution. As regards (a) there exists the difficulty of the varying position of societies, some being in a deficiency, some having no disposable surpluses, others having a varying degree of surplus, and as regards (b) there is the obvious objection that the insured unmarried woman, and other insured persons not possessing dependants, would be contributing towards the cost of medical attendance for the dependants of other insured persons.

Neither of these objections are, however, insuperable. As regards the first, even those Approved Societies that are opposed to pooling of funds in general, are prepared, as the evidence already given before the Commission has shown, to agree to a measure of pooling for the purpose of providing extended benefits of a preventive character; and although difficulties might present themselves, none would be sufficiently strong to prevent the deflection of the required proportion of the total surplus to the medical funds.

With regard to the second objection; this undoubtedly is a more serious one, but on the other hand it loses a good deal of its force when it is remembered that the State bears a considerable portion of the cost of benefits under the Insurance Act. Consider the case of an unmarried woman. Here the actuarial value of the State's grant might be taken, for the sake of argument, at, say, 2½d. per week, and assuming that the excess cost of the medical service per insured person, due to the inclusion of dependants, was as much as 2½d. per head, the insured person in question would still be the gainer, although, of course, not to the same extent as an insured person with dependants, and she would still be getting better benefits for her contribution than she would be able to get for the same contribution in a non-State-aided scheme, in which, however, she did not have to make any contribution to a medical pool of the kind supposed.

A further point that must not be lost sight of is that, though this pooling of medical contributions acts preferentially in favour of one insured person over another, yet this discrimination in favour of the person with dependants is by no means contrary to public policy, and has already been adopted in principle in income tax legislation, where the person with dependants pays, relatively, less tax than the person without. It is, therefore, only in a comparatively small number of cases that the insured person would have any real grievance.

Nevertheless it must be recognised that there would without doubt be a considerable amount of complaint, particularly from insured unmarried women, and if it were felt desirable to obviate this, it is by no means beyond the wit of man to do so by one or more of various expedients, such as giving

an insured person who attains a given age, without dependants, a refund, somewhat similar to that given under the Unemployment Insurance Acts in certain cases.

51. The second source of income practically represents a diversion of a portion of the present Poor Rate from the Boards of Guardians and their Poor Law Medical Service to the new medical authority in respect of the present Poor Law Medical Service, which would be absorbed in the new service. Needless to say, all stigma of pauperism, and of connection with the Poor Law in any shape or form would cease, and no distinction at all would be made between any persons making use of the service.

52. The third source of income presents a difficulty which is inseparable from any scheme of National Medical Service which is not financed wholly from public funds. In the interests of public health it would be fatal to leave out the class of costermongers and other similar people who, although often very poor, yet do not come under the provisions of the Insurance Act, and who, on the other hand, can afford to pay their medical contribution just as well as a great many employed persons who will come under the scheme.

Considerable ingenuity would be needed to bring this class of persons within the scheme, although it is by no means impossible. Experience of the voluntary contributors under the National Insurance Act has uniformly proved the weakness of this form of insurance under a State scheme, but it is submitted that in the case of a benefit such as this, which is not an intangible chance that may or may not happen in the distant future, but which represents a benefit received as frequently as seven times in two years (and more than this in the extended scheme, which will include dentistry, etc.), persons who let their insurance drift under the former scheme would not be so apt to do so under a special scheme for medical service only; particularly if this payment was made compulsory—and there would seem no reason why it should not be, unless it is that it is undesirable for the law to order that which it cannot enforce.

53. After allowing for economies to be effected by co-ordination, the State contribution to the cost of the scheme would not, in the aggregate, exceed by very much the sum total of its present grants-in-aid to the various services absorbed by the unified service. The nature and amount of the Exchequer grants need not, however, be gone into here, it being recognised that an increase, limited but undoubted, would be required to commence with.

54. The institution of such a scheme would afford a fitting opportunity of considering whether special arrangements should not be made for a medical insurance scheme in respect of "higher" medicine, for those of the middle class possessing, for example, incomes of from £250 to £1,000 a year. In the case of this class of the community the financial stress is often very great. It is frequently difficult for such a family to meet the ordinary doctor's bills, and quite impossible to meet heavy charges for specialist's treatment and major operations, etc., and it would be a very fine piece of work if a scheme could be grafted on to the main structure of a National Medical Service, whereby these major risks could be insured against by persons of the class specified.

It would probably be impossible, however, to organise this on a voluntary basis, on account of the adverse selection which would naturally take place, and it is just a question of whether or no public opinion would be sufficiently in favour of such a scheme to allow it to be made compulsory.

55. I suggest the foregoing as the outline only of a development which would be of the utmost value to National Insurance, and to the country as a whole. The advantages to the former include freeing the insurance scheme from what has ever since the troubled days of 1912 been an embarrassment and a source of conflict. It would enable National Insurance to be reconstituted so as to render it possible to consider the relation of payments in times of illness to payments in times when the income of the indi-

vidual has ceased from other causes, such as unemployment, accident, etc.

The advantages from the national point of view are clear, by no means the least being the opportunity which would be afforded by a National Medical Service to make a start with dealing with the Poor Law.

The difficulties in the way of the institution of a National Medical Service, though considerable, are by no means insuperable, and I advocate the scheme as an immediately practicable measure of reform.

56. If, however, the Commission should consider itself unable to recommend this, and would prefer to retain a medical benefit strictly within the financial framework of the National Insurance Act, I would urge that if, as appears likely, it is financially impossible both to amend medical benefit by increasing its scope and to throw it open to dependants of insured persons, that the former is far more urgently required than the latter.

I should, indeed, consider the mere extension of medical benefit to dependants of insured persons as a retrograde step, since it would stereotype the present system so deeply as to render it far more difficult to bring into existence at any future date the co-ordinated medical service which the health of the country so urgently needs.

An extension of the scope of medical benefit on the other hand is a reform which could be carried out with the greatest ease. Such an extension would, as a matter of sober fact, be merely carrying out the explicit direction of the original Insurance Act, which defines medical benefit as "adequate medical attendance and treatment." There probably exist already within the financial structure of the National Insurance Act sufficient funds to finance a complete medical service including specialist, consultant, and institutional treatment, if the existing surpluses are fully pooled and devoted to the purpose.

The finance of such an extension would be greatly simplified by a departure from the present method of remuneration of panel practitioners, which is not only, in my opinion, generous in itself, but is unduly generous in the case of the urban practitioner possessing a large panel.

Without making any definite proposal on this point I would suggest that without lowering the standard of medical remuneration below a fair and even generous level, considerable economies could be effected on the present fee.

The Commission are probably already seized of the proposals of Dr. McKail and Mr. William Jones, which will doubtless be formally brought to their attention by the latter. Without entering in any degree into the details so fully elaborated in the work in question,* I would quote it as showing one method at any rate by which a more economical and efficient service could be set up.

RESERVE VALUES.

57. I desire formally to bring to the notice of the Commission a subject which, although from lack of qualifications I do not feel in the position to give evidence upon, urgently needs fuller consideration than it has hitherto received. I refer to the financial structure of the Insurance Act, whereby full actuarial reserve values were created on paper at the inception of the Act, and are being redeemed in cash throughout a period of years.

As the Commission are aware, this means that a substantial portion of the current revenue derived from contributions is withdrawn to build up a capital

fund for hypothetical use in the future. Actuarially such a reserve is doubtless desirable, and in any ordinary scheme of insurance would, beyond all question, be essential. But in view of the fact that the present scheme is a national compulsory one, and that a steady stream of new entrants at the minimum age is thereby assured, the utility of painfully building up a gigantic reserve fund seems to be questionable to a layman at any rate, and it seems difficult to imagine any circumstances in which the reserve now being built up will be required to pay current benefits.

If this system were altered, it would mean releasing an accumulated sum of approximately nine million pounds and an annual contribution of one-and-a-half million, which would become immediately available for benefit purposes. I would respectfully suggest to the Commission that an investigation should be conducted into the possibilities of setting free this money by an amendment of the financial structure of the Act.

SUMMARY OF RECOMMENDATIONS.

58. (1) That the present system of administration through Approved Societies is open to grave objection.
- (2) That Approved Societies should be reconstituted on a territorial basis, and should be charged with the administration of cash benefits only, e.g., sickness, disablement, and maternity benefits, and additional benefits such as superannuation allowances, payments in want and distress, etc.
- (3) That Insurance Committees now perform no useful function except the hearing of disputes, and they should accordingly be wound up and their machinery utilised in establishing Approved Societies on a territorial basis.
- (4) That by a reorganisation of the Approved Society system or (less desirably) by a pooling of Approved Society surpluses, rates of benefit should be equalised as among insured persons.
- (5) That the present position of additional benefits is extremely unsatisfactory, and both the title to and the administration of them needs reform.
- (6) That dentistry should become a normal benefit of the Act, or, preferably, be merged in medical benefit.
- (7) That section 26 of the National Insurance Act, 1924, should not be repealed, but might be amended.
- (8) That medical benefit should be taken out of the Insurance Act altogether.
- (9) That local Health Committees should be constituted to set up a National Medical Service to co-ordinate all existing forms of medical service.
- (10) That a National Medical Service would best be financed entirely from public funds (national and local), but, if so desired, could be financed in respect of insured persons and their dependants partly through insurance funds.
- (11) That the extension of medical benefit to dependants would be difficult or impossible by itself, and in any case would be a retrograde step.
- (12) That in any case an extension of the scope of medical benefit is urgently desirable.
- (13) That the Commission should call for evidence as to the possibility of an alternative to the present reserve value financial structure of the Act.

ALBAN GORDON

7th January, 1925.

* "A Public Medical Service" by David McKail, M.D., and William Jones.

APPENDIX XIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE JOINT COMMITTEE OF APPROVED SOCIETIES BY MR. P. ROCKLIFF, HON. SECRETARY, WITH MR. F. W. DANIELS, J.P., CHAIRMAN. See Minutes of Evidence of the Sixteenth Day, Questions 8010 to 8420 and of the Seventeenth Day, Questions 8723 to 8813.

PERSONS INCLUDED IN THE SCHEME.

1. It is not desirable at this juncture to press for the inclusion of dependants of the insured persons (*i.e.*, their wives and children) within the scope of medical benefit in view of

- (a) the absence of any clear demand by the insured or their dependants for such inclusion;
- (b) the absence of any clear demand on the part of the medical profession for the extension of contract medical practice;
- (c) the psychological effect, upon women especially, of any attempt at regimentation in regard to their medical needs;
- (d) the fact that, as regards children, medical attention is already in some measure provided for them.

2. Neither is it desirable (for reasons (a) and (b) above) to press for the inclusion within the scope of medical benefit of non-manual workers earning over £250 per annum, who are voluntary contributors under National Health Insurance. It is not considered that any administrative simplification which might thereby be attained would justify serious controversy with the medical profession.

3. Speaking generally, the extension and administration of medical benefit as outlined in the Oxford resolution of the National Conference of Friendly Societies would, in the view of the Joint Committee, lead to an impression (in the minds of the patients, at any rate) that, as regards attendance, it was of the nature of a Poor Law medical service, and, as regards drugs, that they were of the "stock-pot" variety.

4. The present system of medical benefit undoubtedly creates in the minds of no inconsiderable section of the insured misgivings as to the nature, quality and value of the service; and these misgivings would, in the opinion of the Joint Committee, be considerably magnified under such a system as is outlined in the Oxford resolution. Can this be said to be, in any case, desirable?

SOURCES OF REVENUE AND COLLECTION OF CONTRIBUTIONS.

5. (i) The retention of the Treasury contribution of two-ninths is as justified to-day as it was in 1911.

(ii) No new system for collecting contributions appeals to the Joint Committee. The card and stamp system has, on the whole, worked well.

(iii) The evidence given before the Departmental Committee on behalf of the Joint Committee was favourable to a joint card and stamp for health and unemployment purposes.

THE MONEY BENEFITS.

6. The Joint Committee would favour the limitation of cash benefits (in sickness to men) to 18s. in the hope that, with so much surplus apparently at present in the Scheme, a reduction in the weekly contribution might be possible. The Joint Committee believe that, apart from the burden on the employed in present economic circumstances, the charge upon employers for National Insurance premiums adversely

affects industry and assists to prevent a revival of trade. No suggestion that the charge is passed on to consumers militates against this point.

7. The last addition to the contribution was made when trade was still good and when unemployment was slight in comparison with present conditions.

8. Alternatively, if a reduction in the contribution be not found practicable on the ground of inadequacy in the margin left available—the Joint Committee would recommend the utilisation of surplus beyond the sum required to pay the 18s. (and proportionate disablement and maternity benefits) towards additional benefits in kind, or treatment benefits, provided the insured members of each society retain their present right to select such of those additional benefits as best meet the needs or desires of such members.

To take away such right would be undemocratic.

PENALTIES FOR ARREARS OF CONTRIBUTIONS.

9. The Joint Committee would desire to see each society possessed of the right to utilise its so-called "indisposable" surplus to maintain in full benefit its own sick, but unemployed, members. A suggestion in regard to this has already been put before the Minister of Health by Sir Thomas Neill on behalf of himself and others interested, including several members of the Joint Committee.

SPECIAL PROVISIONS FOR PARTICULAR CLASSES OF INSURED PERSONS.

10. As regards Class K, the Joint Committee would infinitely prefer a return to the proposals of the Ryan Committee (originally embodied in the 1918 Amendment Bill) than the retention of the present system. The Ryan scheme would give a surrender value to each woman concerned in the shape of a marriage dowry—the present scheme only advantages a section of the women concerned and is not, therefore, regarded as satisfactory by many insured women who marry.

11. As regards deposit contributors, the Joint Committee would favour allocation (after due notice) of present-day contributors among such societies as intimated their readiness to receive them, and no difficulty, it is believed, would be experienced on the latter head. As regards the future, it is believed that cosmopolitan societies would be perfectly ready to surrender their present right of expulsion. Assuming, however, that societies for special classes would not surrender their right to expel, the Joint Committee would advocate the similar allocation of future "homeless" contributors subject—in the case of a person of bad health—to the expelling society providing an additional transfer value adequate to the risk, or the attachment to such person of such additional transfer value from the Reserve Suspense Fund, even though the ultimate date of redemption of reserve values might be thereby postponed for a comparatively trifling period.

12. The difficulties attendant upon claims by insured married women who are pregnant seem to call for some further consideration. The extent of the right of such women to receive sickness benefit in respect of their pregnancy should, we venture to think, be more clearly defined.

ADMINISTRATION OF MONEY BENEFITS.

13. The Joint Committee are opposed to the idea known as "common pooling" of funds—which idea appears recently to have been dropped by its authors—on the ground that it would be a flagrant violation of the pledge given by Parliament to the insured that they should derive—as particular sections of the community—any advantage flowing from their own good experience or non-liability to sickness (and therefore excessive contribution), as well as from their own good management.

14. The incentive to careful oversight of claims would be destroyed under a scheme of common pooling, and the draft upon the Treasury would be considerably increased.

15. Societies which, because of a heavy claim ratio, have less surplus than others, have nevertheless had the same amount of money (in contribution, reserve values, etc.) to expend as such others, and the only difference between societies is that, whilst some spend their money wholly in cash benefits to their members, others have need to spend less in cash benefits and spend the rest of their money (the so-called "surplus") in benefits of another character to their members. The question of the feasibility of a differential (or additional) reserve value based on occupational risk, might, however, be again considered.

APPROVED SOCIETIES.

16. The Joint Committee are prepared to give consideration to any suggestions for an improvement of the present system of administration—but, judging by Departmental speeches delivered during recent years, the Approved Society system generally has justified itself.

17. Special considerations may, of course, attach to the question of decentralised societies operating through branches as separate valuation units, and also to societies of small numerical size. But both these latter classes, if dealt with at all, would appear to be on the same plane. Assuming this contention to be conceded and the Commission to be desirous of securing a numerical limit to approval, there would seem to be no reason why the present Associations of Approved Societies (formed under section 39 of the 1911 Act), should not be approved on their present numerical limit as associations. Many of the smaller societies have voluntarily banded themselves together in this way already, and there seems no adequate reason why they should be disturbed.

18. The suggestion for a territorial administration of National Health Insurance (along with other schemes of Social Insurance) is not at this moment believed to be practicable, and the Joint Committee do not support it.

19. In their opinion it would again be a breach of faith with the insured population; it would not be supported by the insured generally, and territorial funds would aggravate the very position which the idea of common pooling was said to be designed to cure (i.e., a differentiation in benefit for an identical contribution).

20. Furthermore, political considerations, inherent in local government administration, might easily operate to the advantage, as well as disadvantage, of sections of the insured in localities.

21. The business of Approved Societies is (as regards their offices and staffs) run as far as possible on commercial lines. Local authority administration is not; and any territorial administrative system would not only be costly in itself, but would not be so effective an instrument for checking claims, and the Treasury would materially suffer in consequence.

22. It is a very important factor in this connection that a large majority of the insured population have to be in direct touch with their present Approved Societies for other insurance business, and millions of friendly society and trade union members secure a double benefit by the one and the same procedure which secures to them their State benefit. If the latter were dealt with by another body, a dupli-

cation of work, of letter-writing and of certification, with the resultant cost, would thereby be thrust upon millions of the working population of this country.

23. The arguments found cogent in 1911 for administering National Health Insurance through societies still hold good. The humanitarian touch, inherent in Friendly Society and Trade Union administration, is thereby secured to the advantage of National Health Insurance.

CONTENT OF MEDICAL BENEFIT.

24. The Joint Committee desire to see the benefit given by the Act of 1911 fully conferred upon the insured, i.e., "adequate medical attendance and treatment," and not the restricted form of (domiciliary) medical benefit defined by the regulations.

25. Given the former, there is no need to separately specify here the nature of the extensions desired in the latter.

OTHER TREATMENT BENEFITS.

26. The Joint Committee desire to support the extension of the Fourth Schedule to the Act of 1911 so as to entitle Approved Societies to make monetary grants to enable their members to secure massage, radiant heat and other electrical treatment, blood tests, X-ray, and similar advantages in dealing with illnesses.

27. As regards treatment benefits generally, whilst special considerations might be advanced in regard to a benefit given nationally as a normal benefit under the Act, the Joint Committee are opposed to any transfer out of the hands of the members of Approved Societies of the administration of the present system of monetary grants in aid of treatment.

DENTAL BENEFIT.

28. The only treatment benefit which would seem to justify an effort to secure it upon a national basis is probably dental benefit. Even then it would still, it is believed, be desirable for societies to continue to administer it. The knowledge and experience at the disposal of the Joint Committee enable them to say, however, that such a benefit, if given nationally, would require to be given free of cost to the insured to enable the ill-paid, and not merely the well-paid among the insured to obtain it; further, that its cost could not be met within the limits of the present weekly contribution, and certainly not within the limits of a reduced contribution, if the latter were found possible.

29. The Joint Committee have considered a scheme outlined (and since revised) by Mr. Spurgeon, of the Prudential Society, for the allocation of part of the present contribution to secure treatment benefits to the whole of the insured. Apart from other objections thereto (which they have communicated to Mr. Spurgeon and are prepared to put before the Royal Commission if the plan were eventually submitted to the latter body), the fund proposed to be created for the purpose would be totally inadequate and would therefore prove a mockery of the needs of the insured. It were better that the members of some societies should continue to derive a real advantage from their own surplus than that the whole insured population should be provided with an inadequate fund of little practical benefit to any one individual, or of which, at any rate, only the well-paid section among the insured could avail themselves if such fund were distributed on the basis of a grant-in-aid.

30. It is probable, moreover, that, if dental benefit were to be given nationally with free choice of dentist, the present scale (agreed with a section of the profession for a proportion of the insured and for a limited period) would not be regarded as adequate by the more highly qualified branch of the dental profession, with a consequent material increase in the cost of the benefit.

31. In the great majority of cases at present dealt with by societies (more particularly among men), complete extraction is found to be necessary. The suggestion which has, it is understood, been mooted that a national dental service should (on account of

the cost of dentures) be confined to extracting bad teeth, etc., leaving such societies as possessed the requisite surplus to assist members to fill their toothless gums, only wants stating to be ridiculed.

32. The claim put forward by Insurance Committees that the work at present undertaken by societies as regards additional benefits in kind, should be transferred to them, is founded not upon any suggestion that the work could be performed better or more cheaply by the committees than by the societies (both of which suggestions would be patently false), but is founded upon the fear that, unless the officials of Insurance Committees can find something else to do than divide given sums between doctors and chemists, they may lose their jobs by the decrease, through natural causes or otherwise, of the bodies they serve.

33. The insured population as a whole never come into personal touch with Insurance Committees. This cannot be said in regard to the relation between the insured and their societies; and it is the personal touch which is required in connection with claims for treatment benefits.

34. The suggestion that treatment benefits are of the nature of medical benefit might equally be said of the provision of raiment and food, both of which are requisite to the maintenance of health and capacity to work. The suggestion might receive some attention if doctors, as a class, exercised their opportunity to suggest to societies, on Form Med. 40, what treatment would benefit their members. Experience shows that even as regards nursing (which has the nearest relationship to medicine) it is not the medical practitioner who takes the lead in advising it. Moreover, the effect of the inclusion of treatment benefits within the scope of medical benefit, might have such a bearing upon the financial structure of the Act (medical benefit being, in practice,

a first charge upon the Insurance Fund) as not probably to endanger the continuance of the normal scale of cash benefits.

35. Section 21 of the 1911 Act has been of material advantage, and should not be interfered with. It is believed that no proof can be adduced that societies generally have, by its exercise, endangered their ability to pay the normal benefits to their members.

ADMINISTRATION OF MEDICAL BENEFIT. INSURANCE COMMITTEES.

36. The Joint Committee do not wish to press for any radical alteration of the present system of administration. They gather that—at any rate in London, covering one-seventh of the insured—medical and pharmaceutical opinion is averse thereto. Deputies for regional medical officers, selected from the area involved in the reference, are not satisfactory, and the practice in this regard should be discontinued.

FINANCE. AUDIT. VALUATION.

37. The Joint Committee have no special recommendations to make on these heads, apart from their observations thereon under other heads. They would support one Central Index Committee for the whole Kingdom.

Submitted on behalf of the Joint Committee by its duly appointed drafting Sub-Committee.

F. W. DANIELS.
W. A. APPLETON.
F. G. HARRIS.
P. ROCKLIFF.

4th November, 1924.

SUPPLEMENTAL STATEMENT.

38. Since the original Statement of Evidence was prepared on behalf of the Joint Committee, the Memoranda and Evidence submitted to the Commission on behalf of the Government Departments have been published. The Joint Committee, in view thereof desire to make the following further observations upon the undermentioned headings of their first Statement.

EXTENSION OF MEDICAL BENEFIT TO DEPENDANTS.

39. It is now understood that (as regards the method of administering medical benefit) panel medical opinion has crystallised in favour of the scheme outlined in the Report of Lord Dawson's Committee for the provision of domiciliary and institutional treatment for the whole population, but that it is recognised by the profession that that scheme is an ideal not capable probably of immediate attainment. In this latter view the Joint Committee concur.

40. It is further understood that both panel medical and panel pharmaceutical opinion will favour an extension of medical benefit to some (if not all) dependants of the insured in priority to an improved or complete medical service for the present insured population, assuming the money available (or obtainable) to be inadequate for securing both objects.

41. In this opinion the Joint Committee do not concur. They desire to add to the reasons already given by them the following:—

- (1) They would rather one thing be done perfectly than two things be done imperfectly or indifferently.
- (2) The number of attendances upon doctors by those at present insured under the Act has very materially increased since before 1912, and it has been found necessary, in order to secure efficiency, to limit the number of patients on a doctor's list. The inclusion of a large body of unemployed married women within the scope of medical benefit would bring, not a proportionate, but a disproportionate increase in the volume of work thrown upon a limited number of doctors in congested areas in industrial

centres. The service given under such conditions would, as regards those at present insured, necessarily suffer; the efforts which have been made in past years to secure an improvement in the medical service to the insured would have been wasted and the real value of the service which could be given by the panel section of the profession (at present and for some time to come at any rate) to a greatly increased number of persons entitled to benefit under contract would be small by comparison with the capitation fees which would be demanded.

42. The fact that panel pharmaceutical opinion may favour an extension of contract practice rather than an increase in the present value of medical benefit to the employed population may to some extent be understood when it is remembered that the former would add considerably to their assured income through a substantial increase in the number of prescriptions to be dispensed, while the latter might add, so far as the pharmaceutical profession is concerned, but a few small articles, such as trusses, to the medical appliances to which the insured are entitled.

43. It is furthermore difficult to conceive a willingness on the part of Parliament, employers or employed, in present economic conditions, to add to the present burden of contribution for Health Insurance purposes alone.

SPECIAL PROVISIONS FOR PARTICULAR CLASSES OF INSURED PERSONS.

44. *Class K.*—With regard to Questions 1674-1704 in the Minutes of Evidence given before the Royal Commission, the Joint Committee do not agree that because an amendment was hurriedly inserted by the House of Lords in the Act of 1918, such amendment must stand for all time. The proposal for a marriage dowry was put forward after a full enquiry before the Ryan Committee, it had the approval of the Department, it was passed by the House of Commons, and the only reason why the Lords' amendment was accepted was because time was an important factor

in getting the Bill through. It is certainly not conceded that "Women's Societies" as a whole, or by a majority, desired a change from the dowry proposal to that of Class K. It is indeed doubtful whether the body for whom Lord Knutsford professed to speak could prove that they spoke for insured women at all. It is furthermore interesting to remember that Miss Macarthur pressed the then Chancellor in 1911 to provide women with a marriage dowry (Cd. 5869, p. 13), and principally on the ground that when a woman married, she (in the main) went out of insurance for good.

45. *Married Women.*—As concerns the paragraph upon pregnancy and claims to sickness benefit arising thereupon, it would appear to be worthy of consideration whether the Washington Convention, as regards cessation of work for a definite period before confinement, could form the foundation for a limitation of claim to benefit in respect of pregnancy or illness consequent thereupon or both. It is, of course, recognised that there are two important considerations arising thereupon (a) the willingness of women generally to accept, and of Parliament to decree, a law inhibiting them from working for a definite period; and (b) the financial burden involved to societies by the requirement that they should pay benefit in every case during such period. The practicability of ascertaining the commencement of the period is another factor involved, as well as the diagnosis of sickness arising before that period began.

46. *The Armed Forces of the Crown.*—The Joint Committee are not enamoured (from the information at present before them) of the suggestion that a person on joining the Forces should cease to be a member of the society. In the event of a widespread conflict, large numbers of men would be called up and the financial stability of a society from an administration point of view might be altogether undermined.

ADMINISTRATION OF MONEY BENEFITS.

47. It would appear to be suggested that had Parliament foreseen that there would be material disparity between the benefits derived by different sections of the health insured population, the Legislature would have enacted some other method of administering National Health Insurance than through Approved Societies coupled with free choice to the insured to segregate if they so desired.

48. It is submitted that a careful study of the debates in 1911 and of Command Papers then issued would reveal no support for this view.

49. As an example the following statement by the then Chancellor (Mr. Lloyd George) can be cited (Cd. 5869, p. 47):—

"It is perfectly true that the agricultural labourer is a much healthier person than your town artisan, but the difference is not as great as you imagine. . . . It is only a question of something like 4d. or 3d. a week. If the agricultural labourer wants to get the benefit of his healthier occupation all he has got to do is to form rural societies, and there are a very considerable number of them at the moment, because in that case he gets the full benefit of his own money and he could not mix up his money with the town man at all. If you form rural societies it is to the agricultural labourer's advantage to join them and then he gets the full benefit of the 4d. or 3d. as the case may be."

50. The inference which it was presumably sought to draw is that Parliament would to-day take a different view and adopt another policy.

51. Yet Parliament, in its most recent National Insurance Scheme, has again deliberately followed the policy of allowing certain classes, among whom risks of unemployment are small and the flat rate of contribution would be excessive, to remain outside the Scheme altogether.

52. Only a few months ago Parliament re-affirmed its view that favoured industries, where the risk was small, should be allowed to contract out of the general

scheme and thereby secure materially higher benefits for the same (or even a lesser) contribution.

APPROVED SOCIETIES.

53. *Small Units.*—It is observed from the answer to Question 623 of the Second Day that it is suggested that after the societies have given their evidence, the Department should submit their proposals on this matter (as on other matters) to the Commission. It is contended that this would be unfair unless the societies, after such memoranda had been submitted, were heard thereon.

54. It is believed that small units have shown wonderful results at the second valuation.

55. *Quorum.*—The Table printed on p. 58 of the Appendix, Part I, may (even though such be not intended) create prejudice. These quorums were, in the first instance, approved by the Department.

56. There is an unrestricted right on the part of the insured members to attend the general meetings of practically all societies—or to attend the local meetings at which the delegates to the annual general meetings are elected.

57. If they do not choose to exercise that right in the mass, it is reasonable evidence of general satisfaction with the conduct of the societies. The quorum is not a measure of the actual attendance.

58. One might imagine from this Table that a fining-down of representation so as to ensure the carrying on of the business of an institution were unknown outside the realm of Approved Societies.

59. Paragraphs 23 and 24, on page 35 of the Appendix, might to the uninstructed appear to cast aspersions upon bodies which require 50 members to secure the continuance of benefits to two million of their fellows.

60. Can it have been forgotten that 40 members of the House of Commons can legislate for 45 million persons and that such 40 may include paid Ministers of the Crown who themselves number over 40?

61. If the present Health Insurance Scheme were nationalised into a purely bureaucratic scheme, not a single insured individual (let alone the sum of the quorums of the whole of the Approved Societies) would either be entitled to attend, or be given the opportunity to attend, a meeting to air his grievances, elect his paid servants, and fix their salaries.

TREATMENT BENEFITS—GENERAL.

62. As regards any suggestion for the administration by Insurance Committees of treatment benefits or monetary grants in aid thereof it should be pointed out that every insured person is accustomed to go to his Approved Society for his sickness and disablement benefit. The treatment benefit will often be recommended in connection with such illnesses and such recommendation will be made upon certificates which must, in the normal course, be sent to the societies. Why should 15 million persons constituting the insured population be compelled to apply to two different authorities for what is, in reality, in both cases, a cash benefit?

63. The language of section 37 of the Act of 1911 cannot be overlooked in this relation. It states:

"If upon any such valuation a surplus . . . is found, . . . the society may submit . . . a scheme for distributing out of such surplus any one or more additional benefits among insured persons who are members thereof for the purposes of this Part of this Act, and upon any such scheme being sanctioned . . . the society may distribute such additional benefit or benefits."

64. Moreover, the giving of treatment benefits, or monetary grants in aid thereof, or both, are at present (and are still to be) dependent upon a certain title to benefit, i.e., length of present or previous membership in the patient's then society. No Insurance Committee has, or can have, at the moment of the receipt of an application for treatment benefit the requisite data for expeditious dealing with the claim. If it

were suggested that the committees should apply to the societies for information as to title, the committees would first have to obtain from the applicant his or her full name, membership and branch (or agency) number, present and past addresses, send the same on to the society and await the latter's reply—a circumlocutory process which could not be justified, the expense of which, so far as societies are concerned, could not be borne by them out of their ordinary administration allowance, and, so far as Insurance Committees are concerned, would materially reduce the fund available for the provision of the benefit.

65. Furthermore, if dental benefit, for example, were given as a so-called "statutory" benefit on the basis of a grant-in-aid, and this were to be administered by another body than the patient's Approved Society, it would still be possible for the latter to supplement the "statutory" grant out of its surplus, and to secure this, the member would then be required to make a second application in regard to the benefit, this time to a different body, i.e., his society. Surely a most confusing and needlessly onerous and expensive procedure!

66. It has recently been suggested that the Department should supplant existing arrangements for securing the provision of treatment benefits. The Joint Committee are of opinion that the intervention of the Department in this way would not enure wholly to the advantage of societies or the insured, although it would enure to the advantage of purveyors of certain services. To take dentistry as an example. The Joint Committee are inclined to think that under a national scheme of dental treatment the present scale would not be accepted by the profession. The intervention of the Department may accelerate an increase in the scale. The profession have desired a higher scale than that now operating. The latter has been secured as the result of competitive efforts among societies operating the benefit, and has been and is being adjusted from time to time as the result of experience which only those actually engaged in giving the benefit can appreciate.

67. Moreover, the attitude of the Department tends towards a compulsory utilisation of the services of "1921 dentists." Yet the difference in the nature of the service rendered to societies and their members by the qualified dentist and the "1921 dentist" is marked. The societies who in the past have confined their work to qualified men would be seriously concerned at any step which would rob them of the advantage they at present secure. Many qualified men willing to accept the scale now in operation will not associate themselves with the Public Dental Service Association which is mainly composed of 1921 men. Why should their services be ruled out?

68. Freedom in this and other respects, including the right to establish clinics, has been secured to all societies through the instrumentality of an agreement made with the profession by leading societies at present giving dental benefit. The abrogation of that agreement by the Department would be wholly unjustified and disastrous.

69. Deadly uniformity is not wholly desirable. Joint Committees representative of the societies and the profession exist in relation to dental, nursing and hospital treatment and have done and are doing the spade work. If the Department wishes to be represented thereon no one is likely to object.

DENTAL BENEFIT.

70. Certain officials of Approved Societies, having become possessed of the knowledge that the gross surplus at the second valuation will materially exceed £30,000,000 (at which figure it had previously been put), appear to be alarmed at the prospect of its announcement and seem to be casting about for expedients to suppress or withhold the information or otherwise to obscure its existence before the results of the valuation emerge. The Joint Committee can be no party to anything savouring of deceit in this matter. If the result of the valuation is, as is suggested, beyond even the expectancy, so much the better for the insured population who should and will

in the normal course (under schemes framed in pursuance of section 37 of the 1911 Act) secure to the full the advantages which flow from it.

71. In view, however, of the fact that a very considerable portion of the surplus will be directed by the Government valuer to be retained as a reserve, i.e., as "indisposible," the Joint Committee suggest that the publication when made should be of the net (or real) surplus, i.e., the amount which is in fact actually divisible in additional benefits among the insured.

72. Should the surplus be found to amount (when the 1923 valuation results are known) to the figure now suggested, the Joint Committee would doubtless consider the desirability of utilising such part of that surplus as is requisite to provide a 100 per cent. dental service in priority to (a) a reduction in the weekly contribution, (b) an increase to a limited extent in the normal rates of cash benefit, which were advocated in their original Statement.

73. The Joint Committee have recently had the advantage of reading paragraph 48 of the Statement submitted to the Royal Commission on behalf of the Ancient Order of Foresters.

74. The Joint Committee would, as between the scheme outlined by Mr. Spurgeon for the Prudential Society and that outlined by Mr. Duff for the Ancient Order of Foresters, express a definite preference for the latter; but the inherent defect in any scheme for a limited contribution (even 50 per cent.) towards the cost of a benefit—particularly dental—is that it would inevitably shut out no fewer than 25 to 35 per cent. of the insured population (according to the status or earning power of the insured) from procuring or deriving the benefit because of their inability to find their own proportion of the cost.

75. The grant, whatever its amount, and whether provided out of the individual society's funds or out of any National Dental Pool, would not be procurable by the insured patient until his or her own share of the cost had first been found.

76. If the grant were of less than 50 per cent., experience shows that the number of those unable to obtain the benefit for lack of financial resources would increase to 40 per cent. and beyond.

77. There is indeed evidence that the number of persons who can secure dental treatment if given only upon a 50 per cent. grant basis, is but one-half of those who would require that treatment if no financial barrier existed.

78. The words of Sir Walter Kinnear, in his evidence before the Royal Commission, though uttered in another connection, are appropriate to the present subject. He said (Question 486, Second Day):—

"I think societies recognised it was scarcely right that, on the one hand, they were paying additional cash benefits to their more fortunate members, and, on the other, were allowing large numbers of their members, who helped to build up the surplus out of which these additional cash benefits were being paid, to be deprived altogether of cash benefits. That would be an indefensible position."

79. The only proper solution is to give a 100 per cent. service if dental benefit is, like medical benefit, to be given nationally and (as it should be) irrespective of the depth of the personal pocket of the needy recipient of the benefit.

80. From indications which have been given and opinions which have been expressed, it is firmly believed that a 100 per cent. service is not impossible financially if precedence were given to it over other additional benefits, and the Joint Committee are not impressed by suggestions that the "dentists" available are inadequate in number. It might be true of *qualified* dentists.

81. In one society giving dental benefit on a 100 per cent. basis the cost works out at about 5s. 6d. per member per annum. It is a society composed of Government employees, whose teeth might be expected to have been to some extent attended to in the past.

82. In another society with a poorer class of member, the cost (on the basis that those who applied but could not put up their share of the cost would have been as expensive on the average as those who possessed the wherewithal) works out at 1.1d. per member entitled per week. This, however, takes no account of those who required treatment but made no application knowing beforehand their inability to find their share. Allowing for this and other factors the cost of a 100 per cent. service would probably in this second society amount to 6s. 6d. per head per annum.

83. If it is thought that experience since 1921 is insufficient to enable the cost of a National Scheme to be gauged, it is suggested that in such a scheme—to avoid endangering the normal cash benefits under the Act—the dentists should dip into the Insurance Fund after medical and normal cash benefits have been first provided, and that, if dental benefit were found to be more costly than the sum then available, the dental bills should be discounted as chemists' bills were in days gone by and as doctors' bills also were in the Manchester area.

84. It has been suggested by some that if, from those societies who do give dental benefit, were taken away a portion of their surplus in order that members of societies not at present deriving the benefit might obtain, at any rate, the offer of a grant-in-aid, the benefit would be more widely spread. As regards this suggestion, it is not admitted that the benefit would be secured by (though offered to) a larger number.

85. On the other hand, it is inevitable that, by the taking away of surplus from those to whom it belongs, and who are at present receiving the fruits thereof in the shape of dental benefit, the percentage of the cost at present offered to such members would be reduced and that the number financially able to avail themselves thereof would also be reduced: to use a colloquialism, it would be robbing Peter to pay Paul.

86. In another quarter it has been suggested that members unable to provide their own proportion of the cost of the benefit should borrow the money, or incur indebtedness to the dentist. A National Scheme of dental benefit which was dependent upon either of these expedients could hardly be defended. Moreover, the present scale was fixed on the definite understanding that the dentist should not be required to give credit, accept instalments, or risk bad debts. It is true that some dentists voluntarily afford their patients these facilities, but a material addition to the charges in the present scale would doubtless be insisted upon if the dental profession generally were required to afford these facilities to the indigent insured.

87. It has furthermore been suggested that under a National Scheme of dental benefit there should be a system of priorities as regards eligibility for treatment, depending apparently upon medical recommendation. This idea does not appeal to the Joint Committee. It appears to rule out conservation of the natural teeth and only to apply a radical remedy when the poison has done its work and the health has been undermined by decay of the teeth. Such a system does not seem to be one worthy the name of preventive treatment.

88. The figures given in the table in answer to Question 892 of the Second Day as regards additional benefit No. 2 (Dental) are illusory in so far as an inference may be drawn therefrom that the sum available for dental benefit in 1923 was more than adequate to meet the cost of satisfying the needs of the members applying for treatment.

89. In all but a few cases societies did not give 100 per cent. In the main, the grant was one of 33 per cent.

90. The figures given take no account of the facts (*inter alia*) that (a) some societies exhausted their money before the end of the year; (b) that a large number of applicants could not secure the benefit; (c) that the Audit Department insist that societies should, in their account-keeping, take no heed of

liabilities incurred but not paid within the year of account. Thus, if, instead of "Payments," the cost of "treatment authorised" had been given, the "Expenditure" side would have largely exceeded the "Receipt" side. On the basis adopted by the Audit Department it will be possible apparently for a society which pays out during the five years over which its scheme extends the exact sum set apart for the benefit, to be regarded as solvent, even though at the end of the five years it has liabilities outstanding to the tune of thousands of pounds in respect of treatment authorised but uncompleted and therefore still unpaid for.

SECTION 21 OF THE 1911 ACT.

91. Paragraphs 229, *et seq.*, in the Statement of the Ministry of Health (Appendix, p. 54) seem somewhat prejudiced against this section when compared with the statement on the same subject in the Statement submitted by the Scottish Board of Health (page 130, paragraph 42) that societies "have made cautions and reasonable use of these powers."

92. If the figures for England for the past quinquennium were given of donations under section 21 of the 1911 Act (26 of the 1924 Act), it would probably be found that the total for all societies did not much exceed £50,000.

93. Yet the gross surplus of societies for the same period, after expending this £50,000, will be at least £30,000,000 sterling.

94. The Joint Committee desire to emphasise their belief that no evidence can be furnished to the Commission that societies exercising their rights under section 21 have jeopardised their capacity to pay either the normal or additional cash benefits to their members. Nor can it be denied that members of donating societies have been materially advantaged by the use of the section. In point of fact, societies have done no more than spend surplus declared disposable at the first valuation.

95. The Department has ample powers already, under the "Withdrawal of Approval" Regulations, to deal with any society which acts contrary to the interests of its insured members (as undoubtedly it would be doing if it endangered the payment of its ordinary benefits).

96. But the Department would apparently advocate the taking away from all societies and their members of powers which the Legislature deliberately gave to them by repealing or emasculating this section which is one of the few remaining evidences that a society "is an independent and self-governing body and entitled, so long as it remains approved and conforms to the law, to carry on its operations in its own way." (Appendix, page 35, paragraph 25). In that event it would no longer be possible "for a society to decide whether judicious expenditure of this kind may be expected to have the effect of promoting the recovery of sick members and so relieving the ordinary expenditure on sickness benefit" (paragraph 233, page 55).

97. According to the paragraph 238, page 55, of the Appendix, the donations amounted in 1923 to 9½d. per head of membership of the societies concerned, or little more than one-half of a farthing per member per week. Reference to the Actuarial Reports on which the National Health Scheme was founded (Cmd. 5681, paragraph 73; Cmd. 5885, No. 72; Cmd. 5983, paragraphs 6 and 7), will show that a margin of about one halfpenny per week was left in the contribution above the average sum required to provide the normal benefits, and this position is not affected by the fact that this halfpenny was later on treated as an additional "loading" of the risk (Cmd. 6907, page 555, paragraphs 12 (vi), 13 and 14).

98. An examination of the case of "the large centralised society" referred to in Appendix, paragraph 237, page 55, would show that it realised a profit on its investments in the last quinquennium of something approaching £50,000, or nearly £40,000 more than it spent under section 21. Not one farthing of this profit was anticipated or taken into

account by the Valuer or the Government Actuary when its valuation was made or disposable surplus was fixed in 1918, and no part of it was therefore required either to maintain its normal or additional cash benefits.

99. In the case of another society " (B)," included in Table 28 (Appendix, page 75), its donations under section 21 during the quinquennium came to about £5,000. Its realised (and unanticipated) profit on investments during the same period was between £4,000 and £5,000. The Department admitted that it was spending much less upon its additional cash benefits than the sum set aside for that purpose under its scheme—the anticipated saving on this head being some £25,000 in the five years. That being so, it was obviously spending less than the expected expenditure upon its normal cash benefits. Nevertheless, the Department declined to allow it to set free more money for treatment benefits under section 37. It had £21,000 of its surplus at the first valuation withheld as " indisposable " (i.e., as a reserve fund); it had a contingency fund in 1918 of £16,000 which it has not had to touch, it had realised a large profit from war deaths not anticipated at the first valuation, and it has a surplus in its administration account of over £5,000 (see paragraph 234, page 55).

100. Another society, " D," which has exercised freely section 21, is composed of persons among whom (according to its Secretary) the maternity risk is comparatively trifling. Yet it is compelled to be valued on the basis that it will experience the general average rate of claim.

101. An instance of the value of section 21 may be cited. It has been officially held (Cmd. 8474, pages 238-9) that a man who breaks his artificial leg is incapable of work for the time being. They are not cheap appliances. The Department, by recent regulation, has provided that an insured person shall not be entitled to surgical appliance benefit out of surplus till he has been five years a member of his society. The latter would, therefore (but for section 21), have to pay him sickness benefit if the member was unable himself to procure a new leg. Under section 21 the society can secure it for their member and at once put an end to the sickness claim.

102. It appears to be suggested that there is something improper in members of a society deriving, under section 21, benefits of an " additional " nature which are also obtainable under section 37. If this were a proper view, then society " D," which has freely exercised section 21 to give dental benefit for more than 10 years (during which period many amending Acts have been passed), should not have been specially favoured, but should have been estopped by legislation. Apparently the latter is only to be invoked now that other societies are exercising (though in lesser degree) the same right.

103. It is, however, contended that section 21, in express terms, permitted an " additional benefit," e.g., nursing, to be given by a society independently of section 37 and of the Third Schedule to the Act of 1924, and that there has been no misuse of the section.

104. It is further contended that the advantaging of any member as regards treatment is eminently desirable if prevention of future sickness in the individual and a consequent improvement in the National Health makes, as it should, an appeal to Approved Societies. To allow decayed teeth, for example, to remain unattended to, is neither calculated to conserve the sickness benefit fund nor increase future surpluses, but to reduce both.

105. It has been given in evidence by Dr. Smith Whitaker (Questions 1319-1325, Fourth Day) that the provision of a truss may be a necessity of life itself and that the non-provision of spectacles when needed renders a man inefficient and incapable of performing his work. It is true that both of those appliances may be provided as an additional benefit out of surplus, but only after a membership of five years, and, if there be no disposable surplus, not even then.

The Department does not apparently favour the inclusion of these things as part of medical benefit and the only way in which a society can help its member and save its funds against sickness claims is by utilising section 21.

106. The exercise of this section has been the only means of procuring for the insured medically-advised treatment of a beneficial and sickness benefit reducing character, such as massage, radiant heat and electrical treatment, X-ray, etc.

107. The circular issued to societies in 1913 on this subject (A.S. 106) and the regulation under which donations under this section are treated as expenditure on sickness benefit indicate it is submitted, that the test to be applied was, and is, " Will this expenditure ultimately advantage the Benefit Fund? " The fact that it might ante-date a scheme under section 37 was, indeed, departmentally conceded in the circular referred to: " Societies will be well advised to have regard to their immediate liabilities for expenditure out of their sickness benefit funds and may think it desirable to obtain actuarial advice on the subject . . . Subsequent experience will show whether further expenditure can safely be made."

108. To sum up on this head, it is respectfully submitted:—

- (a) That the powers vested in societies by section 21 were deliberately given by Parliament in the belief and hope that they would be exercised. (See Omd. 5869, p. 53; Cd. 5733, No. 48, p. 14, etc.)
- (b) That such powers were and are in consonance with the principle of self-government conferred by the Legislature upon Approved Societies.
- (c) That such powers have proved useful and beneficial, not only to insured persons, but to hospitals and similar institutions.
- (d) That such powers have been " cautiously and reasonably used."

ADMINISTRATION OF MEDICAL BENEFIT.

109. The Joint Committee desire to express their view that the number of complaints against the panel medical service which reach the Medical Service Sub-Committees falls far short of the actual number of complaints which reach the hands and ears of officials of Approved Societies.

FINANCE.

110. The Joint Committee feel they must join issue with Mr. Strohmer in his evidence (Fourth Day) on the following points:

- (a) Q. 2194.—It is admitted (Q. 2189), for instance, that the Stamp Sales Account is built up partly of cards lost or destroyed. Every society could produce evidence of cards lost or destroyed which should have been surrendered to it. The average contribution income of all societies suffers thereby, and all insured members lose potential benefits by virtue of the fact that surpluses are thereby lessened.
- (b) Qs. 2182 and 2501-13.—The present small earlier advantage to the entrant at age 16 is secured by a greater advantage being made more remote. It cannot be truly said that he really gains anything extra through the existence of a Contingencies Fund derived by impinging on the Fund for the liquidation of reserve values.
- (c) Q. 2541.—The windfall to the Stamp Sales Account will not be " entirely exhausted " in 1926. Fresh income from the same sources (and interest) is always accruing to this Account.
- (d) Q. 2217.—" On merits," societies are entitled to interest in respect of stamps on late cards from an earlier date than they at present receive it. These cards should

have been surrendered to societies at the due dates and would then have begun to earn interest (*vide* Q. 2145). This again gives them a claim upon the Stamp Sales Account.

It is not admitted (as suggested in the answer to Q. 2219) that late cards surrendered by societies consist wholly or largely of cards handed over to them by new entrants. An examination of the late cards surrendered by any society would disprove this.

- (e) Q. 2268.—It is not conceded that the very substantial loss realised by the Department on pre-war investments made by it (over £1,000,000 sterling) "was inevitable whoever held the money." If the figures as to pre-war investments made by societies in Consols were given, the amount would be

found to be trifling when compared with the sum invested therein by the Department, and the loss consequent on the war-time conversion of Consols purchased by societies was (by comparison with that made by the Department) infinitesimal.

- (f) Q. 2274.—The Joint Committee is not at present satisfied that Approved Societies get the whole of the interest on sums temporarily invested for their account. Further inquiry into this is considered desirable.

Submitted on behalf of the Joint Committee by its duly appointed drafting Sub-Committee:

F. W. DANIELS.
W. A. APPELTON.
F. G. HARRIS.
P. ROOKLIFF.

December, 1924.

APPENDIX XV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE STOCK EXCHANGE CLERKS' HEALTH INSURANCE SOCIETY, AND THE BAL TIC AND CORN EXCHANGE HEALTH SOCIETY BY MR. ERNEST EDWARD ENGLAND, SECRETARY OF THESE SOCIETIES. See Minutes of Evidence of the Sixteenth Day, Questions 8421 to 8582.

PARTICULARS OF SOCIETIES.

1. Membership	Stock Exchange.	Baltic
Men	2,745	Men ... 1,719
Women	199	Women ... 369
Invested Funds at	£	£
31st Dec., 1918 ...	11,878	7,144
" " 1924 ...	20,878	13,801

Result of the 1918 Valuation.

	£	£
Gross surplus ...	7,445	3,989
Disposable surplus ...	3,555	2,495
List of Additional Benefits.		
Sickness (Men and Women)...	2s.	2s.
Disablement ...	1s.	1s.
Maternity ...	10s.	10s.

Full dental, optical, surgical treatment, including appliances, payments to hospitals and convalescent homes.

SUMMARY OF MATTERS UPON WHICH EVIDENCE IS TENDERED.

- 2.—(1) The continuance of the present system of control and management of Approved Societies by the members.
- (2) The preservation of the surplus funds against any scheme of pooling to assist other societies.
- (3) The amendment of the Valuation Regulations respecting members transferring from one society to another.
- (4) The amendment of the Medical Benefit Regulations to enable every insured person to make his own arrangements for medical treatment with a doctor who is not on the panel.

ADMINISTRATION.

3. The Committees of the above Societies, being in close touch with their members, have more opportunities of ascertaining their views than those of larger societies.
4. The present system of democratic control of Approved Societies by the members has contributed, particularly with smaller societies, to a closer personal touch and a keener interest in the management of societies. We strongly urge the continuance of this system which has been such an important element of success in the Friendly Society movement of the past, both in the better administration of societies and the preservation of funds against unjust claims. Any questions affecting the rights of members or the disposal of surplus funds should be submitted to them for their consideration and decision. We feel that the surplus funds of the society belong to the mem-

bers, and if they do not claim by way of ordinary benefits they should be entitled to the benefits of the surplus by way of additional benefits. Witness therefore advocates the continuance of the present system of control and management of Approved Societies by the members and the preservation of the surplus funds against any scheme of pooling to assist other societies.

VALUATION.

5. The present Valuation Regulations under which members transferring from one society to another are disentitled to any additional benefits from either society for about five years, operates unfairly to members who, for reasons of desire, convenience, necessity and often compulsion, transfer their membership. Witness therefore advocates:—

The amendment of the Valuation Regulations to enable societies to admit transferring members immediately upon transfer to at least the same additional benefits to which they were, or would have been, entitled, had they not transferred; until such time as they become entitled to participate in the scheme of additional benefits given by the society to which they have transferred.

MEDICAL BENEFIT.

6. The Panel Medical Service has always been most unpopular with a large number of our members. We have had many complaints from insured persons who feel that they are not receiving the attention and treatment that was promised to them, that the doctors agreed to give, and for which the members have paid.

7. We are aware that Insurance Committees already have power to allow insured persons to make their own arrangements, but the conditions are so strict that only a few cases are allowed. We believe that if every insured person is allowed to have absolute free choice of doctor, one of the principal objections to the National Health Insurance Act will be removed.

8. We attach great importance to the sympathetic relation between doctor and patient, and consider that the faith of a patient in his doctor is largely contributory to his recovery. Any system therefore of State medical benefit would be most unwelcome to our members. Witness therefore advocates:—

The continuance of the Panel Medical Service with an amendment of the Medical Benefit Regulations, to allow of the unrestricted right of every insured person to make his own arrangements for medical benefit with a doctor who is not on the panel.

APPENDIX XVI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF LLOYD'S HEALTH INSURANCE APPROVED SOCIETY BY PAYMASTER LIEUT.-COMMANDER E. G. HOLDWAY, R.D., R.N.R., SECRETARY AND TREASURER. See Minutes of Evidence of the Sixteenth Day, Questions 8421 to 8582.

PARTICULARS OF SOCIETY.

1. Lloyd's Health Insurance Approved Society, No. 1663, was formed in 1912 under the authority of the Committee of Lloyd's managing the affairs of the Corporation of Lloyd's.

It is a private Approved Society for persons employed in England for business purposes by the Corporation of Lloyd's, or by any member or members, subscriber or subscribers to Lloyd's, or by any Limited Company connected with Lloyd's, any firm of Average Adjusters, any Marine Insurance Company, the London Salvage Association, Lloyd's Register of British and Foreign Shipping, and others, subject to the approval of the Committee.

The membership is as follows :—

	<i>Men.</i>		<i>Women.</i>
Classes A and C	3,963	Classes E and F	1,437
Class B	33	Class K	64
	<u>3,996</u>		<u>1,501</u>
Total	5,497		

Invested Funds.

2. Invested by Society (at cost)	£17,647
Amount standing to credit of Society in N.H.I. Investment Account	15,463
Total :	<u>£33,110</u>

Ordinary Benefits Paid during 1924.

	<i>Men.</i>			<i>Women.</i>		
	£	s.	d.	£	s.	d.
3. Sickness	1,281	10	6	371	17	4
Disablement	292	12	6	119	13	3
Maternity	154	14	0	30	18	6
	<u>£1,728</u>	<u>17</u>	<u>0</u>	<u>£522</u>	<u>9</u>	<u>1</u>
Total :	<u>£2,251</u>	<u>6</u>	<u>1</u>			

Result of 1918 Valuation.

4. Disposable surplus: £5,365.

List of Additional Benefits in Force.

5. Increased Cash Payments :—
- | | | |
|---------------------|-----|-----------|
| Sickness Benefit | 3/- | per week. |
| Disablement Benefit | 1/6 | per week. |
| Maternity Benefit | 6/- | |
- Full Dental Treatment.
Full Optical Treatment.
Medical and Surgical Appliances.

SUMMARY OF MATTERS UPON WHICH EVIDENCE IS TENDERED.

6. (1) The continuance of the present system of control and management of Approved Societies by the members and the preservation of the surplus funds against any scheme of pooling to assist other societies.

(2) The amendment of the Valuation Regulations respecting members transferring from one society to another.

(3) The amendment of the Medical Benefit Regulations to provide that members may have the right to make their own arrangements for medical treatment with a doctor who is not on the panel.

GENERAL.

7. The Committee of Lloyd's Health Insurance Approved Society is in close touch with the members, who take a keen interest in the management of the Society. This is largely due to the present system of democratic control as laid down in the National Health Insurance Act, 1924.

8. The Committee is also in touch with the employers of the members and it is, therefore, probable that the Committee has opportunities of ascertaining the views of the members which are denied to the committees of larger Approved Societies.

9. As evidence of the sympathy existing between the employers of the members and the Committee of Lloyd's Health Society, it may be mentioned that a private fund contributed by employers connected with Lloyd's was set up in 1916, called Lloyd's Hospital and Convalescent Home Fund, which is administered by the Committee of Lloyd's Health Society for the benefit of the members. This fund is maintained by annual voluntary contributions and is of incalculable advantage, enabling the Committee to give assistance in suitable cases, supplementing the ordinary benefits under the Insurance Act.

10. The Committee strongly urges the continuance of the present system of control and management, and submits that any questions affecting the rights of the members, or the disposal of the surplus funds, should be placed before the members for their consideration and decision.

11. The Committee submits that as the funds of the Society are contributed by employers and employees connected with Lloyd's, and as any realised surplus depends mainly on the accuracy and care with which the Society is administered, any division of such surplus to other Societies would be both an injustice and a discouragement. Any surplus should, in the Committee's opinion, be devoted to additional benefits.

12. Witness, therefore, advocates the continuance of the present system of control and management of Approved Societies by the Members, and the preservation of the Society's surplus funds against any scheme of pooling to assist other societies.

VALUATION.

13. The present Valuation Regulations, under which members transferring from one society to another are disentitled to any additional benefit from either society for at least five years, operate unfairly to members who, for reasons of desire, convenience, necessity and sometimes compulsion, transfer their membership.

14. Witness, therefore, advocates the amendment of the Valuation Regulations to enable societies to admit transferring members, immediately upon transfer, to at least the same additional benefits to which they were, or would have been, entitled had they not transferred, until such time as they become entitled to participate in the scheme of additional benefits given by the society to which they have transferred.

MEDICAL BENEFIT.

15. The Panel Medical Service has always been most unsatisfactory to the majority of our members. Complaints have been received from time to time from insured persons that they are not receiving the attention and treatment which were promised to them, and which the doctors agreed to give, the cost of which is borne by funds to which they contribute.

16. A large number of the Society's members do not make use of the services of panel doctors but prefer, for the reasons mentioned above, to pay the doctor's usual fee for medical attention.

17. An expression of opinion upon this matter was given at the Annual General Meeting of the Society, held on the 13th July, 1923, when a vote was taken.

18. No member voted in favour of the Panel System of medical treatment, and practically all voted that they were not in favour of it. The general feeling was that they preferred to be attended by the doctor of their own choice rather than take advantage of the arrangements in force under the Panel System.

19. The Committee attaches great importance to the sympathetic relation between doctor and patient, and considers that the faith of the patient in his doctor is largely contributory to his recovery. Any system, therefore, of State Medical service would be most unwelcome to the members.

20. Witness, therefore, advocates an amendment of the Medical Benefit Regulations to allow of the unrestricted right of every insured person to make his own arrangements for medical treatment with a doctor who is not on the panel.

21. The reason that very few insured persons take advantage of the provision of the Insurance Act which

allows such persons to make their own arrangements for medical treatment is that this provision of the Act is but very little known to members and that the procedure is uncertain in its operation. There can be no doubt that in the case of such an Approved Society as Lloyd's, the vast majority of members would prefer a system under which the member made his own arrangements, even though he received less than the actual cost of medical treatment and had to contribute from his own resources. Given under my hand this 19th day of January, 1925.

E. G. HOLDWAY,
Secretary and Treasurer,
Lloyd's Health Insurance Approved Society.

APPENDIX XVII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE GROUP OF CATHOLIC APPROVED SOCIETIES, BY MR. CHAS. H. WARING, SECRETARY, AND MR. J. MOSS. See Minutes of Evidence of the Seventeenth Day, Questions 8583 to 8722.

THE CASH BENEFITS FOR WOMEN.

1. The heavy drain on the benefit fund, owing to women members' claims before and after confinement, requires serious consideration and financial adjustment, particularly in view of the lax way in which many doctors issue certificates for "pregnancy" and "debility following confinement" when the women to all appearances are not incapacitated from work.

The benefit experience of women generally requires serious review.

ADDITIONAL BENEFITS.

2. The Group is in favour of the disposable surpluses on valuation being expended by way of non-cash (treatment) benefits rather than by increasing the ordinary cash benefits.

3. Extra cash benefits largely benefit those who have done little to provide the valuation surplus, and are of small advantage to those who are rarely on the funds. On the other hand treatment benefits are of more advantage to the general body of insured persons. From experience we find that dental and optical treatment are frequently asked for by members who rarely claim any other benefit, whilst convalescent treatment has proved of great value to those who, after severe operations, require building up to enable them once again to resume work.

4. The Group further recommends that provision should be made for voluntary co-operation between societies and between branches of Approved Societies in the matter of treatment benefits:—

- (1) In a large society with branches the individual branches may not have practical experience or facilities for adoption of a particular treatment, but through the parent body an efficient scheme may be found practical.
- (2) The parent body or a combination of societies can often arrange a more economical scheme than separate units.
- (3) The incidence of risks in a small branch would in some cases prevent the adoption of a particular benefit feasible in a combination where the risks are spread over a larger area.

INMATES OF INSTITUTIONS.

5. The Group is of opinion that the present provision of the National Health Insurance Acts should be so amended as to prevent persons receiving under a will or nomination, balances of benefit (amounting to considerable sums in many cases) which have accumulated during an insured person's presence in

an asylum, or other rate-aided establishment, and prior to the member's death in the institution. These persons have in many cases no insurable interest, and have probably never done anything to warrant them receiving the benefits.

CLASS K.

6. As regards Class K, the Group suggests the abolition of the multiplicity of dates and the substitution of date of marriage as date of unemployment. Women who work for any period after marriage to continue as Class E, and not be eligible for Class K.

ADMINISTRATION OF MEDICAL BENEFITS.

7. The Group are strongly opposed to Insurance Committees administering in any way the non-cash or treatment benefits, as they consider that Approved Societies, being the custodians of the members' benefit funds, the said societies are the proper authority to administer these benefits, seeing that they are more in touch with the insured persons.

MEDICAL CARD.

8. It is suggested that medical cards should be issued to insured persons by the Approved Societies. The insured person would then be instructed to present the card to the doctor, who would in turn send it on to the Insurance Committee.

REGIONAL MEDICAL STAFF.

9. It is suggested that as most of the cases submitted for examination arise from careless and unsatisfactory certification, the cost of the regional medical officers should come from the benefit fund. The societies are at present contributing for the regional medical service from the Benefit Fund Account, and we submit that the total service should be payable from that fund. Any action taken by a society is for the protection of its benefit funds, and some societies may be restricted in their action because the charges made for each member submitted are against its Administration Account.

BENEFIT OVERPAYMENTS.

10. It is generally felt that the present system of charging overpayments to the Administration Account requires revision, particularly in view of the fact that in many cases officials who are in no way responsible are the people penalised. The practice of the Department in allowing these overpayments to be charged to Benefit Fund Account in cases where, if they were not allowed, a deficiency would be caused

in Administration Account practically puts a premium on extravagance and unduly penalises economical administration.

We suggest that Article 43 (bb) 1923 Amendment Regulations should terminate at the word "thereunder."

AUDITS.

11. With regard to audits it is suggested that the audit of books of Approved Societies by the Treasury Audit Department requires unification. At present experience proves that whilst in some areas a strict but at the same time common-sense attitude is taken, in other areas the position taken is unreasonable.

TRANSFERS.

12. The Group suggests legislation to prevent undue pressure by the whole time agents of industrial and other societies. It has been found on investigation in many cases that not only is undue pressure brought to bear on the insured person, but that distinctly false and misleading information is given by the said agents.

Submitted for and on behalf of the Group of Catholic Approved Societies.

CHAS. H. WARING,
Hon. Secretary.

4th December, 1924.

APPENDIX XVIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL INSURANCE BENEFICENT SOCIETY BY MR. G. W. CANTER AND MR. P. ROCKLIFF. See Minutes of Evidence of the Seventeenth Day, Questions 8814 to 9208.

ADDITIONAL (TREATMENT) BENEFITS.

I.—GENERAL.

1. The enquiries made by the Insurance Department of the Ministry of Health (as per the Form P 15 shown in Appendix A) must necessarily have resulted in the receipt of incomplete data, since the document does not explicitly require a return of

(a) Cases where application was made for the benefit but no steps were taken to make use of the "letter" (or other authority) issued by the society;

(b) Cases where the "letter" (or other authority) was used to obtain an estimate of cost, but the member's proportion of that cost was not forthcoming.

2. The cases coming under these two heads are very substantial in number, especially as regards dental benefit, and would affect materially any estimate as to the real incidence of claim and proper cost of the benefit.

3. The cases coming under these two heads also materially increase the burden of the administrative work involved and affect the real cost of administration, inasmuch as, under the regulations framed by the Department, no allowance is made to societies therefor.

4. There is a third class of case which undoubtedly exists, but whose dimensions cannot be measured, though it is believed to be not inconsiderable, i.e., those who need the benefit, but, knowing their own inability to provide any portion of the cost, refrain from preferring a claim.

II.—DENTAL.

5. Suggestions have been made that claims to this benefit will soon reach their maximum, and would thereafter speedily decline.

6. The N.I.B.S. can find no evidence to justify these suggestions.

7. There is such an arrear of dental work among the industrial population (due to disinclination to sit in a dental chair, as well as to the want of the necessary cash) that it will be many years—certainly not less than ten years, even if the benefit were now to be almost universally given—before the apogee of demand can be hoped for. Thereafter it may be that a reduction in the present heavy percentage of total extractions and replacement by dentures may be looked for, but it is hoped that thereafter also will arise a desire by the insured population to preserve their natural teeth more carefully than in the past, and the cost of fillings would in that case be a material item in future expenditure on conservative work.

8. It is doubtless true that the effect of dental treatment will be reflected in generally improved health, but those who seem to anticipate an almost

immediate return in this way for their expenditure on dental treatment are, to say the least, very optimistic. That the result will show itself in the end is undoubted, but it is difficult to produce demonstrably clear evidence that what has so far been done by some societies has already provided them with a return. One must, it is felt, be content to "wait and see" a little longer.

9. The N.I.B.S. has assisted about 100 societies of all types, some large, others small in size, to administer dental benefit.

10. Previously to the coming into operation in July, 1921, of schemes under section 97 of the 1911 Act, the N.I.B.S. circularised all the qualified dentists on the Register and asked their acceptance of a scale of fees of a more remunerative character than those prevailing among various well-known institutions then giving dental treatment. About 1,200 qualified dentists expressed their willingness to accept the scale, and, at the beginning of July, 1921, therefore, societies operating through the N.I.B.S. were able to administer their schemes.

11. As a result of the success of the N.I.B.S. with its scale, the B.D.A. issued an official scale of fees for National Insurance work of a substantially more expensive character, and sought to induce those dentists who had joined the N.I.B.S. panel to secede therefrom. The effort was unsuccessful; but in the course of the contest between the N.I.B.S. and the B.D.A. a request was made to Mr. Rockliff (through a member of the Metropolitan Branch of the B.D.A.) that he would see Mr. Lindsay, the Dental Secretary of the B.D.A., and endeavour to effect a compromise. The suggested interview took place and eventually there was agreed between the N.I.B.S. and the B.D.A. the scale which (with various modifications since agreed upon) is the scale to which most Approved Societies conform at the present time.

12. Towards the end of 1921 Mr. Rockliff (acting for the N.I.B.S. and the Joint Committee of A.S.) convened a conference in London of societies operating dental benefit; this was followed by a combined conference with representatives of all the dental societies, and therefrom was formed the Joint Committee which has since controlled the administration of dental benefit to insured persons; has settled the specification of workmanship and materials to be provided for the scale fee; has provided a system of dental referees; has established a method of disciplinary control of dentists; has arrived at an agreement on the subject of clinics; has agreed, as occasion required, modifications of the scale and extensions of its period of operation; has disposed of questions arising on the interpretation of the scale; and has appointed arbitrators to settle points arising between societies and dentists on the working out of the scale.

13. Since July, 1921, the N.I.B.S. has issued (directly and through societies) approximately 35,000 dental letters. Many thousands of these have not progressed beyond the estimate stage.

14. The following information is given as the experience of particular societies.

(1) *Society A.*—Membership of a type where (by reason of occupation) dental treatment is desirable, if not absolutely essential.

July, 1921–July, 1923—Letters issued ...	1,730
No action taken on letter ...	189
Estimate obtained, but member's proportion unpaid ...	187
	376
Work authorised ...	1,354
	1,730

Extent of grant given: whole of treatment plus half the cost of denture.

Proportion of applicants not treated, nearly 22 per cent.

In same society, for 14 months, 5th July, 1923, to 5th September, 1924, the figures were:—

Letters issued ...	1,012
No action taken on letter ...	166
Estimate, but nothing further ...	148
	314
Work authorised ...	698
	1,012

Proportion of applicants not treated, 31 per cent.

(2) *Society B.*—Membership not restricted to any particular occupation. Possibly, as a class, more poorly paid than society A.

Gave dental benefit under section 21 of 1911 for about two years before July, 1921.

Thereafter gave it under section 37 of 1911 (i.e., out of surplus) till annual sum under scheme exhausted. Then continued under section 21 for rest of year.

The following figures relate to section 37 cases only:—

Period, July, 1921–December, 1921.

Letters issued to applicants ...	208
Treatment given ...	133
No effective step taken by applicants ...	75
	208

Grant: whole cost of treatment, half cost of dentures, representing 61 per cent. of cost paid by society and 39 per cent. of cost paid by member.

Percentage of non-effective applications, 36 per cent.

Women non-effectives' lower percentage than men. Period, January, 1922, to December, 1922.

Letters issued ...	437
Treatment given ...	292
Non-effective applications (30 per cent. of total) ...	145
	437

Grant: 50 per cent. of total estimate.

Period, January–June, 1923.

Applications ...	523
Treatment given ...	344
Non-effective applications (34 per cent. of total) ...	179
	523

Grant: whole of treatment, half of dentures (i.e., society paid 53 per cent., member 44 per cent., of estimate).

Per capita cost per week on membership entitled (on basis of non-effective cases being, on average, equal to cost of effective cases) = 1d.

Period, January–June, 1924.

Applications ...	673
Treatment given ...	400
Non-effective applications (40 per cent. of total) ...	273
	673

Grant: 50 per cent. of total estimate.

Per capita cost per week (on above basis) = 1 1/10d.

Per capita cost for women exceeds, that for men. This society's grant has, since June, 1924, been reduced to one-third of total estimate.

The number of applicants for the benefit is continuously on the up-grade.

The proportion of non-effective applications has increased with the reduction in the grant made.

15. The number of non-effective (i.e. non-completed) applications for benefit varies materially in relation to the extent of the grant made by the society.

16. In the case of society C, the initial grant was one of 50 per cent. of the estimate. Later on this was increased to 100 per cent., with the result that the number of completed cases was double that when the grant was one of but 50 per cent. It is fair to assume therefore that in any national (or other) scheme of dental benefit not based on a full grant, the number of applicants who would be deprived of the benefit for financial reasons would be somewhere about 50 per cent.

17. In the case of society D, where a grant of 50 per cent. was reduced to one of 25 per cent., the percentage of uncompleted cases rose from 24 per cent. to 57 per cent. The comparatively low percentage of uncompleted cases on a 50 per cent. basis in this case was due to the making of special arrangements with the dentists concerned for (a) the splitting up of the estimate into two portions, the work (and payment therefor) being undertaken in two sections, i.e., treatment and prosthetic; (b) acceptance of payment of patient's proportion by instalments.

18. On the basis of a grant of less than 100 per cent. the poorer section of the insured population would be excluded from the benefit.

19. To suggest that the dental profession should, as a condition of a national scheme of dental benefit, undertake the mass of detail book-keeping involved in the collection of small weekly instalments, the giving of receipts therefor and the incurring of the risk of bad debts would involve a material addition to the scale of fees for the accommodation, work and risk, apart from the undesirability of making a large section of the population incur debts and obligations which circumstances beyond their control may compel them to repudiate or fail to discharge.

20. A minority only of the qualified dentists on the Register have so far accepted the invitation to join the Public Dental Service Association, which is mainly composed of the "1921 dentists." The unqualified dentist is at present far below the qualified man in skill and professional honour. To bring in the great majority of qualified men into a national scheme would appear to be essential and a national scheme would probably involve a raising of the scale to (at least) the original official B.D.A. scale.

21. Any attempt to bring in dependants for dental benefit on a national basis would also materially increase the scale, inasmuch as the clientele from which the profession might hope to derive higher fees than the scale would thereby be reduced.

22. From the fact that the cost of dental benefit exceeds 1d. per week in the case of society B (not including those who failed to apply because the grant was only one of 50 per cent., and excluding also those members not entitled under section 37), and allowing a margin for an inevitable increase in the scale under national benefit conditions, it is considered that the minimum cost of a 100 per cent. benefit on an "all-in" basis would be 1 1/2d. per week. State

grant on this would be $\frac{1}{2}$ d., seven-ninths being $1\frac{1}{2}$ d. But would it remain at that figure? It is believed that dentists would prove to be very much like doctors—never satisfied. Inasmuch as it is undoubted that the present scale contains a reasonable measure of profit (seeing that dentists make dentures for institutions at lower rates, which rates cannot involve loss), the setting up of clinics in industrial areas manned by whole-time dentists would undoubtedly effect a saving of cost both to societies and patients (on a grant basis) and also to a National scheme (on a 100 per cent. basis).

23. Clinics would, however, reduce the volume of work available to individual dentists, and clinics might consequently be opposed as part of a National scheme. It has already been contended that a clinic should not charge a patient less (as his share of the cost) than if the work were done by an outside dentist, and free choice to the patient as between a clinic and an individual practitioner has been insisted upon.

24. Unless clinics were of an attractive character and care were taken as regards the staffing and the manner in which treatment was given, clinics would soon come to be regarded as Poor Law Institutions and fail of their purpose.

25. It is understood that the dental profession, in order to secure that dental benefit shall be a National (or primary) benefit under the Insurance Act, and being apprehensive that the cost of a 100 per cent. service may be thought to be financially impossible at the moment, are prepared to advocate, before the Royal Commission, the limitation of such National service to the surgical side of dentistry, *i.e.*, to exclude therefrom the provision of dentures. Approved Societies would then be faced with a toothless membership, liable to all sorts of further ill-health through want of the means of masticating food. The profession believe that this state of things would then almost immediately result in an agitation for a complete service, and that the end they have in view would thus be speedily obtained by taking two steps instead of one. There is ground for believing that neither the insured nor their societies would be content to accept this truncated form of a National Dental Service.

26. It is believed that the Ministry of Health have it in their mind to require that small societies offering dental benefit out of the surplus disclosed at the second valuation shall be required to give (six months hence) 100 per cent. of the surgical side and 50 per cent. of the cost of dentures. This idea has met with considerable support among societies generally. The dental profession have, as from 1st January, 1925, agreed that dentures should not be inserted after multiple extractions until three months from the date of the latter. In this interval the patient will be enabled, in very many cases, to save his own 50 per cent. share of the denture. It is understood, however, that certain very large societies, who believe they may not be in a financial position at their second valuation to offer (18 months hence) as much as 100 per cent. of surgical and 50 per cent. of denture, will then raise the question of the legal right of the Ministry—under section 37 of 1911—to estop a society from giving its members such dental treatment as the members may desire and as the society's financial resources may permit.

27. There appears to be ground for the view that the refusal of the Ministry to sanction a scheme on such grounds would not be upheld by the Court.

28. It is also believed that the Ministry propose to refuse to sanction schemes for dental treatment unless every dentist on the register willing to accept the society's scale of fees is allowed to perform the work. In other words, if the members of the society desire their dental treatment performed by qualified surgeon dentists and none other, the Ministry will forbid it. It is possible that the legal validity of any such refusal would be questioned by societies specially interested in this phase of the subject.

29. The requirement that a medical certificate should be furnished by an applicant for dental benefit would seem to effect no other purpose than to transfer up to 5s. from the pocket of the needy recipient of the benefit to the pocket of the doctor giving the certificate.

30. In the thousands of cases where this formality has been required at the request of societies, the N.I.B.S. is unaware of any single case in which a certificate has not been forthcoming.

31. The N.I.B.S. Incorporated has recently opened a dental clinic, equipped with the most up-to-date appliances, for the reception (*inter alia*) of Approved Society patients. It is hoped thereby to overcome the abuses which are, unfortunately, found to exist in contract dental practice, and at the same time to secure to patients:—

- (a) that no unnecessary work, or needless extraction of natural teeth, shall be performed;
- (b) the use only of the best materials and workmanship;
- (c) the services of a highly qualified dental surgeon or surgeons.

The agreed scale of fees (as modified 1st January, 1925) binds the surgeon in charge of the clinic.

An anaesthetist and nurse are attached to the clinic.

III.—OPTICAL.

32. The N.I.B.S. in 1921 issued to those whose names were published in the Calendar of the Institute of Ophthalmic Opticians, a scale of charges for optical work under the Insurance Act which was an improvement upon the charges then made by opticians for hospital work (*i.e.* for the making up of prescriptions given to out-patients), and by other institutions.

33. As a result of this offer, an invitation was extended by the Council of the Institute to the witnesses to meet leading representatives of the various optical societies. The meeting duly took place at Staple Inn. Objection was taken to the scale offered by the N.I.B.S. on the ground of its inadequacy as regards the margin of profit allowed to opticians. It was explained to the witnesses that the usual rate of profit on optical goods was 300 per cent., and that the quality of the goods and workmanship supplied in hospital work was of the poorest.

34. Negotiations followed, and ultimately, as the result of a conference between Mr. Canter of the N.I.B.S., Mr. Harcombe Cuff for the I.O.O., and Mr. J. H. Sutcliffe for the B.O.A., a Memorandum of "Points agreed upon," was drawn up between the N.I.B.S., the Institute of Ophthalmic Opticians and the British Optical Association which provided for an agreed sight-testing fee and for a defined and limited measure of profit based on the wholesale price of the goods supplied. This Memorandum of agreed terms was initialled by Mr. Harcombe Cuff (*see* copy in Appendix B), but was almost immediately afterwards repudiated by Mr. Sutcliffe. In the meantime, however, a circular had been drafted for issue to the optical profession setting out the essential features in the agreed Memorandum.

35. The National Association of Opticians thereupon accepted the agreement, and have since loyally carried out the same. The same terms were and still are open to any individual opticians, even though not connected with the N.A.O., and many members of the I.O.O. and B.O.A. are quite content to work under it.

36. Mr. Sutcliffe subsequently, through the formation of a body styled "the Joint Council of Qualified Opticians," sought to induce opticians to refrain from performing work for the N.I.B.S., in which campaign he has proved unsuccessful. In the course of this campaign he formulated a scheme under which opticians were to provide "utility" glasses in steel frames at 10s. 6d. (spherical lenses only) including sight-testing; but if the patient required anything better, either in the shape of lens or frames,

the ordinary retail charge of the optician was to apply, less 15 per cent. Societies operating this scheme pay, it is understood, the 10s. 6d. and wash their hands of any excess charged to the patient. Wholesalers are offering to the Joint Council of Qualified Opticians contract qualities for supplying to insured persons at something near 20 per cent. below first class prescription rates.

37. The N.I.B.S. supplies glasses in steel, of a quality equal to "utility," at approximately 10s. 6d. per case, if such glasses be required by the patient (which is seldom). This includes the services of a surgeon for examination and prescription. In the great majority of cases the patient requires something other than steel in the way of frames, and the charge made by the N.I.B.S. is then very considerably below that which the optician would ordinarily make to a customer, *i.e.*, a sight-testing fee of 6s. 6d., plus the wholesale price of the goods supplied increased by about 10 per cent. only. As between the N.I.B.S. and the J.C.Q.O. a considerable saving is effected by societies operating through the former.

38. If it be proper to insist that societies shall permit every dentist to perform dental work under the Insurance Act, it would be difficult to apply a different principle to opticians, and undoubtedly any attempt to give a monopoly of insurance optical work to any one body would be resisted.

39. The N.A.O. was founded in 1910 and is an examining body. The section of the examination relating to the recognition of ocular diseases required for the Fellowship Degree, is conducted by Dr. P. Eldon Gorst, Hon. Ophthalmic Surgeon to the Birkenhead Eye Hospital and the St. Paul's Eye Hospital, Liverpool.

40. The number of members of the N.A.O. is about 900, of whom between 300 and 400 are Fellows. Included in the membership are some 70 members holding the diplomas of the S.M.C. and B.O.A.

41. On an average, members of the N.A.O. have had about 20 years' actual experience in the optical business.

42. A claim has recently been put forward by the medical profession that no optician should be allowed to prescribe optical benefit to insured persons, unless such persons had been first examined by an ophthalmic surgeon, or by some medical man, panel or other, who claims to possess knowledge and experience as regards diseases of the eye.

43. It is said, in support of the medical contention, that 5 per cent. of all persons requiring glasses are suffering from a disease of the eye which would pass undetected by an optician, however qualified as an optician he might be; that a further 45 per cent. possess diseases of the eye which the optician can discover, and that the remaining 50 per cent. would not be suffering from any disease of the eye, but merely require a correction of vision which the optician would be perfectly qualified to undertake. In reality, therefore, the claim of the medical profession is that the whole 100 per cent. of claimants for optical benefit should be compelled, in the first instance, to see a doctor, in order that the 5 per cent. amongst them who possess diseases of the eye, not ordinarily patent to an optician, might be ascertained and properly advised or treated.

44. For examining each person in the 100 per cent., the medical fraternity propose to charge one guinea, although admittedly their intervention in 50 per cent. of the cases would be needless and would constitute money thrown away.

45. As regards the 45 per cent. where the disease could and should be detected by the optician, the optical scheme of the N.I.B.S. provides that in any case of doubt, presumption, or evidence of optical disease, the optician shall refer the case back to the N.I.B.S. for surgical examination, the optician receiving exactly the same fee for referring the case back as if he had, in fact, found no evidence of disease and had issued a prescription with the necessary measurements, etc.

46. The British Medical Association have recently advertised for claimants among the medical fraternity for the privilege of charging the aforesaid guineas. The applicant has apparently only to allege that he has made a study of the subject and has had some practice therein. It would seem to be anything but difficult for a panel practitioner to put forward a claim to be included in the list which the B.M.A. is compiling and which, it is understood, at present includes 200 persons, of whom 70 are said to be available in London. Refraction and retinoscopy have already been held to be outside the contract of service entered into by panel medical men with Insurance Committees; that is to say, it is a service which general medical practitioners as a class are ordinarily incapable of rendering. Any panel doctor who claims to be possessed of skill in ophthalmology may therefore refuse to render that service to an insured person unless the latter is prepared to pay the doctor a fee for the service.

47. There are about 1,400 doctors on the panel in the County of London, and during the past 12 years less than 20 have claimed to possess skill in this direction and have notified the Insurance Committee of their having made a charge to the patient in respect thereof.

48. It is believed that the charge hitherto made has been materially less than one guinea, and more generally 7s. 6d. or 10s. 6d.

49. The County of London possesses one-sixth of the insured population of England, and assuming an equal proportion in other industrial areas of panel doctors claiming to be possessed of skill in ophthalmology, it would follow that the number of doctors on the panel possessing this skill is little (if any) more than 100.

50. It is true that there may be specialists in the treatment of the eye outside the ranks of panel medical men, but even so, on the basis of the figure of 200 given by the B.M.A. the number is quite inadequate to deal with the whole insured population, a large proportion of whom may be actual or potential applicants for optical benefit.

51. Moreover, an insured person who would, in the normal course, even if there were no Insurance Act, consult an optician if he believed himself to be in need of glasses, would be quoted a fee by the optician which in many cases, inclusive of the examination, prescription and glasses, would be less than one guinea.

52. In most cases therefore the insured member applying for the benefit would consider that he had had no financial relief in the procuring of glasses through his society. The only practical method of meeting in some degree the medical view as to examination and at the same time meeting the question of cost necessitated thereby would be to establish clinics in populous centres at which well-known ophthalmic surgeons would attend on a time basis of remuneration, which remuneration could then be distributed over the number of cases dealt with during the period of time covered by the surgeon's fee.

53. The N.I.B.S. Incorporated established, some two years ago, an Optical Clinic in London and secured the services of a London (West End) Ophthalmic Surgeon as Principal.

54. The Surgeon-in-Charge is remunerated on a basis which enables one guinea to be distributed over three patients. He is limited to 12 patients per session of two hours.

55. Societies who administer their optical benefit through the N.I.B.S. and who possess members in London are thereby enabled to obtain examination of their members by an exceptionally qualified ophthalmic surgeon at a fee of 7s., which includes the giving of a prescription.

56. If the surgeon feels that he would like to see patients more than once, no extra charge is made in respect of such additional attendance.

57. The clinic has been fitted up with all the most modern instruments under the supervision of the Surgeon-in-Charge and the electric lighting has been specially adapted for the purposes of the clinic.

58. It has been found from practical experience that the policy of giving appointments to patients for attendance during their working hours cannot advantageously be pursued, involving, as it would, in many cases, a loss of working time and of putting employers to considerable inconvenience.

59. The clinic is therefore opened three or four times per week from 5 p.m. until 7 p.m. After the patient has been examined and prescribed for by the surgeon, he or she is seen in an adjoining room by a qualified optician. The patient is then invited to select the type of frame desired and the necessary measurements are taken.

60. The basis of the optician's charge is the wholesale price, plus approximately 10 per cent. The society is then informed of the cost of the service, including both the surgeon's and the optician's fee, and on receipt of authorisation to proceed the latter makes up the prescription and forwards the goods to the insured.

61. Should the surgeon in the course of his examination of the patient discover cases where an operation is necessary, he makes (either directly or through the N.I.B.S.) arrangements for the admission of the patient to an Institution where the operation is performed.

62. In cases where a provincial optician refers the case back to the N.I.B.S. for surgical opinion, the patient is invited to attend upon the nearest qualified ophthalmic surgeon for examination and report.

63. It is true that the surgeon's fee in such cases is calculated upon a single case basis which may not be less than the guinea asked for by the B.M.A., but it is rarely that that figure is exceeded.

64. The N.I.B.S. is quite prepared to place its services at the disposal of Approved Societies generally for the setting up of optical clinics in urban centres, subject to its being assured of the support of societies with a sufficiently large and well distributed membership to permit of the clinic being maintained by such a degree of business as would justify the engagement of an ophthalmic surgeon or surgeons in the area on a time basis of remuneration. The N.I.B.S. is not an association carried on for profit.

65. A grant of less than the full amount of the optical service results in a number of patients requiring the benefit not being able to acquire the same by reason of their inability to provide their share of the cost.

66. Although the percentage of applicants so situated is less than in the case of dental benefit, yet the number of cases involved was such that it became necessary to require the Approved Society to undertake liability for the surgical examination whether glasses were subsequently provided or not, or, alternatively, that the insured person should pay a deposit sufficient to cover his or her share of the surgeon's fee.

67. It requires little demonstration that an allowance of 5 per cent. to societies for the administration of optical benefit is inadequate to cover the cost of the printing and postage involved, to say nothing of the clerical work attaching thereto.

68. Moreover, as concerns those cases where the patient cannot complete the matter, no allowance whatever accrues to the society for administration.

69. As regards this particular benefit, the service rendered by the N.I.B.S. to Approved Societies is rendered at a loss to the N.I.B.S.

70. (N.B. The Surgeon-in-Charge of the N.I.B.S. Optical Clinic has expressed his willingness to attend

with the witnesses before the Royal Commission, in case the members of the Commission desire to put to him any questions on the subject.)

IV.—NURSING.

71. Nursing as an additional benefit has been a comparative failure.

72. The N.I.B.S. took the initiative in 1921 in the setting up of a Joint Committee composed of representatives of Approved Societies and of the Queen Victoria Jubilee Institute for Nurses, and, as the result of the setting up of that Committee, a scheme of visitation nursing for insured persons was organised.

73. The area covered by the Queen Victoria Jubilee Institute is about 80 per cent. of the whole country, and in all but a few areas Nursing Associations affiliated to the Queen Victoria Jubilee Institute have been willing to work on the basis of the agreement arrived at.

74. In a few areas, a higher fee than that agreed upon with the Queen Victoria Jubilee Institute is required by the local Nursing Association.

75. The agreement with the Queen Victoria Jubilee Institute is as follows:—

- (a) The payment of 1s. 4d. per visit up to 30 visits and thereafter 5s. per week. If, however, after the 30th visit, the number of visits paid would, at 1s. 4d. per visit, come to less than 5s. per week, then the 1s. 4d. per visit continues to apply. The N.I.B.S. operates this scheme.

There is, in addition, an allowance to the nurse of 5s. for attendance upon an operation.

- (b) The payment of 1s. per visit by the society, the Nursing Association having the right to collect 4d. per visit from the patient. This scheme is operated mainly by Industrial Assurance Approved Societies.

A nursing voucher covering 10 visits is issued; at the end of 10 visits a further voucher has to be obtained before the society's liability is extended.

Under both (a) and (b) the society retains the right to terminate its liability for nursing at any time in any particular case, and to terminate its liability under the agreement by six months' notice.

76. In its original form the agreement provided for a rebate to be made by the local Association to the patient if the latter were contributing to the Association under any local scheme for the provision of nursing. Towards the close of the negotiations, this clause was dropped in view of objections raised by certain Associations affiliated to the Queen Victoria Jubilee Institute. The dropping of this provision has very materially affected the agreement.

77. In very many parts of the country there exists an arrangement under which for a contribution paid to the Nursing Association by the industrial section of the community, nursing is secured for them when needed.

78. The insured persons who have made this provision, finding that no financial benefit accrues to themselves by bringing the Approved Society into the matter, simply exercise their right under the local nursing scheme to require the attendance of the visiting nurse.

79. The latter apparently takes little interest herself in notifying the Approved Society that she is nursing a member of that society, although, as the result of such notification, payment may accrue from the society to the Association which would assist in the provision of additional remuneration to the nurse. The secretaries of the local nursing associations also pay little heed to the possibilities of the agreement in providing financial assistance for the extension of their work.

80. It is believed that, as regards 1923 for instance, only 12 per cent. of the amount set aside for nursing was expended in that year. Most societies have found the amount of money set aside for nursing to be more than is required for that purpose and have utilised it for the provision of benefits which appear to be more frequently called for.

81. A society of nearly half-a-million members spread all over the country which had set aside £5,000 for the nursing of its sick members, finds only about £2,000 to be required each year.

82. In a society whose members are largely centred in London a whole-time nurse is engaged by the society and every applicant for sickness benefit is informed that nursing can be provided, if required, or if advised by the doctor.

83. Experience has shown that nursing was desirable and has resulted in a speedier recovery of the patient, with a consequent saving to the benefit fund, in a considerable number of cases. Rarely, however, has the doctor attending the patient taken the initiative in advising that the nurse be sent for.

84. Should the case appear to be one which the society's Health Visitor considers might be benefited by skilled nursing, the Visitor notifies this to the society and thereupon its nurse is instructed to call and to put herself into touch with the member's medical adviser.

85. Where the patient appears to be outside the range of the whole-time nurse's area, a visiting nurse is provided by the society under the Queen Victoria Jubilee Institute scheme.

86. One cause of the failure of nursing as an additional benefit is the fact that in a very large percentage of cases where continuous nursing is desirable, it is provided in hospitals and other institutions to which the patient is removed. One of the societies administering its nursing benefit through the N.I.B.S. instituted an enquiry as to the apparent failure of the benefit in the case of its own members.

87. An examination of the results of that enquiry showed that where nurses had not been sought or provided for its members, the larger percentage were institutional cases and not home-nursing cases.

88. The accommodation available to the industrial population in their homes practically prohibits resident nursing.

89. From the experience of the past three years no society could justify the payment of a capitation fee for nursing in respect of the whole of its membership.

90. The most that societies are likely to continue to do under schemes following the second valuation is to set aside a sum which, on past experience, will enable them to pay for the nursing of members where the same is required and applied for.

91. As regards the 20 per cent. of the country not covered by the Queen Victoria Jubilee Institute, local nurses are found by the N.I.B.S. through associations not affiliated to the Queen Victoria Jubilee Institute, and, where these latter do not exist, the doctor concerned in the case is asked to recommend a person possessing capabilities which in some measure enable her to undertake the nursing.

92. Here again it requires little demonstration that the cost of administering nursing benefit on a per attendance basis cannot be met on a 5 per cent. allowance.

V.—HOSPITALS.

93. The N.I.B.S. in 1921 took the initiative in getting into touch with the British Hospitals Association with a view to securing in-patient treatment for insured persons, and, in the result, a joint committee formed of representatives of Approved Societies and of members of the Executive of the British Hospitals Association was set up.

94. The arrangements made by societies with the hospitals are two-fold. Under one arrangement a definite sum is paid per week of in-patient treatment. In other cases, the sum set aside by the society is divided amongst the hospitals each quarter in proportion to the number of members of the society treated in the institution during the quarter.

95. It was agreed that the payments made by the society should not prohibit the hospital from claiming further financial assistance from the patient if the latter were in a position to afford the same.

96. Evidence was adduced that, on the average, an in-patient cost the hospital about £4 per week. It is believed that the grant made by no society exceeds £1 ls. per week per patient.

97. In view of the fact that very many insured persons are sent as out-patients to voluntary hospitals by the panel doctor, there would seem to be ground for reconsidering the refusal of the right to societies to assist their members with respect to out-patient treatment.

98. The relief which panel practitioners obtain by transferring insured persons to the out-patient wards of hospitals, would seem to entitle the latter to some consideration in the distribution of the money provided for medical benefit under the Insurance Act.

VI.—CONVALESCENT HOMES.

99. The financial importance to Approved Societies of affording Convalescent Home treatment to those who have been or are upon their benefit funds is considerable. It shortens the period of recovery and helps to build up the body against a relapse. The N.I.B.S. has entered into arrangements with many Convalescent Homes throughout the country for the reception of its patients; in addition to which it makes annual payments to a number of institutions which undertake (in consideration of the payment) to reserve a number of beds exclusively for the reception of cases sent to them by the N.I.B.S. This latter arrangement has proved of exceptional value to societies inasmuch as it has materially shortened the waiting period which would ordinarily have had to be undertaken, especially in the summer months, before a case could have been received. The result has been to save the society many payments in sickness benefit and has removed the patient from local conditions which would have operated against rather than in favour of recovery.

100. In reserving beds in this way a certain financial risk has been incurred by the N.I.B.S. inasmuch as, although the beds can be kept filled during the spring, summer and autumn there is a disinclination on the part of patients to enter a Home in the winter months. The financial risk thus undertaken has been somewhat lessened by loading the charge made to societies in respect of accommodation provided during those months of the year when claims for such accommodation are at their height.

101. It is believed that most societies give convalescent home benefit free, that is to say, without making any call upon the patient's sickness benefit. Indeed, in many cases, where the member finds a difficulty in meeting the cost of travelling to the home, the society either pays the whole or a proportion of the cost of travelling, in addition to the cost of the accommodation.

VII.—SURGICAL INSTRUMENTS.

102. In the ordinary course a society operating this benefit itself would be compelled to purchase, or to permit its member to purchase, the instrument required from a retail house. The N.I.B.S., on the other hand, has been able to make arrangements with wholesale firms in the surgical instrument trade, and the reduction in the cost of the article is passed on to the society. Surgical instruments may cost but a few shillings, as in the case of trusses elastic stockings, &c., or may run into many pounds.

as in the case of artificial limbs. Whilst simple trusses could doubtless be provided as part of medical benefit from the stock usually kept by chemists, even these instruments sometimes require to be specially made. The patient making a claim for a surgical instrument is invited to call upon a well-known firm in his locality for examination and measurement, is then invited to provide his own share of the cost and, on receipt thereof, authority is given to the firm by whom the goods are made and the goods dispatched to the patient.

103. Trusses undoubtedly constitute the article most frequently required under this benefit, but where artificial limbs are concerned, great difficulty is often experienced by the patient in providing his share of the cost. Under this benefit, as under other treatment benefits, there are quite a number of cases where everything has been done except the actual ordering of the goods, and then it is found that the patient is financially unable to complete the matter.

104. The percentage of such cases is, however, less than in the case of dental benefit; possibly because the instrument is in most cases a necessity for the purpose of continuing at work, whereas dental treatment, although its non-provision may gradually undermine the health, is not, at the moment, a disabling condition.

105. As regards this benefit also (the majority of cases representing a few shillings), the cost of administration cannot be met on a 5 per cent. allowance.

VIII.—MESSAGE AND ELECTRICAL TREATMENT.

106. This is now frequently medically recommended both by hospitals and panel practitioners following some other treatment or (it may be) operation. It has proved itself of great value in cases of neuritis. Societies have hitherto been unable to provide it for their members except through the medium of section 21 of the 1911 Act, but its provision has been a source of profit to the Benefit Fund, as the cost of the treatment, though charged to that fund, has resulted in a saving to the same fund in sickness benefit greater than the cost of the treatment. Its inclusion within the list of additional benefits which may be given (or towards which monetary grants may be given) by societies out of surplus is overdue. The same may be said of means for securing the provision of X-ray photographs, blood-tests, &c., which are often advised in the course of medical treatment, but which the insured is unable himself to procure.

APPENDIX A.

COPY OF MINISTRY OF HEALTH FORM A.S. 131/P. 15.

Particulars of Accounts for the Year ended 31st December, 1923, in respect of each non-cash additional benefit included in Society's Scheme.

Please state separately for each non-cash additional benefit:—

	£	s.	d.
(a) (1) Amount normally available for year			
(2) Balance (if any) brought forward from previous year ...			
(3) Amounts (if any) transferred from sums available for any other non-cash benefits ...			
(4) Total amount available for the year 1923			
(b) (1) Amount actually spent by the Society on benefit during 1923 (exclusive of charges for administration either by the Society or by the N.I.B.S.) ...			

(2) Amount of sums (if any) recovered during 1923 from members by way of repayment	£	s.	d.
(3) Amount debited to Additional Benefit Account and credited to Administration Account for 1923			
(4) Total net amount expended on the benefit (including administration)			
(c) Balance carried forward to the year 1924 in respect of the Additional Benefit Account			
(d) Number of claims covered by (b) (4) above			
(e) (1) Approximate total membership as at 31st December, 1923 ...			
Men			
Women			
Total,			
(2) Approximate number of members as at 31st December, 1923, entitled to participate in scheme of additional benefit...			
Men			
Women			
Total,			
(f) (1) Cost in pence per head of total membership in 1923 represented by (b) (4) above ...			
(2) Cost in pence per head of membership entitled in 1923 to additional benefits			
(3) Cost per head of members who received the benefit represented by (b) (4) above ...			

APPENDIX B.

INSTITUTE OF OPHTHALMIC OPTICIANS.

Staple Inn Buildings,
London, W.C.1.

Secretary:

Mr. J. HARCOTTE CUFF, F.S.M.C.

Assistant Secretary:

Mr. F. T. GREGG, M.A., F.I.S.

OPTICAL TREATMENT CONFERENCE.

Points agreed upon at a Conference held on Wednesday, the 2nd November, 1921, between Mr. G. W. Canter, representing the National Insurance Beneficent Society, Mr. J. H. Sutcliffe, representing the British Optical Association, and Mr. J. H. Cuff, representing the Institute of Ophthalmic Opticians, and upon which it is suggested an agreement may be made between the three societies represented.

1. The N.I.B.S. will send all members of Approved Societies connected with it, who desire optical treatment, to opticians holding one or more of the diplomas of the Spectacle Makers' Company or the British Optical Association, and to them only.
2. The service to be rendered only by opticians actually holding the diplomas of the S.M.C., or the B.O.A., and the person doing the sight testing shall sign any certificate or document required by the Society with the addition of the initials or full description of his membership of those bodies or of the I.O.O.

3. The N.I.B.S. will give the insured person the opportunity of selecting the optician to whom he shall go, and wherever possible will give effect to the wishes expressed.
4. The N.I.B.S. will pay a fee of 5s. for each person sent and (where glasses are supplied) the price of the glasses. All glasses to be charged at the prices set out in a Standard Prescription List to be agreed upon by the N.I.B.S., the B.O.A. and the I.O.O.
5. All accounts to be paid monthly, and in consideration of the fact that the glasses are to be supplied at list price the N.I.B.S. undertakes that all prices shall be strictly confidential between the Society and the optician.
6. The optician shall be free to see the patient by appointment.
7. Any dispute under this agreement shall be referred to a committee consisting of an equal number of representatives of the opticians, appointed by the B.O.A. and the I.O.O., and of the N.I.B.S.

(Signed) J. H. C.

APPENDIX XIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE BRITISH DENTAL ASSOCIATION, BY MR. JOHN H. BADCOCK, L.D.S., M.R.C.S., L.R.C.P., MR. ERNEST T. RICHARDSON, L.D.S., AND MR. BRYAN J. WOOD, L.D.S. See Minutes of Evidence of the Eighteenth day, Questions 9209 to 9461.

The British Dental Association desires respectfully to submit to the Royal Commission certain observations on the subject of dental treatment with particular reference to:—

- I. The nature and extent of dental treatment at present available under the National Health Insurance Acts.
- II. The need for a wide extension of dental treatment and for its establishment as a permanent benefit under an amended Act.
- III. The nature and extent of the dental service which would most economically and efficiently supply the required extension of dental treatment, as an addition to the medical benefit or of any modification of that benefit under amendments of the National Health Insurance Acts.

I. PRELIMINARY AND EXPLANATORY.

Efforts of the British Dental Association to Provide Treatment.

1. The need of dental treatment for the industrial classes has been keenly appreciated by the British Dental Association for many years. Long before National Health Insurance was projected, individuals and groups of its members were endeavouring to organise schemes of provident dental aid under which those persons who could not afford private dental fees might obtain skilled dental treatment upon such terms as they could afford. The Brighton and District Public Dental Service, established in 1907, and the Reading Public Dental Dispensary, opened in 1913, are examples of these efforts. Following upon the passing of the Act of 1911 and independently of State support or recognition, a scheme for a Public Dental Service to be available for all persons coming under the wage limit of the National Health Insurance Act was drawn up and preparations were made for making dental treatment available under it in all parts of the country.

Reasons for Discontinuance of Scheme.

2. The outbreak of the European War prevented the realisation of this project. Prior to the passing of the Dentists Act, 1921, the dental profession in this country numbered less than 6,000. So many dentists were called up for active service first as combatants and later as commissioned dental officers, that the dental service to the civilian population was depleted beyond the possibility of any attempt to institute the dental service projected in 1913. Services which had been established prior to and during the early years of the War in such centres as Bournemouth, Brighton, Bedford, Birmingham, Bristol, Glasgow and Reading, and other places, were largely used in giving dental treatment to

soldiers enlisted under the Kitchener scheme prior to the ultimate establishment of dental treatment in the Army, and thereafter were for the most part given up.

Scheme Revived after First Valuation.

3. When, after the termination of the War, the first valuation of the funds of Approved Societies (which but for the War would have been made in 1915) was actually completed, and certain Approved Societies which had surplus funds submitted schemes for providing additional benefits to those of their members entitled to participate in these benefits, the British Dental Association proceeded to call meetings in all parts of the country which every dentist then upon the Register was invited to attend, with the object of organising panels of dentists who would undertake to treat persons insured under the National Health Insurance Act.

Reasons for Change of Control.

4. While the British Dental Association, as the only existing professional body capable of doing so, thus voluntarily undertook in the public interest, the trouble and expense of inaugurating the formation of these dental panels, it was impossible for it to assume the organisation and control of the movement inasmuch as the composition of such panels was not limited to its own members, but included any registered dentist who wished to join. The panels so formed soon felt the need for co-operation and for uniformity of action and control, and in December, 1922, combined to form themselves into the Public Dental Service Association of Great Britain, Limited.

5. The Public Dental Service Association now numbers nearly 7,000 members, and comprises among them dentists holding academic qualifications and many placed upon the Register pursuant to the provisions of section 3 of the Dentists Act, 1921.

6. Its organisation is such that in almost every part of the country where dental treatment is required there exists, so far as the personnel of the panels is concerned, ample provision for that treatment. The system has now been in operation for two years and has worked as satisfactorily as could be expected of a new and untried scheme.

7. While the British Dental Association does not deal directly with the details of the administration of the service, it retains a close and intimate interest in the general policy. Long experience in dealing with all questions of dental policy and in the preparation of schemes for all kinds of public dental service, and its position as representative of the qualified members of the profession, give it peculiar authority in such questions, especially as it does not act exclusively in the interests of its own members but in the interests of the dental profession as a whole and of the public welfare.

THE NATURE AND EXTENT OF THE PRESENT DENTAL TREATMENT GIVEN AS ADDITIONAL BENEFIT AND OTHERWISE UNDER THE NATIONAL HEALTH INSURANCE ACTS.

The Nature of Dental Treatment.

8. Dental treatment comprises all dental operations; but the treatment at present required by the majority of insured persons is the extraction of diseased teeth and the provision of artificial dentures. As the effect of dental care of the rising generation during the school age becomes evident, conservative work should take an increasingly important place.

Persons entitled to Dental Treatment.

9. Inasmuch as dental treatment is not a permanent benefit under the National Health Insurance Act, it is only available for certain of the members of those approved societies which possess surplus funds available for additional benefit and which have selected dentistry as an additional benefit.

Limitations of Present Treatment.

10. Moreover, the interest of the patients has been affected by the unexpectedly large demand for dental benefit. Societies were required to set aside a definite sum of money for each additional benefit selected, to be expended over a given period of years. At first certain societies undertook to pay the entire cost of the dental treatment, but later, on account of the large number of claims on the limited funds available, it was found necessary to reduce the grant to one-half the cost, and in many cases a still further reduction of the part of the fee paid by the society took place. This left the patient responsible for so large a portion of the dentist's fee that in very many cases he or she was unable to find the money and had consequently to give up the claim.

Further Defects of the Present System.

11. When, therefore, the statement is made that about seven millions of insured persons are entitled to participate in dental treatment at present, an erroneous impression may be created unless it be borne in mind that on account of the position referred to in the previous paragraph, the numbers who actually receive the benefit are very much smaller. Adolescents joining societies which give dental treatment as additional benefit are not eligible for such treatment when they join but must wait a variable number of years before they become entitled to the benefit, thus losing the advantage of dental treatment at the very age when it is most needed and would do the greatest amount of good. It is evident also that the conditions referred to in paragraph 10 are bearing hardly on the poorer members of the societies possessing surplus funds, that cases where urgent dental treatment is necessary as a health measure are delayed to the prejudice of the patients, or may have to be abandoned altogether, and also that dental treatment is altogether denied to all members of societies which have not shown a surplus, as well as to deposit contributors, all of whom must be presumed to need such treatment no less than their more fortunate fellows.

Present Organisation a Source of Delay and Expense.

12. It is necessary to draw attention to the fact that as the expenditure of the surplus funds shown on valuation is entirely in the hands of the individual societies possessing them, dental benefit, as well as other additional benefits, is arranged for separately by each society. Members of very many approved societies are widely scattered over all parts of Great Britain and it consequently happens that when, for instance, an English society has a member in some remote part of Scotland, extensive correspondence may be necessary with the headquarters of his society in England before that member can obtain dental treatment; similar conditions hold with respect to Scottish societies having members resident in England. The average insured person shrinks from correspondence of this nature, and thus the overlapping and multiplication of organisation in such cases is a hindrance to the prompt settlement of claims, as well as a source of additional expense.

Complete Arrangements of Dentists.

13. While the arrangement on the side of the dentists is remarkably complete, and capable of dealing effectively with a very large extension of the present service, it is evident that the amount of treatment available under present conditions is quite inadequate to meet the need.

Present Scheme Experimental.

14. It would appear therefore that the possibilities of benefit from dental treatment as at present given are limited by the conditions under which the treatment is made available; that the most that can be said about the present service is that it has afforded opportunity for the experimental testing of a means of supplying dental treatment and has demonstrated that the members of Approved Societies are eager to take advantage of such facilities for dental treatment as have so far been provided.

Panel Arrangements for Treatment.

15. Under the panel system the person desirous of treatment is furnished by his Approved Society with a list of the dentists in his neighbourhood. From this list he selects the dentist of his choice, and, armed with an authority from the society, visits him at his ordinary consulting rooms, and gets an estimate of the cost of the treatment required. This estimate having been approved by his society, the treatment is undertaken by the dentist and charged for according to a scale previously agreed upon between representatives of Approved Societies and of dentists.

16. Payment of the whole or some proportion of the fee is made by the society to the dentist; for the remainder the dentist must look to the patient.

17. The present system of dental panels organised on a territorial basis could with comparatively little alteration be adapted to any expansion of dental treatment. The existence of these panels over a period of years has familiarised a large number of members of the dental profession with the general organisation of such a service, and the fact that 7,000 dentists have voluntarily taken part in this work is itself a guarantee that, given satisfactory conditions, there would be no difficulty in staffing such a service.

The Clinic System.

18. Under the clinic system, the patient attends, not at the dentist's private consulting rooms, but at an institution specially organised for the purpose.

Two kinds of Clinics.

19. A public dental service clinic as understood by dentists has in the past been an institution managed by dentists, set up at the expense of dentists at which they attended at specified hours and saw those patients who wished to consult them or other cases in rotation. The institutional expenses were a first charge on the fees. The dental profession favours this type of clinic.

20. There is a conception of the clinic which is becoming common as premises fitted up by some body such as an Approved Society where whole-time salaried dentists are employed, where the control is not in the dentists' hands. The dental profession is opposed to this type of clinic.

Respective merits of the Two Systems.

21. The arguments for and against these systems may be stated briefly thus:—

The clinic system permits of the handling of large numbers where a continuous supply of patients is assured, as in the Army, but is impracticable in sparsely populated districts. It is claimed that it ensures economical working and provides easy facilities for supervision and inspection of the work done; but it to some extent tends to limit freedom of choice of dentist on the part of the patient. The clinic system also involves considerable capital expenditure in setting up the clinics.

22. The panel system on the other hand is readily adaptable to supply either small or large demands for treatment; it facilitates free choice of dentist.

The expense for premises or equipment is not a direct public charge. Its main disadvantage is that it is difficult to ensure adequate supervision and inspection, although this might be overcome by the institution of a system similar to that employed by the Ministry of Pensions for the inspection of dental treatment for pensioners or to that at present in operation with reference to medical benefit by means of regional medical officers.

23. A careful consideration of these two different methods seems to suggest that the panel system may be the most suitable, generally, over the greater part of the country for the dental work involved in a scheme of permanent dental benefit; but it is to be noted that the only form of clinic approved by the British Dental Association for adult dental treatment is a clinic staffed by dentists working on a part time basis and under professional control.

Special arrangements would require to be made for such sparsely populated districts as the Highlands and Islands of Scotland.

II. THE CASE FOR A WIDE EXTENSION OF DENTAL TREATMENT AND ITS ESTABLISHMENT AS A PERMANENT BENEFIT UNDER THE AMENDMENT OF THE PRESENT ACTS.

Justification of Extensive Scheme.

24. The case for a wide extension of dental treatment as an essential part of National Health Insurance must rest upon the benefit which such treatment would confer on the national health. Recognition of the harm which dental disease causes, both locally and constitutionally, is no longer confined to the healing professions; it has become a commonplace of the lay press and is widely appreciated by the general public. The Report of the Departmental Committee on the Dentists Act (Cmd. 33, 1919), the Report of the Departmental Committee on Sickness Claims (Cmd. 7087), the Annual Reports of the Chief Medical Officer to the Ministry of Health and to the Board of Education, and the Report of the School Medical Officer to the London County Council, extracts from which form an appendix to this Statement, prove the case for a wide extension of Public Dental Service up to the hilt.

Bad Dental Conditions a Menace to Health.

25. To the dangers to health resulting from the presence in the mouth of diseased teeth as impairing mastication, there must also be added those still greater dangers due to oral sepsis. All recent and contemporary medical and dental literature may be appealed to as evidence of the serious nature of the danger to health and to life which the present condition of the teeth of the nation entails, and it points to the tragic error involved in any plan of campaign against national disease and physical unfitness when what has been aptly described as one of the chief outposts of preventive medicine is neglected.

Benefit of Dental Treatment.

26. The present scheme of dental treatment as an additional benefit has been in force for too short a time to show from statistics of sickness returns any conclusive evidence of the effect of dental treatment in reducing the incidence of illness among insured persons; but certain statistics prepared by Mr. Alban Gordon, Secretary of the United Women's Insurance Society, are interesting in this connection. The United Women's Insurance Society has offered dental treatment to its members since 1915, under a scheme based upon the provisions of section 26 of the National Health Insurance Act, 1924. With a view to ascertaining the effect of this provision of dental treatment upon the incidence of illness among members of the Society over seven years, the Secretary has divided the illnesses recorded into two groups. In the first group, called "Dental illnesses," were placed those illnesses most commonly associated with bad dental conditions, such as anæmia, dyspepsia, gastritis and other gastric complaints and rheumatism; and into the second group, termed "Other illnesses," were placed all other causes of incapacity recorded.

Statistical Evidence.

27. Taking the incidence of sickness in each group for the year 1915 as 100, the falling ratio is shown in the following table for each of the years to 1922:—

	Dental illnesses.	Other illnesses.
1915	100	100
1916	86	89
1917	81	91
1918	64	77
1919	59	70
1920	57	71
1921	59	82.5
1922	56	89

28. These figures are not exact; they can only be accepted as approximate. But they show remarkable results. A fall of 44 per cent. as recorded for 1922, in the incidence of illnesses commonly associated with bad teeth during a period in which dental treatment was given, justifies the acceptance of that treatment as an important cause of the fall, and this is emphasised by the fall of 11 per cent. shown in the incidence of "Other illnesses." Even here we are justified in saying that healthy mouths capable of discharging their proper function as a result of dental treatment were a factor in the decrease of the incidence of sickness recorded. What that 44 per cent. fall represented in increased happiness, in freedom from pain and therefore in industrial efficiency, in saving of working hours which would otherwise have been lost to the worker and the nation, as well as in the monetary saving to the funds of the society, is not difficult to judge.

General Testimony to Benefit of Dental Treatment.

29. While it is difficult to obtain statistical evidence proving the beneficial effects of dental treatment upon the general health, the testimony of general medical and dental practitioners as to the benefit which has followed with almost magical effect in individual cases upon proper dental treatment, is a commonplace of professional experience. Employers of labour who have established dental clinics for their workpeople are unanimous in testifying that, philanthropy apart, the treatment pays in increased efficiency of the worker and diminished loss of working hours through indisposition. The case as regards the individual is established. It may therefore be accepted that similar results will follow with reference to the health of the mass of insured persons following upon the institution of a comprehensive scheme of dental treatment organised on lines similar to those on which medical benefit under the Acts are organised.

Economy in Health and Money.

30. Great as have been the benefits to the national health resulting from the institution of medical benefit under these Acts, there can be no question that a properly organised scheme of dental treatment as an adjunct to the original medical service would have resulted in even greater improvement; incidentally such a service would have been the means of saving large sums of money expended in the supply of drugs employed in the palliative treatment of digestive and other disorders as well as a substantial part of those sums paid in sickness benefit.

Dental Treatment Preventive in its Constitutional Effect.

31. When looked at from the standpoint of the promotion of health, dental treatment, even when of an operative or curative nature, may be really preventive in its effects on the incidence of illness; but in addition to provision for the treatment as set forth above it is strongly urged that a very definite part of any dental scheme should be a carefully devised and strongly pressed scheme of propaganda in oral hygiene designed, by timely advice to prevent those septic conditions of the mouth and teeth so common at present. This policy, in conjunction with an adequate school dental service, may be confidently expected in a comparatively short period to effect a marked reduction in the necessity for tooth extraction and the fitting of artificial dentures. It will certainly also reduce the expense of medical treatment and of sickness benefit in the future.

III. THE NATURE AND EXTENT OF THE DENTAL SERVICE WHICH IT IS PROPOSED SHOULD BE INSTITUTED AS PART OF AN AMENDMENT OF THE NATIONAL HEALTH INSURANCE ACTS.

The Remedy not Extended Additional Benefit.

32. From what has been said as to the inadequacy of the present provision of dental treatment as an additional benefit, it will be obvious that the desired effect on the general health of insured persons cannot be secured by any extension of the present system resulting from increase in the funds available as a result of the second valuation at present in course of completion.

33. The greater amount of money available may permit Approved Societies to pay a larger proportion of the dentist's fee and thus reduce, or entirely eliminate the hardship on their poorer members, to which reference has been made in paragraphs 13 and 14; but it has to be remembered that not all the members of the fortunate societies are entitled to participate in these surplus funds, and even were they all brought in, there would still remain the case of the members of those other societies which on valuation show no surplus, whose members, paying the same contribution as their more fortunate fellows, see themselves denied similar privileges. There are, in addition, the large classes, including the dependants of insured persons, who are, at present, entirely outside the scope of the Act.

A Complete Service.

34. A complete scheme would include: (1) Dental treatment at Maternity and Child Welfare Centres; (2) Treatment during school age; (3) Treatment for adults and their dependants under an insurance scheme. The more efficient (1) and (2) become, the less the need will be for (3), and the greater the gain to the nation in money, health, and happiness. Such a scheme as applied to the adult population is to be found in the National Health Service outlined in the Interim Report of the Consultative Council on Medical and Allied Services (Cmd. 693) presented to the Minister of Health in 1920, in which provision is made for dental treatment at the primary and secondary centres proposed to be set up under that service.

Dental Benefit should be Permanent.

35. Whether such procedure as is indicated above be adopted or no, it would appear from the proved necessity for dental treatment, if the benefits of medical treatment are to be effectively realised, that in future dental treatment should be a permanent benefit co-extensive with medical benefit and administered on the same general principles. The logical conclusion points definitely to the inclusion of dental treatment as a permanent benefit under an amended Act in which dependants of insured persons would participate in the benefits.

Administration.

36. It may be presumed that in considering the conditions under which dental benefit could be introduced into the scheme of National Health Insurance, the precedent of medical benefit will be followed; that similar care will be taken to secure to the insured person that free choice of dentist which is essential in the relations of the professional man and the patient; that dental benefit will be administered by the body which administers medical benefit; and that there will be adequate dental representation on the Insurance Committees or other bodies controlling the administration of that benefit.

Scope of Suggested Treatment.

37. The scope and nature of the treatment which would be necessary under such a scheme as is here recommended may be briefly defined as follows:—

The extraction of teeth under local or general anaesthetics.

The scaling of teeth and the treatment of inflammatory conditions of the mouth.

The filling of cavities in carious teeth.

The provision and repair of partial and complete artificial dentures.

A Dental Health Service.

38. These operations have been found to include all that is ordinarily required for the purpose of promoting health. In addition, there would continue in the future, as at present, provision for the use of any materials or the performance of any operations which the special nature of particular cases rendered necessary.

The Immediate Future.

39. It would be foolish, however, to ignore or to attempt to minimise the fact that adult dental treatment for some considerable time must consist largely of the extraction of septic teeth and roots and their replacement in due course by artificial substitutes. This has been the experience with reference to the dental treatment of pensioners under the Ministry of Pensions scheme, and it is, at present, the experience under the scheme of dental treatment as an additional benefit.

Public Attitude towards Dental Treatment.

40. The improved dental methods available and the emphasis which has been laid in recent years on the importance of dental treatment as bearing upon health, have effected a great change in the attitude of the public towards it as is proved by the manner in which the claims under the present scheme of additional benefit have progressively increased. This, taken in conjunction with the fact that dental disease is so generally prevalent among the classes from which insured persons are drawn, makes it certain that the demands under any scheme of permanent benefit would be large until the effects of an extended system of school dental treatment began to be felt. It has also to be borne in mind that the dental requirements of deposit contributors, dependants of insured persons and other uninsured classes whose need is equally great must be taken into account.

Cost of a Complete Scheme.

41. While, therefore, the British Dental Association recommends that dental treatment as set forth in paragraphs 32 to 36 as a permanent benefit to the extent defined in paragraph 37 be given to all insured persons as a necessary part of any adequate National Health treatment and also recommends that such treatment should be extended to dependants of insured persons and others unable to afford dental treatment by private dental practitioners in the degree to which, by amendment of the present Act, medical benefit is so extended; it is recognised that the cost of such a scheme, under present conditions, may be found prohibitory to its complete installation in the immediate future.

The Only Effective Remedy.

42. The British Dental Association desires again to repeat that the first and urgent necessity in the interests of the health of the nation is a complete school dental service staffed and organised so that every school child during its entire school age has dental treatment of a preventive and curative nature available, and that this service should be linked to and follow on an equally complete scheme of dental treatment for children under school age and for expectant and nursing mothers. In time this will render such dental conditions of the adult population as set forth in the Report of the Departmental Committee on the Dentists Act impossible by checking the tendency to dental disease at its source, and will materially reduce the cost and alter the nature of the dental treatment of the future; it will also do away with the necessity for much of the present medical treatment and sickness benefit.

43. Until these services are effectively organised, adult dental treatment of the industrial classes must remain chiefly a matter of extraction of septic teeth and the insertion of dentures, which is a perversion of the highest requirements of public health and an outrage on common sense.

Selective Treatment.

44. Should considerations of expense make such a scheme as that set forth above impossible of adoption in its entirety at the present time, it might be modified so that dental benefit should include (a) operative treatment only (viz., extractions, anaesthetics local and general, scaling, treatment of inflammatory conditions of the mouth, and fillings not involving the pulp), with entire exclusion of the provision of artificial dentures; (b) operative treatment and such dentures as might be certified by the competent authority as necessary for health or vocational reasons; (c) operative treatment with part payment for dentures.

45. By some such means of selection the primary requirements of health might be assured, and the benefit given could be extended in its degree, or modified in its nature, to meet future requirements as a result of experience.

46. Inasmuch as it is recognised that the question of cost must enter very largely into the consideration of any scheme for the extension of dental benefits, the British Dental Association will be prepared to place at the disposal of the Commission all the evidence which it can obtain upon the subject, both as regards the remuneration of the dentist and the cost of such treatment to the State.

47. What has been aimed at is to demonstrate the necessity for the extension of dental treatment to the industrial classes of the community, to show the inadequacy of the present provision of that treatment, and to suggest means whereby it may be extended and improved, and the Association will be prepared to support and to extend by oral evidence the case outlined in this Statement.

APPENDIX SHOWING:—

- (1) The constitutional diseases and defects associated with bad dental conditions;
- (2) The beneficial effects of dental treatment;
- (3) Recommendations.

THE CONSTITUTIONAL DISEASES AND DEFECTS ASSOCIATED WITH BAD DENTAL CONDITIONS.

1. Extracts from the Report of the Departmental Committee on the Dentists Act (Cmd. 33), Section V.—Dental Disease in Relation to the Health of the People.

Para. 55. The British Medical Association: ". . . a considerable economic loss arises from the effect of dental disease owing mainly to the reflex influence thereof on the general bodily health, particularly through digestive trouble and resulting anæmia. The effect is most noteworthy in women."

Para. 56. Report of Departmental Committee on Sickness Benefit Claims: "It is stated that the absence of any provision for dental treatment—which, it may be observed, is a possible additional benefit in the event of a society realising a surplus—has produced much sickness of various kinds resulting in a drain on the sickness benefit funds, which would have been avoided had there been provision for the treatment of teeth. Inattention to teeth results in certain cases in prolonged gastric illnesses, and in a very large group of cases, on which benefit is being paid, no permanent cure is possible until the teeth have been attended to. Even in the event of decayed teeth being removed, there is ground for believing that there is no sufficient means by which artificial dentures can be supplied to insured persons, either gratuitously or at a reduced cost."

Para. 57. Questionnaire issued to Approved Societies: "(1) Have you had cases brought to your notice in which neglect of teeth trouble has led to ill-health? (2) In particular, has your attention been directed to the following diseases being attributed to or aggravated by defective teeth? (a) Anæmia. (b) Gastric troubles. (c) Debility. (d) Tonsillitis. (e) Neurasthenia. (f) Rheumatism."

Para. 58. Replies from Approved Societies:—

Prudential Approved Societies (membership 3,000,000): "Neglect of teeth trouble is the cause of quite half of the ill-health found among the industrial classes, and of these a large majority in young women. "The chief sequelæ of dental caries and oral sepsis are found to be (in the following order of importance): (a) General debility (the starting point); (b) anæmia (especially in young women); (c) rheumatism, including premature senility, myocardiac and arterial degeneration (in older people, especially men); (d) gastric troubles, including chronic gastritis and ulcer, appendicitis and chronic constipation; (e) neurasthenia."

National Federation of Women Workers (membership 20,000): "The absence of provision for dental treatment under the National Health Insurance Act has resulted in many claims upon the Sickness Benefit Funds of the Society. Many claims would never have been made, while a still larger percentage have been prolonged in duration by the fact that the member has been unable to obtain dental treatment prescribed as necessary by the panel doctors."

Para. 59. Replies from Insurance Committees under the National Insurance Act, 1911: "I am directed to state that there is a definite relation between 'uncared for' mouths and pulmonary tuberculosis. Unsound teeth and septic conditions of the mouth predispose to tuberculous infection and render recovery more difficult when the disease exists. The experience of the Sanatorium Benefit Sub-Committee is that very many consumptives recommended for benefit have need of dental treatment."

Replies to the like effect were received from the Aberdeenshire Panel Committee, the County of Durham Insurance Committee, the Birmingham Panel Committee, the Edinburgh Insurance Committee, and the Manchester Insurance Committee.

Para. 65. Chief Medical Officer to the Board of Education: "The gravamen of dental defect is its secondary result. Dental sepsis is associated with four effects—(i) tooth caries, (ii) periodontal inflammation (pyorrhœa), (iii) conditions due to dead teeth or irregularities or abnormalities of denture, (iv) the collection of tartar and mucopurulent matter in the denture. Obviously, these conditions vary widely in degree and prevalence. Here, too, the gravity of the condition is its secondary result, the absorption of toxine and so forth.

The principal secondary results of dental disease in children, often appearing subsequently, are as follows:—

- (a) The inflammation, pyorrhœa and ulceration of the gums, leading to diseased conditions of the mouth and to glandular infection. Many medical and dental authorities hold that even tuberculous infection may be established in this way.

- (b) General malaise of the child, tiredness, lassitude, depression—in fact, a toxic neurasthenia.
- (c) A group of microbic intoxications which in some cases lead to joint affections simulating rheumatism in its symptoms.
- (d) Various forms of anæmia.
- (e) There is a group of somewhat mysterious and remote results of dental disease which leave their mark on the skin (acne, urticaria, eczema, etc.), affect the eyes (recurring iritis) or ears, and dispose to nervous disorders.
- (f) There is a large group of alimentary toxæmia or gastro-intestinal conditions traceable to continued dental sepsis.

Further, it must not be forgotten that many cases of adolescent and adult mal-nutrition or dyspepsia are due to loss of teeth in childhood."

Para. 67. Memorandum received from the Army Council: "The loss of man power to the State owing to defective dentition can best be gauged from a comparison of medical and surgical cases in hospital. It will be noticed that men returning sick show 25.4 carious teeth, as compared with 6.4 only of wounded, and 4 sound teeth only as compared with 17.6. Of the 304 medical cases examined, 160 are according to the medical officers suffering from troubles directly attributable to defective teeth; e.g., gastritis and indigestion, and from 60 to 70 from troubles indirectly so attributable; e.g., rheumatoid arthritis, rheumatism, etc."

2. Extract from the Report of the School Medical Officer to the London County Council for 1923.

Page 5. Teeth. "The grave amount of oral disease in the eight-year-old children appears to account for the poorer figures for nutrition which that group invariably yields in comparison with the others."

THE BENEFICIAL EFFECTS OF DENTAL TREATMENT.

3. Extract from the Report of the Departmental Committee on the Dentists Act (Cmd. 33): Section V. Dental Disease in Relation to the Health of the People.

Para. 58. Domestic Workers' Friendly Society (Membership—women only—63,000): "A number of patients, after the completion of dental treatment, have stated that they

have been much improved in health thereby. Many of these had been undergoing medical treatment for various complaints, but stated that this only gave temporary relief."

4. Extract from the Report of the School Medical Officer to the London County Council for 1923 on the results of dental treatment.

Page 6. "Between 1913 and 1923 the proportion of twelve-year-old boys with apparently sound teeth had increased from 50 per cent. to 67.7 per cent., while that of those with extensive caries has diminished from 10 per cent. to 2.7 per cent. A corresponding improvement is shown by the girls."

RECOMMENDATIONS.

5. Extract from the Report of the Departmental Committee on the Dentists Act (Cmd. 33): Section X. —Dental Treatment under the National Health Insurance Act, 1911.

Para. 126. Resolution of the Executive Committee of the Association of Approved Societies representing over 2,000,000 insured persons. "In view of the fact that much of the sickness for which Approved Societies are called upon to pay sickness benefit arises directly or indirectly from dental trouble, and of the report of the Chief Medical Officer to the Board of Education, that a very large proportion of children leaving school need dental treatment, this Association of Approved Societies considers it of the utmost importance that a Public Dental Service should be instituted in every locality, adequate treatment being available for all who need it, irrespective of their financial position."

Section XII.—A Public Dental Service.

Para. 142. Recommendation of the Departmental Committee: "The provision of an adequate dental service to meet the existing needs is impossible at present owing to the shortage of dentists, but your Committee are strongly of opinion that, simultaneously with the enforcement of prohibition of unqualified practice, the nucleus of a public dental service should be set up in populous areas for the treatment of dental disease, and that dental treatment by such a service should be available for persons needing it free of charge. We think that the service should be established as a definite branch of Public Health work and should be entrusted to Public Health Authorities."

APPENDIX XX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE BRITISH SOCIETY OF DENTAL SURGEONS BY SIR FRANK COLYER, K.B.E., F.R.C.S., L.D.S., PRESIDENT, AND DR. E. W. FISH, A MEMBER OF THE COUNCIL OF THE SOCIETY, See Minutes of Evidence of the Eighteenth Day, Questions 9462 to 9626.

1. The British Society of Dental Surgeons desires to present a Statement before the Royal Commission on National Health Insurance, emphasising the necessity for a Public Dental Service and indicating the lines upon which the Society considers such a scheme might be inaugurated and in due course extended. The Statement is divided into sections and describes:—

- I.—The prevalence of dental disease in the country (paras. 2-3).
- II.—The existing schemes for providing dental treatment (para. 4).
- III.—The scope of a complete scheme (paras. 5-9).

IV.—In view of the expense of a complete scheme the Society makes recommendations for an immediate scheme which could be extended as opportunity arises. (paras. 10-23).

An Appendix is added, consisting of notes on certain aspects of dental treatment in connection with the promotion of Public Health.

I.—THE PREVALENCE OF DENTAL DISEASE.

2. More than two-thirds of the whole school population show dental defects, and of these "the vast majority are still neither inspected nor treated dentally."—(Annual Report of Chief Medical Officer

to the Board of Education, 1923). Of those whose teeth are healthy during the years of school life a large number will inevitably succumb to disease later, and it cannot be disputed that dental disease is almost universal amongst our adult industrial population, as was observed amongst the recruits in the late War. The problem to be dealt with is thus one of enormous proportions.

3. *The Effect of dental disease on the health.*—Dental disease is now recognised as a most important factor in the development of many pathological processes in other parts of the body. It leads to ill-health—(1) by the constant swallowing of septic matter, which may start diseases of the gastrointestinal canal; (2) by the direct absorption of bacteria or their toxins into the blood stream. In effect, dental disease lowers the resistance of the body cells as a whole, and more especially those cells which are inherently susceptible to toxic influences.

It should be noted that the dental diseases which have the most harmful effect on the body cells are generally of a chronic type and frequently are not accompanied by pain.

II.—EXISTING SCHEMES FOR PROVIDING DENTAL TREATMENT.

4. They are:—

- (a) *Certain voluntary institutions*, such as the Surgical Aid Society, whose scope is very limited.
- (b) *School dental clinics* controlled by the Board of Education, which have already been noted to reach only a small percentage of school children.
- (c) *Dental clinics at Welfare Centres.*—The dental treatment of the expectant and nursing mother is of the utmost importance to the future population and to the well-being of the women concerned. The scheme is, however, inadequate in extent.
- (d) *National Health Insurance additional benefits scheme.*—Arrangements under this scheme for the provision of dental treatment by a panel of dentists working under the control of Approved Societies have proved inadequate and any extension thereof is likely to do so because:—
 - (i) The scheme attempts to provide complete treatment for the patient while having at its disposal very limited funds. It is only available to a few of the members of those societies which have surplus funds, and is therefore often not available to those most in need of it.
 - (ii) When dental benefits are offered the cost of treatment has still largely to be defrayed by the patient, who often cannot afford this and so has to forego the benefit.
 - (iii) The control of the service by Approved Societies is irksome to the practitioners concerned. This lay control has led to attempts to influence treatment by adjusting the fees payable for certain types of service and to other abuses which could not be tolerated by any profession (e.g., the distribution of work by insurance agents).

The remedy is to make dental benefit a statutory benefit under the Act and to exclude the approved Societies from any control over it.

III.—THE SCOPE OF A COMPLETE SCHEME.

5. The appalling prevalence of dental disease and the miseries incidental to it in individual cases naturally lead to the consideration of schemes to deal

with this evil. Although an ideal scheme may be impossible at the moment, it is worth considering in order that such steps as prove practicable may follow the right lines and allow of orderly development in the future.

6. *Prevention.*—The prevention of dental disease is of far greater national importance than remedial treatment, and prophylactic measures should have the first consideration. It is admitted that public interest is not so easily aroused in prophylactic as in curative schemes but there are signs that the longer view is gaining more general acceptance than hitherto. An ideal scheme should therefore act boldly on the principle that prevention is better than cure.

Dental disease is in a great measure due to the stagnation of food debris about the teeth, the food-stuffs mainly responsible being starches and sugars. During recent years the consumption of sugars has increased by leaps and bounds and the starches have been prepared in a manner which renders them more liable to adhere to the teeth.

Foodstuffs, too, are now prepared in such wise that a lessened degree of mastication is required, and therefore the cleansing action and stimulating effect of chewing food is lost.

7. *Propaganda and the necessity thereof.*—We are of opinion that effective prevention of dental disease can be brought about by educating the public on the action of the various foodstuffs on the teeth. This could be accomplished by lectures, by pamphlets and by enlisting the assistance of voluntary and other health agencies, such as educational bodies, &c.

8. *Remedial treatment and inclusion of dependants.*—In this connection it is important that the public should be instructed as to the necessity of regular visits to the dental practitioner so that disease, if present, can be treated in its earliest stages.

If the greatest amount of good is to be obtained from the least expenditure, it would seem necessary that dental treatment be available from the early years of childhood; and, further, it is important that the dental authority responsible for the treatment of the pre-school child should also be responsible for the treatment of school child and adult. It would also be a distinct economy to the State and simplify the administration if all the dental services for which the State is responsible could be co-ordinated under one scheme instead of being undertaken by several and different authorities.

We are therefore of the opinion that it is of the utmost importance that the wives and children of the insured be included under the National Health Insurance Scheme as dependants as soon as funds become available, but we realise the inadvisability of this step at present.

This unification of control would appear to be more satisfactory than any elaboration of dental treatment at Child Welfare Centres and at School Clinics, though of course dental inspection might still be carried out at these places, and instruction given in dental hygiene.

9. *Nature of remedial treatment.*—In order to provide for the conservative treatment described above and also to remedy those serious dental conditions which arise when early conservative treatment has been neglected it would be necessary to arrange for the following:—

Fillings.—To check the progress of dental caries.

Scalings.—To remove accumulations of tartar and other septic matter from the teeth.

Extractions.—Where teeth are hopelessly infected or when indicated in order to prevent overcrowding with consequent disease and deformity.

Anæsthetics.—For the performance of painful operations such as extractions.

Dentures.—To replace teeth lost but only where such appliances are absolutely essential.

It is fully recognised that the institution of a scheme providing such extensive treatment is at present economically impossible, but it seems advisable to formulate it in order to obtain a clear conception of the ultimate goal of such measures as it may be possible to proceed with at the present time.

IV.—RECOMMENDATIONS FOR AN IMMEDIATE SCHEME.

10. General considerations.—It is suggested that the scheme to be described in this section could be undertaken at once and is capable of orderly development towards the complete scheme already outlined. It might be included in a revision of the National Health Insurance Act making dental treatment a statutory benefit. The immediate object of the measures suggested is the establishment of the "Clean Mouth," or, in other words, the elimination of pain and septic absorption from the mouth.

In general the administration advocated follows that of the National Health Insurance Acts, and it is felt to be of importance that dental benefit should be associated as closely as possible with all other forms of medical benefit.

Prevention being of necessity a matter of propaganda, it will involve methods to which Insurance Committees, etc., are largely unaccustomed, but there is no reason to suppose that they are anything but adequate to deal with them. The cost of the treatment provided and of subsequent extensions of such treatment will be very greatly reduced if suitable propaganda can be put in hand at once. When the oral tissues have become deeply infected, radical and very expensive treatment is the only possible procedure, but in practically all cases disease can be prevented by comparatively simple and cheap methods.

11. Prevention.—Money spent on prevention yields far greater return than money spent on treatment.

This means propaganda and has already been mentioned. It would require that a certain amount of the sums available should be set apart for this purpose, and these sums should be a first charge on the general fund. The exact form of propaganda should be decided by the Ministry of Health and the Dental Board of the United Kingdom, in consultation with the Central Dental Committee referred to later.

12. Persons to be entitled to benefit.—In view of the fact that in the majority of individuals irreparable and easily preventable damage has been done to their teeth before they become old enough to be insured, it is, as we have said, of the utmost importance to extend dental benefit to the dependants of insured persons as soon as possible. It is, however, felt that at first it would be wise to restrict treatment to insured persons until the experimental stage has been passed.

13. Scope of benefit.—There are no statistics available upon which it is possible to base an estimate of the cost of full dental treatment including extractions, scaling, fillings and dentures but the average estimate under the present scheme has amounted to some four pounds per head of those who have received the benefit and as practically all of the 15,000,000 insured people require treatment, even leaving out of account their dependants, such sums would be required each year as are not likely to be available. It is suggested therefore that the sums to be provided should be expended in securing (a) propaganda (b) extraction of tender or hopelessly infected teeth under suitable anaesthetics and (c) scaling of the remainder.

A service restricted in this way would be directed solely toward the eradication of infection from the mouth and would not be concerned with æsthetic details. Such a service would be of immense hygienic value and would at the same time afford a means of estimating how much technical skill is available for contract practice, and would provide a sound basis for extensions.

14. Cost of the scheme.—This might be estimated approximately if figures of the average number of extractions required by soldiers in 1914-1918 are available since in their case also the amount of treatment given was reduced to a minimum though fillings and dentures were provided. If we suppose that at first only one in ten persons would apply each year for treatment and that they would require an average of six extractions and the remaining teeth scaled, a capitation fee of approximately 3s. per insured person would cover the cost of treatment plus sixpence for administration and propaganda. Provision would, of course, have to be made for revision of these amounts if necessary at an early date.

Steps must be taken, however, to ensure that such treatment as is given under the scheme is paid for entirely out of Insurance funds and does not leave a proportion of the cost to be paid by the patient direct.

15. Source of funds.—The State will make such provision as it sees fit, but presumably contributions will be obtained by weekly payments from the same source as at present. According to the above estimate the sum of a halfpenny a week would be required from the insured person and a halfpenny a week from the employer, the surplus to be allotted as explained later for anaesthetics.

16. Payment to dental surgeons and dentists could be made either by capitation fee or in accordance with an agreed scale of fees, but as the administration charges would be much higher where a scale of fees is employed and only a certain sum would be available in either case it would be to the advantage of all concerned to have payment by a capitation fee which would also obviate the necessity of much private clerical work.

17. Administration.—There seems to be no reason why this should not be effected through the Insurance Committees and great saving would result from utilising existing machinery. If these Committees should be abolished there would no doubt arise in their place others as well able to administer dental benefit.

(a) *Local Dental Sub-Committees.*—These would be directly elected sub-committees of panel committees consisting of dental surgeons and dentists and possessing very full powers. We consider that some such arrangement is necessary in order to ensure the fullest co-operation between medical and dental services, a co-operation which we believe to be essential to the future development of public health service of all sorts.

(b) *Central Dental Committee.*—There should be set up a Central Dental Committee which would consist entirely of representatives of Local Dental Sub-Committees. All negotiations would take place with this body which would become the statutory representative of all dentists participating in the service.

18. Formation of panels of dentists.—These should be formed as are medical panels and should be included in the same publications on view at Post Offices.

19. Free choice of dentist.—It is suggested that the patient should have absolutely free choice amongst dental surgeons and dentists willing to serve and that this should be exercised by means of the existing medical card, which would require adaptation for the purpose. It is admittedly difficult to persuade patients to choose a doctor and it is anticipated that even more difficulty would be experienced in persuading them to choose a dentist—the possibility of whose services being required is generally felt to be more remote. We therefore suggest that when a card is presented to a doctor he should ask and record the patient's choice of dentist. The dentist would then be notified by the local Insurance Committee that such and such an insured person had chosen him and would be free to accept

or refuse after any enquiry that he chose to make. When he had made known his acceptance, the name would be placed on his list and he would be provided with a dental record card for that patient.

20. Anæsthetics.—It will be necessary to arrange for general anæsthetics, particularly nitrous oxide gas, to be available when necessary for the extraction of teeth. For this purpose an addition might be made to the medical capitation fee to enable the patients to obtain the services of their panel doctors. (See para. 15 on source of funds).

21. Records.—It would be necessary for the dentist to keep some sort of record of work done. The obligation placed on all doctors to keep records has produced such unsatisfactory results that it would probably be wise to abandon this procedure and procure records only from selected dentists who would be paid extra for providing them.

22. Referees.—A strictly limited number of referees, perhaps four, would be necessary. They would act as technical advisers to Insurance Committees and the Ministry of Health and as liaison officers between these bodies and the individual dentist.

23. Discipline.—This should be exercised by a Dental Service Sub-Committee analogous to that already existing for the medical services, but where any penalty is sought to be imposed there should be the option of an appeal to the Courts or to the Dental Board, and, on the request of any accused, evidence should be taken on oath.

APPENDIX.

NOTES ON CERTAIN ASPECTS OF THE SCHEME.

24. Extent to which the benefit would be taken up.—For some little time there would be a certain amount of disinclination on the part of the insured to avail themselves of the benefit until remedial measures were out of the question and only radical treatment was possible. This could be met in two ways:

- (a) Propaganda and education would ultimately effect a marked improvement in the attitude of the people towards dental treatment.
- (b) Since only the removal of diseased teeth and the treatment of septic tissues could be undertaken at first, the public would soon realise that it was to their advantage to avoid the necessity of total extraction which would involve their purchasing dentures at their own expense or putting up with the consequent inconvenience of doing without. They would therefore seek early treatment for themselves and their children.

25. Value of treatment.—Apart from the improvement in dental and general health that would follow wise dental propaganda, the treatment suggested would eliminate gross infection from the mouth, and even in cases where the number of healthy teeth that could be retained was small the patient would be better able to eat than if he were left with diseased teeth. Moreover, patients almost invariably increase in weight and improve in health after total extraction of septic teeth even before dentures are fitted. These facts should be made widely known and form part of the education campaign.

26. Extension of the scheme.—When funds permit, the first extension of the scheme should be to include children of insured persons under the partial scheme because:

- (a) caries is very rapid and destructive in childhood and youth, while the serious effects of oral sepsis on the health of the growing child cannot be exaggerated.
- (b) if early treatment is neglected the cost of dental treatment in later years is considerably enhanced.

The next extension would be to provide fillings for children and adults, and finally it might be possible to supply dentures when necessary for the patient's health. General regulations could be framed to control the decision as to the necessity of these appliances in individual cases.

27. The formation of clinics.—It is very important that the scheme should be so framed as to allow of any practitioner undertaking the work in his private practice, as otherwise practitioners in industrial areas would be very unfairly affected. It is unlikely that clinics would be introduced while the scope of the benefit remained so limited, but if they were formed in industrial areas for the carrying out of this treatment they should be organised by the local panel committees and operated by any of the local practitioners who wished to undertake service at them. It would be objectionable to the local dentists to institute whole-time clinics run by salaried dentists.

28. The services of the dental profession.—As described in the *Dentists' Register*, the dental profession consists of qualified dental surgeons holding diplomas from the colleges or universities, and dentists, 1921, who were placed upon that register under the Dentists Act, 1921 and 1923, by virtue of being in unregistered practice for some years prior to the passing of the Act.

Of the 13,000 men on the register, some 7,000 at least have expressed their willingness to work even under existing schemes of public Dental Service, and no shortage of dental practitioners seems likely to occur in any part of the country given equitable conditions of service.

Some difficulty might at first arise owing to differences of individual interpretation of the object of the scheme and the type of treatment to be given under it. There might be a tendency to extract teeth which if treated could be made useful, but as most patients would be unable and unwilling to supplement privately the treatment available, and as the small capitation fee would tend to limit the extent of operative procedure, a standard of treatment involving the minimum sacrifice of teeth which would render the mouth comfortable and reasonably healthy would soon become established as was the case with civilian panels working for the soldiers in 1914-18.

Since it would be impossible for some time to come to include all forms of dental treatment within the scope of the benefit, it is conceivable that the patient might wish to arrange for further treatment—such as the insertion of fillings or the provision of dentures—the expense of which he or she would meet privately. It would therefore be necessary, in order to prevent misconception, to make it very widely known amongst the insured population—as, for instance, by having the fact printed on their insurance cards—that only extractions with anæsthetics and scalings were provided by their insurance, and that for the time being at least it was only possible to provide that the insured be given the opportunity of having the mouth freed from infection.

29. Alternative of capitation fee or agreed scale.—The advantages of a capitation fee are:—

- (a) The administration expenses would be far less heavy and the existing machinery (Insurance Committee, etc.) could be used very largely. If estimates for each patient had to be passed as at present is the case where treatment is an additional benefit, it would be necessary to have an Advisory Dental Officer employed for probably each 100,000 of the insured population. This would create 150 officials whose expenses would be considerable, and as they would have to be qualified dental surgeons it would divert one in forty of the qualified men from actual practice.
- (b) A capitation fee would enable treatment to be given at once if it were urgent without the delay of an estimate being sent.
- (c) Remuneration on a capitation basis would prevent the State becoming liable for

treatment that was dictated by considerations other than requirements of the health of the patient.

The objection that might be raised by the dental profession to a capitation fee is largely due to the expectation that fillings and especially dentures would be included under the scheme, and that the demand would be so great that there was no prospect of the capitation fee being adequate. As, however, it seems unlikely that such extensive provision could be made for many years, this objection would cease to exist, and probably there would be no further opposition to a capitation fee if it were realised that payment under an agreed scale could only be *pro rata* since the State could not provide unlimited funds, and that the heavier administrative expenses of this

method would have to be borne out of the funds available.

30. *Anæsthetics.*—When two dental surgeons or dentists are working in partnership it is common practice for each to administer nitrous oxide for the other's patients. To permit of this it might be possible to institute a separate small capitation fee of, say, sixpence per head, payable to either doctor or dental surgeon or dentist for dental anæsthetics and the name of the practitioner selected would then be entered in an appropriate space on the medical card. The practitioner selected might be either the panel doctor or any dental practitioner other than the one who was to undertake the ordinary dental treatment of the patient concerned.

APPENDIX XXI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE PRUDENTIAL APPROVED SOCIETIES, BY MR. E. F. SPURGEON, F.I.A., TREASURER, AND MR. R. J. MELLER, M.P., SECRETARY. See Minutes of Evidence of the Eighteenth Day, Questions 9627 to 9786.

1. There are four Prudential Societies, viz.:—
Prudential Approved Society for Men, Prudential Approved Society for Agricultural and Rural Workers, Prudential Approved Society for Women, Prudential Approved Society for Domestic Servants.

MEMBERSHIP.

2. The membership of these Societies is approximately as follows:—

Prudential Approved Society for Men	1,727,000
Prudential Approved Society for Agricultural and Rural Workers	30,220

Total number of men	1,757,220
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Prudential Approved Society for Women	1,230,210
Prudential Approved Society for Domestic Servants	230,700

Total number of women	1,460,910
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Men and women combined, total	3,218,130
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3. Extract from Rules of Society for Agricultural and Rural Workers:—

“The Society shall consist of an unlimited number of members, being insured members, who shall all be of the male sex and, except as may otherwise be determined by the Committee of Management, engaged in agricultural or rural work,”

Extract from Rules of Society for Domestic Servants:—

“The Society shall consist of an unlimited number of members, being insured members, who shall all be of the female sex, and engaged in domestic service,”

In neither of these Societies is there a rule that a member must leave the Society on change of occupation.

4. The membership in the four countries is as follows:—

Prudential Approved Society for Men:—

England	1,439,800
Scotland	197,900
Northern Ireland	23,400
Wales	65,000
	<u>1,727,000</u>

Prudential Approved Society for Agricultural and Rural Workers:—

England	22,730
Scotland	5,390
Northern Ireland	80
Wales	2,020
	<u>30,220</u>

Prudential Approved Society for Women:—

England	1,046,600
Scotland	132,160
Northern Ireland	24,050
Wales	27,400
	<u>1,230,210</u>

Prudential Approved Society for Domestic Servants:—

England	203,800
Scotland	15,320
Northern Ireland	560
Wales	10,520
	<u>230,700</u>

THE MONEY BENEFITS.

5. Tables I to III below are submitted showing the percentage of the actual to the expected sickness experience from 1919 onwards in the Prudential Approved Societies.

It is suggested that in the variations in the percentages shown from year to year (see Table I) the effect of plentiful employment and of widespread unemployment on the sickness experience can be traced.

The disablement benefit experience amongst women (see Table II) is remarkably heavy, and indicates that the allowance for this benefit in the actuarial Tables on which the valuations of Approved Societies are based is inadequate.

In 1923 the combined experience of sickness and disablement benefit amongst women (see Table III) is in every case in excess of the expected.

Table IV contains the percentage of the actual to the expected experience of claims for maternity benefit in the year 1923.

TABLE I

SICKNESS BENEFIT.

Percentage of the actual sickness benefit experience to that expected according to the tables issued by the Ministry of Health.

—	1919.	1920.	1921.	1922.	1923.
<i>Men (including Rural Workers):</i>					
England	81	69	64	71	63
Scotland	90	78	89	70	59
Ireland	108	123	99	99	—
Wales	109	83	89	99	85
All Countries	84	72	66	72	63
<i>Women (including Domestic Servants):</i>					
England	65	69	76	84	83
Scotland	70	72	76	84	80
Ireland	99	127	124	126	—
Wales	91	91	108	119	113
All Countries	67	71	78	86	83

NOTE.—For 1923 the percentage for "All Countries" does not include Ireland.

TABLE II.

DISABLEMENT BENEFIT.

Percentage of actual disablement benefit experience to that expected according to the tables issued by the Ministry of Health.

—	1921.	1922.	1923.
<i>Men (including Rural Workers):</i>			
England	57	75	80
Scotland	60	78	80
Ireland	110	151	—
Wales	73	89	104
All Countries	59	78	81
<i>Women (including Domestic Servants):</i>			
England	98	119	134
Scotland	113	132	146
Ireland	211	257	—
Wales	145	171	190
All Countries	103	124	137

NOTE.—For 1923 the percentage for "All Countries" does not include Ireland.

TABLE III.

COMBINED SICKNESS AND DISABLEMENT BENEFITS.

Percentage of the actual sickness experience (sickness and disablement benefit combined) to that expected according to the tables issued by the Ministry of Health.

—	1921.	1922.	1923.
<i>Men (including Rural Workers):</i>			
England	61	73	71
Scotland	65	74	69
Ireland	103	121	—
Wales	82	94	94
All Countries	63	75	71
<i>Women (including Domestic Servants):</i>			
England	84	96	101
Scotland	88	99	101
Ireland	157	170	—
Wales	120	136	138
All Countries	87	99	102

NOTE.—For 1923 the percentage for "All Countries" does not include Ireland.

TABLE IV.

MATERNITY BENEFIT.

Percentage of actual to that expected from the Tables issued by the Ministry of Health.

—	1923
<i>Men (including Rural Workers):</i>	
England	83
Scotland	94
Wales	91
All Countries	85
<i>Women (including Domestic Servants):</i>	
England	47
Scotland	70
Wales	64
All Countries	48

MARRIED WOMEN—SUGGESTED ABOLITION OF CLASS K.

6. The provisions of Class K. and the conditions of transfer to that class introduce into the administrative work of a society a number of details which involve trouble and expense without any corresponding advantage to the members.

It is suggested that in place of Class K. each insured woman marrying shall be offered the option of taking:

- A bonus on marriage, the payment of the bonus to terminate the contract of insurance, a fresh contract being set up (with fresh waiting periods, etc.) in the event of the member continuing in employment or re-entering employment; or
- having her insurance treated as continuous, subject to the ordinary conditions as regards "Free Year," etc.

The option should be open for four weeks from the date of marriage, and where it is not exercised within that period (whether or not this is due to the marriage not having been notified) the insurance should automatically be treated as continuous, that is, as if (b) had been selected by the member.

Table V. is submitted showing the number of women in the Prudential Approved Societies who married during the period of 4½ years and the number of these who continued in insurance as employed contributors and the number who were transferred to Class K.

Table VI. shows the number of women transferred to Class K. and the number and proportion of these who claimed sickness and maternity benefit respectively.

TABLE V.

MARRIED WOMEN.

Return of Marriages of Insured Women during the period July, 1918 to December, 1922.

	Number of Marriages.	Continuing as employed contributors.		Transferred to Class K.		Transfers to other societies, Gone Abroad, Deaths, &c.
		Number.	Percentage.	Number.	Percentage.	
England	251,535	43,173	17·16	208,188	82·76	174
Scotland	25,531	1,647	6·45	23,871	93·49	13
Wales	7,808	419	5·36	7,386	94·59	3
Ireland	4,530	1,347	29·73	3,179	70·17	4
Totals	289,404	46,586	16·09	242,624	83·83	194

TABLE VI.

CLASS K BENEFITS.

Period July, 1918, to December, 1922.

	Number transferred to Class K.	Claiming sickness benefit.		Claiming maternity benefit.	
		Number.	Percentage.	Number.	Percentage.
England	208,188	14,302	6·86	126,493	60·75
Scotland	23,871	1,860	7·79	16,955	71·02
Wales	7,386	407	5·51	5,006	67·77
Ireland	3,179	552	17·36	2,058	64·73
Totals	242,624	17,121	7·05	150,512	62·03

APPROVED SOCIETIES.

7. The administration of money benefits requires very close supervision by Approved Societies and their representatives, and in view of the results which have been achieved, it is suggested that the value of administration by societies has been abundantly proved.

Considerable importance is attached to the competitive spirit introduced by the existence of a number of societies anxious to demonstrate, by efficiency of organisation and management, that they can administer these benefits so as to provide the greatest possible advantage to their members.

SCHEME FOR DEALING WITH TREATMENT BENEFITS.

8. It is suggested that treatment benefits should be rendered available for all insured persons, and not, as at present, provided to members of some societies and not to others.

The plan suggested is, briefly:—

- (1) that a portion of each weekly contribution be transferred to the existing Central Fund;
- (2) that the first charge on this fund shall be those deficiencies which are not due to maladministration and which are not entirely met by Societies' Contingencies Funds;
- (3) that the Central Fund shall be maintained at a minimum figure of £1,500,000;
- (4) that the remainder of the Central Fund shall be divided amongst Approved Societies in proportion to the number of members; the amount received by each society to be applied solely in providing members with treatment benefits (in particular, dental treatment) in accordance with a scheme to be approved by the Minister of Health.

9. The transfer of a portion of each weekly contribution will apply to the contributions of all insured persons and will, consequently, at a valuation of a society, either

- (a) reduce the surplus;
- (b) convert what would otherwise be a small surplus into a deficiency; or
- (c) increase the deficiency.

10. On the other hand, the Central Fund will be increased to a very large amount and, as mentioned in paragraph 8 (2) above, the first charge on this Fund will be the wiping out of deficiencies.

11. The amount of each weekly contribution diverted to the Central Fund must not be too large, but must leave an "average" society with a prospect of showing a surplus at valuation which can be applied solely for the benefit of its own members; in other words, the society should be in such a position that its members will derive material benefit from efficient organisation and administration.

12. On the basis of 15,000,000 insured persons and 48 contributions per person, $\frac{1}{4}$ d. per contribution would produce the sum of £1,500,000 per annum.

13. It is also suggested that in order to provide funds for meeting the heavy demands for dental treatment that would arise during the first few years, this deduction of $\frac{1}{4}$ d. per contribution might be made retrospective to the beginning of 1919 and the amount for the five years 1919-1923, without interest, drawn from the funds of societies before the results of the second valuation are ascertained. This would result in setting up a fund at the commencement of about £7,000,000.

14. All payments from the Central Fund for treatment benefits should carry the State grant.

15. There should be only one Central Fund for all the four countries, England, Scotland, Wales and Northern Ireland.

CENTRAL INDEX COMMITTEE.

16. It is recommended that there shall be one Central Index Committee to deal with the indexes of Insurance Committees in England, Scotland and Wales.

VALUATION UNITS.

17. The option to combine Countries, which have been valued separately, into one Valuation Unit, should again be granted to societies and should remain open, provided that, in order to take effect for any particular valuation, such combination must be decided upon not less than 12 months before the valuation date.

APPENDIX XXII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE PUBLIC DENTAL SERVICE ASSOCIATION OF GREAT BRITAIN, LIMITED, BY COL. C. H. HOWKINS, C.B.E., D.S.O., M.R.C.S., L.D.S., MR. J. CLIFFORD WING, L.D.S., MR. A. H. CONDRY, AND MR. P. I. WIGODER, L.R.C.P. & S., L.D.S., *See Minutes of Evidence of the Nineteenth Day, Questions 9787 to 10,060.*

The Public Dental Service Association of Great Britain, Limited (which will be hereafter alluded to as "The Service"), presents the following statement on:—

- I.—Dental disease as affecting the public health and the necessity for a Public Dental Service.
- II.—The present agencies providing public dental treatment under the National Health Insurance Acts and otherwise, and
- III.—The proposed organisation which would afford a complete Public Dental Service for the provision of dental treatment as a statutory benefit under the National Health Insurance Acts or modifications thereof.

I.—DENTAL DISEASE AS AFFECTING THE PUBLIC HEALTH AND THE NECESSITY FOR A PUBLIC DENTAL SERVICE.

1. Before proceeding to state the organisations which at present supply such public dental treatment as is now given, and to suggest the extension of such treatment, it is necessary to establish the claim of national necessity for the maintenance and extension of public dental treatment. The Service (whose members number approximately 7,000 dental practitioners) regards the great benefit to national health which would result from the dental treatment of the population as self-evident. It cannot, however, be expected that such a view, due to their professional acquaintance with the results upon health from the neglect of necessary dental treatment and the benefits which accrue from its proper employment, can be accepted without evidence by any but a purely professional body, and the Service therefore submit the following considerations in support of the necessity of public dental service.

2. The claim that such a service is necessary can only be based upon the benefit which dental treatment confers on the national health, both (a) in the prevention of the diseases which directly or indirectly result from neglect of the teeth, and (b) in the improvement in the health and increased general efficiency of the persons so treated.

Evidence of the vital importance of dental treatment, both in the young and in the adult, will be found in the reports of Public Health Authorities, and in the opinions of the medical profession and the Medical Press.

One of the most convenient summaries of this evidence which the Service ventures to present to the notice of the Commission will be found in the Report by the Departmental Committee of the Privy Council appointed to inquire into certain matters connected with the practice of dentistry in the year 1917, which Report is embodied in Cmd. 33 of the year 1919.

3. The sources of the evidence on which the Committee in question based their conclusions were:—

- (1) The Chief Medical Officer of the Board of Education,
- (2) Medical Officers of Health.
- (3) The Approved Societies under the National Insurance Act, 1911; and other sources.

The evidence may be divided into two parts.

- (a) That which establishes the evil effects of dental neglect, and
- (b) That which establishes the extent to which dental neglect is prevalent among the population.

As regards (a) the effect of dental neglect was summarised by the Chief Medical Officer of the Board of Education as follows:—

Pyorrhœa and ulceration of the gums leading to unhealthy conditions of the mouth and glandular infection.

Tiredness, lassitude and depression.

Microbic intoxications leading to affections of the joints, simulating rheumatism.

Various forms of anæmia.

Certain results of dental disorder leaving their mark on the skin, i.e., acne, eczema, etc., and affecting the eyes or the ears and disposing to nervous disorders.

A large group of gastro-intestinal conditions traceable to continued dental infection.

Malnutrition and dyspepsia.

The evidence of the Approved Societies as to the effects of dental neglect on the health of insured persons was summarised as being the cause of "half the ill-health" found among the industrial classes, especially among young women. The results of dental decay and oral inflammation were found to be

General debility.

Anæmia.

Rheumatism.

Gastric diseases, including chronic gastritis and ulcer, and chronic constipation.

Neurasthenia.

4. As to (b) the evidence as to the condition of the teeth of the masses of the people was derived largely from the reports of the Board of Education as to the condition of school children, and from the reports as to the condition of the adult male population, taken from examination of the dental condition of men on joining the Army.

The results can only be arrived at by means of percentages, and although in many classes the percentage is even higher, a conservative estimate is that at least 60 per cent. of the population, children and adults, are dentally deficient and require dental treatment.

The Committee in the Report referred to, on page 23 (section 76), summarises the evidence of these questions and their views thereon as follows:—
"Having regard to the large amount of preventable sickness and chronic invalidity terminating, in many instances, in premature death which results from the effect of oral sepsis and decayed teeth, the Committee view the facts which have been brought to their notice with the gravest concern. They are of opinion that the state of affairs revealed should receive early attention with a view to the improvement of the health of the nation and an increase in its industrial efficiency."

5. To complete the evidence for the necessity of public dental treatment, it is necessary to show that in cases where such treatment has been provided there have been beneficial results in reducing ill-health among the persons so treated. That the provision of such treatment would prevent and that the absence of such treatment has caused many claims upon the sickness benefit funds of the Approved Societies is evidenced by the Report Cmd. 33 above referred to, on page 18.

In another Report of the Departmental Committee on Sickness Benefit Claims, Cmd. 7687, para. 193, is found the following passage:—"It is stated that the absence of any provision for dental treatment . . . has produced sickness of various kinds resulting in a drain on the sickness benefit funds which would have been avoided had there been provision for the treatment of teeth."

6. The statistics available at present as to the effect of dental treatment in reducing sickness among persons insured under the National Health Insurance Acts are, owing to the fact that such treatment has only recently been provided, not extensive, but such as are available, show in a striking manner a great decline in cases of illnesses among those persons for whom dental treatment has been provided.

In an article published in the "British Dental Journal," and written by the Vice-Chairman of the Service, certain statistics supplied by the Domestic Workers' Insurance Society are quoted as follows:—

"In the seven and a half years to December, 1922, the Society administered treatment to no less than 13,224 provincial members, whilst the number of attendances for treatment in London in the same period was 44,781. The number of members in those years averaged some 20,000 in London and 40,000 provincial."

"The results of the provision of effective dental treatment over the years during which the scheme has been in operation are well shown in an analysis of the benefit claims which Mr. Gordon has made, wherein he distinguishes between 'dental illnesses' (anæmia, dyspepsia, gastritis and other gastric complaints and rheumatism) and all other causes of incapacity commencing with year 1915. Taking that year as 100, the course of claims in percentages has been as follows:—

			Dental illnesses.		Other illnesses.
1915	...	...	100	...	100
1922	...	...	56	...	89

These figures, showing a most remarkable decline in illness where dental treatment is provided, are not absolute evidence that the dental treatment was the sole cause of the decline. Other factors unknown may have contributed to such decline, but it may fairly be claimed that, even after making allowance for such unknown factors, the decline evidenced by these figures strongly supports the claim for the provision of dental treatment as a preventive of other illnesses.

7. The testimony of medical practitioners is universal to the effect that the general health of individuals is enormously benefited by effective dental treatment.

8. It is unfortunate that it was found impossible to include the provision of the dental treatment of insured persons as a permanent and statutory benefit under the National Health Insurance Act of 1911.

From the evidence adduced it is obvious that the provision of such treatment would have saved a large portion of the sums expended on medical benefit under the National Health Insurance Acts by

- (a) Lessening the number of claims for medical treatment made in respect of the diseases above mentioned as following dental disease;
- (b) In reducing the amount expended on the purchase of drugs employed in the treatment of dyspepsia and other gastric affections which constitute a considerable part of the medical benefit supplied under these Acts;

and that such dental treatment would have lessened considerably the claims made on sickness benefit funds due to incapacity.

It may be urged therefore that the cost of the provision of public dental treatment would to a large extent be offset by the reduction in the necessity for medical treatment caused by the improvement in the dental condition of the populace.

9. That the Approved Societies under the National Health Insurance Acts (which are brought into the closest relationship with insured persons) are of opinion that a public dental service is necessary, and would be the cause of a considerable saving in the provision of medical benefit, is evidenced by the following resolution passed by the Association of Approved Societies and quoted on page 34 of Cmd. 33 above referred to:—

"In view of the fact that much of the sickness for which Approved Societies are called upon to pay sickness benefit arises directly or indirectly from dental trouble, and of the report of the Chief Medical Officer of the Board of Education that a very large proportion of children leaving school need dental treatment, this Association of Approved Societies considers it of the utmost importance that a Public Dental Service should be instituted in every locality, adequate treatment being available for all who need it, irrespective of their financial position."

10. The Service submits, therefore, that the results arising, and to arise, from the provision of effective dental treatment are direct, visible, tangible, practical and immediate; and that the provision of a dental service on a national basis has (apart from the vital National Services for Defence, Judiciary, etc.) at least as high a claim as many of those services now provided from public funds.

II.—THE PRESENT AGENCIES PROVIDING PUBLIC DENTAL TREATMENT UNDER THE NATIONAL HEALTH INSURANCE ACTS OR OTHERWISE.

11. The existing provision for the public of dental advice and treatment (conservative and prosthetic) is described below.

12. *Poor Law Service.*—The Poor Law Authorities are empowered to provide medical attendance and treatment for the poor and are a Public Medical Service including treatment of teeth among their other functions. It is obvious that only a very small proportion of the population are eligible for such treatment, and that no extension of Poor Law activity could provide a public service for the vast majority of persons who are not eligible for the relief administered by the Poor Law Authorities.

13. *Dental Inspection and Treatment of School Children by Education Authorities.*—Much valuable work has been done in the conservation and treatment of the teeth of children attending the State schools of the country. A certain proportion of this work will enure to the permanent benefit of the children when they have grown up. It is obvious, however, that as they pass outside the control of the public authorities after they leave school, this work, however valuable, cannot provide the necessary treatment for the young person or the adult, and it appears impracticable to provide adult treatment by means of any extension of a system controlled by authorities who, *ex hypothesi*, are concerned with child welfare only.

14. *Maternity and Child Welfare Grants.*—Under schemes submitted by local authorities and approved and subsidised by the Ministry of Health for maternity and child welfare is included all that is necessary for maintaining the health of expectant mothers, nursing mothers and children, the latter up to the age of five. Under such schemes there is power to treat the teeth of both mother and child and provide dentures. But facilities for such treatment are not universally available and, from the nature of the case, provision of such treatment only applies to, comparatively speaking, a limited class and for a limited time.

15. Other Miscellaneous Dental Services.

(1) Hospitals.

Dental hospitals afford conservative and other dental treatment of the best kind. But the number of these is few, and their scope therefore limited.

General hospitals, as a rule, mainly confine their treatment to extractions, combined, in a few cases, with the provision of dentures by means of monetary assistance from some other charitable organisation.

(2) Some charities aid in the provision of dental treatment, e.g., the Charity Organisation Society, the Hospital Saving Association, and the Ivory Cross.

(3) Some public spirited employers (for the most part corporations or large firms) provide facilities for the dental treatment of their employees at their works or factories, on a contributory or other basis. But the number of these is limited. For convenience these may be referred to as "factory clinics."

The work above referred to is, however, a very small contribution to the general body of existing dental treatment.

16. Public Dental Service under the National Health Insurance Acts.—It is not compulsory on Approved Societies to provide dental benefit under the National Insurance Acts, as it is merely an additional benefit. Only those Approved Societies which have a surplus and choose to devote the whole or part of such surplus to dental treatment do give dental benefit. They do not give dental benefit to all their members, but only to some of them, namely, to those persons who have been continuously insured since 1918, and who joined the particular society on or before July 5, 1920. Reckoning the branches of a society as separate societies, there are about 500 Approved Societies which give dental benefit, and there are about 7,000,000 persons in the country under present arrangements who are entitled to such benefit, being about half the total number of insured persons.

17. Some of these societies originally undertook to pay the entire cost of the dental treatment of their members, but, as they only have a certain amount of money to expend, they found later that they were unable to continue doing this and had to reduce the amount of their contribution in a few cases to one-half or a greater proportion of the total charge, in the majority of cases to one-third of the total charge, and in other cases to a lesser proportion, leaving the patient (the insured person) to provide the remainder. In many cases the patient, whose income is below the insurance limit, is unable to find the money for his proportion of the benefit, and has to abandon proceeding with the treatment, or forego the necessary artificial dentures required. From the experience of the Service it is known that a considerable proportion of the claims for dental treatment are not completed. Doubtless the Approved Societies from their records can establish that the percentage of those completed is relatively small. This does not take into consideration the large number of members who urgently desire treatment but do not even apply on account of the outlay involved. A certain number of cases also occur where the work is commenced but only partially completed, e.g., teeth are extracted, but the patient is unable to afford to pay his proportion of the price of the necessary artificial substitutes, and has to go without them.

It is evident, therefore, under present conditions, that for monetary reasons the number of persons who actually receive dental treatment under the Acts is very much less than the number of those needing such treatment who are entitled to obtain it. So far as the State and Approved Societies are concerned, the amount of dental treatment given is small and imperfect compared with what is really required.

18. On the other hand, the organisation of the dentists prepared to give such treatment is comprehensive, efficient, and capable of dealing with any number of patients likely to be brought within its scope.

The initial organisation was the work of the British Dental Association in 1913. That Association recognised the necessity for the provision of a dental organisation to meet such dental service as might be required under the Insurance Acts.

The necessity for improved organisation became apparent after the War, and on December 27, 1922, the Service was registered as a company, limited by guarantee, under the name of the Public Dental Service Association of Great Britain, Ltd. The Service is sub-divided into local panels open to all persons on the Dentists' Register.

The whole area of England, Scotland, Wales and part of Ireland is now covered by these panels, comprising a membership of 7,000 registered dentists, being more than one-half of the total number of dentists practising in the country, and comprising the vast majority of all those engaged in or likely to engage in the treatment of patients under the National Health Insurance Acts.

19. The Service, which works in close touch with the Approved Societies giving dental benefit, has now been in operation for two years, and may claim to have carried out without friction and with efficiency by far the greater part of all dental treatment which has been given under the provisions of the Acts. It has provided:—

- (a) Professional control;
- (b) A standard of quality of treatment; and
- (c) A forum for the adjustment of questions arising between patients, Approved Societies and dentists.

III.—THE PROPOSED ORGANISATION WHICH WOULD AFFORD A COMPLETE PUBLIC DENTAL SERVICE FOR THE PROVISION OF DENTAL TREATMENT AS A STATUTORY BENEFIT UNDER THE NATIONAL HEALTH INSURANCE ACTS.

20. There will be a second valuation made by the Approved Societies in the year 1925, and it is anticipated that a very much larger surplus will be disclosed as a result of that valuation. About half a million of money was set aside for dental treatment over the years 1921-1926, but it is anticipated that at the next surplus a larger sum may be available for and may be set aside for the provision of dental benefit. The mere provision of these further funds will not, however, effectively secure the necessary benefit to the health of insured persons and others. The larger sums of money available may enable the Approved Societies to pay more toward the total cost of the treatment and so obviate the abandonment of some of the claims above referred to; but, as before mentioned,

- (1) All Approved Societies do not have a surplus applicable to dental benefit;
- (2) All members of Approved Societies having a surplus are not necessarily entitled to dental benefit, and
- (3) No deposit contributor under the Acts is entitled to dental benefit;
- (4) There are the large classes of persons entirely outside the scope of the Insurance Acts, which classes include all the dependants (wives, children, etc.) of the insured persons, and these classes will not be benefited by the expenditure of additional surplus funds.

21. In connection with the future administration of dental benefit on the State side, certain anomalies should be pointed out which now exist owing to the administration of such benefit through the Approved Societies:—

- (a) The expenditure of the funds (which are all derived from public money) is entirely in the hands of each society which gives dental benefit.
- (b) Different arrangements are made for administration by the various societies; hence there is no uniform system prevailing.

- (c) Members of different Approved Societies residing in the same district often have to communicate with the headquarters of their society at a considerable distance before they can obtain dental treatment; the routine of application for and sanction of treatment is often elaborate and complicated.
- (d) The system under which the benefit is obtained and the amount of the benefit varies for persons of similar trades and occupations residing in the same area according as they may happen to belong to one Approved Society or another.
- (e) Of two persons of similar occupations, residing in the same street, enjoying the same income and paying the same contribution to the insurance funds, one may, and the other may not, be entitled to dental benefit, simply according as they happen to belong to one society or another.
- (f) Considerable expense is incurred (which diminishes the amount available for dental benefit) in maintaining separate organisations and separate systems for dental benefit by different Approved Societies, and uniformity of system and centralisation and uniformity of organisation would considerably decrease the expense of administration.

22. It is further to be remembered that, as under present arrangements, only those who have been insured for some years are eligible for dental benefit, young persons now becoming insured might be ineligible for dental treatment for five years, during the period of life which, from the dental point of view, is the most important time of their lives.

The universal testimony of the medical and dental professions, as well as the dictates of common sense, make it certain that any scheme of dental benefit is defective which does not link up with the existing provisions for the treatment of dental disease among children, and avoid any gap in the supervision and treatment of dental disease between childhood and maturity.

It is not unreasonable to claim that dental treatment should be available, not only for every child, but for every young person and adult in the country.

23. It cannot be doubted that the best form of dental service for the adult population might be found in the provision of dental treatment as suggested in the Interim Report of the Consultative Council on Medical and Allied Services, Cmd. 693. A step towards such a scheme would be the creation of a medical service, including dental service, with nursing and other auxiliary services, on a territorial basis, under separate control and outside of the provisions of the National Health Insurance Acts.

24. If after consideration it appears that medical benefit should remain within the Acts and be administered by Insurance Committees or other bodies, the Service submits that dental treatment should be included as a "permanent benefit" and be administered by the same bodies or authorities as those administering medical benefit in the future, and that the dependants (wives, children, etc.) of insured persons should participate in such dental treatment.

25. Assuming that dental treatment be thus wholly or partially extended to cover a wider area, it remains to be considered how the present dental organisation (as apart from the State administration side) requires to be extended or modified to meet its additional duties.

26. The Service is frankly of opinion that the present system of voluntary panels open to all registered dentists organised on a territorial basis can easily be adapted to any State scheme. The numbers already engaged in panel work are an adequate guarantee that if the conditions of State employment are equitable, there would be no lack of the necessary dentists.

27. The word "panel" is used for convenience, but the system differs from the medical panel in that there is no annual *per capita* payment, but each case is paid by fees calculated on the actual work done.

28. The advantages of what may thus be called the panel system, are, in the opinion of the Service, as follows:—

- (a) It allows the patient free choice of dentist (which is absolutely essential), ensuring that a patient may be attended by such dentist as he or she may select.
- (b) By giving free choice of dentist it preserves those personal and professional relations between dentist and patient indispensable even in a State service, and this is appreciated by the patient as it imparts additional confidence and comfort when dental treatment is given by those in whom personal reliance is placed.
- (c) No outlay is required in the provision of buildings, equipment or materials, as these are provided by the individual practitioner.

29. An alternative method of providing a Public Dental Service is that known as the "Clinic System." This involves the provision of premises for specially organised clinics staffed by dentists devoting the whole or part of their time to such service at a salary.

Such clinics have been adopted in giving dental treatment to school children under the Education Acts.

The Service does not consider that the clinic system, as a whole, would serve the best interests of the patients or the profession in a Public Dental Service for the following, among other, reasons:—

- (1) The patients might be deprived of the free choice of dentist which the Panel System affords, as they would be required to attend at the clinic and be treated by the staff of the clinic, whoever they may be.
- (2) Patients in the main prefer to be treated as private patients at the premises of the dentist rather than attend an institution such as a clinic.
- (3) The clinic system may permit of the handling of a continuous daily stream of patients, compulsorily assembled as in the Army during the War, but is impracticable in thinly populated districts.
- (4) The analogy of school children all compulsorily attending the same place daily for educational purposes is not to be applied to adults whose work or residence does not compel them to collect daily as a body.
- (5) An extension of "factory clinics" would be impracticable (a) because large numbers of insured persons do not work under factory conditions; (b) the establishment of a clinic in every factory would be impracticable on the ground of cost alone.
- (6) Considerable capital expenditure is required to set up and maintain the premises and equipment of a clinic.
- (7) In any district where such clinics are established the practice of individual dentists would be seriously diminished and would cause many of them considerable losses.

30. On comparison of these alternatives it appears to the Service that the panel system should be adopted as the standard system for the whole country.

31. In endeavouring to formulate any scheme for a National Public Dental Service, perhaps two of the most important aspects of the scheme have been left to the last for consideration. These are—

- (a) The quality of the treatment to be given and
- (b) The cost.

As to (a), it is obvious that it is impracticable to provide out of national funds a treatment involving

the use of precious metals in large quantities and methods not indispensable in the provision of adequate treatment for the preservation of health. There is little difficulty in defining the broad outlines of the measures necessary to safeguard adequately the national health from dental disease, and the Service submits that professional opinion would be found almost unanimous in approval of the following schedule:—

Carefully organised propaganda as to the care of teeth, with a view to the prevention of dental caries and other disease.

Scaling of teeth and treatment of inflammatory conditions of gums.

Fillings.

Extraction of teeth under—

- (1) Local
- (2) General anaesthetics.

Provision of—

- (1) Complete and
- (2) Partial artificial dentures.

32. As to (b), the cost: Assuming that the present system of contributions by employer, patient, etc., is maintained, the funds for further dental treatment will have to be provided either by deduction from some of the funds at present employed on other benefits, or by the imposition of an additional contribution by employers and insured persons and the State.

33. An endeavour has been made to ascertain the cost. In dealing with such figures as are available, it must be remembered that up to the present, as before stated, a smaller proportion of persons than are actually entitled to dental benefit have claimed it owing to the necessity as present for their having to bear part of the fees, while so soon as this necessity ceases to exist the proportion of those entitled to benefit which claims it, will almost certainly increase. The figures available suggest that taking the total membership of any Approved Society the sum of 3s. 6d. per head of such total membership might provide dental treatment for such members of the society as actually required and claimed it. Other figures seem to show that a sum of 1d. per week per insured person added to the present contributions under the National Health Insurance Acts would pro-

vide dental treatment for all persons requiring and claiming it.

The Service, however, thinks it right to record its opinion that it may be found that these figures are under estimated.

34. On the other hand, certain deductions may fairly be claimed against the cost of any such system; especially after it has been in operation for some years, when the claims should be reduced by the fact that the children and young persons whose teeth have already been treated will have attained maturity, and inasmuch as their dental condition has been improved during youth, fewer claims will be made by them. These deductions consist, as above stated, of

- (a) Reduced claims for sickness benefit.
- (b) A reduction in the cost of drugs supplied under medical benefit for digestive disorders, etc.
- (c) Reduced cost of medical benefit.

It is the opinion of the Service that while these deductions may be precisely measured in monetary terms, sight must not be lost of the enormous benefit—not precisely so measurable—in the increased efficiency which will result from an adequate and comprehensive scheme of national dental treatment. World conditions appear at the present time to point to the necessity for the highest bodily and mental efficiency among the population if, for some considerable time at any rate, they are to continue to maintain their place and standard of living in face of the conditions of world competition now prevailing and the pressure of lower standards of civilisation. Just as in industry, expenditure upon the provision and maintenance of improved machinery for the carrying on of work would be, and is, considered as justified by its results, so the Service submits that moderate and reasonable expenditure in promoting the general health of workers with hand or brain is as necessary for the national welfare.

Presented by direction of the Central Committee of the Public Dental Service Association of Great Britain, Limited.

28th October, 1924.

10, New Square, Lincoln's Inn,
London.

APPENDIX XXIII.

STATEMENT OF EVIDENCE SUBMITTED BY MR. BENJAMIN BROADBENT, C.B.E., M.A., LL.D., J.P., HUDDERSFIELD. See Minutes of Evidence of the Nineteenth Day, Questions 10,061 to 10,173.

EXPERIENCE IN PUBLIC HEALTH AND INFANT WELFARE WORK.

1. I was actively engaged in Public Health work as member of the Sanitary and Health Committees of the Huddersfield Corporation for 27 years, 1886-1913; as Chairman of Health Committee, 1890-1914; and of Infantile Mortality Committee, 1903-1914; Mayor of Huddersfield, 1904-5 and 1905-6.

I made it a matter of special interest to press on the Council the necessity of caring for Infant Life and Health.

For three years I personally visited over 300 homes in special districts of the Borough.

I took an active part in obtaining a clause in the Private Act relating to Huddersfield for Compulsory Notification of Births in 1905, and in the passing of the General Adoptive Act in 1906.

2. I was very greatly interested in the first Insurance Act, especially in the maternity benefit. Though the benefit was very limited, it seemed to

give an opportunity for bringing assistance to the mother in the home in an effective way.

MATERNITY BENEFIT A GREAT OPPORTUNITY MISSED.

3. With proper administration the opportunity might have been used for making maternity safe and infant life more secure. This aspect of the question did not so much as enter into the minds of those who framed the Act. This was shown by one section in the Act which stated in so many words that the maternity benefit was the property of the father. The whole duty of those who administered the Act was discharged when they had handed 30s. over to the father. This absurdity was pointed out, and shortly afterwards was rectified by making the maternity benefit the property of the mother. But it was still nothing more than a money benefit. There was no precaution taken to help the mothers to make the best use of the money. The real purpose which Parliament had in view was undoubtedly to make childbirth safer alike to mother and child. This purpose cannot be fulfilled merely by a grant of money.

THE MATERNITY BENEFIT HAS NOT ANSWERED ITS PURPOSE.

4. As administered under the Insurance Acts I submit that the maternity benefit has not answered its purpose. There is no means whatever for impressing on the mothers the fact that the maternity benefit money is given to her solely in virtue of her motherhood in trust for the child, and that it is morally a fraudulent use of the money to spend it on anything that does not help her to be a better mother and to rear her child healthily. It is even open to question whether the maternity benefit has had any appreciable effect in the reduction of Infantile Mortality, in other words, whether it has improved motherhood.

5. The same doubt applies to the larger "bonus" paid to mothers in Australia. Those interested in Infant Welfare work in the Dominion with whom I have come in contact express their uneasiness as to the utility of the £5 grant in improving the conditions of maternity.

6. My own personal experience convinced me that money, or the promise of money, was of no service in inducing a mother to bestow greater care on herself as a mother or to take greater care for the welfare of her child. The value of my own personal effort to help the mothers lay in quite a different direction.

EXAMPLE OF NEW ZEALAND.

7. The same indication is given by the experience of New Zealand, where there is no money grant whatever. In its place there is active propaganda on educational lines throughout the Dominion, and free advice and free care for expectant and actual motherhood. They do better in New Zealand without money than Australia does with its £5 bonus. The New Zealand rate of infantile mortality is the lowest in the British Commonwealth of Nations.

MATERNITY BENEFIT NOT ALTOGETHER WASTED.

8. It may be admitted that in many cases the grant of money is a real help and it is a source of great satisfaction that with advancing knowledge there is evidence of the money allowance being used more and more advantageously. Good mothers make a good use of the money, but careless mothers make a bad use of it. The good is balanced by the harm. There ought to be some means of helping the good mothers to make a still better use of the cash and to prevent the careless mothers from wasting it or to persuade them to make a proper use of it.

PRESENT METHOD OF ADMINISTRATION A FAILURE.

9. After careful consideration I have come to the conclusion that the maternity benefit, when it does nothing more than put a little money at the disposal of the household, is of comparatively little value. There ought to be much more than that; some measures are absolutely necessary to ensure that the money shall be used with the clear and definite object of helping the mothers and saving the babies. The maternity benefit ought to be made to fulfil this purpose. The present method of administering the benefit is a failure; there requires a complete change in the whole system of administration.

PROPOSED ADMINISTRATION BY THE PUBLIC HEALTH AUTHORITIES.

10. The suggestion I have to make is a bold one but I make it confidently. There is in existence an organisation which has been proving more and more efficient and effective during the last 20 years, and to this organisation the whole administration of

the maternity benefit might safely and fittingly be entrusted. That is the Public Health Authorities with the Ministry of Health at its centre.

11. There needs no exposition of the large share which the Public Health Authorities and the Ministry of Health have taken in the care of infancy and, in a less degree hitherto, of maternity. There is now a large body of public servants on the staff of every town and county who have an intimate knowledge of all the conditions affecting infancy; they are already in touch with all the homes. At the present time the one point which most of the health workers are straining every effort to reach is the prevention of pre-natal, natal and neo-natal fatalities. Up to the present time most of the efforts to lessen the mortality before birth, at birth and immediately after birth, are very incomplete. If the administration of the maternity benefit (it would certainly be advisable to include maternity sickness) were placed in the hands of these most efficient and zealous public servants, it would give them exactly what is wanted to make their work one administrative whole. It is simply a case of putting the tools in the hands of those who know how to use them.

12. The suggestion may be considered altogether impracticable. It was made when the first Insurance Act was passed; it was made again in 1914. On both occasions it was deemed hardly worthy of notice. I make it once more in the hope that after the experience of these years it may be accorded at least some consideration. It will certainly be done sooner or later.

UNSATISFACTORY ADMINISTRATION BY APPROVED SOCIETIES.

13. The Approved Societies appear to have found their administration of maternity benefit a difficult and unsatisfactory job; they seem to be anxious to get rid of it in one way or another. In the very nature of things such a result is inevitable; it would indeed be a miracle if a body of mere men, absorbed in totally different interests, could deal satisfactorily with giving counsel and advice to new-made mothers. To do the work properly, the societies would require an additional staff of specially trained women to fulfil all that a proper administration of maternity benefit demands.

POSSIBLE OBJECTIONS TO TRANSFER TO PUBLIC HEALTH AUTHORITIES.

14. No doubt there would be some reluctance to hand over the money; but considerations of efficiency and economy and public utility should be sufficient inducement for the transfer from an authority that apparently does the work only partially and indifferently well to another authority that manifestly could do it much better.

15. On the other hand it is quite possible that health authorities might object to have yet another burden placed upon their already weightily-laden shoulders.

16. Possibly there might be some kind of permissive legislation initiated whereby it might be allowed that the Health Committee of a borough should agree with the Insurance Committee for the same area that the whole maternity benefit should be administered by the Health Authority. Given a willingness on both sides, the transfer should not be impossible. It would be necessary that due regard should be paid to the important part that the midwives would have to take in any redistribution of responsibility for the administration of the maternity benefit. The same consideration would have to be given to the medical practitioners who undertake midwifery cases.

APPENDIX XXIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE UNITED WOMEN'S INSURANCE SOCIETY BY THE LADY EMMOTT, J.P., CHAIRMAN OF THE COMMITTEE OF MANAGEMENT, AND MR. ALBAN GORDON, SECRETARY. See Minutes of Evidence of the Nineteenth Day, Questions 10,174 to 10,389.

PARTICULARS OF THE SOCIETY.

1. The Society was formed in July, 1912, under the name of the Domestic Servants Insurance Society specially to administer the National Health Insurance Act for domestic servants. The name of the Society was changed in 1916 to the Domestic Workers Friendly Society, and again in 1922 to its present title.

2. The membership of the Society touched 65,000 in 1913, declined to 46,000 in 1922, and is at present 54,000.

3. The Society has at different times accepted the transfer of the engagements of five other women's societies.

4. Coincident with the change of name the scope of the Society was extended in 1922 to include practically all insured women, though the Society does not usually admit factory workers to membership, partly from policy and partly from the remaining influence of an understanding with another women's society arrived at in 1912 as to non-competition. On a rough estimate the present membership may be taken to consist of a little more than two-thirds domestic servants and a little less than one-third other women workers, viz., clerks, nurses, shop assistants, etc.

5. The outstanding feature of the Society's history has been its use of section 21 of the 1911 Act (section 26 of the existing Act) for the purpose of conferring extra privileges upon members, the principal of these being dentistry, which has been given to all members of the Society since 1915. A full statement on this subject will be found in the appended Memorandum.

6. In addition to dentistry many other privileges have been conferred upon members through the same instrumentality, notably massage, electrical treatment, Convalescent Home facilities, and surgical appliances, all since 1916, and optical treatment (supplementary to the benefit given under a scheme made for disposal of surplus) since 1922.

7. As was anticipated, the Society's sickness and maternity expenses have, in the past, been relatively light, and as a result of the first Valuation the Society had a higher disposable surplus than any other large society. The principal valuation figures were as follows:—

Membership	...	...	59,337.
Receipts	...	...	£737,455 13 7
Payments	...	...	£296,948 13 8
Surplus of assets over liabilities	...	...	£123,535 0 0
Disposable surplus	...	...	£95,867 0 0
Balance carried forward	...	...	£27,668 0 0

8. The scheme for the disposal of this surplus was as follows:—

Additional sickness benefit	3s.
Additional disablement benefit	1s. 6d.
Optical treatment	£1,000 a year.
Surgical appliances	£500 a year.
Convalescent Homes and Hospitals	£4,000 a year.
Payments in want and distress	£7,000 a year.

9. The position of cash benefits of recent years has, however, been such as to give rise to some anxiety in view of the steady increase in sickness and disablement benefit, more particularly the latter, which has steadily gone up year by year, and shows no signs at present of reaching finality.

10. A calculation of seven-ninths of the Society's expenditure on cash benefits expressed in terms of pence per member per week is as follows:—

Cost of $\frac{7}{9}$ ths of Benefits.
(Pence per member per week.)

	1920.	1921.	1922.	1923.	1924
Sickness* ...	·895	1·544	1·862	1·895	1·986
Disablement* ...	·420	·687	·903	1·070	1·140
Maternity ...	·226	·216	·158	·147	·146
Grants under Section 26.	·256	·290	·410	·559	·830
Total ...	1·797	2·737	3·333	3·671	4·102

The contribution attributable to these benefits is sickness benefit 2·68, disablement benefit ·92, maternity ·49 pence per member per week. These latter figures are, however, not strictly comparable, since the Society's expenditure on cash benefits includes an increment paid by way of additional benefit in the case of sickness and disablement benefit of 3s. and 1s. 6d. per week respectively.

11. The Society's expenditure by way of donations under section 26 is as follows:—

	£	s.	d.
1914	...	100	0 0
1915	...	2,000	0 0
1916	...	4,500	0 0
1917	...	3,450	0 0
1918	...	3,800	0 0
1919	...	3,200	0 0
1920	...	3,860	0 0
1921	...	4,050	0 0
1922	...	5,950	0 0
1923	...	8,100	0 0
1924	...	12,500	0 0
		£51,510	0 0

Since 1922 a considerable proportion of these sums is in effect in relief of expenditure under the Society's scheme of additional benefits, because instead of meeting the whole cost of Convalescent Homes, ophthalmic treatment and the provision of surgical appliances for its members through its additional benefits scheme, the Society has borne part of the cost through the machinery it has set up under section 26, and of the surplus arising from the first Valuation to be distributed under its scheme of additional benefits a large sum is now being carried forward as follows:—

	Total Amount available 1921—1924.	Amount Spent.
	£	£
Optical Treatment	3,496	3,077
Surgical Appliances	1,900	945
Hospitals	11,026	6,103
Convalescent Homes	3,497	525
Want and Distress	24,145	3,357
	£44,154	£14,007

* Includes "additional" cash.

12. Having made such extensive use of section 26 of the Act the Society is naturally not desirous of seeing any alteration made in the terms of this section. It is recognised however, that it may be argued that the section lends itself to possibilities of abuse; but it is contended that such abuse could be prevented by making payments under the section subject to the approval of the Ministry.

It would not meet the Society's views if the powers under this section were abrogated in favour of a scheme which put at the disposal of the Society a sum for making payments in cases of want and distress. The Society has already such a fund under its additional benefits scheme, but the cases dealt with under section 26 are mainly those in which there is no actual "want or distress," but in which it is expedient to give various forms of assistance to members to promote and preserve their health, and thus to prevent claims on the benefit funds from arising.

ADDITIONAL BENEFITS.

13. The Committee of Management are of the opinion that the present regulations, whereby insured persons lose their rights to additional benefits for a term of years upon transfer from one society to another, are unwise, and contrary to the interests of public health, more especially as regards the non-cash benefits which are of a preventive character. So far as is compatible with the financial stability of a society it should be permitted to make the fullest possible provision for preventive treatment benefits for its members.

14. Under existing circumstances there is no uniformity in the definition of additional benefits, and a society purporting to give dentistry or optical treatment may, in effect, merely be making a limited contribution towards the cost of such treatment, whereas another society under the same title of benefit may be giving the fullest possible measure of assistance. This is not only unjust to societies which interpret their obligations liberally, but it is confusing to insured persons who are unable to be certain of their rights.

It is, therefore, suggested that benefits such as dentistry, optical treatment, etc., should be standardised.

15. With regard to treatment benefits in general, it is the opinion of the Committee that such should form part of a comprehensive medical service, and as such should be administered through the Insurance Committees, or whatever other bodies may be entrusted with the administration of such service.

16. The Committee have, ever since the coming into operation of the additional benefits scheme, felt profound dissatisfaction at the unsatisfactory nature of the "payments to hospitals" made under the scheme. (Owing to the attitude adopted by the authorities of the majority of hospitals, such payments are a benefit to the hospital without being a benefit to the member, because the hospitals receiving such a payment from the society do not accept this as being made on behalf of the member but still require her to contribute the same sum that she would have contributed had the society not made a payment on her behalf, and consequently the position of members of the society is in no way superior to that of members of a society which does not give this benefit.)

The great difficulty in this connection lies in the multiplicity of hospitals, and the impossibility of entering into arrangements with them all. The Committee have more than once expressed their willingness to make payments to hospitals on a higher scale than the guinea per week now allowed under the Society's scheme, provided that the hospitals would accept such sum in full satisfaction of their demands upon the patient.

It is suggested that failing the inclusion of arrangements for hospital service as part of a general medical service as is advocated below, the Ministry of Health should negotiate with the hospitals of the country so as to arrive at an agreed scheme by which payments

of this nature will not only be beneficial to the hospitals, but will be a direct benefit to the members as well.

MEDICAL BENEFIT.

17. In the Society's experience cases such as that submitted in para. 35 of the personal evidence of Mr. Alban Gordon are comparatively frequent, and there is no doubt that the lack of specialist and institutional treatment on the one hand, and the lack of co-ordination between medical benefit and other existing forms of medical service on the other hand, are responsible for a large amount of preventable sickness. The Committee are strongly of the opinion that medical benefit should not stand as at present as an isolated general practitioner service, but should be linked up with all existing forms of medical service, and supplemented by whatever further provision of consultant, specialist and institutional services are necessary.

Such a widening of the scope of the Insurance Act medical service is the paramount need of the Insurance Scheme at the moment, and it is more important to arrange such an extended and co-ordinated service than merely to throw open the existing medical benefit to the dependants of insured persons.

18. The Committee do not desire to advocate any specific method of establishing such a co-ordinated medical service, nor to suggest any particular method for financing it. They are, however, fully convinced that the establishment of a service is as practicable as it is desirable, and that with a comparatively limited extension of existing subsidies from public funds a service could be set up of the greatest possible benefit to the insured population, both in the prevention and cure of sickness.

GENERAL.

19. In the opinion of the Committee section 13 (4) of the National Insurance Act, 1924, should be strengthened by the insertion in line 5 of the proviso after the word "able" of a phrase "owing to the physical or mental effects of the disease or disablement." This is the natural interpretation of the proviso and is one which has been upheld by the umpire upon appeal, but it is frequently contended on behalf of members of the society from whom benefit is withheld in accordance with the terms of the section that "not reasonably able" covers inability through circumstances such as change of address, loss of papers, etc., and consequently the interpretation of the section gives rise to considerable friction.

20. In the opinion of the Committee the whole of section 17 of the National Insurance Act, 1924 (payment of benefit to inmates of hospitals), should be repealed and substituted by a section making periodical payments obligatory in the case of insured persons with dependants, and in other cases giving societies power to pay either whilst the person is in the hospital or when he comes out at its option.

The effect of the section in its present form is merely to introduce an unnecessary complexity. It is useless from the point of view of Approved Societies, in that in every case payment has to be made sooner or later, except perhaps in the rare cases where a person dies in hospital leaving no heirs or interested persons to make a claim.

A further and most unjust effect of the section in its present form is that on the death of an insured person whilst in hospital a very large sum of money, running in extreme cases into hundreds of pounds, may stand to the credit of his estate, and may be, and frequently is, claimed by persons who have only distant relationship with the insured, and have contributed nothing either towards his upkeep or his funeral. Payments in these circumstances should in any event either be limited in amount or only payable by way of refund where the heirs have been put to any expense either during the illness or funeral of the deceased, or otherwise on his behalf.

21. In the case of international societies a great deal of unnecessary labour is involved in making monthly applications to the three separate countries for issue of funds. In the case of this Society for example, 97 per cent. of its membership is in England, the remaining 3 per cent. divided between Wales and Scotland; but every month an elaborate analysis of income and expenditure has to be made as between the three countries for the purpose of

applying for paltry advances from Wales and Scotland and substantial advances from England. A considerable simplification would ensue if only one complete financial analysis need be made in each area for purposes of account as between the three countries, the monthly advances of funds being made only by the country in which the membership is largest.

MEMORANDUM ON THE FIRST 9½ YEARS' EXPERIENCE OF THE SOCIETY'S DENTAL SCHEME.

GENERAL.

22. The Society's dental scheme was planned in 1914, and came into operation on the 1st of July, 1915. During the period 1915-1925 the Society's membership (all women) averaged 55,000, the whole of whom have been made eligible for dental benefit.

23. The benefit throughout the whole of its course has been financed by donations made under section 21 of the National Insurance Act, 1911 (section 26 National Health Insurance Act, 1924), to a "charitable body" known as the United Women's Benevolent Association (U.W.B.A.).

24. The U.W.B.A. was incorporated on March 3rd, 1914 (as the Domestic Servants' Association), the word Limited being omitted by licence of the Board of Trade. The Association, which is limited by guarantee, not by shares, commenced with a capital of £1,200, raised by private donations and subscriptions, and has since, except for minor sums, been financed entirely by donations made by the U.W.I.S. The Association, in addition to the dental service, carries on many other enterprises for the benefit of members of the U.W.I.S., and has, since 1915, provided massage, electrical treatment, convalescent homes, optical treatment, surgical appliances, and other benevolent services; but the dental service has throughout been financially the most important branch of its work.

25. Dental benefit has, from the commencement always included—

- (a) Surgical dentistry of every description entirely free of charge to the member, without limit of cost; and
- (b) the provision of dentures on the repayment by the member of part cost. The member's contribution to the cost of dentures was originally one-third, but was increased to one-half in 1916, at which level it remains.

Until 1922 the only qualification for title to the benefit was that the person should be insured under the National Insurance Act and a member of the U.W.I.S. In July, 1922, it was, however, resolved that no member should be entitled to the benefit until she had been insured for not less than 26 weeks, and 26 weekly contributions had been made by her.

26. Since the inception of the scheme the following donations have been made by the U.W.I.S. in respect of the dental service:—

TABLE 1.

Year.	U.W.I.S. Donations:
1915-1916	£5,200
1917	£2,050
1918	£3,200
1919	£2,900
1920	£3,100
1921	£3,800
1922	£4,850
1923	£5,500
1924	£9,500

These are in addition to donations made under the same section for purposes such as massage and

electrical treatment. In the nine and a half years ended December 31st, 1924, the total of donations made by the U.W.I.S. to the U.W.B.A. was £51,510 of which £41,000 was in respect of dental treatment.

METHOD OF OPERATION.

27. It was decided in view of the fact that the Society's membership was distributed approximately one-third in London and the remaining two-thirds scattered throughout England, Scotland, and Wales, to administer the benefit under two separate systems:

- (a) As regards London, a central clinic was established by the U.W.B.A., at which all London members applying for benefit were required to attend.
- (b) As regards the provinces, a panel was compiled, comprising one or more selected dentists in every town of importance throughout the country, arrangements being made by the Association with such dentists to honour a voucher for treatment presented by the Society's members.

These arrangements remain substantially unaltered at present, with the exception that as the demands upon the service increased, so the area within which members were required to present themselves for treatment at the central clinic was reduced, and at present "London" is defined as covering a circle with a radius of five miles from Charing Cross, whereas originally districts such as Croydon, Richmond &c., were included.

28. As between the two systems of administration, it has been found impossible to institute a direct comparison of cost, since the accounts are kept on a different basis, the clinic accounts being kept on an attendance basis, and the provincial cost on a case basis. As far as can be gathered, however, the cost of dental work performed at the central clinic would appear to be approximately half the cost of similar services rendered on a fee basis throughout the country, whilst it has been possible to maintain the standard of services rendered at the clinic at a higher level than the average standard of services throughout the country.

29. Until 1923 it was a cardinal feature of the scheme that none but registered and fully qualified dentists should be employed. But after other Approved Societies commenced dental schemes in 1921 and 1922, it was decided, for the sake of uniformity, to abandon the former closed panel of qualified dentists, and to allow members to go to any dentist they pleased, whether qualified or "1921."

Under the earlier system the U.W.B.A. had a binding contract with every dentist of its panel in the following terms, signed by the dentist:—

"I request that you will place my name on your panel of Registered Dentists agreeing to render treatment to members of the United Women's Insurance Society in return for fees, payable by your Association, in accordance with

its scale of fees dated November 1st, 1922, and on the understanding that it shall only be removed therefrom, either by you or by me, by one month's previous notice in writing.

In consideration of the above I undertake, so long as my name remains on your panel, not to make any charge on nor to accept any fee from any member of the United Women's Insurance Society holding your printed voucher for treatment in respect of or for any professional services, which I may render to her and which come within the scope of your Association's scale of fees."

As a result of this arrangement the most satisfactory relations prevailed between the Association and its dental panel, a feature of which was the entire absence of complaint either as to the nature of the services rendered, or as to any supplementary fees being charged to members. Since the abandonment of this system, however, many complaints have been received under both headings.

30. The present operation of the system is as follows:—Upon a member applying for the benefit her title to benefit is established by reference to the Society's records, and it is then determined whether she is to be regarded as a London or provincial case.

(a) If a London member, she is informed that she will be required to receive her treatment through the clinic, and is given two or three alternative appointments. The hours of the clinic are from ten till six, with an extension to seven on one evening a week. If, on examination at the clinic, it is found that dentures will be necessary, she is informed of their estimated cost, and is required to pay her share of one-half of such cost before the work is put in hand. Surgical treatment is proceeded with without any question of payment. In general it is found that persons attending the clinic for treatment require on the average 4.75 attendances to complete the treatment.

(b) If she is a provincial member she is sent a voucher bearing an undertaking to pay the whole charge of her treatment, surgical or mechanical, subject to the conditions printed on the voucher. This may be presented to any dentist who is willing to accept her for treatment, and the dentist reads on it in prominent type that he must not commence any treatment costing more than 10s. without specific sanction from the Association. The member is also furnished with a postcard addressed to the Association for her to hand to the dentist with the voucher, to be used by him. This is for furnishing an estimate of the cost, and requesting sanction for treatment. On receipt of this postcard the Association collects from the member, in advance, her share of one-half of the cost of dentures, if any, and on receipt of the remittance authorises the dentist to commence the treatment, and in due course bears the whole of his bill. If no dentures are required, sanction for treatment is issued immediately the postcard is received from the dentist.

In certain cases where through poverty the member cannot afford to pay her share of the dentures, it is paid for her, either from the Society's private Benevolent Fund or, if she is a member entitled to receive additional benefits, from the "Want and Distress Fund," which is one of the additional benefits given by the U.W.I.S. under its statutory scheme. Another way in which assistance is rendered to poorer members is to grant them a loan from such sources to defray their share of the cost of dentures, such loan being repayable in small instalments.

31. In the case of sudden emergency, where "first aid" treatment is required to dispel pain, the Association meets the cost of such treatment up to a

limit of £1, without any previous sanction, but in all other cases it is a strict rule that no grant is made for any treatment incurred without previous application to, and sanction by, the Association.

FINANCIAL RESULTS.

32. It was thought in 1914 that there would be a flood of applicants for the benefit on its initiation, and that a maximum pressure of work might be expected within a short time from the commencement of the scheme. To some extent this was justified, and the demands on the service in its first half-year (1915) were roughly equal to the demands on the service for the whole of the succeeding year. But this initial rush soon died away, and the years 1917, 1918, 1919, and 1920, showed a fairly constant demand on the service. The figures showing this are as follows:—

TABLE 2.

Year.	Number of provincial vouchers issued.	Number of attendances at central clinic.	U.W.I.S. donations.
1915 (half-year)	1,277	3,681	} * £5,200
1916	2,418	3,403	
1917	1,491	5,234	£2,950
1918	1,511	3,765	£3,200
1919	1,429	5,221	£2,900
1920	1,377	5,642	£3,100

* This defrayed not only current expenses, but a preliminary expense of £620 for equipping the central clinic.

33. During the whole of this time every possible step was taken to bring the benefit to the notice of members. A special circular was sent them each half-year, and special slips were inserted in all communications emanating from the Society's offices. Not only this, but the Committee of Management of the U.W.I.S. actually made it their policy to bring a degree of pressure to bear upon members suspected of having faulty teeth to induce them to take advantage of the dental benefit. Every attempt was made, too, to co-operate with the medical profession, and in addition the benefit was fairly widely advertised in the Press. It was, therefore, not unjustifiably estimated that the demand for the benefit had become stabilised at this 1917/20 level.

34. Events, however, proved that this conclusion was remarkably erroneous, and the subsequent course of events throw an interesting light on what may be termed mass education. During 1921, with the coming into operation of the scheme of additional benefits, consequent upon the first valuation, other organisations commenced to give dental benefit. For six years the U.W.I.S. had been the only Society affording such facilities to its members, but now other Approved Societies, representing, it is true, a minority of the insured persons, but, nevertheless, a considerable number, afforded to their members a greater or lesser degree of assistance towards dentistry.

Almost instantly the members of the U.W.I.S. commenced to realise what they must have been told a score of times in the past, without having realised, that they were entitled to dental benefit from their Society, and speedily an enhanced number of applications for the benefit commenced to pour in, with the result that the next four years' history of the scheme present a remarkable picture of increasing expenditure, as is graphically represented in Chart I on the opposite page.

The issue of vouchers to provincial members has been taken as the index, because the central clinic has, for some time past, been working at maximum capacity, and any demands for treatment have been met by a shrinkage of the London area, thus thrusting the whole surplus on to the provincial arrangements, which accordingly truly reflect fluctuations in the demands for the benefit.

The figures appropriate to this period are as follows:—

TABLE 3.

Year.	Number of provincial vouchers issued.	Number of attendances at central clinic.	U.W.I.S. donations.
1917-20 (average)	1,452	4,965	£3,037
1921	1,503	5,841	£3,800
1922	2,293	6,994	£4,850
1923	3,772	8,200	£5,500
1924	4,052	8,312	£9,500

35. The Committee of the U.W.I.S. have, naturally, during the last four years asked themselves with some anxiety, where this somewhat alarming increase would stop. There is now reason to believe that this abnormal rate of progress is ceasing, or has ceased, and it may be predicted with some degree of certainty that a maximum rate of expenditure has been reached. In the first place, it would seem probable that nine and a half years should be long enough for members to realise that dental benefit is given by their Society, and in the second place the curve of the graph in Chart I. shows a distinct tendency to become flat once more.

36. The expense of the scheme has, of course, been enhanced during the last eight years in accordance with the diminished value of money. In the case of the central clinic this has resulted in an increase in the rates of salaries, the salary of the chief dental surgeon, which was £500, being now increased to £800.

In the provinces the Association, being the pioneer in this field, had after negotiations with the dental profession drawn up its own scale of fees, and in the years that followed this was necessarily considerably varied. But except for alterations consequent upon the changes in the cost of living, the Association's scale remains in substance the basis of all dental arrangements of the kind now in existence.

The principal items in the original scale were as follow:—

Extractions with local anæsthetic	2s. 6d. for one or two teeth; 1s. per tooth after.
Extractions under anæsthetic	5s. up to three teeth; 1s. 6d. per tooth above this number, with an anæsthetic's fee of 5s. per case.
Fillings (simple) ...	3s. 6d.
Fillings with root treatment	4s. 6d. to 6s.
Scaling	2s. 6d. per sitting.
Dentures	5s. 6d. per tooth, with a maximum of £2 5s. 0d. for complete upper or lower, and £4 10s. 0d. for complete set.

The corresponding fees now paid have been agreed by an informal committee containing representatives of the Approved Societies and the dental profession as follows:—

Extractions with local anæsthetic	2s. 6d. per tooth.
Extraction under anæsthetic	2s. 6d. per tooth, plus an administration fee of 7s. 6d.
Fillings (simple) ...	5s. to 7s. 6d.
Fillings with root treatment	10s. to 15s.
Scaling	5s.
Dentures	6s. per tooth, with a minimum of £1 and a maximum of £3 5s. 0d., upper or lower; £6 10s. 0d. upper and lower.

Extraction fees not to be charged where full, or nearly full, dentures are required.

37. The financial operation of the scheme as it affects the Society's finances may be summarised in the following tables, Table 4 showing the distribution as between London and the provinces on the one hand and between the Society and members on the other, and Table 5 the total cost of dentistry in terms of membership.

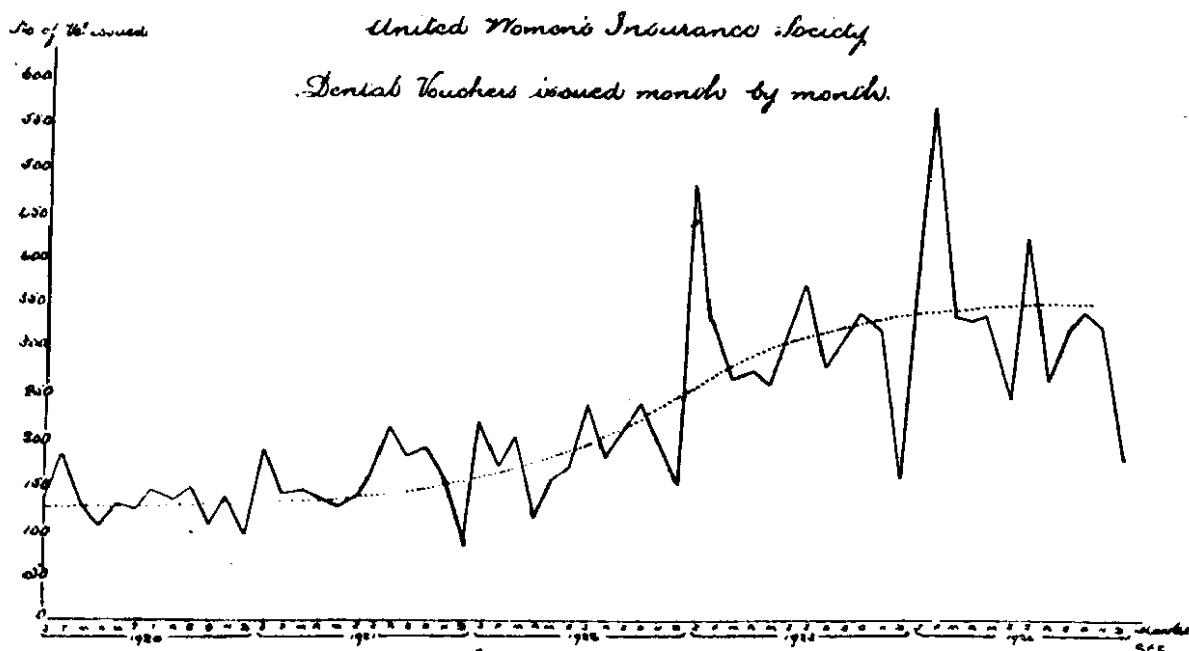


Chart I.
Demands made on the dental service 1920-1926
The curve from 1918-1919 is approximately flat.
(The dotted line shows the average tendency).

TABLE 4.

GROSS COST (£).			INCOME (£).	
Period.	Central clinic.	Provincial.	U.W.I.S. donations.	Members' contributions.
1915-1916 (18 months)	2,342	5,134	5,200	2,816
1917	1,236	3,705	2,950	1,798
1918	1,456	2,975	3,200	1,432
1919	1,890	2,884	2,900	1,514
1920	2,132	3,035	3,100	1,842
1921	1,976	4,184	3,800	2,276
1922	2,157	5,316	4,850	2,891
1923	2,300	8,604	5,500	4,774
1924	2,306	11,850	9,500	5,276

TABLE 5.

Period.	Approximate membership.	Gross total cost of Dentistry (£).	Gross total cost per head of membership (shillings).	Cost to Society per head of membership (shillings).
1915-16	64,000	7,376	2.31	1.63
1917	62,500	4,941	1.58	.94
1918	60,000	4,431	1.48	1.07
1919	58,000	4,774	1.65	1.00
1920	54,000	5,167	1.91	1.15
1921	50,000	6,160	2.46	1.52
1922	52,000	7,473	2.87	1.87
1923	52,000	10,904	4.19	2.11
1924	54,000	14,156	5.25	3.52

COST OF DENTAL BENEFIT.

38. If the prediction referred to in paragraph 35 is anything like correct, it would appear from Table 5 that the all-in gross cost of an inclusive dental service, both surgical and prosthetic, for insured persons, would be in the neighbourhood of 5s. 3d. per member per annum, of which approximately 3s. 5½d. may be ascribed to dentures and 1s. 9¼d. to surgical dentistry and the cost of administration.

It must be borne in mind, however, that in the case of the U.W.I.S. the benefit is given on easy terms, the member qualifying for it on payment of only 2s contributions, and a very substantial reduction would be effected if a longer qualifying period were enacted.

39. The foregoing experience relates, of course, entirely to women, the majority of whom are domestic servants. It is, however, a matter of general repute that the teeth of this class are considerably worse than the average of the community, and it is probable that the cost of dental benefit as given by the foregoing calculations is, in any case, not less heavy than would be the case in a Society of mixed membership.

RESULTING ECONOMY IN SICKNESS BENEFIT.

40. There now falls to be considered the advantages which may be expected to offset the very considerable expenditure on the benefit. In deciding to institute this scheme, the Committee of the U.W.I.S. formed the opinion that after the lapse of a few years the improvement in the oral condition of members as a whole would be such as to lead to an improved standard of health.

Before giving statistical evidence that this expectation has been realised, it may be mentioned that the

Association retains the services of a Harley Street Ophthalmic Surgeon, who has now had through his hands some thousands of members of the Society. In the course of his ophthalmic duties he naturally investigates the mouth of the patient, and he has informed the Society that the average condition of the mouth of a member of the U.W.I.S. is on the whole considerably higher than that prevailing among his private patients.

This is an interesting sidelight on the facts which will now be set out.

41. The Committee of the U.W.I.S. have been advised that in the case of women the ailments most affected by bad conditions of the mouth are anaemia, gastritis, dyspepsia, and rheumatism. In the office of the Society a careful record has been kept since 1915 of the diagnosis on the first certificate of every claim for sickness or disablement benefit, and in this way the Society possesses a record of sickness claims arranged under the heading of sixty different forms of illness. These have been divided into two groups, Group A consisting of the above-mentioned four "dental" illnesses, and Group B consisting of all other illnesses, and a comparison has been instituted between the course of these two groups of illnesses as affecting members of the Society.

For the purpose of this comparison certain allowances have been made to correct for the different epidemics of influenza which have occurred during the period.

After making this correction the number of new claims annually per 1,000 of the Society's membership has been calculated, and from the figures thus obtained an index figure has been set up, taking as standard (100) the year 1915, when no such influence as dental benefit was at work.

The following table emerges:—

TABLE 6.

Period.	No. of new claims per 1,000.		Index number.	
	Illness due to bad teeth. "A"	All other illnesses. "B"	"A"	"B"
1915	25.5	78.7	100	100
1916	22.3	70.4	87	89
1917	21.5	73.4	84	93
1918	17.5	64.4	69	82
1919	14.8	60.7	58	77
1920	17.4	66.7	68	85
1921	19.3	83.3	76	106
1922	17.7	87.4	70	111
1923	18.0	93.3	70	119
1924	18.4	95.6	72	122

On the basis of the index numbers shown by the foregoing table the following graph has been constructed:—

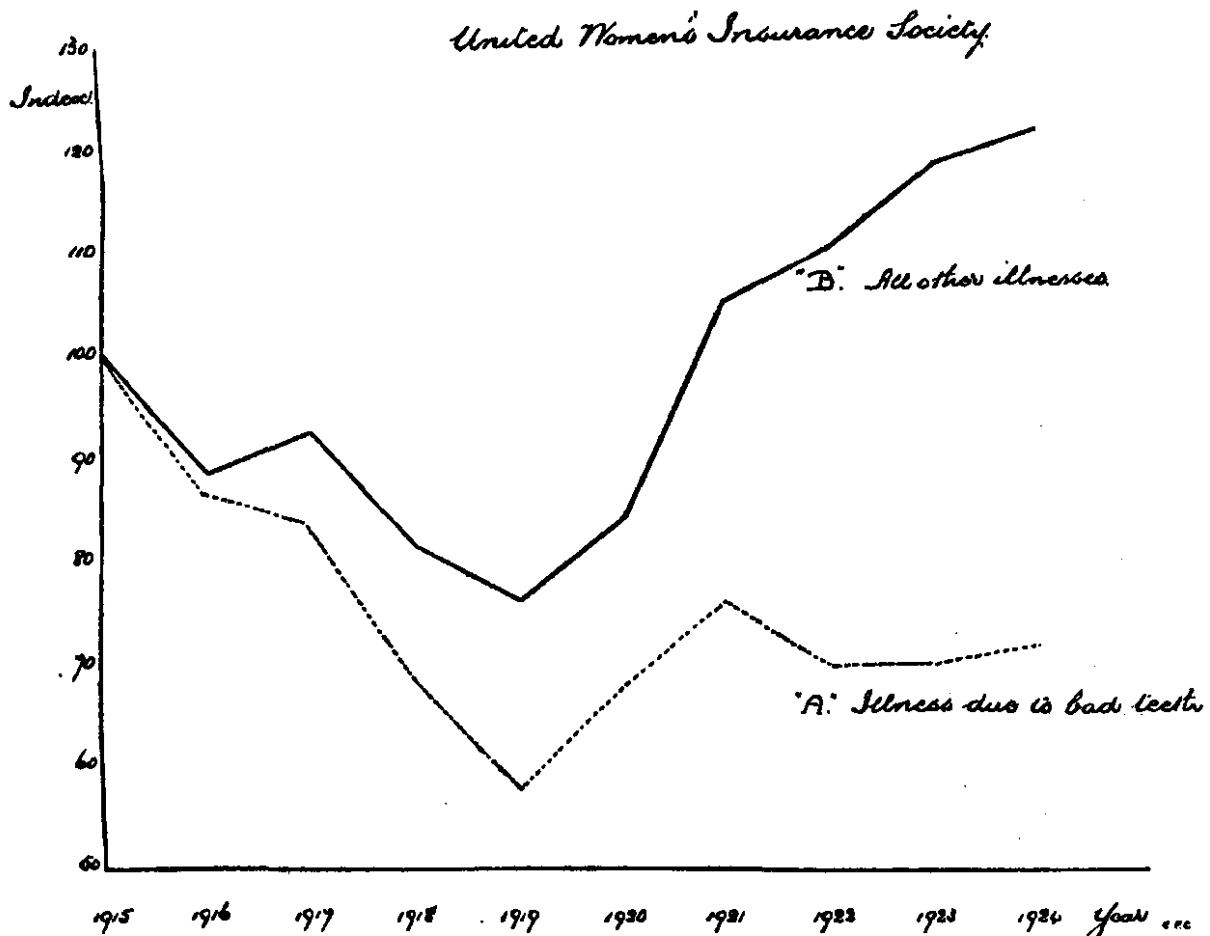


Chart II
Showing course of Index Figures
(1915 = 100) for illness due to bad teeth (A)
and all other illnesses (B)

42. The foregoing demonstrates in an astounding fashion the gradual effect on the health of the Society's members of an improved condition of the mouth. Considering the relatively small size of the Society, averaging 55,000, and allowing for clerical inaccuracies due to the exceedingly difficult conditions of War years, it cannot be claimed that the

foregoing figures constitute a mathematical and scientific proof of the case. But even after making abundant allowance for these factors, the inferences to be drawn from Table 6 cannot be overlooked.

43. An attempt has been made to translate the foregoing figures into terms of money. Here again, owing to the lack of financial resources of the Society

on its administrative side and the consequent absence of actuarial or other professional advice, a certain

measure of reserve must attach to the figures. The following is the result of the calculations:—

TABLE 7.

Year.	Actual number of "A" claims.	"A" claims adjusted.*	New claims saved in each year.	Average cost of each such claim.	Amount of sickness and disablement benefit saved.	Cost to the Society of dentistry.
1915	1,634	1,634	—	—	—	} £5,200
1916	1,416	1,449	33	£2·370	£78	
1917	1,343	1,487	144	£2·370	£341	£2,950
1918	1,050	1,248	198	£2·370	£469	£3,200
1919	855	1,135	480	£2·375	£1,139	£2,900
1920	939	1,174	235	£3·472	£816	£3,100
1921	968	1,350	382	£4·535	£1,732	£3,800
1922	922	1,462	540	£4·911	£2,652	£4,850
1923	934	1,587	653	£4·911	£3,207	£5,500
1924	991	1,678	697	£4·911	£3,374	£9,500
				Totals ...	£13,808	£41,000

* By ratio of "A" and "B" Index figures (Table 6).

In the foregoing table the average cost of each claim has been obtained by estimating the average duration of claims in general, and multiplying by a figure estimated to be the average rate of payment of sickness and disablement benefit during the period. Where doubts existed the lower figure has been taken, and it is probable that such errors as may have arisen have had the effect of reducing the estimate of benefit saved rather than increasing it unduly. It would seem, therefore, that the Society has already recouped in the form of benefit saved a sum in the nature of £14,000, as against its outlay to date of £41,000.

It should be borne in mind, moreover, that the saving in sickness and disablement benefit is likely to be a progressive figure for some years to come, whilst it is hoped that the annual cost of dentistry has reached, or almost reached, the maximum.

44. Apart from the financial saving, it is obvious that an immense boon has been conferred on the members of the Society in general, and there is little doubt that in the long run there are few more potent factors in promoting the health of the people than an inclusive scheme of dental benefit.

ADMINISTRATION.

45. With regard to the administration of the benefit, the Society has some cause to be proud of its record, particularly bearing in mind that the work was undertaken without any experience of any description whatsoever as a guide, and without any direct provision in the Act for so novel a departure.

46. Nevertheless, the Society would not recommend that its organisation should be taken as a perfect model for the administration of a National scheme. Grave difficulties are inherent in any scheme in which a lay body attempts to control a professional body, and the absence of any serious friction between the Society and the dental profession in the whole of the nine-and-a-half years of its experience has only been due to the utmost tact and goodwill on both sides, and, since 1922, to a degree of lessening of the efficiency of the service; for it has been deemed expedient to sacrifice in some degree the clearly marked lines of the scheme to prevent difficulties created by the uncertain nature of the situation that has arisen.

47. With regard to its central clinic, the Committee of the U.W.I.S. recognises that whilst this possesses very great advantages, it has also certain minor drawbacks. The clinic has been efficient to the highest degree, and literally thousands of letters have been received in the offices of the Society, expressing glowing appreciation of the skill, promptness, and kindness of both dental and clerical staff. This treatment, too, as has been indicated, cost relatively only half as much as treatment paid for on a fee basis.

On the other hand, there is the drawback that it is impossible to conduct a clinic on a voluntary basis. All the members in the area for which it is provided must be definitely required to attend there, so as to ensure the clinic working to its full capacity. If a free choice is given them, between attendance at the

clinic and attendance at the private dentist of their selection, they will, naturally, in a great many, if not the majority of cases, prefer the latter, since it is less trouble to them and is attended by less prejudicial associations.

In the case of the U.W.I.S. clinic, practically no complaints whatever were raised against compulsory attendance at it by the London members so long as the Society remained alone in giving dental benefit. But since other Societies have entered the field with schemes based in all cases but one on "free choice of dentist," some measure of discontent has made itself felt, even though financially the benefit under the schemes referred to is, on the whole, nothing like as that of the U.W.I.S.

Furthermore, the existence of the clinic raises a distinct measure of hostility amongst those members of the dental profession who are thereby deprived of the possibilities of a lucrative business.

48. It is a question of the utmost moment whether these disadvantages, mainly based on prejudice though they may be, are sufficiently grave to outweigh an undoubted superiority of the clinic system from every other point of view.

49. With regard to administration through private dentists or panels of dentists, the great difficulty to be contended with is that caused by the practitioner who either states, or more generally implies, that the article which he will furnish under the panel scheme would be distinctly improved upon by the payment of a small supplement by the member. Even graver and more difficult to cope with is the tendency on the part of the less scrupulous practitioner to indulge in the more profitable work of extractions and provision of dentures rather than the more arduous but more beneficial conservative work which is generally recognised to be the better from the patient's point of view.

The extent of this danger is shown by the increased fees per case payable of late years since the Society abandoned its closed panel in favour of the whole Dental Register in 1922.

This difficulty must be overcome in framing a National scheme.

TABLE 8.

DENTISTS' FEES PER CASE COMPLETED† (PROVINCIAL).

Year.	Number of cases completed.	Dentists' fees (£)	Fees per case (£)
1915-16-17 (bulked)	4,410	8,839	2·004
1918	1,361	2,975	2·19
1919	1,302	2,884	2·21
1920	1,430	3,035	2·12
1921	1,570	4,184	2·67
1922	1,740	5,316	3·055
1923	3,227	8,604	2·67
1924	3,553	11,850	3·34

† The number of "cases completed" is on the average only 83 per cent. of that of the vouchers for treatment issued.

CONCLUSION.

50. In the opinion of the Committee, it is desirable that dental benefit should take its proper place as part of an all-embracing medical service, and they would strongly urge upon the Commission the desirability of recommending this course.

If, however, dentistry is to remain a benefit by itself, the question should be taken into consideration of whether the most suitable body to administer the scheme might not be the Insurance Committee. It is clear that there is no greater administrative difficulty in the Insurance Committee ascertaining from the Approved Society whether a given individual has a title to the benefit, than in the individual himself corresponding or dealing with the society.

If, however, it should be thought fit to recommend that dentistry should be a benefit administered by the

Approved Societies, then, at the least, nationally organised machinery should be set up, including representative bodies for determining fees and conditions of service, for investigating complaints against the service, and for setting up referees or consultant dental surgeons of experience to settle the many surgical points involved in the administration of the benefit.

51. With regard to finance, it seems clear from the long experience of the Society that in no case should the gross total cost of an all-in scheme of dental benefit exceed 5s. 3d. per member per annum, of which a substantial portion could be recovered from the individual member. This cost could further be reduced by a stricter qualifying period than the 26 weeks of the U.W.I.S., and would be offset to a very marked and increasing extent by the saving in sickness benefit which would undoubtedly result.

APPENDIX XXV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL AMALGAMATED APPROVED SOCIETY BY SIR THOMAS NEILL, J.P., CHAIRMAN, MR. E. C. FARMER, ACTUARY, AND MR. J. S. PIKE, CONTROLLER OF THE SOCIETY. See Minutes of Evidence of the Nineteenth Day, Questions 10,390 to 10,636.

1. The following statement is submitted to the Royal Commission on National Health Insurance on behalf of the National Amalgamated Approved Society, which was approved by the National Health Insurance Joint Committee on the 7th June, 1912, under section 23 of the National Insurance Act, 1911.

2. In the reports of the proceedings of the House of Commons, short extracts of which are given in Appendix A, it will be seen that the Government of the day expressed, through the Chancellor of the Exchequer, the wish that the Industrial Assurance Organisations should take part in the administration of National Health Insurance, and the National Amalgamated Approved Society was formed by the managements of a number of industrial assurance companies and societies (herein referred to as the "Associated Offices"), for the sole purpose of administering the scheme of National Health Insurance.

3. The Associated Offices, through the staffs of which the Society administers benefits, are:—

The Albion Friendly Society.
The Britannic Assurance Company, Limited.
The British Legal Life Assurance Company, Limited.
The Hearts of Oak Assurance Company, Limited.
The London and Manchester Assurance Company, Limited.

The Pearl Assurance Company, Limited.
The Pioneer Life Assurance Company, Limited.
The Refuge Assurance Company, Limited.
The Royal London Mutual Insurance Society, Limited.

4. The Society wishes to identify itself with the proposals which have already been submitted to the Royal Commission on behalf of the National Conference of Industrial Assurance Approved Societies, and to support the recommendations of that Conference. Being an International Society, however, with a common fund for men and women, operating throughout England, Scotland, Wales and Northern Ireland, it is considered that the Society's experience might, in some degree, be of value to the Royal Commission.

MEMBERSHIP.

5. The Society's Scottish and Welsh memberships are subject to a separate Valuation; but the English and Northern Irish memberships are valued together. The Society has, therefore, three Valuations, and in each case the male and female membership are valued together in one fund.

6. The membership figures in each country for the years 1913, 1918 and 1923 are as follows:—

	1913.		1918.		1923 (Estimated).													
	Men.	Women.	Men.	Women.	Men.	Women.												
England	} 998,045	684,902	1,101,338	915,807	} 1,142,300	824,100												
Ireland							} 76,472	42,115	83,081	59,124	} 11,150*	10,090*						
Scotland													} 77,720	28,112	77,067	34,138	} 85,550	54,690
Wales ... ..																			} 1,152,237	755,129	1,261,486	1,009,069	} 1,316,000	919,500
TOTALS	} 1,907,366	2,270,555	2,235,500															
GRAND TOTALS																		

* Northern Ireland only.

BENEFITS.

7. The total payments made by the Society in respect of cash benefits since the Act came into

operation, up to and including the year 1924, amounted to £17,326,262.

8. The details of the benefits paid for the years 1923 and 1924 are as follows:—

	Sickness.		Disablement.		Maternity.		Total.
	Men.	Women.	Men.	Women.	Men.	Women.	
England—	£	£	£	£	£	£	£
1923	509,470	503,360	259,928	255,155	167,786	72,450	1,768,158
1924	577,423	584,536	278,626	289,664	167,409	74,030	1,971,688
Scotland—							
1923	33,996	28,379	21,287	14,599	13,826	5,493	117,570
1924	39,855	34,713	21,794	15,464	13,888	5,519	131,233
Ireland—							
*1923	7,289	9,508	5,410	8,961	2,941	1,361	35,479
1924	5,953	10,409	4,382	7,903	2,290	1,249	32,186
Wales—							
1923	48,005	19,890	26,336	9,066	12,416	2,576	118,289
1924	55,820	23,052	28,833	9,959	12,359	2,725	132,748
TOTAL—							
1923	598,760	561,137	312,970	287,781	196,969	81,879	2,039,496
1924	679,051	652,710	333,635	322,990	195,946	83,523	2,267,855

* Includes (six months) benefits paid in respect of Southern Ireland.

CLAIMS EXPERIENCE.

9. Tables are given in Appendix B, showing the relation between the actual claims experience of the Society in each country during the five years 1919 to 1923, and the expected claims approximately calculated.

ADMINISTRATION.

10. Although the Society was formed by the Associated Offices, it is a separate entity and an independent organisation, administered through a Committee of Management appointed in accordance with the Rules.

11. *Agency Staff.*—For the purpose of providing the members of the Society with the advantage of a "home service," the Outdoor Staffs of the Associated Offices are utilised for the purposes of the enrolment of new members, the payment of claims, the distribution and collection of contribution cards and arrears cards, the notification of changes of address and alterations in insurance status, and all work incidental to these several duties.

12. In order to obtain the services of these staffs the Society entered into agreements, approved by the Ministry, with seven of the Companies and Societies covering the whole membership (with the exception of approximately 25,000 members who are attended to through the representatives of two Offices under special arrangements). Under the terms of these agreements, certain duties are undertaken by the Associated Offices for a prescribed remuneration payable to the Office on a membership basis. In consideration of this payment the Offices undertake to remunerate their representatives and indemnify the Society against any responsibility therefor. By means of these contracts the Society has placed at its disposal the services of 22,000 agents and 2,600 supervisory staff, together with a number of district office clerks in the larger areas.

13. It will be observed that the outdoor staffs of the various Offices are not technically representatives of the Society, but are responsible to the Associated Offices. This maintains the vital principle of a single control. While the agents' duties in respect of National Health Insurance constitute only a part-time service, it has none of the disadvantages of such a service, inasmuch as the agents are responsible to their respective Offices for the proper discharge of their National Health duties.

14. The duties for which the Associated Offices are responsible to the Society are set out in the respective agreements in full detail and in precise terms. The agreements, as approved, are in the hands of the Ministry.

15. *Sickness Visitation Staff.*—For the purpose of ensuring that the rules of the Society are observed by members in receipt of benefit, the Committee of Management appoint and control a staff of sickness visitors. In order to meet the varying conditions throughout the Kingdom, this staff is comprised of whole-time and part-time visitors as follows:—

Whole-time	...	...	...	274
Part-time	...	...	...	141

16. The visitors are advised from the Head Office of every new claim for benefit immediately notice of sickness is received, and a "first" visit is made as early as possible. Thereafter, the frequency of visits in a particular case is governed by the nature of the complaint and the prospects of recovery. The number of visits made by this staff during the years 1923 and 1924 were approximately as follows:—

1923	...	...	...	1,666,000
1924	...	...	...	1,790,000

17. *Head Office.*—Apart from the duties undertaken by the Associated Offices under the terms of their agreements and those of the sickness visitation staff, the work of the Society is entirely centralised at its Head Office in London, where the membership, contribution and benefit records of all the Society's members are dealt with.

18. *Claims for Benefits.*—Under the terms of the agreements all applications for benefit are received at the Head Office direct from the officers in charge of the districts, to whom authorisations to pay are despatched direct. No cash, however, passes between the Society and the districts, it being a condition of the agreement that a certain sum be deposited with each of the contracting Offices, and that benefits shall be paid from the funds provided in this way. The benefits paid are subsequently reimbursed to the Associated Offices by the Society on the imprest system. Under the terms of the authority issued by the Society, the agent continues to pay benefit for so long as the incapacity is supported by medical certificates; unless he becomes aware of any evidence which suggests that the member has ceased to be entitled to benefit, or is otherwise instructed by the Society. A weekly list of the payments so made, accompanied by the relative receipts and medical evidence, is sent to the Society from each district. These documents are checked with the authorisations, and the payments recorded in the Society's books at Head Office. During the year 1924, such payments numbered 3,647,332, representing a weekly average of 70,141.

19. *Contribution Cards.*—Each district is similarly required to despatch to Head Office all contribution

and arrears cards collected, accompanied by a complete list of such cards. These contributions are entered on the members' records at Head Office and, after scheduling and analysis, are despatched to the appropriate Official Departments. The number of cards received each half-year and dealt with in this way now exceeds 2,000,000.

20. *New Members.*—Applications for membership are received at Head Office and, if accepted, the various documents necessary to the setting up of the membership and to supplying the evidence of the member's title to medical benefit are prepared and distributed. The Insurance Committee Index Slip is despatched to the Central Index Committee for England and Wales (or, in Scotland, to the appropriate Insurance Committee); the record card to the District for delivery to the member; a ledger account opened at Head Office and a Reserve Value card and alphabetical index card prepared.

21. The number of the clerical staff employed at the Head Office of the Society is 1,408.

22. *Cost of Administration.*—The following statement relates to the cash payments, under main headings, made in respect of administration for the years 1922, 1923 and 1924:—

	1922.	1923.	1924.
	£	£	Approx. £
Payments under Agreements with Associated Offices and to the representatives of the two Offices referred to in paragraph 12...	185,376	192,450	195,672
Sickness Visitation Staff Salaries and Travelling Expenses...	33,714	33,611	33,516
Registered Office Salaries	208,746	213,273	212,009
Printing, Stationery, Carriage and Postage ...	20,464	18,629	19,681
Rent, Rates, Lighting and other Incidental Office Expenses...	20,171	17,026	20,085
Committee of Management Fees and Travelling Expenses ...	329	289	275
Legal and other Professional Charges ...	3,649	5,149	5,438
Medical Referees ...	5,571	5,644	6,035
TOTAL ...	£ 478,020	486,071	492,711

23. The item in respect of remuneration paid to the Associated Offices under the terms of the agreements represents the amount actually paid by the Society for all the duties performed by the Outdoor Staffs.

VALUATIONS.

24. The first valuations of the society disclosed a total surplus of £1,461,856, of which sum £358,834 was declared by the Government Valuers to be disposable.

ADDITIONAL BENEFITS.

25. The sums declared by the Government valuers to be disposable, namely, £350,177 in respect of England and Ireland and £8,657 in respect of Scotland, were insufficient to allow of any increase in the normal cash benefits of the Act. The Society therefore confined itself to utilising the amount available to the best advantage of those members entitled, by providing treatment benefits. The scheme adopted by the Society and approved by the Ministry embraced contributions to Voluntary Hospitals in respect of the cost of treatment of members of the Society who were in-patients; the provision of dental, optical, nursing, and convalescent home treatment and of medical and surgical appliances.

26. Although applications for all these benefits are on the increase, yet the one which makes the strongest appeal to members is undoubtedly that of dental treatment, and despite the fact that the Society is now spending on this benefit at the rate

of £90,000 per annum, it will not be possible to contribute more than one-half of the cost of such treatment on approved applications. Of every 100 applications now being received for the following treatment benefits the proportions in each case are:—

	Per cent.
Dental	71
Optical	18
Convalescent Home Treatment	7
Medical and Surgical Appliances	4

27. The total sums spent under the Society's present scheme of Additional Benefits up to the 31st December, 1924, in respect of each of the foregoing benefits are as follows:—

	£
Contributions to Hospitals ...	118,446
Dental Treatment	104,936
Optical Treatment	9,569
Convalescent Home Treatment ...	16,065
Medical and Surgical Appliances	4,330
Nursing	3,985

28. The Society is so impressed with the value of, and the need for, dental treatment that it strongly supports the scheme submitted on behalf of the National Conference of Industrial Assurance Approved Societies.

ACCIDENTS AND INDUSTRIAL DISEASES.

29. In order that the Society may safeguard the interests of its members in the matter of compensation, and also obtain the relief contemplated by the Act, it maintains a staff for the examination of all cases of incapacity which appear to be due to accident and industrial disease. During 1923 there were 58,514 cases so considered, and compensation obtained for members in 21,425 cases.

INSTITUTIONAL CASES.

30. Having regard to the considerable contributions of the Society to voluntary hospitals under its scheme of additional benefits, and to the relationship generally of Approved Societies to these institutions, it may be of interest to the Commission to know that at a recent examination it was found that of 79,889 members of the Society on the funds 8,733 were inmates of institutions, 5,769 of whom were men and 2,964 were women. Of these the following proportions were inmates of the types of institutions indicated:—

	Per cent.
Voluntary Hospitals or Homes ...	30·5
Sanatoria	16·5
Poor Law Institutions	20·0
Mental Asylums	21·5
Hospitals under Ministry of Pensions	9·5
Infectious Diseases Hospitals ...	2·0

TUBERCULOSIS.

31. It was also recently found that of the total number on the funds 10 per cent. of the men and 7·5 per cent. of the women were suffering from tuberculosis. Of those suffering from tuberculosis, 28·7 per cent. of the men and 22·6 per cent. of the women were receiving sanatorium treatment, and 30·5 per cent. of the men and 32·1 per cent. of the women were receiving domiciliary treatment.

32. The following is an analysis of the figures:—

	Male.	Female.
No. suffering from tuberculosis ...	3,561	3,047
(a) Number receiving Institutional Treatment, either Hospital or Sanatorium	1,021	698
(b) Number receiving Domiciliary Treatment	1,086	979
(c) Number not in receipt of either	1,454	1,360

These figures indicate the serious charge on insurance funds from this one cause alone, and appear to suggest that the complaints of inadequate facilities for the treatment of this disease are well founded.

INVESTMENTS.

33. All sums declared by the Ministry and the Boards of Health to be available for investment by the Society have been paid over to the Society half-yearly and invested by the Committee of Management. The total sum so invested as at the 31st December, 1924, was £5,656,267, yielding an annual interest income of £282,922, equivalent to an average rate of £5 Os. 0½d. per cent. per annum. The present market values of these investments total approximately £5,969,253, representing an appreciation on cost price of £312,986, or 5.53 per cent.

34. The sum invested by the Ministry and Boards of Health on behalf of the Society was, at the same date, £5,073,719, making the grand total of the Society's investments £10,729,986.

30, Euston Square,
London, N.W.1.

2nd February, 1925.

APPENDIX A.

(Referred to in paragraph 2.)

EXTRACT FROM OFFICIAL REPORT OF PARLIAMENTARY DEBATES IN HOUSE OF COMMONS, MONDAY, 29TH MAY, 1911.—Vol. 26, No. 79, pages 772, 773, and 774.

MR. LLOYD GEORGE.

I come to collecting societies. . . . A good deal of criticism has been directed against them and industrial insurance societies, but I say without hesitation, after examining the thing very carefully for the last few months, that there is this to their credit, that they have saved millions of homes from being broken up in the hour of their most helpless need, and that is a great thing to be said for any society. . . .

These societies are managed with great skill by men of consummate business ability, and the reason I say that is not because I want to buy off opposition, but because I want their help. They are men of such admirable experience and ability that I think it would be valuable to get their able experience in the working of a great scheme like this. . . . I should like to get the active aid and co-operation of these societies with their magnificent machinery. There is nothing to prevent their forming subsidiary departments. They would have to keep the money absolutely separate; they would not be allowed to pass one penny of it to the other part of their business; they would not be allowed to make any profit out of the money compulsorily collected by the State; but they would be entitled to do this. They have something like 100,000 agents in the country, trained men, who are constantly visiting the houses for the purpose of collecting premiums for death benefits, which will still go on. These men would be invaluable for the purpose of checking malingering and of administering the sick department of their societies. The societies would be entitled to pay what the Friendly Societies now pay to their secretaries for purely secretarial work. It would benefit the agents to the extent that the societies would be entitled to pay them purely secretarial charges in addition to their present remuneration.

I say that, because I should like to get all these societies into this very large scheme of insurable interests now created for the first time. You have six million people covered by Trade Unions and Friendly Societies, but you have eight millions or nine millions outside, and the Friendly Societies, with all respect to them, with all their magnificent machinery, could not possibly assimilate this huge mass of insurable lives within the next two or three years. The assistance of these societies would be an advantage to the State. It would also be an advantage to the Friendly Societies; otherwise you would have nine million propositions dumped upon them before they could sift and examine them, whereas the industrial and collecting insurance

societies have a great machinery, with a 100,000 agents, in every town and village, in every corner and quarter of the land, already prepared to work an organisation of this kind. So far from the collecting societies being injured it would be a magnificent thing for them. But it would be a still better thing for the State to secure all this machinery for the purpose of working out this great scheme.

APPENDIX B.

NOTE ON APPENDED TABLES.

The expected claims for sickness and disablement benefits (except for married women) are those according to the average number of weeks sickness and disablement benefits payable to a member within one year given in Table II of the Valuation Regulations (S.R. & O., 1924, No. 1316). The expected claims for maternity benefit are those according to Table III of the Regulations.

As regards married women, the rates of expected sickness for all years have been increased to include the additional provision made in respect of married women shown in Table V of the Valuation Regulations as an addition to the liability in respect of a married woman. The amount of additional liability at each age has been transformed into weeks of incapacity on the basis of 12s. 9d. per week. The whole of this additional liability has thus been treated as applying to sickness benefit, and none was allocated to disablement benefit.

Up to the year 1921 provision was made for the heavier claims of married women as compared with those of spinsters and widows, by means of the Women's Equalisation Fund. In order, therefore, that proper comparisons may be made, the adjusted rates of sickness have been used for all years alike.

The membership for the year 1923 is an estimate and the expected claims for all years have been calculated on an approximate distribution of the membership over attained ages.

TABLE I (*sickness benefit claims*).

For the last few years there appears to be a tendency for the sickness claims of men to become lighter each year, whereas in the case of women the general tendency is in the opposite direction.

TABLE II (*disablement benefit claims*).

The claims for disablement benefit from male members, although increasing, are still below the expected in England and Scotland. The disablement claims from female members, however, have been increasing rapidly during the four years, and for the three Countries in the year 1923 were 201 per cent. of the expected.

TABLE III (*maternity benefit claims*).

The claims for maternity benefit in respect of men's insurances have, for the Society as a whole, been about equal to the expected. A notable fluctuation appeared in the years 1920 and 1921, corresponding to the abnormal increase in the birth rate occurring in those years. In the case of women, however, the actual claims have been very considerably below the expected. This saving constitutes a useful off-set to the loss on disablement benefit.

TABLE IV (*women's sickness and disablement claims—year 1923*).

For the year 1923 the percentages of actual to expected sickness benefit claims are shown separately for married women and for spinsters and widows. For the Society as a whole the latter are well within the expected, whereas those of married women are about 25 per cent. in excess of the expected, even after applying to this benefit the whole of the

additional provision made in respect of married women.

For the same year the corresponding percentages in respect of disablement benefit are shown. In this case, for the Society as a whole, the claims of married women do not appreciably exceed those of spinsters and widows, the latter being 199 per cent. of the expected and the former 208 per cent.

Combining the two benefits for all women the excess, on the basis of weeks of incapacity, is 28 per cent. and, on the basis of cash benefits, 23 per cent.

The significance of these figures upon the quinquennial valuation results of the Society will be appreciated when it is pointed out that the proportion of female and male members of the Society in the 1918 valuation was 44.4 per cent. women and 55.6 per cent. men. This compares with the figures of all societies—34.3 per cent. women and 65.7 per cent. men. Stated in another way, the Society had 18.1 per cent. of all the women and 11.8 per cent. of all the men or altogether 14 per cent. of all insured persons.

As regards married women, no official figures are available as to the total number of married women insured persons, but we have reason to believe that the Society has quite 30 per cent. of all the insured married women. As at the 31st December, 1923, the number was approximately 210,000 (apart from 27,500 newly-married women who were entitled to the restricted benefits of Class K) out of a total female membership of 919,500.

As already stated in paragraph 4 of the Society's Statement of Evidence, the Society has only one fund for men and women, and consequently the women share equally with men whatever surplus accrues in the common fund.

TABLE I.

Percentages of Actual to Expected Sickness Claims.

MEN.				
Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	74	80	84	75
1921 ...	73	80	99	75
1922 ...	73	74	97	74
1923 ...	66	59	89	67

WOMEN.				
Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	87	88	93	87
1921 ...	101	92	113	101
1922 ...	100	94	125	100
1923 ...	101	90	123	101

TABLE II.

Percentages of Actual to Expected Disablement Claims.

(The expected claims are those according to the average number of weeks disablement benefits payable to a member within one year, published by the National Health Insurance Joint Committee, in Valuation Regulations—S.R. & O., 1924, No. 1316.)

MEN.

Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	52	62	77	54
1921 ...	67	77	98	70
1922 ...	75	83	112	78
1923 ...	82	86	132	85

WOMEN.

Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	117	138	164	120
1921 ...	167	181	214	169
1922 ...	184	177	236	185
1923 ...	200	190	256	201

TABLE III.

Percentages of Actual to Expected Maternity Claims.

(The expected claims are those according to the probability of issue to a member during one year, published by the National Health Insurance Joint Committee, in Valuation Regulations—S.R. & O., 1924, No. 1316.)

MEN.

Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	125	134	122	126
1921 ...	113	126	116	114
1922 ...	100	113	96	101
1923 ...	95	109	96	96

WOMEN.

Year.	England.	Scotland.	Wales.	All Countries.
1920 ...	73	92	77	74
1921 ...	57	77	66	58
1922 ...	51	68	57	52
1923 ...	52	72	58	53

TABLE IV.

Percentages of Actual to Expected Sickness and Disablement Claims for the Year 1923 showing Married Women separate from Spinsters and Widows.

Sickness Benefit.

	Spinsters and Widows.	Married Women.	All Women.
England ...	90	126	101
Scotland ...	84	112	90
Wales ...	125	113	123
All Countries ...	91	125	101

Disablement Benefit.

	Spinsters and Widows.	Married Women.	All Women.
England ...	197	205	200
Scotland ...	202	161	190
Wales ...	275	194	256
All Countries ...	199	203	201

APPENDIX XXVI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL CONFERENCE OF FRIENDLY SOCIETIES, BY MR. JOHN WOOLLANDS SHAW, PRESIDENT, MR. ALFRED J. E. SAUNDERS, VICE-PRESIDENT, AND MR. WILLIAM MARLOW, SECRETARY. See Minutes of Evidence of the Twentieth Day, Questions 10,637 to 11,027.

GENERAL.

1. The National Conference of Friendly Societies was established in the year 1880, the primary objects being to promote mutual co-operation in extending the principles of the voluntary thrift movement and to watch any particular action likely to interfere with the operations of registered Friendly Societies.

2. In the year 1912, consequent on the introduction of National Health Insurance, the objects were extended to include the mutual co-operation of Approved Societies connected with the Conference, and to take into consideration matters relative to Health Insurance and the Regulations and Orders in connection therewith, and generally to take any action that might be considered necessary or desirable to promote improvements in the National Insurance Act and the administration thereof.

3. The National Conference of Friendly Societies is composed of 72 separate societies, 63 of which are registered under the Friendly Societies Act and provide voluntary insurance benefits; included in that number 56 are Approved Societies for National Health Insurance, the remaining societies being associated with the Conference for National Insurance purposes only.

The voluntary membership of the societies connected with the Conference varies from 747,568 to 128, but there are only four of a smaller membership than 1,000. The membership of the societies at the last available date was:—

Adults	3,458,168
Juveniles	1,238,423
Colonial and Foreign	1,406,569
Honorary Members	34,739
Wives and Widows	1,294,145
Total voluntary membership	7,432,044

4. The particulars furnished by 59 societies show the income for the year 1923 to be £9,305,443, and there was paid during that year in voluntary benefits the following sums:—

Sickness benefit	£ 3,506,815
Death and funeral benefits	795,523
Medical benefit and grants in distress	702,311
	£5,004,649

The total funds held by the societies amounted to £62,681,182.

5. The number of State insured members of societies comprising the Conference is 4,048,524.

GOVERNMENT.

6. The Conference is governed by the Annual Meeting composed of representatives appointed by the societies affiliated to the Conference. The Annual Meeting appoints officers and a committee to act on behalf of the Conference between the Annual Meetings.

7. Between the years 1908-1911, when the Government of the day was considering the introduction of National Health Insurance the Committee of the Conference were consulted by the then Chancellor of the Exchequer, and many features of Friendly Society Administration were subsequently incorporated in the National Insurance Act.

8. A very large majority of the societies connected with the Conference, for nearly a century have been engaged in the business of mutual sickness and death

insurance, and the unrivalled knowledge of the officials was of incalculable service to the State in putting the National Health Insurance Act into operation.

9. A number of the societies are of the branch type, while others work on the centralised system. Having regard thereto, this Statement has been confined to general principles affecting all types of societies alike, and any comment on domestic administration has been excluded.

PERSONS INCLUDED IN THE SCHEME.

10. It is submitted that the present age limits, 16-70, should be continued. From enquiry addressed to the constituent societies, witnesses are informed, that there appears to be no general desire for these limits to be altered.

11. Societies have been questioned whether they experience any difficulty with out-workers, and whether any alteration in the law should be made with regard to their insurance. The replies reveal that very little difficulty is experienced, except in the supervision of claims of home-workers, but not of such a serious character as to warrant out-workers being excepted from insurance.

SOURCES OF REVENUE.

12. It is submitted that the present sources of revenue are adequate, and that there is no call for any revision of the rates of contributions of employers, employees and the State.

13. The method of collecting contributions by means of stamps affixed to cards is regarded as being satisfactory, and it is urged that the present half-yearly card should not be changed for a longer period card. Serious administrative difficulties would arise with the adoption of a yearly card.

MONEY BENEFITS.

14. The opinion is held that the rates of sickness benefit should not exceed £1 per week, including any additional cash benefits arising from valuation surplus.

15. It is considered that the present method of discharging arrears is quite satisfactory and very favourable to the insured person.

DENTAL BENEFIT.

16. There is a general desire throughout the societies associated with the Conference that, at the earliest date, dental benefit should be made one of the normal benefits under the National Insurance Act, with a possible restriction of the cost of full dentures to 50 per cent.

SPECIAL CLASSES.

17. *Class K.*—It is recommended that the present Class K be abolished, and that women should cease to be insured on marriage and be entitled to a free year's insurance as in the case of other persons ceasing to be insured.

18. *Foreign-going Seamen.*—Consideration has been given to the position of Foreign-going Seamen, and witnesses are informed that comparatively little difficulty is experienced in dealing with this class of insured person. They, therefore, recommend that Foreign-going Seamen should continue to possess freedom of choice of Approved Society.

19. *Serving Soldiers and Sailors.*—It is the expressed desire of societies that men joining H.M. Forces should continue to be insured and remain members of Approved Societies.

20. *Deposit Contributors.*—The Conference is of the opinion that the present Deposit Contributor Class should be abolished, and that some arrangement should be made whereby the present members of that class be absorbed by Approved Societies, and that, for the future, persons not becoming members of an Approved Society within a fixed period of their entry into insurance should be allocated by the Department amongst Approved Societies.

SIZE OF APPROVED SOCIETIES.

21. Having regard to the constitution of the National Conference of Friendly Societies, we make no suggestion as to the minimum number of members that should constitute an Approved Society.

MEDICAL BENEFIT.

22. The Conference is of the opinion that until a Public Medical Service can be instituted medical benefit should be extended to include the provision of specialist and consultant services for insured persons, at the cost of the General Medical Benefit Fund.

23. There is a general desire for medical benefit to be extended to dependants of insured persons. Probably the only satisfactory way of providing an extended medical service without further overlapping and duplication of administration costs is by the setting up of a Public Medical Service, as to which a statement is appended hereto.

POOLING OF SURPLUSES.

24. It is highly desirable that the present system of separate funds for each Approved Society should be maintained, and that there should be no general pooling of valuation surpluses.

25. Witnesses are, however, in favour of the pooling of a percentage of the valuation surpluses of branches within an Affiliated Society in order that, as far as possible, uniform treatment benefits may be provided in the Society.

PRESERVATION OF APPROVED SOCIETIES.

26. A majority of the insured members of Friendly Societies are also members for voluntary business, and they would keenly resent being deprived of the facilities now given to them of making claims to and receiving benefits from the one source. Moreover, it is to the advantage of the nation that voluntary thrift and National Health Insurance should remain closely associated.

27. Probably amongst the many types of Approved Society there is no type that provides the same facilities for the members to attend meetings and to take part in the administration of National Health Insurance as does the Friendly Society. In the very large majority of cases, the officers of Friendly Societies who are responsible for the collection of contribution cards, the paying of cash benefits to the members and the visiting of sick members, are themselves insured persons. It follows that the business of such societies under the National Insurance Act, is largely under the control of the members, being insured persons.

28. It is therefore submitted that it would be difficult to conceive a more economical or efficient way of administering National Health Insurance than by the present Approved Society system, and that without the machinery possessed by the Approved Societies, insured persons would experience a very real difficulty in obtaining, as promptly as they do now, the benefits which the National Insurance Act confers upon them.

ADMINISTRATION OF TREATMENT BENEFITS.

29. It is strongly urged that all treatment benefits should continue to be administered by Approved Societies.

PUBLIC MEDICAL SERVICE.

30. For some time the National Conference of Friendly Societies has had under consideration the desirability of co-ordinating the various public medical services and bearing in mind the many persons who advocate a considerable extension of the present medical benefits under the National Insurance Act, it is suggested that it will become necessary in the near future to seriously consider the setting up of a national or public medical service. Submission on the subject is contained in an appendix to this statement.

APPENDIX.

SUBMISSION FOR AND ON BEHALF OF THE NATIONAL CONFERENCE OF FRIENDLY SOCIETIES ON A PUBLIC MEDICAL SERVICE.

31. In the first place, cognisance has been taken of the many separate forms of Medical Service now in existence, which are all highly necessary. These include:

- (a) A General Medical Service for the destitute sick. (At present administered under the Poor Law.)
- (b) A Public Health Service for the prevention of epidemic and other sicknesses that might be caused by general lack of hygiene. (At present administered by the local authorities.)
- (c) A specialised system of treatment—institutional and domiciliary—for consumption. (At present administered by the local authorities.)
- (d) A free and universal Hospital Service for infectious diseases. (At present administered by local authorities or special public bodies.)
- (e) A free and universal system of medical inspection—with or without treatment—of elementary school children. (At present administered by the Educational Authorities.)
- (f) A Medical Service for maternity and infant welfare. (At present administered by the local authorities.)

32. In addition to these six main forms of Medical Service, there are:

- (a) The Voluntary Hospitals.
- (b) Various minor services, such as the Home Office Factory Surgeons, Police Surgeons, &c.
- (c) Semi-private services, such as the Post Office Medical Service.

33. It will be agreed that it is desirable to supersede the present Poor Law by something more effective and humane, and that before this can be done it is necessary to provide efficient machinery to carry on the existing Poor Law Medical Service, which includes both a general practitioner service and a complete range of specialist and institutional treatment.

34. Few will deny that it is highly wasteful and inefficient to allow six or more separate organisations for medical services (all paid for wholly or mainly out of public funds) to exist side by side, as they do to-day, with consequent over-lapping, friction, and duplication of expense.

This becomes all the more marked when it is remembered that for one-third of the entire population there is, in addition, a general practitioner service provided in the form of medical benefit under the Insurance Act.

35. Notwithstanding all these various medical services, there exists little or no provision for specialists' and consultants' services for the fifteen million insured persons, whilst for the twenty millions or so dependants of insured persons there is no general medical service except that of the Poor Law.

Owing to lack of means, it is impossible for the poorer classes to obtain the services of doctors on fee-paying terms, and for this reason it was deemed necessary to introduce a system of compulsory insurance to include free doctoring. It is submitted that the need is equally great to-day for similar provision for the remainder of the population below an income limit of, say, £250 a year, including the dependants of such persons, as well as those of insured persons.

36. If this were done by merely extending medical benefit on its present basis to dependants of insured persons, it would:

- (a) Greatly intensify the over-lapping of services already referred to.
- (b) Be extremely costly, because a large number of panel practitioners would be, in effect, working full time on payment basis devised for part-time work.
- (c) Leave out of the scheme at least one and a half millions of persons including not only the destitute, but a number of non-insured persons, such as hawkers, small shopkeepers, &c.

37. It is, therefore, suggested that the best way of organising the provision of medical treatment is to merge *all* existing forms of public medical service (including medical benefit under the National Health Insurance Acts) into one National Medical Service, thereby creating one unified organisation for the prevention and cure of disease. Under this system, the service would be provided for all persons below a given income limit.

38. The system might take the following form:—

(a) GENERAL PRACTITIONER SERVICE.

Every individual below a fixed income limit would be entitled to this, a definite capitation fee being paid to the Medical Fund in respect of them:

- (I.) As regard insured persons *and their dependants* from National Health Insurance Funds.

(II.) As regards destitute persons, from public funds.

(III.) As regards other persons, by a contribution paid by themselves.

Contributions under (I.) and (III.) would carry a State grant as medical benefit under the National Health Insurance Act does at present, and in addition the Medical Fund would receive various payments from the local rates or the Central Exchequer (or definite grants in commutation thereof) in lieu of the present direct payments made for the service now undertaken under one or other of the headings set out under paragraph 31.

To give full effect to this, the Medical Service should be of a whole-time character.

(b) SPECIALIST AND CONSULTANT SERVICE.

This would be available for all persons referred to in paragraph 38(a) and the cost would be met from a fund built up in the same way.

39. It should be noted that the above services 38(a) and (b) should include a complete range of medical and allied service—dentists, nurses, ophthalmologists, consultants, hospitals, sanatoria, midwives, masseurs, and, in fact, everything needed for the prevention and cure of sickness and to restore a sick person to health.

40. As to the method of administration, the scheme should be controlled by a local Medical Committee, or Health Committee, similar in constitution to the local Education Committee, *i.e.*, partly elected by the local Council and partly appointed to represent various interests, such as doctors, insured persons, dentists, etc.

41. I may be found desirable at a later stage, in order to make a complete and effective service, to include provision for persons in receipt of more than £250 per annum, but, for the purposes of this Submission, the Conference has confined its attention to persons within the income limit, under the National Health Insurance Acts.

APPENDIX XXVII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE COMMITTEE OF MANAGEMENT OF THE ROYAL INSURANCE OFFICIALS' BENEVOLENT ASSOCIATION, By MR. DUNCAN C. FRASER, a Trustee of the Association, and MR. E. W. SYDER, Honorary Secretary of the Association. See Minutes of Evidence of the Twentieth Day, Questions 11,028 to 11,201.

OBJECTS OF THE ASSOCIATION AND MEMBERSHIP.

1. This Association was formed in October, 1903, by members of the staff of the Royal Insurance Company, Limited, the objects being:—

A. To form a fund out of which, at the discretion of the General Committee:—

- (1) Aid may be given to members in case of sickness by contributing towards their medical, surgical and nursing fees.
- (2) To aid necessitous members in keeping in force their Life Insurance policies.
- (3) To assist necessitous widows, children or other dependent relatives of deceased members.
- (4) To make grants in aid of the support and education of children of disabled, incapacitated or deceased members; and,

B. To promote and watch over the interests of existing and superannuated members.

2. When the National Insurance Act, 1911, was passed, the objects of the Association were enlarged and its rules altered so that it could become an Approved Society under the Act, with a view to its insured members having the full benefit of the favourable experience in respect of sickness which it

was anticipated would result from the special nature of its membership. Eligibility for membership was, at this time, also extended to the staffs of any other Company in which the Royal Insurance Company, Limited, might have a controlling interest, but, so far as the National Health Insurance Section of the Association is concerned, only forty employees of such Companies are at present members.

3. The Association was approved to operate in England, Scotland, Ireland and Wales, but is valued as a whole. The Irish Free State members have now been transferred to an Irish Society.

4. Female members of the Association are not eligible to become insured members, as at the time the Association became an Approved Society there were very few female employees on the staff of the Royal Insurance Company, Limited, and the admission of women would have entailed the keeping of separate records for male and female members.

5. For the purposes of this statement, the term "insured members" is used to signify members of the Association who are insured persons under the National Health Insurance Acts and who have selected the Royal Insurance Officials' Benevolent Association as their Approved Society, and the term "Association" is used to apply to the Association in its capacity as an Approved Society.

6. The original number of insured members of the Association on the 15th July, 1912, was 980. The mean membership for subsequent years has been as follows:—(The membership of Part 1, Benevolent Branch, of the Association for the corresponding years is given for purposes of comparison).

Year.	Insured Members.	Members of Part 1.
1913	979	1,722
1914	978	1,838
1915	1,086	1,894
1916	1,083	1,968
1917	1,023	1,927
1918	864	1,864
1919	713	1,818
1920	662	2,121
1921	622	2,193
1922	592	2,191
1923	586	2,186
1924	607	2,317

All the insured members are on the staff of the Royal Insurance Company, Limited, with the exception of forty who are employed by affiliated Companies. The decrease in the membership is due to the fact that as the Association consists entirely of non-manual workers, the increased standard of remuneration prevailing in recent years has had the effect of bringing a large number of members outside the provisions of the Acts.

7. The average age of the existing members at the 31st December, 1924, was 22·6 years. The age distribution of the members as at 31st December, 1924, and 15th July, 1912, was as follows:—

	At 31st Dec., 1924.	At 15th July, 1912.
Under age 20	219	408
Age 21-25	271	274
„ 26-30	118	180
„ 31-35	22	68
Over age 35	5	50

8. An analysis of the members ceasing insurable employment during the past four years demonstrates the fact that the average period of eligibility for National Health Insurance is a remarkably short one as regards the members of the Association and the age at exit is correspondingly low:—

	Average age last birthday at exit.	Average completed years of insurance.
1921	30·3	7·8
1922	28·1	7·9
1923	26·0	8·1
1924	24·6	8·0

CONTRIBUTIONS AND BENEFITS.

9. A statement of contributions and benefits paid from the inception of the Act till 31st December, 1923, is appended:—

	15/7/12 to 31/12/18.	Year ending December 31,					Total to 31/12/23.	Year ending 31/12/24.
		1919.	1920.	1921.	1922.	1923.		
Mean Membership...	976	713	662	622	592	586		607
Contributions	£ 2,933	£ 462	£ 736	£ 875	£ 1,205	£ 1,015	£ 8,500	} Not yet advised.
State Grant...	546	1	24	51	271	55	948	
Interest	906	282	337	367	218	412	2,522	
Total	4,385	1,575	1,460	1,293	1,775	1,482	11,970	
Medical and Sanatorium Benefit (including administration thereof).	909	124	276	288	328	294	2,214	Not yet advised.
Sickness Benefit	74	17	4	15	12	20	142	3
Disablement Benefit	14	—	—	—	4	—	18	18
Maternity Benefit	128	12	18	9	14	12	193	26
Subscriptions to Hospitals	—	—	—	—	14	—	14	—
Dental Treatment	—	—	—	—	33	47	80	90
Want or Distress	—	—	—	—	10	28	38	32
Administration	546	87	129	147	128	124	1,161	126
Total	1,671	240	427	454	543	525	3,860	

* Credit under sec. 26 (2) N.H.I.A. 1918.

† Amounts transferred from Contingencies Fund.

BENEFIT EXPERIENCE.

Year.	Mean Membership.	Number of Members who received					Yearly Total.
		Sickness Benefit.	Disablement Benefit.	Maternity Benefit.	Dental Benefit.	Want or Distress.	
1913	979	5	—	14	—	—	19
1914	978	3	2	20	—	—	25
1915	1,036	—	—	18	—	—	18
1916	1,083	—	—	16	—	—	16
1917	1,023	—	—	8	—	—	8
1918	864	—	—	8	—	—	8
1919	713	2	—	8	—	—	10
1920	662	3	—	11	—	—	14
1921	622	2	—	5	—	—	7
1922	592	1	1	6	16	1	25
1923	586	2	—	6	12	4	24
1924	607	1	1	13	19	4	38
		19	4	133	47	9	212

10. It would appear from the above that the statutory benefits are of little value to the members. This is due to several causes:—

- (a) The fact that the insured members of the Association are almost all young men, as indicated in paragraph 7.
- (b) They are all selected by medical examination on entering the Company's service.
- (c) Their occupation and conditions of service are conducive to health.

SICKNESS BENEFIT.

11. Largely in consequence, no doubt, of the favourable factors alluded to in the preceding paragraph, the sickness experience of the members has been unusually light, and, moreover, as it is the practice of the Company to continue the payment of salaries during periods of sickness, members have not been in the habit of claiming sickness benefit.

MATERNITY BENEFIT.

12. This has, no doubt, been taken advantage of to the full, but the proportion of married men is small, owing to the low average age of members and the fact that few men of the social position of the members marry whilst on salaries which bring them within the scope of National Health Insurance.

MEDICAL BENEFIT.

13. As regards this benefit, it is difficult to ascertain to what extent the members avail themselves of it, but enquiries have been made of 668 insured male persons in the Company's service, of whom 538 are insured members of this Association, and 485 stated that they had registered with a panel doctor—approximately 73 per cent. It is a fair inference that this ratio holds good as regards the insured members of the Association taken alone.

VALUATION AND ADDITIONAL BENEFITS.

14. At the first valuation of the assets and liabilities of the Association, it was shown that out of the total receipts, amounting to £7,747 for the period under review, the balance unexpended was £5,428, and the ascertained surplus £2,839. Of this last amount £1,060 was certified as available for additional benefits.

15. Out of the list of additional benefits available, the following were selected as being the most suitable to the members:—

- (a) An increase in the maternity benefit of £1 (calculated to absorb £490 of the surplus).
- (b) Dental benefit (calculated to absorb the balance of £570 of the surplus).

Additional benefit (a) was selected because although it was appreciated that the number of insured members who became eligible for maternity benefit was a small one, yet it was felt that a man in the position of one of the insured members who was called upon to meet the expenses of a confinement in the present time of high prices would be subjected to considerable hardship and deprivation and that it was desirable that a portion of the surplus should be applied in affording him some additional help. The amount which was required to be set aside out of the surplus to provide an additional benefit of this nature was on such a high basis that it was only possible to grant an additional payment of £1, and after a few months' experience this particular benefit was cancelled and there was substituted one providing for payments to members who are in want or distress (additional benefit No. 11).

16. The amounts paid in additional benefits since the surplus was allocated are:—

Benefit.	Amount expended.				Total.
	1921 from July	1922.	1923.	1924.	
Additional Maternity Benefit.	£ —	£ 2	—	—	£ 2
Dental Benefit ...	—	33	47	90	170
Want or Distress Benefit	—	10	28	32	70
. Total ...	—	45	75	122	242

As the above amount represents the payments over a period of three and a half years, it seems probable that a considerable portion of the disposable surplus will be unexpended at the close of the period ending 3rd July, 1926.

17. One of the factors which has largely contributed to restricting the payments on account of additional benefits is the brief insurance life of the members, as referred to in paragraph 8, taken in conjunction with the waiting period prescribed for eligibility for the benefits. The following table demonstrates the point:—

At Date.	Total Membership.	No. of Members entitled to Additional Benefits.	No. of Members not entitled to Additional Benefits.
4.7.21	586	436 (74%)	150
31.12.21	592	384 (64%)	208
31.12.22	593	333 (56%)	260
31.12.23	580	290 (50%)	290
31.12.24	635	283 (44%)	352

18. It will be observed from the statement in paragraph 9 that the total benefits paid during the period covered by the first Valuation, including the cost of administration, amounted to £1,671. In his Valuation Balance Sheet, as at 31st December, 1918, the Government Valuer estimated the present value of future benefits at £33,225. It will be noticed, however, that the average amount expended by the Association in the five years, 1919-1923 (the figures for 1924 not yet being available) was less than £500 per annum, including additional benefits. The estimate in the Valuation Balance Sheet would, therefore, appear to represent over 66 years' purchase of the benefits at the present rate, whereas the average insured life of the members is about eight years.

TRANSFERS.

19. Since the 1st January, 1920, formal notice to transfer to another society has been served on 92 members, owing to their having left the service of the Royal Insurance Company, Limited. Of these, 20 ceased insurable employment on leaving and may, therefore, be disregarded. Of the remaining 72, 22 joined other societies, and 50 became members of the Deposit Contributors Fund.

CONCLUSIONS.

20. The conclusion to which the Committee of this Association is forced is that, within the ambit of the National Health Insurance Acts, as they stand at present, it is not possible to provide benefits for the insured members in any way equivalent to the contributions paid. The contributions under the Acts are calculated on the assumption that the member will remain an insured person throughout life up to the age of seventy. In the case of the members of the Association, however, they remain insured persons for a brief period of their lives only, and that the period when sickness experience is at its lightest. In other words, to state an analogous position from a Life Insurance point of view, a whole

life premium is being charged for a short term assurance of a young life. The benefits under the Acts relate to sickness, the maintenance and preservation of health and maternity expenses, and any substituted or additional benefits are directed towards the same ends, but at the ages of the insured members of the Association these benefits apply only to a small number. The Committee can only, therefore, hope that by applying a scheme of additional benefits to the full, the funds of the Association may be more fully utilised for the benefit of the members. If the present allowance of one year of free insurance were modified so that after the termination of insurable employment the members of this Association remain entitled to additional benefits for an extended

period, it would, in the opinion of the Committee, be equitable. At the present time, within a short period of a member qualifying for additional benefits, he ceases to be insurable and loses all title to share in the disposal of the surplus he has helped to build up.

21. The Valuation Report on the Association as at the 31st December, 1922, received the 29th January, 1925, only serves to accentuate the anomalous position of the members of the Association in regard to the benefits of the National Health Insurance Acts. It would appear from the figures in the report that the amount available for additional benefits for the five years commencing the 6th July, 1925, will be over £1,000 per annum.

APPENDIX XXVIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INCORPORATED DENTAL SOCIETY, LTD., BY MR. WILLIAM F. BOWEN, PRESIDENT, AND MR. F. BUTTERFIELD SECRETARY. See Minutes of Evidence of the Twentieth Day, Questions 11,202 to 11,392.

RELATIONSHIP OF MEDICINE AND DENTISTRY.

1. In considering the question of national health the medical and dental professions now realise that the co-relationship of medicine and dental treatment has become of paramount importance.

2. This opinion is equally shared by certain Government Departments and a number of Approved Societies who are giving dental benefits as an additional optional benefit to be administered from their surplus funds; but societies in possession of surplus funds have not all chosen dentistry for various reasons, some because the management of the society have decided otherwise, others because it has been left to the choice of the members, the latter have been guided by the lure of additional cash benefits rather than more serious considerations.

CHAOTIC ADMINISTRATION OF DENTAL BENEFIT BY THE APPROVED SOCIETIES.

3. Even where a society has chosen to administer dental benefit, the method of doing so is peculiar to each society, so that from a general point of view, the result is anomalous and absurd.

4. Certain societies will pay only for dental operations, such as extractions and fillings, other will pay for some portion of the provision of dentures, whilst the cost of all treatment and dentures is a fixed and known amount. The various societies give grants varying in amount but generally working out to little more than a third of the insured person's liability to the dentist.

5. All who contribute to the Health Insurance pay alike, consequently, if such differential treatment is given, it fosters a justifiable concrete complaint, because all the insured are not receiving the same benefits from their Approved Societies.

6. The methods of administration also differ in every conceivable way. Approved Societies issue different types of dental letters and require different methods of collecting the account.

7. One will allow the dentist to collect his share, another will not, but requires payment in full of the patient's share before giving authority to the dentist to proceed.

8. Some require a medical certificate irrespective of the fact that the necessity for treatment in most cases is too obvious for such a condition being laid down.

9. Again, some societies seek to secure for their members the exclusive services of a small group of dentists in each locality irrespective of the patient's desire for free choice, quite in opposition to the spirit of the Insurance Act itself which allows free choice of practitioner in medical administration.

10. The result of all these diverse methods is that the number of claims made by those eligible for benefit is less than it otherwise would be and, together with the fact that only a portion of the insured population are so eligible, renders the administration of dental benefit under present conditions quite inadequate to the requirements it was designed to meet.

NO PROVISION FOR NON-MEMBERS OF APPROVED SOCIETIES.

11. There is no provision under the Health Insurance Act for poor insured persons who may be ill and in receipt of sick pay yet needing dental treatment, if such are not members of an Approved Society or members of an Approved Society that does not give dental benefit as an additional benefit from their surplus funds. On the other hand, certain Approved Societies have elected to pay for treatment but not for dentures, hence a person may have the teeth extracted and remain toothless. If he belongs to a society administering dental benefit he will be assisted by the society roughly to the extent of one-third of the agreed estimate.

INADEQUATE ASSISTANCE TO VERY POOR.

12. The latter arrangement is taken advantage of by the eligible insured worker to a great extent, but it is obvious to the dental practitioner in working class districts that the sum represented by two-thirds the cost of provision of dentures is beyond the means of numbers of insured enquirers needing drastic dental treatment who upon learning of the probable extent of assistance offered them, refuse to apply, or apply in the hope of receiving a larger grant only to abandon the project subsequently when the grant is finally fixed.

URGENT NEED FOR LEGISLATION.

13. It will thus be seen that not only does the Act provide little or no remedy for the dental sufferer, but it actually differentiates between insured persons in this respect and what little assistance it does provide to some it entirely withholds from others quite irrespective of their varying needs for treatment.

14. Thus it is that one insured person whose life may be endangered by disease has no means of obtaining dental treatment under the Act, whilst another whose need may be slight obtains the required assistance.

15. Not only that, but the present conditions are such that workmen, working at the same bench in the same shop, receiving similar wages and paying the same contribution to the fund find that when applying for dental treatment though each is insured, each is treated differently in the measure of assistance, or entire lack of it. Such an anomaly alone would seem to demand a different system.

16. What would be said if the Insurance Act which demands equal contributions from the workers offered them differing medical assistance? To some all the treatment they needed; to other advice without the provision of medicine; and yet again to others, so many visits free by the doctor, the rest to be paid for separately by the patient; and finally to another group, no medical benefit at all. Yet that is exactly how dental benefits are administered to the insured person to-day.

AGREED COST OF TREATMENT.

17. The cost of treatment is everywhere the same, decided on a fair scale agreed between the Dental Profession and the Approved Societies concerned. And yet the insured person finds that he has to pay more for his dental treatment than his neighbour or fellow workmen, owing to the differences in the methods of administration; and owing to the fact that the benefit is optional, his friend in another Approved Society can get no benefit at all.

18. The remedy for all these problems is that the Insurance Act should be amended to include equal dental benefits for all insured persons.

19. This will inevitably bring in time a saving to the funds available for sick pay, although it will entail certain additional initial cost, and, in considering the latter, the question of the extent of dental benefit to be given must be taken into consideration as well as the method of administration.

20. The number of dentists available for the scheme and willing to work under it would be, at present, not more than 10,000, and as there are 15,000,000 insured persons, it is obvious that no system would meet the case other than one that did employ all the dentists willing.

FREE CHOICE OF DENTISTS.

21. It will be necessary to meet the desire of the patients and, as in the case of the medical precedent, the patients would need to have free choice of dentist.

22. Free choice of dentist assures that the best service will be received, because a man must depend on personal recommendation for success in practice. Besides which, the existing dental organisations could be relied upon in conjunction with the Dental Board to exercise disciplinary control over the panel dentists so engaged.

COST AND METHOD OF PAYMENT.

23. The extent of, and the method of payment for the dental service provided, is the real problem, and certainly the insured person ought to receive free of charge under the Act all dental treatment such as extractions and fillings, and the cost of the provision of dentures.

FUNDS.

24. Assuming that the present agreed scale of fees were acceptable as the basis of payment it could be accomplished on the basis of an increased contribution of 1½d. per week, per person, to be collected in the proportion of ½d. from the insured, ½d. from the employer and ½d. from State. This will bring in, approximately, four and three-quarters million pounds, and thus obtain sufficient funds to provide adequate dental treatment after the first three years' rush is over and cover all administrative expenses.

25. The first three years would be the most expensive owing to the number of would-be applicants for dental treatment. This extra cost could mainly be met by the surplus funds of the Approved Societies which at the next valuation may approximately yield forty to forty-five million pounds. The income from contributions of three-halfpence per week would then suffice for all purposes, and if found more than enough could be reduced accordingly.

TREATMENT WITHOUT DENTURES INADEQUATE.

26. Dental treatment alone as distinct from the provision of dentures would not meet the case.

27. In the first place, if that were adopted solely, the present scale of fees would not be acceptable to the profession because for obvious reasons it has been agreed upon as a whole, and the charge for extractions has been laid down in relation to the provision of dentures.

28. Public habits and opinions would have to undergo a tremendous revolution before insured persons would take adequate advantage of conservative work or treatment only, and it is to be feared that the mere offer of the latter would result in dental benefits not being accepted at all, or that the insured persons would visit the dentist to have an occasional tooth extracted when pain dictated and still be left in their present position of inability to provide for their replacement when required.

CLINICS NOT POPULAR WITH PUBLIC.

29. It has been suggested that the necessary work in the busy and crowded areas could be undertaken by the establishing of clinics.

30. This we do not agree with for the following reasons:—

Clinics are contrary to the psychology of the average insured person and looked upon as the out-patient department of a hospital; the patronage given to the private medical practitioners' panel in preference to out-patient hospital treatment confirms this statement.

31. Again evening hours are practically the only time available for the average working insured person to have dental treatment—the usual hours would be 6 to 9. Average time available per patient—20 minutes. This means nine patients only per evening would get time to receive proper attention, hence leading to the danger of clinics becoming merely a business office from which a patient was sent to a dentist's private surgery where the work was done. This has proved to be the case in several centres where clinics have been established.

CLASS OF INSURED NEEDING DENTAL TREATMENT.

32. It cannot be too clearly understood that the thousands of insured persons who need treatment can be classified as follows:—

Those in need of

- (1) Drastic treatment—this includes those persons who require all or almost all of their natural teeth extracted and their mouths refitted with appropriate dentures.
- (2) Treatment involving several extractions and fillings and the provision of partial dentures.
- (3) Treatment involving a few extractions or a few fillings.
- (4) Emergency treatment such as fractures and alveolar abscesses, broken dentures, etc., etc.

33. It is desirable to ensure that class (3) should be treated adequately and educated to the necessity of repeated examination for treatment and so ultimately prevent them from falling into classes (1) and (2) but it is certainly clear that to leave classes (1) and (2) without adequate means of obtaining treatment would merely be touching the fringe of the problem.

DENTAL AID SOCIETY.

34. The Incorporated Dental Society in August, 1914, instituted throughout the British Isles a National Public Dental Service under the title of "The United Dental Services, Limited." The service was available to all persons whose income did not exceed £160 per annum. Panels were set up in 22 areas and the fees were well below hospital prices. The scheme was continued with marked success until the Approved Societies decided upon dental treatment from surplus funds, when the company was wound up.

35. Lists of panel areas, agreement between dentists and company, ticket for treatment and scale of fees are still in existence, and will be supplied if desired.

CONCLUSION AND REMEDY.

36. The Incorporated Dental Society is of the opinion that, of all benefits offered by the Approved Societies to their members, the dental one has proved to be the most popular and beneficial.

- (1) The dental benefits, if to be of any value at all, must be of an adequate nature and without any cost to the patient. At present the poorest section of the insured population, who are in most need of dental treatment, are not receiving the dental benefit because they cannot afford their proportion of the costs. (Many cases of this kind have already occurred.)
- (2) Provision should be made whereby emergency treatment may be proceeded with without delay, otherwise serious complications may ensue that will cause intense suffering and difficult eradication of the evils following delay.
- (3) The control and administration should be that of the Ministry of Health.
- (4) Insured persons should have free choice of any dentist who is willing to do the work upon agreed terms and scale of fees. This will provide the patients with comfort-

able and cheerful waiting rooms, well-equipped surgeries with modern and scientific apparatus to hand, personal attention, kindness and courtesy, thereby greatly reducing that fear of the dentist which is so inherent in every patient's mind. It will also help to bring about a mutual confidence and thus mitigate the "fright-shock" which every dentist has to contend with daily and has proved to be the chief danger in the administration of anaesthetics during operations.

DENTISTRY REDUCES THE SICKNESS PAYMENT.

37. The acceptance of dentistry as one of the most important factors in preventive medicine has been amply established by the results already achieved by effective dental treatment provided by the domestic workers and other insurance societies, and has proved without doubt that dental benefit will eventually be the means of substantially decreasing the present heavy sickness payments.

38. The Incorporated Dental Society is of the opinion that the Government should take the earliest opportunity to provide adequate dental treatment for the needs of the community under the National Health Act.

PROVISION FOR DEPENDANTS.

39. It must not be overlooked that under the present insurance system no provision is made for the wives and dependants of insured persons—and these constitute a large proportion of those who require dental treatment.

40. To neglect this will be false economy and entail many diseases, much hardship and suffering.

41. Science demands that we do our part by the prevention of infection. We must stop as far as possible handing down to the coming generations a legacy of diseases that can now be dealt with and brought under subjection, if not totally eradicated from the human system.

APPENDIX XXIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE NATIONAL FEDERATION OF RURAL APPROVED SOCIETIES BY MR. W. WOOD, MEMBER OF THE EXECUTIVE COMMITTEE AND MR. W. HYDE, SECRETARY. See Minutes of Evidence of the Twenty-first Day, Questions 11,393 to 11,759.

Subject.	Paragraphs.
Constituent Societies	1-3
Medical Benefit	4-5
Medical Certification	6-9
Remuneration of Doctors	10-13
Medical Attendance at Confinement	14
Regional Medical Officers	15
Deposit Contributors	16
Arrears and Prolongation of Insurance	17
Disposal of Surpluses	18
Dental Treatment	19
Section 26	20
Married Women	21-22
Staff Superannuation	23

CONSTITUENT SOCIETIES.

1. The Federation consists of the aftermentioned Approved Societies and groups of Approved Societies, which are associated for the purposes of consultation and co-operation in the administration of the National Health Insurance Acts. The total membership of the constituent societies at 31st December 1924 was 154,600, of whom 121,000 were men and 33,600 women. Practically all the members reside in the rural parts of England and Scotland. On the first valuation of societies, which took place as at

31st December 1918, all the societies in the Federation had substantial surpluses.

2. The names of the constituent societies and their respective memberships at 31st December 1924 are as follows:—

	Membership.
The Scottish Rural Workers Approved Society	68,000
Wiltshire Conservative Benefit Society	22,000
Rural Workers Insurance Society (Lincolnshire)	12,500
Yorkshire Rural Friendly Society	10,500
Counties' Society for National Insurance	10,000
Eastern Counties' National Insurance Association	5,400
Lancashire Federation of Rural Friendly Societies	6,000
Bedfordshire United Insurance Society	5,000
Royal Berkshire Friendly Society	4,500
East Yorks United Friendly Society	3,200
East Yorks Association of Village Clubs	3,000
Cumberland Rural Insurance Society... ..	1,800
Dorset Rural Insurance Society	1,700
Royal United Benefit Approved Society	1,000
	154,600

3. Most of the societies in the Federation are centralised societies having branches for certain administrative purposes, but no registered branches. Two Associations in the Federation—the Eastern Counties' Association and the East Yorks Association of Village Clubs—contain a number of societies separately approved. The Lancashire Federation of Rural Friendly Societies has a number of registered branches. Each society affiliated to the Federation is an independent unit managing its own affairs. With the exception of the Scottish Rural Workers Approved Society, all the centralised societies pay their benefits through branch secretaries. The principal duties of a branch secretary are to receive applications for membership, to issue and collect contribution cards, to receive claims for benefit and forward them to Head Office, and to pay benefits as instructed by Head Office. The system of the Scottish Rural Workers Approved Society differs from that of the other societies in the Federation, and is explained in a separate Statement, which, it is understood, that Society is submitting to the Commission.

MEDICAL BENEFIT.

4. In the opinion of the Federation it is a defect of the National Health Insurance Scheme that medical benefit is confined to the services which an ordinary general practitioner can render. Medical benefit should be extended to include all necessary medical services and medical and surgical appliances. Since 1921 medical services and medical and surgical appliances which are outside the scope of medical benefit have been provided in necessitous cases by certain societies in the Federation through institutions to which the societies grant donations under section 26.

5. The Federation regards the provisions of medical benefit to dependants of insured persons as a desirable extension of the National Health Insurance Scheme, but it appears to be impracticable on financial grounds, unless the present contribution be increased.

MEDICAL CERTIFICATION.

6. As regards medical certification, the position, although improving, is still far from satisfactory. Practitioners frequently grant certificates in cases where the insured person cannot in any reasonable sense be regarded as incapable of work. This is specially noticeable in the case of women whose insurable employment is casual, or part time, and whose main occupation is their household duties at home. Many of these women when suffering from some minor ailment which may prevent them from engaging in outdoor work, are certified incapable of work, although they are able to do and in fact continue to do their household work at home.

7. In other respects there is often failure by doctors to observe the medical certification rules. The following are instances which frequently occur, viz. :—

- (1) The antedating and postdating of certificates.
- (2) The granting of final certificates after an insured person has resumed work.
- (3) The granting of certificates bearing dates on which the insured person was not examined.
- (4) The granting of voluntary certificates on the official form in cases where its use is not authorised.
- (5) The granting of certificates in which the cause of incapacity is stated in vague or indefinite terms when the precise cause is known.

8. With regard to the last-mentioned instance, the cause of incapacity, instead of being stated with precision as required by the rules, is frequently stated in such vague terms that benefit cannot be paid or continued without further enquiry. Many doctors resent any enquiry by a society regarding their certificates, and refuse to reply to any communication on the subject. Others demand a fee before giving

further information. In the opinion of the Federation the Medical Certification Rules should contain a provision that where, in the opinion of a society, the cause of incapacity is not stated with sufficient precision to enable the society to understand the condition of the insured person and in what respect he is incapable of work, it shall be the duty of the certifying practitioner to give such further information as may be necessary on request by the society or its medical officer.

9. Failure on the part of doctors strictly to observe the Medical Certification Rules causes delay in the admission of claims and much correspondence and other trouble to societies and insured persons which might be avoided. Until societies can rely upon a medical certificate being a guarantee that the insured person was examined as stated in the certificate, and that his incapacity for work at the time was not reasonably in doubt, the administration of sickness and disablement benefits will be rendered needlessly difficult for societies, and there will not be the full co-operation between the medical profession and societies which is desirable in the interests of sound administration of the National Health Insurance Scheme.

REMUNERATION OF DOCTORS.

10. In the opinion of the Federation the majority of insurance practitioners are over paid for their services to insured persons by the present capitation fee, which was fixed on what appears to the Federation to have been an erroneous basis. The Special Court of Enquiry which fixed the fee was informed by the Ministry of Health that the average number of visits and attendances which a doctor makes to insured patients might be assumed to be 8.5 per insured person per annum, this figure having been arrived at as the result of a certain test made by officials of the Ministry. Reference is made to the evidence of Dr. Smith Whitaker on this point submitted to the Court of Enquiry as reported on page 39 of the Supplement to the *British Medical Journal* of 12th January, 1924. It will be seen that, for the purpose of the test, certain practices the records of which were known to be well kept, and each of which represented a fair sample of practices as a whole, were selected and the number of visits and attendances by the doctors ascertained; but before determining the average, certain of the selected practices which showed an average number of visits much lower than the others, were excluded. The Federation does not know on what grounds these practices were excluded, but their exclusion obviously resulted in a higher average being shown by the test, and it is believed that, as a consequence, a higher capitation fee was fixed than would have been the case if all the practices originally selected had been included.

11. The Federation recommends that doctors be remunerated for their services to insured persons according to a graduated scale instead of by a uniform capitation fee as at present, and it is suggested that the highest rate should be paid in respect of the first 500 insured persons on a doctor's list, a lower rate or rates being paid in respect of the remainder. Such a method of payment would be fairer to the rural practitioner and generally to the practitioner with a small panel, who as a rule has a capital outlay and working expenses as great as that of the urban practitioner with a large panel. A panel of 1,000 does not take twice as much time and expense to work as one of 500, nevertheless it is paid for as if it did.

12. The Federation recommends that a proportion only of the normal capitation fee, instead of the whole fee as at present, be paid to the Central Practitioners Fund in respect of insured persons who have not chosen a doctor. As a rule these persons are unaware that they have the right to free medical treatment from any panel doctor, and chiefly for this reason few of them exercise their right. It is true that insurance practitioners as a whole have accepted responsibility for the treatment of these persons, but seeing this obligation is far less onerous than their similar obligation to insured persons who are actually on their lists, it does not call for payment at the same

rate. It is suggested that it would be a fair arrangement if one-third of the normal capitation fee were credited to the Central Practitioners Fund in respect of these persons.

13. From 1913 to 1919 mileage allowance was paid in respect of insured persons resident beyond three miles from the residence of their doctor; but this distance was reduced to two miles in 1920, largely because of the high prices then prevailing for motor cars and petrol. These reasons no longer prevail, and the Federation is of opinion that the three miles radius should be restored; and that, excepting in cases where the Insurance Committee may otherwise determine, mileage allowance should be paid only for the distance from the insured person's house to that of the nearest available doctor.

MEDICAL ATTENDANCE AT CONFINEMENT.

14. The Federation recommends that insured women and the wives of insured men should have the right to requisition the services of an insurance practitioner at confinement and that the appropriate fee for such services should be fixed in the Practitioner's Agreement. The experience of the Federation is that in many cases where a doctor has been called in at confinement, his fee absorbs the whole of the maternity benefit received from the Approved Society, and there is nothing left to provide other necessities for the mother and child.

REGIONAL MEDICAL OFFICERS.

15. As a general rule the reports of regional medical officers fall short of the standard laid down for medical referees' reports in the Reported Decisions on Appeals under section 67, and in this respect the Medical Referee Scheme as at present worked is unsatisfactory. Reference is made to Case XXXVI. (A.B. against an Approved Society) reported in Part II. of the Official Reports of Decisions on Appeals under section 67 where the essential requirements of a medical referee's report are set forth. The reports of regional medical officers in England and district medical officers in Scotland seldom give sufficient information to enable a society to understand clearly the condition of the insured person, and frequently contain little more than an expression of opinion as to the insured person's capacity for work. If it is not incumbent on medical referees under the Scheme as it stands to give a report in accordance with the decision above referred to, the Scheme should be amended to bring it into harmony with that decision.

DEPOSIT CONTRIBUTORS.

16. The Federation does not favour the abolition of the Deposit Contributors Fund, being of opinion that it is a necessary adjunct of the National Health Insurance Scheme. The Federation however recommends that deposit contributors who satisfy the Ministry that they are unable to gain admission to a society by reason of the state of their health should be entitled to maternity benefit at the normal rate, and to sickness and disablement benefits at such rates, not exceeding the normal rates, as the funds available would provide. It is suggested that there should be made available for the purpose of providing these benefits, after a contributor's individual credit has been exhausted, the unappropriated interest on the Deposit Contributors Fund, amounting at a recent date to £359,000, and the balances of deposit contributors ceasing insurance which under existing arrangements are transferred to the Reserve Suspense Fund. Deposit contributors who are unable to satisfy the Ministry as aforesaid should remain entitled to benefits as at present.

ARREARS AND PROLONGATION OF INSURANCE.

17. The Federation regards the present Arrears Scheme as on the whole satisfactory. With regard to the Prolongation of Insurance Act, while this Act may have been justified as an emergency measure, its provisions are contrary to fundamental insurance principles, and in the opinion of the Federation the Act should now be allowed to expire.

DISPOSAL OF SURPLUSES.

18. The Federation is opposed to the pooling of the surpluses of societies, and to any interference with the existing right of societies to distribute their surpluses in their own way and amongst their own members. During the passage through Parliament of the National Insurance Bill of 1911, a definite assurance was given by the Government that societies would have that right, and one of the attractions held out to insured persons to join the societies in the Federation was the additional benefits to which members would become entitled out of the surplus funds which it was anticipated the societies would have for distribution after each Valuation.

DENTAL TREATMENT.

19. It is understood that it has been suggested to the Commission that dental treatment should be provided to insured persons as a normal benefit. The experience of the societies in the Federation which are now providing part of the cost of dental treatment to their members as an additional benefit has shown that the cost of providing such treatment as a normal benefit would be so great as to render its provision impracticable without an increase of contribution. The Federation is of opinion that any increase in the present contribution for this purpose would not be acceptable either to employers or insured persons.

SECTION 26.

20. The Federation is opposed to the repeal of section 26 of the National Health Insurance Act, 1924, having found the powers which the corresponding section of the Act of 1911 conferred on societies of great advantage in enabling the societies in the Federation not only to grant donations to hospitals and for the support of district nurses, but also, as explained in para. 4, to provide medical and surgical appliances and other necessary services to members when there were funds available. It appears from evidence already submitted to the Commission on behalf of the Ministry of Health that the Ministry favour the repeal of the section, on the ground apparently that a society might make improper use of the section and grant a donation when it could not afford to do so. On the other hand, the Scottish Board of Health have stated to the Commission that societies in Scotland have made cautious and reasonable use of their powers, and that the Board see no reason to repeal or even to amend the section. In the opinion of the Federation the experience of the last twelve years has shown that the fears of the Ministry are groundless. The success of the National Health Insurance Scheme has been in large measure due to careful administration on the part of Approved Societies, and societies may reasonably claim that their powers should be extended rather than curtailed.

MARRIED WOMEN.

21. 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 arrangements be not disturbed.

22. The societies however find that the administration of sickness and disablement benefits to married women members who are ordinary employed contributors is attended with difficulties arising from the facts that usually the principal occupation of such members is their household work at home, and that in many cases they continue to do this work while drawing benefit. The supervision of such members by a society so as to ensure that they are observing the rules relating to behaviour during sickness, has been found to be impracticable. In the opinion of the Federation, it would be a more satisfactory arrangement if employed married women were insured for medical and maternity benefits only, the same rate of contribution being paid in respect of them by their employers as is now payable in respect of exempt persons. Such an arrangement would relieve societies of the heavy risk which they now carry in respect of married women who as a rule are not dependent for

their livelihood on their earnings from employment, and would enable other insured women whose need is greater to obtain larger benefits than they now receive.

STAFF SUPERANNUATION.

23. In the opinion of the Federation it is desirable that societies should be in a position to provide for the

superannuation of their staffs, but this cannot be done out of the present administration allowance, which is wholly required for normal expenses. The Federation recommends that societies should be empowered to make contributions to a Staff Superannuation Fund, any contributions so made to be in addition to and independent of the ordinary allowance for administration.

APPENDIX XXX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SCOTTISH RURAL WORKERS APPROVED SOCIETY BY MR. JAMES FALCONER, PRESIDENT, AND MR. WILLIAM WOOD, SECRETARY. See Minutes of Evidence of the Twenty-first Day, Questions 11,760 to 11,905.

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PRELIMINARY.

1. The Society is one of the constituent societies of the National Federation of Rural Approved Societies, and concurs in the Statement of Evidence on behalf of that Federation submitted to the Commission. The following Statement is supplementary, and deals with the Society's own position and experience, and with certain matters peculiar to the administration of National Health Insurance in Scotland.

CONSTITUTION AND GOVERNMENT.

2. The Society is a centralised International Society, having its Head Office in Edinburgh and 500 unregistered branches throughout Scotland and the northern part of Northumberland. It was established immediately after the passing of the National Insurance Act, 1911, as the Scottish Rural Workers Friendly Society, for the purpose, as was then emphasised throughout Scotland, of securing for the rural workers of Scotland the fullest possible benefits of the National Health Insurance Scheme. Its original rules provided for the transaction of life insurance and annuity business under the Friendly Societies Acts as well as National Health Insurance, but it was subsequently decided to carry on the State business by a separate society, and in 1920 the Scottish Rural Workers Approved Society was formed and took over the National Health Insurance engagements of the Friendly Society. The membership of the Approved Society at 31st December, 1924, was approximately 68,000, of which 51,500 were men and 16,500 women. There is separate valuation of men and women, but no separate national valuation.

3. The Society is managed by a Board of Management consisting of 12 persons. The Board of Management is elected by the Annual General Meeting of the Society, which consists of the officers of

the Society and delegates appointed by 19 Districts into which the country is divided. Each branch appoints one or more representatives according to its membership, and once a year a meeting of these representatives in each district is held, and delegates are appointed to represent the district at the Annual General Meeting of the Society. The affairs of the Society are thus subject to the absolute control of its members.

4. Each branch has a Local Committee and Secretary. Once a year a General Meeting of the members of the branch is held, at which the Local Committee, Local Secretary, and representative to the District Meeting are appointed. Many branches hold a social gathering of members and their friends, this gathering frequently taking place on the same evening as the General Meeting of the branch. The principal duties of the Local Secretary are to receive and report upon applications for membership, to issue and collect contribution cards, to visit or arrange for the visitation of sick members when so instructed from Head Office, and generally to assist members in all matters connected with their insurance.

PAYMENT OF BENEFITS.

5. With the exception of claims for maternity benefit in Orkney, which are paid from Kirkwall, all claims for benefits are dealt with at Head Office, and from there benefits are paid mainly by means of the system of postal drafts specially provided for payment of National Health Insurance benefits. A draft for the amount of each payment is sent by post to the member entitled to it, and may be cashed at any Post Office within one month of the date of issue. The Society finds that this system is preferable to that of payment in cash through local agents, particularly in districts with a scattered population, such as exist in many parts of Scotland. Medical certificates are transmitted direct to Head Office by members, a stamped addressed envelope for the purpose being sent with each payment of benefit excepting the final payment. The Society has the advantage of the services of a Medical Officer who attends regularly at Head Office for the purpose of advising in regard to claims for sickness and disablement benefits. In cases where, after full enquiry, the Medical Officer is not satisfied with the evidence of incapacity, the claims are submitted to the Board of Management or a committee thereof for further consideration, and no claim is refused excepting on their instructions.

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BALANCE-SHEET.

6. The following is a summary of the balance-sheet of the Society as at 31st December, 1923, viz.:—

ASSETS.		LIABILITIES.	
I. Investments:		I. Benefit Fund Account:	
1. Held by Trustees	£269,074 19 5	Men	£655,950 19 2
2. In National Health Insurance Fund (Investment Account)	240,357 0 0	Women	111,583 6 8
	£509,431 19 5		£767,534 5 10
II. National Health Insurance Fund:		II. Contingencies Fund:	
(1) Reserve Values Account	£252,941 18 10	Men	£25,209 1 5
(2) Current Account	42,766 6 5	Women	5,183 9 10
	295,708 5 3		30,392 11 3
III. Deposit with Postmaster-General	1,866 0 0	III. Administration Account:	
IV. Recoverable Advances under Section 11	78 3 10	Balance at Credit	3,776 3 3
V. Head Office Premises, Furniture, &c.	3,000 0 0	IV. Administration Reserve Account	3,000 0 0
VI. Cash	2,267 1 7	V. Outstanding Benefits and Administration Expenses	7,648 9 9
	£812,351 10 1		£812,351 10 1

The income of the Society for 1923 amounted to £190,240 16s. 10d., and the expenditure to £159,511 18s. 2d., leaving a balance of £30,728 18s. 8d. The contribution income for 1923 was equal to an average of 50 weekly contributions in the case of men and 48 in the case of women, out of a possible total of 53.

FIRST VALUATION.

7. The following is a summary of the first valuation of the Society:—

—	Men.	Women.	Total.
	£	£	£
Assets	1,777,235	311,070	2,088,305
Liabilities	1,650,491	284,954	1,935,445
Gross Surplus	126,744	26,116	152,860
Of which carried forward	41,444	7,425	48,869
Leaving disposable surplus	85,300	18,691	103,991
To which add State Grants and accruing interest during distribution period of five years	42,650	9,345	51,995
Amount Available for Additional Benefits...	127,950	28,036	155,986

ADDITIONAL BENEFITS.

8. In his Valuation Report the Treasury Valuer stated that if the Society should desire to apply the whole of its disposable surplus in increasing the rates of sickness, disablement, and maternity benefits, the surplus would allow the rates of these benefits to be increased over a period of five years to the following extent, viz.:—

	Men.	Women.
	s. d.	s. d.
Sickness benefit	5 0	4 0
Disablement benefit	2 6	2 0
Maternity benefit	10 0	8 0

The Society pointed out to the Scottish Board of Health that, judging by the past experience of the Society, these increases would absorb about one-half only of the amount available, and submitted for the Board's provisional sanction a Scheme which provided for increases of sickness, disablement and maternity benefits at the rates above specified, and also for certain other additional benefits desired by the members for which there appeared to be funds available. The Board however were unable to sanction the

Scheme excepting as regards the increases in the cash benefits, but they explained, with reference to the other benefits proposed, that it was open to the Society to avail itself of the powers conferred by section 21 of the Act of 1911. The Scheme was accordingly limited to the before-mentioned increases of the cash benefits, and came into operation in July, 1921.

9. The following table shows the extent to which the amount available for additional benefits during the five years ending July, 1926, was drawn upon during the 3½ years from July, 1921, to January, 1925, to meet the additional cash benefits referred to:—

—	Men.	Women.	Total.
	£	£	£
(1) Amount available during 5 years, July, 1921, to July, 1926	127,950	28,036	155,986
(2) Amount expended during 3½ years, July, 1921, to January, 1925	40,000	9,708	49,708
(3) Balance remaining unexpended at January, 1925	87,950	18,328	106,278

DONATIONS UNDER SECTION 21.

10. When the Scheme above referred to had been in operation for a year, it became evident to the Society that not more than one-half of the amount available would be required for the purposes of the Scheme, and that there would be ample funds for the provision of further benefits. On this position being reported to the Annual General Meeting of the Society in 1922, the Meeting authorised the Board of Management to exercise the Society's powers under section 21 by granting donations to Hospitals, Nursing Associations, and other charitable institutions which were or might be in a position to render services to members of the Society. The Board have acted on this authority, and up to 31st December, 1924, have granted donations amounting in all to £19,698, the amount of each donation being fixed with reference to actual services rendered to members by the institution concerned. The services so rendered include hospital treatment, nursing, electrical and massage treatment, dental treatment, the conveyance of members to and from hospital, and the supply of medical, surgical, and optical appliances other than those provided as part of medical benefit. In exercising the Society's powers under the section the Board of Management have been careful to see that the amount of the donations granted in any one year was

well within the amount appearing to have been saved in the previous year on the cost of the Scheme of Additional Cash Benefits as estimated by the Treasury Valuer.

APPEALS UNDER SECTION 90.

11. In two important respects the system of hearing Appeals in Scotland from the decision of the arbitration tribunals of societies differs from the system in England. In England Appeals are determined by one or more members of a body of referees, all of whom must be barristers-at-law or solicitors, and no person is eligible to be a member of the body of referees who is an officer of the Ministry of Health or a member of any Consultative Council appointed under the Ministry of Health Act, 1919. In Scotland such Appeals are decided by a special body or bodies appointed by the Scottish Board of Health to act as referees, but there is no provision, as in England, that the members of these bodies shall be persons having legal qualifications, nor are members or officials of the Board or members of any Consultative Council declared to be ineligible to act as referees. In the experience of the Society, the questions which fall to be decided by these referees require legal knowledge for their determination, and in the Society's opinion such questions should be referred only to persons with legal qualifications. Further, when an insured person in Scotland thinks that he has a grievance against his Society, he usually writes to the Scottish Board of Health for advice and assistance, but in view of the Board's position as possible referees in the event of an appeal, neither they nor their officials are free to advise insured persons as they would be able to do if they were not liable to be called upon to act as referees. For these reasons it is submitted that article 180(2) of the Approved Societies Regulations should correspond

with article 163 (1) as regards the persons who are eligible to determine Appeals.

12. The Official Reports of Decisions on Appeals under section 67 of the 1911 Act do not give the names of the persons who have decided the Appeals and whose opinions are published for the information and guidance of all concerned. The value of a legal or medical opinion depends largely on the authority and standing of the person whose opinion it is, and the Society has found that arbitrators are not disposed to accept as authoritative the opinions of anonymous referees. The Society recommends that in future Reports of Decisions the names of the referees be given.

COMPLAINTS UNDER MEDICAL BENEFIT REGULATIONS.

13. Under the existing regulations, any question raised by a society as to the action of an insurance practitioner with regard to any medical certificate which he is required to furnish to a member of the society is investigated by the Medical Service Subcommittee and a decision is afterwards given by the Insurance Committee on the Report of the Subcommittee. In the opinion of the Society this system is unsatisfactory in its operation, especially in the county areas. The procedure is cumbersome and costly to all the parties concerned, the decision of the Insurance Committee can hardly be given within a reasonable time, and in the Society's experience when a complaint is proved the Committee seldom takes any effective action. The Society submits that it would be a more satisfactory arrangement if the Scottish Board of Health were alone empowered to deal with such complaints in Scotland.

35, Buckingham Terrace,
Edinburgh.

14th February, 1925.

APPENDIX XXXI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SEAMEN'S NATIONAL INSURANCE SOCIETY BY SIR NORMAN HILL, BART., CHAIRMAN OF THE COMMITTEE OF MANAGEMENT. See Minutes of Evidence of the Twenty-first and Twenty-second Days, Questions 11,906 to 12,177.

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CREATION OF THE SOCIETY.

1. The Seamen's National Insurance Society was established under section 48 of the National Health Insurance Act 1911, with the powers of an Approved Society and an Insurance Committee.

It was established:—

First to meet the exceptional needs of the Sea Service, and,

Secondly to enable a bargain made between the Seamen's Unions and the Shipowners' Parliamentary Committee on the one hand and the then Chancellor of the Exchequer (Mr. Lloyd George) on the other hand, to be carried into effect.

THE EXCEPTIONAL NEEDS OF THE SEA SERVICE.

2. The Act as a whole, and the general administrative system built up to carry the Act into effect, are, it is submitted, based on the insured person having at all times a known home. There may be changes in the employment, or in the employer, or in the home address, or in the place of employment, but it is taken for granted that every insured person will at all times have a home address at and through which he can keep in touch, and be kept in touch,

with his Approved Society, and at which or through which he can be given his benefits.

It is the fact that all benefits are made dependent on the individual member lodging his cards with his society, but the success with which the cards have been collected and placed to the credit of the individual entitled has been in no small measure brought about by the activities of the societies, and their activities are based on the touch they can keep with each one of their members, and that can only be maintained through a home address known to the society. If there is no such home address then the individual drifts into the Deposit Contributor Class or falls out of insurance.

Further, the Act and the general administrative system built up to carry the Act into effect, are based on the need for providing the benefits to the insured persons throughout the year.

NUMBER OF INSURED SEAMEN.

3. The number of men engaged in the Sea Service is small in comparison with the total number of insured persons, but the conditions of their employment, to a great extent, and the habits and customs of the men following the sea to a certain extent, divide them sharply from the land workers.

4. To follow the working of the Act in relation to the Sea Service it is important to have in mind the number of seamen, and in particular of seamen employed in the Foreign Trade, who are insured persons. A very complete investigation was made when the 1911 Act was before Parliament, and it was then estimated that the total number of seamen employed in 1909 (the last year for which the figures were then available) had been as under:—

	Foreign Trade.	Coasting including Home Trade.	Fishing Trade.	Total.
(1) British Seamen	129,000	38,000	32,000	199,000
(2) Domiciled Foreigners.	7,000	1,000	—	8,000
(3) Foreigners not domiciled.	14,000	1,000	—	15,000
(4) Lascars not domiciled.	29,000	—	—	29,000
(5) Foreigners engaged in Foreign Trade in vessels trading entirely abroad.	8,000	—	—	8,000
(6) Lascars engaged in Foreign Trade in vessels trading entirely abroad.	15,000	—	—	15,000
	202,000	40,000	32,000	274,000

The insured persons are all included in classes (1) and (2). The seamen in classes (3) and (4) only come under the Act for the purpose of the collection from their employers, of a sum equal to what would have been the employer's contribution if those seamen had been in classes (1) and (2). The seamen in classes (5) and (6) are outside of the Act.

The figures in the above table include seamen of all ratings, and a considerable percentage, in the case of the British seamen, are by reason of their pay and conditions of work outside of the Act. The number so excluded can only be estimated.

5. In the Foreign Trade, the Master, Chief Officer, and Chief Engineer, and generally the Wireless Operator, in respect of all vessels will be outside of the Act. In such ships as have a speed of 12 knots and upwards (which have never exceeded 1,100 in

number) probably the Second Officer and Second Engineer will be also outside of the Act. In the Passenger and Mail Liners (which have never exceeded 600 in number and are included in the vessels of a speed of 12 knots and upwards) other officers and engineers will be outside the Act.

The number of vessels upon which the seamen were serving in the Foreign Trade in 1909 was 4,802, and therefore the average crew of such vessels was in that year 42, of whom 27, were British. It was then estimated that on the average not more than 6 out of the 27, or 22 per cent., would be outside of the Act.

On this basis the figures for 1909 indicated that there would be brought under the Act in respect of the Foreign Trade:

(1) British Seamen 129,000, less 22 per cent = 28,000	...	...	...	101,000
(2) Domiciled Foreigners	...	...	...	7,000
				108,000

Since 1909 British tonnage in Foreign Trade has substantially increased but the number of vessels employed has decreased. Further, the proportion of British to Foreign seamen has substantially increased.

The number of vessels in the Foreign Trade and of their crews since 1912 has been as under:—

Year.	Number of vessels.	Crew.			Total.
		British.	Foreign.	Lascar.	
1912 ...	4,704	140,276	28,697	47,211	216,184
1913 ...	4,640	153,822	30,307	46,848	220,977
1914 ...	4,547	*	*	*	226,980
1915 ...	*	*	*	*	*
1916 ...	*	*	*	*	*
1917 ...	*	*	*	*	*
1918 ...	*	*	*	*	*
1919 ...	3,631	144,990	15,527	46,599	207,116
1920 ...	3,676	151,672	14,146	50,273	216,091
1921 ...	3,648	144,686	14,988	53,513	213,187
1922 ...	3,511	141,490	10,853	55,266	207,609

* Not available.

Since the war the average crew of such vessels has been 58, of whom 40 have been British. The decrease in the number of ships has decreased the number of Masters, and although more officers and engineers who are outside of the Act are carried on the bigger ships, it is not probable that the number of excluded seamen average more than 8 per ship or 20 per cent. on the total of the British seamen.

It is further probable that at least one-third of the total number of foreign seamen carried are domiciled in this country. On the basis of these estimates the total number of insured seamen in the Foreign Trade coming under the Act have been as under:—

Year.	British Total, less 20 per cent.	Foreign 83½ per cent. of Total.	Total Seamen in Foreign Trade under the Act.
1912 ...	112,000	9,500	121,500
1913 ...	123,000	10,000	133,000
1914 ...	*	*	*
1915 ...	*	*	*
1916 ...	*	*	*
1917 ...	*	*	*
1918 ...	*	*	*
1919 ...	116,000	5,000	121,000
1920 ...	121,000	4,500	125,500
1921 ...	116,000	5,000	121,000
1922 ...	113,000	3,500	116,500

* Not available.

6. In the Coasting, including the Home, Trade the number of vessels and of their crews since 1912 have been as under:—

Year.	Number of Vessels.	Crew.			Total.
		British.	Foreign.	Lascar.	
1912 ...	4,057	34,322	1,330	—	35,652
1913 ...	3,999	33,835	1,448	—	35,283
1914 ...	*	*	*	*	*
1915 ...	*	*	*	*	*
1916 ...	*	*	*	*	*
1917 ...	*	*	*	*	*
1918 ...	*	*	*	*	*
1919 ...	2,916	25,298	1,121	—	26,419
1920 ...	3,013	28,004	1,073	—	29,077
1921 ...	2,982	28,424	802	27	29,253
1922 ...	2,957	28,453	710	—	29,163

* Not available.

Here again, by reason of the decrease in the numbers but the increase in the size of the ships, the average crew has increased from 9 to 10 hands. For the same reasons the average number of seamen excluded from the Act by reason of their pay and conditions of work is probably smaller than it was in 1912. It is not probable that they average more than 2 per ship or 20 per cent. of the total number of British seamen employed.

It is further probable that at least one-third of the total number of Foreign seamen carried in this trade are domiciled in this country. On the basis of these estimates the total number of insured seamen in the Coasting, including the Home, Trade have been as under:—

Year.	British Total, less 20 per cent.	Foreign 88½ per cent. of Total.	Total Seamen in Coasting, including the Home Trade under the Act.
1912 ...	27,500	400	27,900
1913 ...	27,000	450	27,450
1914 ...	*	*	*
1915 ...	*	*	*
1916 ...	*	*	*
1917 ...	*	*	*
1918 ...	*	*	*
1919 ...	20,000	200	20,200
1920 ...	22,400	200	22,600
1921 ...	22,700	150	22,850
1922 ...	22,700	150	22,850

* Not available.

7. In the Fishing Trade the number of vessels, and of their crews, since 1912 have been as under:—

Year.	Number of Vessels.	Crew.		Total.
		British.	Foreign.	
1912	4,297	34,037	933	34,970
1913	4,350	34,913	884	35,797
1914	*	*	*	*
1915	*	*	*	*
1916	*	*	*	*
1917	*	*	*	*
1918	*	*	*	*
1919	2,667	22,870	255	23,125
1920	3,678	33,204	221	33,425
1921	3,506	31,627	149	31,776
1922	3,426	30,122	163	30,285

* Not available.

Share fishermen are excluded from the Act, and there is no information available showing the proportion of the crews dealt with in the above table, that were serving on the share basis. It was almost certainly less than 50 per cent., and it may be reasonably conjectured that there have been at least

the under mentioned number of insured seamen in the Fishing Trade:—

Year.	Seamen in the Fishing Trade under the Act, 50% of total.			
1912	17,500
1913	17,500
1914	*
1915	*
1916	*
1917	*
1918	*
1919	11,500
1920	16,500
1921	16,000
1922	15,000

8. If the foregoing tables are summed up, the total number of insured seamen under the Act has been as under:

Year.	Foreign-going.	Coasting, including Home.	Fishing.	Total.
1912 ...	121,500	27,900	17,500	166,900
1913 ...	133,000	27,450	17,500	167,950
1914 ...	*	*	*	*
1915 ...	*	*	*	*
1916 ...	*	*	*	*
1917 ...	*	*	*	*
1918 ...	*	*	*	*
1919 ...	121,000	20,200	11,500	152,700
1920 ...	125,000	22,600	16,500	164,100
1921 ...	121,000	22,850	16,000	159,850
1922 ...	116,500	22,850	15,000	154,350

* Not available.

CONDITIONS OF EMPLOYMENT.

9. In the Foreign Trade, under normal conditions of trade, it is estimated that on the average a steady and capable seaman is on Voyage Articles for about 42 weeks in the year.

The times and the places during which he is off Articles vary greatly. If he is serving in the North Atlantic on a fast liner he may make in the year 12 round voyages, each of which occupies from 21 to 25 days, and be off Articles from 6 to 8 days between each of those voyages. If he is serving on such a Liner in the Australian Trade he will make two round voyages and be off Articles about one month between each voyage. Or he may make from two to five round voyages in the year in a tramp, and be off Articles for varying periods and in varying places between those voyages. Or he may serve continuously on a tramp for two years and longer and then take a spell on shore, or ship again within a few days.

Amongst the foreign-going seamen there are some who engage in the Coasting and Home trades, or in fishing, or as crofters, or on yachts, or as dock workers for some months in the year. There are others who go to sea again as soon as the wages earned on the voyage have been spent.

The average time on and off Articles is controlled largely by the employment offering to shipping. If many ships are laid up, the time off Articles is long, especially in the case of the casual hand.

The place where the time off Articles is spent is uncertain. Among the regular men serving in the mail and passenger lines it will be at their homes, which are usually in or near the home port of the line, but not infrequently even in these cases the home may be elsewhere.

The same holds good but in a less degree in regard to the men serving on the cargo lines, and in a still less degree in regard to the regular hands serving on the tramps.

But very many of the seamen have no fixed homes, and live between voyages in the sailors' homes or lodging houses.

It is therefore quite impossible to group the foreign-going seamen generally according to the

areas in which either they reside, or in which their benefits must be provided. Even the men who have fixed homes are scattered all over the country between voyages, and the men who have no fixed homes are to be found now at one, and now at another port as they are signed off Articles.

10. In the Coasting, including the Home Trade the employment is more constant throughout the whole year, and most of the seamen have settled homes in one of the ports with which the vessel trades, but many of them need their benefits in other ports, and there are a considerable number of casual hands employed who shift from ship to ship.

PAYMENT OF WAGES.

11. The seaman in the Foreign Trade is paid his wages in a lump at the end of each voyage, and the State takes extraordinary steps to protect him against his own carelessness and improvidence. He can only be signed off Articles before a Government Official, who is charged with the duty of seeing that he receives the amount to which he is entitled. Further, every facility is afforded by the State to enable the seaman to bank his money, or to remit it to his family.

COLLECTION OF CONTRIBUTIONS.

12. To meet these conditions, the system of Voyage Cards was introduced on the passing of the Act in the Foreign Trade. Under this system, at each pay off the shipowner has to provide for each individual seaman a card to which stamps have been affixed, by or on behalf of the shipowner, covering the whole period of the voyage, whether it be for a few days, or for many months, or even years. Each of these cards is supposed to be filled in with the name of the seaman, and certain other information sufficient to enable the society to which he belongs to identify the card with one of its members. The Board of Trade official superintending the "pay off" is supposed to see that all cards contain this information, and that they are all sufficiently stamped. He is further bound to see that each seaman is handed his own card. It is then left to each seaman to forward his own card to his own society.

In practice the cards are very frequently filled up in a hurry, names are often incorrectly spelt, Christian names are frequently omitted, addresses are not given, and the writing not infrequently is almost unreadable.

The identification of such a card, if it reaches the hands of a society, with the member to whom it belongs is difficult, and in some cases impossible, and in very many cases the cards are never forwarded to any society.

13. No doubt the Voyage Card system enables a careful and provident seaman to remit his contributions to his society, but the nature of his employment makes it difficult for the society to keep in touch with such a member even if he has a fixed home. But very many of the seamen are neither careful nor provident, and many of them have no fixed homes. In their cases the system results in a very serious loss of cards, and, moreover, it fails in keeping the society in touch with such members. The result is that no society is able to give to its seamen members anything like the assistance it gives to its landsmen members in the getting in of their contributions.

14. The extent to which the system has failed in getting in the seamen's contributions is dealt with in paragraphs 33 to 38 of this Statement. It is estimated that from 25 to 33½ per cent. of the contributions paid in respect of seamen engaged in the Foreign Trade have been lost.

15. The extent to which the system has failed to enable the society to keep in touch with its members in the Foreign Trade, is dealt with in paragraph 26 of this Statement.

THE BARGAIN MADE BETWEEN THE SEAMEN'S UNIONS AND THE SHIPOWNERS' PARLIAMENTARY COMMITTEE AND THE CHANCELLOR OF THE EXCHEQUER.

16. Seamen for two generations had had under the Merchant Shipping Acts many of the benefits conferred for the first time by the Act of 1911 on land workers.

The Merchant Shipping Act dealing with these benefits is now the Act of 1906. Section 34 of that Act replaces and extends the provision of section 207 of the Act of 1894, which had replaced and extended the provisions of section 228 of the Act of 1854.

Shortly the benefits to which all seamen are now entitled under the Merchant Shipping Acts are as follows:

In all cases of hurt or injury in the service of the ship, or of illness whilst on Articles, the shipowner is bound at his own cost and without any deduction on that account from the wages of the seaman:

- (a) to provide the necessary surgical and medical advice and attendance and medicine.
- (b) to maintain the seaman until he is cured, or dies, or is returned to a proper "returned port."
- (c) to provide for the conveyance of the seaman to such a port.
- (d) to bear the expenses of his burial if he dies.
- (e) to pay the expenses of removal, and of medical advice and attendance and medicine and maintenance if the seaman is removed from his ship for the purpose of preventing infection.

And the sick or disabled seaman is entitled to full pay and maintenance until he is signed off Articles before a proper Authority, unless it be proved that the illness was caused by his own wilful act or default; and under an Act of 1923 venereal disease is no longer regarded as such an illness.

In the old days of sailing ships and long absences from port, the sick and disabled seaman had often to depend on the skill of the captain and on the ship's medicine chest, but now few ships are out of port for more than 20 days, and the great majority are in port far more frequently. Provision can be, and is, made for skilled medical attention at every port in which the vessel loads or discharges cargo. In many foreign ports it is the custom for the shipowner to engage the services of a doctor who, for a fixed fee, attends the ship during its stay. In other foreign ports a "hospital rate" is levied on the ship's tonnage, and in return free medical treatment is given to the seamen. On the passenger liners, and on some of the larger cargo vessels upon which big crews are carried, a medical man is included in the ship's staff.

When the Act of 1911 was before Parliament, the Shipowners' Parliamentary Committee published a report in which they said:

"As the result of careful enquiry we estimate that it costs the shipowner engaged in the Country's foreign trades to provide what is described in the Bill as the medical benefit and sickness benefit for all seamen until they are discharged at the proper return port the sum of 7d. per week throughout the whole year for every member of the crew. We give in the appendix a statement showing the actual expenditure on this account during 12 months of 12 typical shipping companies whose vessels do not carry doctors and are engaged in the foreign trades of this Country, both as cargo liners and as tramps."

The seamen have still all these benefits quite apart from the National Health Insurance Act, and the cost at which they are provided by the shipowner has increased very substantially since 1911.

17. In these circumstances it was manifest that benefits had not to be provided for seamen throughout the year under the Act of 1911.

In a Report dated 27th October, 1911, of the Government Actuaries on the Scheme for Seamen, they made the suggestion that the saving in sickness in respect of seamen in the Foreign Trade might

be taken as two-thirds of the cost of sickness in a year.

In dealing with this Report, Mr. Duncan Fraser, the Actuary said:

"A table on page 40 of their Report of 20th May, 1911, gives the means of estimating the cost of sickness in each year of age.

"The cost of providing 10s. a week during a sickness of 26 weeks or less is shown below, but specimen ages and the amount saved to the society on the basis of two-thirds of this cost are also stated:

Age.	Cost in the Year of 10s. per week for sickness of 26 weeks or less.			Saving in a Year to the Society, being two-thirds of the cost of sickness.		
	£	s.	d.	...	s.	d.
20 ...	0	8	4	...	5	7
25 ...	0	7	10	...	5	3
30 ...	0	8	2	...	5	5
35 ...	0	8	10	...	5	11
40 ...	0	10	0	...	6	8
45 ...	0	11	4	...	7	7
50 ...	0	13	5	...	8	11
55 ...	0	16	4	...	10	11
60 ...	1	0	0	...	13	4
65 ...	1	5	8	...	17	1

"The amount of the saving varies from 1½d per week at age 20 to 4d. per week at age 65."

The saving in medical benefit is best shown by the fact that under the regulations of the Ministry of Health, the panel fee is reduced at the rate of 1.2/7d. in respect of each week the seaman is on Articles in the Foreign Trade. If, therefore, the seaman is on Articles for 42 weeks in the year, the reduction amounts to 4s. 6d., which is equal to a reduction of 50 per cent.

18. It was believed when the Act of 1911 was before Parliament that the State organisation provided to deal with the "pay off" of all seamen in the Foreign Trade, would be effectively used for the collection in bulk of the seamen's contributions, and that thereby the cost of administration would be substantially reduced. Unfortunately no use has been made of such State organisation, and the system of Voyage Cards has proved a costly and disastrous failure.

19. With the above considerations in mind when the Act of 1911 was before Parliament:

- (1) The seamen engaged in foreign trade contended that they should not be called upon to pay the same contributions as land workers.
- (2) The shipowners contended that in respect of all seamen the benefits they were already providing under the Merchant Shipping Acts should be taken into account, and that therefore they should not be called upon to pay the same contributions as the land employers.

As the result of negotiations with the Chancellor of the Exchequer it was ultimately agreed that there should be a reduction of 1d. per week in the weekly contributions of both seamen and shipowners. In the case of the seamen the reduction was carried into effect by an arrangement under which the seaman's four payments at the full rate were to be treated as equal to five payments at the reduced rate.

These reductions were not accepted by the representatives of the seaman and shipowners as equivalent to the saving in sickness and medical benefits under the Act of 1911. They were satisfied that the benefits provided under the Merchant Shipping Acts would relieve the National Insurance of liabilities representing substantially more than those reductions. They were accepted because, and only because, it was agreed that if they were under estimated the amount over collected would be available for the benefit of the insured seamen.

20. The shipowners raised a further point: they contended, and in justice their contention could not be challenged, that no contributions should be collected in respect of uninsured seamen, as for example foreigners and Lascars domiciled abroad. The basis of the Act was that contributions were levied

in respect of benefits, but the Chancellor of the Exchequer was unable to act upon this principle, which he himself had laid down, as he thought that it might be supposed to operate in favour of the employment of foreign seamen on British ships. He agreed that Lascars and foreigners serving on vessels stationed and trading regularly between foreign ports were as much outside of the Bill as the workmen employed in any British factory abroad, and that they should be excluded from the Bill. He further agreed that whilst the shipowner must pay the contributions in respect of all other Lascars and foreigners he employed, it would be inequitable to make these men contribute for benefits in which they could never share.

The shipowners accepted this arrangement as a compromise, but again only on the understanding that the contributions paid by them in respect of the uninsured Lascars and foreigners would be made available for the insured seamen.

21. It was of the essence of the bargains referred to in paragraphs 19 and 20 that all seamen should be grouped in one society, and the Bill originally provided for this.

The Board of Trade was to be entrusted with the duty of forming such a society, and in consideration of the shipowners accepting the reduction of only 1d. off the rate of contributions, and paying for the uninsured Lascars and foreigners, provision was made for the shipowners having representatives on the committee that was to be entrusted with the management of the affairs of that Society.

Unfortunately for the seamen the Bill was amended in Committee so as to enable a seaman to join any society.

22. The contributions collected from the shipowners in respect of the uninsured Lascars and foreigners have remained earmarked for the benefit of seamen as a class. And the fund so established has been increased by similar contributions collected from shipowners under the Unemployment Insurance Act. The result is that a Pension Fund has been established under the joint management of the seamen and shipowners. This Fund is now represented by upwards of £550,000 of investments; it is paying pensions at the rate of £2,200 per month or £26,400 a year; and within the next 4 years it is estimated that it will be paying pensions at the rate of £76,000 a year, to seamen between the ages of 65 and 70 who have had long sea service.

23. The other contributions paid by seamen under the Act of 1911 have not been earmarked for the benefit of the seamen as a class.

The bargain made with the seamen and shipowners has therefore not been honoured, and in consequence the seamen as a class have lost probably £500,000.

THE SEAMEN'S NATIONAL INSURANCE SOCIETY.

24. *Constitution.*—The constitution of the Seamen's National Insurance Society was drafted by a committee called together by the Board of Trade representing all the Masters, Officers, Engineers, and Seamen's Unions, Fishermen, and the Shipowners' Parliamentary Committee. This Constitution places an obligation on the Society to accept all seamen applying for membership.

25. *Management.*—The Management of the Society consists of:—

- (a) 21 members appointed by the Board of Trade, consisting of 7 representatives of the Board of Trade, 7 representatives of the Shipowners, and 7 representatives of the Insured Persons.
- (b) General Purposes Committee, consisting of 3 representatives of the Shipowners and 5 representatives of the Insured Persons.
- (c) A Treasurer—the Assistant Secretary for Finance of the Board of Trade.
- (d) General Secretary, appointed by the Management Committee.
- (e) Local Committees, appointed at all the important Ports in the United Kingdom.
- (f) Local representatives, appointed at the Ports to attend to the wants of local members.

26. Membership.—Since the formation of the Society it has been found impossible to ascertain the actual membership.

The short and simple method, which is open to all Landsmen's Societies, of communicating periodically with every individual on the books to ascertain whether or not he is a continuing member, has never been open to the Society because so many of its members have no permanent home address. In many cases the only evidence the Society has of the continued existence of the member, is the receipt of his stamped Voyage Card collected by the Society's representative as the member is paid off. In very many cases the Society never comes into communication with the member until he claims benefit. In very many cases the stamped cards are retained by members for months, and even years.

The difficulties in the way of forming reliable estimates of membership were greatly increased by the War. A very large percentage of the members joined the Navy or Army, and the arrangements made for the purpose of keeping the Society in touch with its Service members were, in a very great measure, ignored by the members and the Services.

In the face of these difficulties, the only positive figures available for the assessment of the membership have been:—

- (1) the number of applications for membership received,
- (2) the number of deaths, transfers, and withdrawals notified, and
- (3) the number of members from whom contributions were actually received during the year under review.

Up to the 31st December, 1914, applications had been received from 77,870 members, but after deduction of duplicate applications and applications which never became effective, the Society estimated, and the Government Auditor certified the membership, for that year at 65,057.

At the end of the War, that is, up to the 31st December, 1918, effective applications had been received from 90,829 members and the Society had notice of:—

Deaths	...	...	...	4,227	
Transfers Out	...	...	...	2,426	
Withdrawals from Insurance	...	...	...	2,225	
					8,878
Leaving an apparent effective membership for the year 1918 of					81,951

To test this figure the Society took:

- (1) The number from whom cards were actually received during 1918 44,816
 - (2) Estimates of the members in the Services, based on such information as it had:

Navy or Army	...	...	17,300
Mercantile Marine Reserve	...	...	2,827
			20,127
 - (3) Estimates of the members on long voyages from whom cards had still to come in... .. 8,757
- 73,700

These figures and the facts on which the estimates were based were placed before the Government Auditor, and he certified the membership for 1918 at 73,700.

The Government Actuary for the purposes of the valuation as at the 31st December, 1918, took the membership as on that date at 70,213.

Estimating on a similar basis the Government Auditor was not prepared to certify positively a membership above 66,785 for 1919, although he was prepared to pass a higher figure subject to a report on the special circumstances. The Society accepted and acted on the figure of 66,785.

In 1920, the regulation, the effect of which is to exclude from effective membership all members who at any time during the year have not lodged contributions for 12 months, which had been suspended

during the War, came into operation. Under this regulation the Government Auditor certified the membership for 1920 at only 48,654.

Apart from the War years the certified membership has been as under:

1914	...	...	...	...	65,057
1919	...	...	...	...	66,785
1920 (In accord with regulation)	...	...	...	...	48,654
1921	"	"	"	"	49,376
1922	"	"	"	"	50,862
1923	"	"	"	"	52,683

As against these figures, up to the 31st December, 1923, effective applications had been received from 117,400.

And the Society has had notice of:

Deaths	...	...	...	8,562
Transfers Out	...	...	...	3,862
Withdrawals from Insurance	...	...	...	6,150
				18,574
Leaving an apparent effective membership on the 31st December, 1923, of				98,826

Contributions are still being received for every one of the years since 1914, and the Society has in its ledgers 46,143 unclosed accounts over and above the number for which the Government Auditor certifies under the regulation.

The Government Actuary in basing the valuation on a membership of 70,000 estimated for liabilities substantially in excess of those incident to a membership in the neighbourhood of 50,000, and consequently under-estimated to a like amount the available surplus. But after full consideration of all the information before them, the Committee of the Society cannot take upon themselves the responsibility of advising that the Government Actuary's estimate of a membership at the end of 1918 of 70,000 was an over estimate.

Since that date new members, who still remain effective members, have been admitted up to the number of 17,149. Of these 10,726 have joined since the regulation was enforced, but the certified membership has under that regulation increased only from 48,654 to 52,683.

The fact is that the conditions of the Sea Service, and the collection of contributions by means of the Voyage Card system, make it impossible for the Society to keep in effective touch with its members generally.

27. Benefits.—The following benefits had been distributed up to the 31st December, 1923:—

	£	s.	d.
Sickness Benefit	161,423	7	8
Disablement Benefit	43,332	19	5
Maternity Benefit	60,868	18	6
Medical Benefit	109,649	7	11
Sanatorium Benefit	27,060	9	4
Benevolent Fund	1,530	8	1
Total	£403,865	10	11

Benefits paid in 1923 were:—

	£	s.	d.
Sickness Benefit	19,618	0	0
Disablement Benefit	10,007	15	10
Maternity Benefit	6,962	12	6
Medical Benefit	15,565	9	1
Sanatorium Benefit	34	16	0
Benevolent Fund	272	4	8
Total	£52,460	18	1

Benefits paid in 1924, subject to audit, were:—

	£	s.	d.
Sickness Benefit	20,868	13	8
Disablement Benefit	11,167	2	6
Maternity Benefit	6,815	11	6
Medical Benefit	16,377	10	7
Benevolent Fund	263	18	5
Total	£55,492	16	8

28. Balance Sheet.—The Balance Sheet as at 31st December, 1922, shows the following balances:—

	£	s.	d.
On Benefit Fund Account ...	560,427	19	9
„ Sanatorium Fund Account ...	289	5	1
„ Administration Account ...	1,268	5	0
„ Contingencies Fund Account ...	35,305	8	3
„ Benevolent Fund Account ...	276	8	5
Total	£597,567	6	6

29. Investments.—The total amount of the Society's invested funds at 31st December, 1923, was £318,510 6s. 11d.

30. Valuation.—The result of the valuation of the Society as at 31st December, 1918 showed:—

	£
A gross surplus of	41,780
A disposable surplus of	8,746

The valuation was based on a membership of 70,000. The Society estimate that up to the 31st December, 1918, they had failed to get in at least £130,000 of the contributions paid in respect of its members.

31. Additional Benefits.—The additional benefits granted by the Society as a result of the disposable surplus are:—

- Increased Maternity Benefit.
- Convalescent Homes Treatment.
- Surgical and Medical Appliances.
- Optical Treatment and Appliances
- Dental Benefit.

The total distributed up to the 31st December, 1924 has been £4,268.

32. Medical Benefit.—In view of the considerations dealt with in paragraph 9 of this Statement the Society decided that the interests of the seamen could be only served by adopting the system of paying for each attendance made, and for the doctor supplying the necessary medicine and appliances.

The aim of the Society was to secure a thoroughly efficient medical attendance, the primary objects being to give promptly the help needed, and to minimise the time seamen are on sickness benefit.

After consultations with doctors of the highest professional standing in London, Liverpool, Glasgow and Southampton, a scale of fees was adopted to include drugs and medicines. This scale was submitted to the British Medical Association, which accepted it, as in the circumstances reasonable.

The Society believed the scale to be substantially higher than the rates previously paid, or even promised and sometimes not paid, by the great majority of seamen in the principal ports. The Insurance Commissioners left the Society to adopt the scale on its own responsibility, being evidently under the impression that the Society had assumed a responsibility substantially above that which would have been imposed by the adoption of the capitation system of payment.

In adopting the fee system the Society realised its serious responsibility and felt bound to exercise supervision over the choice of doctors. The Society therefore appointed a certain number of doctors at each port to attend members. In making these appointments the aim has been to secure an adequate number of doctors to provide a thoroughly efficient and trustworthy service in every part of the port, and it has left the members a free choice between those doctors. If a member, whose home is in any such port, has been in the habit of consulting a particular doctor not amongst those so appointed, the Society has allowed the member to continue to be attended by that doctor. This practice is in operation in London, Liverpool and Glasgow, and in the ports of the United Kingdom generally.

In Southampton and Lowestoft the doctors preferred that the members should be given a free choice among all the doctors in these ports. The seamen of Southampton serve almost entirely on regular lines trading from that port, and in Lowestoft the seamen are almost all serving in the Steam Fishing Service, and many of them have their homes at these ports. The same difficulties did not arise, and the doctors'

proposals were therefore adopted. In both Southampton and Lowestoft the doctors undertook to keep in touch with one another so that this system of choice should not be abused.

The system by which the doctors act under the direct control of the Society has worked satisfactorily, and, so far as the Society is able to judge, has been approved by the doctors. There has been no difficulty in getting doctors to give the service under its conditions.

The scale of fees adopted at the commencement of the Act has been revised from time to time, as follows:—

On 1st January, 1919, a bonus of 20 per cent. to the total of the doctor's quarterly account, was added.

On 1st April, 1920, the bonus was increased to 50 per cent.

On 1st July, 1922, the bonus was reduced to 40 per cent., and

As from the 1st January, 1924, the Society proposed that the bonus be reduced to 25 per cent. This proposal is still under consideration with the British Medical Association.

The following is a copy of the Society's original scale of fees:

SCALE OF MEDICAL FEES.

One visit and medicine for two days ...	0	2	6
Each intermediate visit in dangerous cases (including medicine, if prescribed) ...	0	2	6
If beyond two miles, and under three miles (outward) extra	0	0	6
If beyond three miles, and under four miles (outward) extra	0	1	0
Over four miles, extra per mile	0	1	0
One attendance at Surgery and medicine for two days	0	1	6
One fresh supply of medicine for two days Extra per visit between the hours of 9 p.m. and 8 a.m. the following day, in response to call between those hours ...	0	1	6
Extra per attendance at Surgery between the same hours	0	0	6
Special Report, if required, after six weeks' illness	0	2	6
Treatment of fracture of Clavicle or Ribs	1	0	0
Treatment of dislocation of Lower Jaw	0	10	6
Treatment of other dislocations or simple fractures	1	0	0
Other minor operations without anæsthetic (Teeth extraction excepted)	0	10	6
Other minor operations with Anæsthetic (Teeth extraction excepted)	1	1	0
Passing Catheter	0	2	6
Passing Catheter, if at patient's house, extra	0	2	6

The scale includes fees for operations, and special cases involving specialists' or consultants' fees are considered by the Society before the liability is undertaken, and the bonus is paid on the total sum of the account.

The Society's system has worked satisfactorily, and is warmly appreciated by the members. There has been no cause of complaint of the doctors. In very few instances has it been necessary to inform the doctors, that while the Society recognises their desire to assist members to a speedy restoration to good health, and while wishful to secure for the members all necessary attendance, the funds do not warrant attendances, which though gratifying to the patient, are in the nature of luxuries rather than necessities.

PAYMENT AND COLLECTION OF THE SEAMEN'S CONTRIBUTIONS.

33. The information collected and made public by the Ministry of Health is still too incomplete to enable final conclusions to be drawn as to:—

- (1) The total number of insurable foreign-going seamen in respect of whom foreign-going contributions are being paid;
- (2) the total amount that is being paid in respect of such foreign-going contributions; and
- (3) the total amount that is being surrendered by insurable foreign-going seamen to their Approved Societies.

34. For the year 1921 the Ministry of Health state that the total amount received in foreign-going contributions (men only) by all the Approved Societies was as under:—

	£
Seamen's National Insurance Society	28,174
Sailor's and Firemen's Union	22,324
All other Units	51,489
	<hr/>
	£101,987

Some of these contributions relate to voyages prior to the date on which the normal contribution was raised from 6d. to 8d. per week, but the Ministry has ascertained that the average weekly rate actually paid in 1921 was 7.597d. per week, and therefore the payment of £102,000 represented the employment of 61,000 insurable seamen per week throughout the whole 52 weeks.

The average length of foreign-going service of the seamen making these contributions has not been ascertained, but it is manifest from the total amount received that either contributions were not paid in respect of many insurable seamen, or if paid were never surrendered to the societies.

If the average length of foreign going service in the year 1921 be assumed at:—

42 weeks, then the £102,000 would represent the contributions of seamen	77,000
36 weeks, then the £102,000 would represent the contributions of seamen	90,000
30 weeks, then the £102,000 would represent the contributions of seamen	108,000

The Board of Trade Returns show that there were actually employed at some time during the year on 3,648 vessels, 159,000 seamen in the foreign trade exclusive of Lascars, and on the best estimates that can be made (paragraph 5) not less than 121,000 of these men were insurable under the Act. The £102,000 could only represent the contributions from such a number on the assumption that they served on the average only 26 weeks in the year—and on any such assumption the ships actually at sea could never have been manned.

35. Following established practice, the Board of Trade took a census of the number of seamen actually employed on the 19th June, 1921, on British ships in Foreign Trade.

As the Board of Trade point out: "It was unfortunate that the date on which the Census was taken in 1921 occurred in a period of acute depression in shipping accentuated by the coal dispute." The result was that the Census showed only the crews of 1932 foreign going vessels, the numbers excluding Lascars being as under:—

British Seamen	78,184
Foreign Seamen	10,991
	<hr/>
	89,175

of whom (on the basis adopted in paragraph 5) insurable seamen would have numbered—

British, 78,184 less 20 per cent.	62,500
Foreign, 10,991, at 33½ per cent.	3,600
	<hr/>
	66,100

The Census would appear, therefore, to have included only a little over half of the ships and crews employed during 1921.

36. The abnormal conditions created by the coal strike no doubt reduced the average length of service in the Foreign Trade in the year 1921, but the total tonnage entrances of British steamships (including their repeated entrances in the year) in the trade of the United Kingdom in 1921 was 19,927,541 tons net, as against 21,645,275 tons net in 1920, a decrease of only 8 per cent. And 1920 was not a bad year for shipping.

Further, apart from the delays resulting directly from the coal strike, there was, in 1921, no "lying up" of vessels.

There is, therefore, nothing in the Census figure discrediting the accuracy of the Board of Trade's

Return of the ships and seamen employed in 1921, and there is warrant for thinking that if it had not been for the coal strike the Census would have shown four-fifths—that is, 97,000 of the 121,000 insurable seamen—as serving on the 19th June, 1921.

Indeed, the ships that were employed throughout that year could not have been manned without from 90,000 to 100,000 insurable seamen being on Articles constantly throughout the whole of that year.

If 90,000 be taken as a minimum figure, then at 7.597d. per week the total contributions paid for the year should have been £143,125, as against the £101,987 actually received by the societies.

On this basis the loss of contributions equalled 29 per cent.

37. It is probable that on the average, the foreign-going seaman who is a member of a society other than the Seamen's Societies is both in more regular employment and is more careful of his cards than the average member of the Seamen's Societies. He is a man with a home address which is known to his society, and he and his family are frequently members for benefits other than those provided under the Act.

For these reasons it is probable that the Seamen's Societies suffered more than their proportion of the lost contributions.

38. There is no reason for supposing that the loss was less in the years preceeding 1921—on the contrary the Ministry of Health claim that there has been an improvement in the surrender of the Voyage Cards. And since 1921, so far as the Society can judge, there has been no substantial improvement although possibly a little more care is now being taken in both stamping and surrendering the Voyage Cards.

39. The Society has for years endeavoured to get this loss stopped.

The real remedy is to go back to the scheme originally agreed to—that is to place all seamen in one society. It is only by doing that that the seamen can be given the full benefit of the bargain made when the contributions were reduced by only 1d. a week.

40. Whether or not that remedy is applied, the Voyage Cards should be replaced by schedules furnished by the shipowner at the end of each voyage giving the names, ratings, address, society (if known), etc., of each insured seaman, and the amount of contributions payable in respect of each seaman. The total of the contributions as shown by such schedules should be paid by the shipowner in bulk to the Board of Trade official at the "Pay off." The schedule should then be sent to a Clearing House in London, to enable the contributions to be credited to the individual seamen.

The Society maintain that it would be a far simpler and less costly matter to fill up such a schedule than a multitude of separate cards, even although additional information had to be inserted in the schedule to enable the individual seaman to be more readily identified. This view is shared by the ship-owners and by the officers by whom the cards are now prepared.

The cost of the work of carrying the amounts credited on the schedules to the accounts of individual seamen in different societies would be far less than the amount the societies now lose through lost and mislaid cards.

Schedules would enable the seamen in need of benefit to establish beyond doubt that his contributions had been paid, and they would thus help materially in the many cases of hardship and suffering with which the society has now to deal.

It is the unanimous belief of the Committee, which represents all ratings of seamen and all Associations and Unions of Seamen, besides the shipowners and the Board of Trade, that the schedule system would be far more effective and less costly than the Voyage Card system.

41. If the Voyage Card system cannot be changed, then it is submitted that there is no necessity to hand the card to the seaman at the "pay off," but that it should be sent to a Clearing House in London and there distributed between the societies to which the seamen belong. Such method would stop the deplorable loss of contributions, and would not be more costly than the present system.

42. It is suggested:—

- (1) That at each "pay off," instead of filling in a separate card for each seaman, the shipowner should lodge a schedule, giving the names of all the crew, and in regard to each the other information which should be (but which frequently is not) inscribed on the cards.
- (2) That with this schedule, the shipowner should lodge with the Board of Trade Official the total amount that would have been payable in stamps on the separate cards. This payment could be vouched by stamps attached to the schedule, or in such other way as might be found convenient.
- (3) That the schedule be sent up to a Clearing Office in London which should work under the supervision of the Ministry of Health.
- (4) That all seamen should be grouped in one single society.

- (5) If it is not possible to group all seamen in one society that the Clearing Office should account to the society to which each seaman belongs for the amount paid on his behalf.

ADMINISTRATION.

43. Under the existing system the administrative work connected with seamen's insurance is greater than that connected with land societies.

The insurance cards of foreign-going seamen are issued by the master of the ship, and not by the member's society, and contain little information to enable the society to identify the member.

It is often necessary to communicate with likely members, with shipowners, with the Board of Trade, and with other societies before the seaman can be identified, and the correct membership number placed on the insurance card.

All this work is additional to land-workers' cards which are issued to members with membership numbers thereon.

The work entailed in keeping a seaman's contribution account is many times greater than that of the landsman.

The following are examples of actual foreign-going and home-trade seamen's accounts showing the labour involved in the former as compared with the latter:—

FOREIGN-GOING (No. 140,166).					HOME-TRADE (No. 33).		
Period.	Name of Ship.	Date of Termination of Voyage.	Contributions.		Period.	Home 10d.	
			Home 10d.	Foreign 8d.			
1921	Mauretania	12.2		3	1921		
	Aquitania	5.3	3	3			
	Mauretania	15.4		3			
	"	19.5	4	3			
	Aquitania	21.6		3			
	"	12.7	2	3			
	"	20.9	1	3			
	Berengaria	22.8		3			
	"	10.10		3			
	Aquitania	1.11		3			
"	22.11	2	3	26			
"	20.12		3	26			
1922	Aquitania	14.2	1	3	1922		
	"	7.3	5	3			
	"	10.4		3			
	Mauretania	1.5	2	3			
	Berengaria	5.6		3			
	"	26.6		3			
	"	17.7		3			
	"	14.8	2	3			
	"	10.9		2			
	"	30.9		3			
	"	16.10	1	3			
	"	27.11		3			
	"	19.12		3				26
1923	Berengaria	8.1		3	1923		
	"	26.2	2	3			
	"	5.2		3			
	"	30.4	1	3			
	"	21.5		3			
	"	11.6		3			
	"	2.7		3			
	"	23.7		3			
	"	20.8		3			
	"	10.9		3			
	"	1.10		3			
	"	22.10		3			
	"	12.11		3			
	"	3.12		3			
"	28.12		3	27			

The work is therefore greater, whilst owing to the failure of the Voyage Card system the membership upon which the administration allowance is calculated is smaller than in the land societies.

It is therefore suggested:—

- (1) That the administration allowance be 5s. in respect of each foreign-going seaman.
- (2) That 15 per cent. be added to the number of effective foreign-going seamen, as ascertained under the existing regulation.

DEPOSIT CONTRIBUTORS.

44. The Society is bound to admit any seaman who applies for membership.

Many applicants for membership surrender contribution cards covering years of employment.

Not having joined the Society within the time allowed (6 to 12 months) after becoming insured or re-insured, these automatically become deposit contributors, and a transfer to the Society has to be effected, and the contributions prior to the date of transfer surrendered to the Ministry of Health.

It is suggested:

That where no account for a seaman has already been opened in the Deposit Contributors Fund the Society treat the applicant for membership as a new entrant from the date of the first contribution surrendered.

APPENDIX XXXII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE GOVERNING BODY OF THE SPECIAL FUND FOR SEAMEN (COMMONLY CALLED THE LASCAR FUND), BY SIR NORMAN HILL, BART., CHAIRMAN. See Minutes of Evidence of the Twenty-second Day, Questions 12,178 to 12,236.

1. Health Insurance contributions are not payable by a seaman serving on a British ship who is neither domiciled nor has a place of residence in the United Kingdom. The employer of such a seaman is, however, required to pay the employer's share of the contribution unless the ship is engaged in regular trade on foreign stations. (National Health Insurance Act, 1924, section 62 (4).)

2. Originally it was provided that all contributions paid by shipowners in respect of seamen domiciled abroad should be credited to the Seamen's National Insurance Society, and that the Committee of Management of the Society should prepare, with the approval of the Board of Trade and the National Health Insurance Commissioners, a scheme of benefits, including pensions for seamen with long sea service, payable out of the Fund derived from these contributions. (National Insurance Act, 1911, section 48 (6) (7).)

3. Under the scheme of benefits referred to above, provision was to be made not only for the inclusion as beneficiaries of members of the Seamen's National Insurance Society, but also for the application of a proper proportion of the sums credited to the Society towards the payment of pensions or superannuation allowances granted by other Approved Societies to their members, who, if they had been members of the Seamen's National Insurance Society, would have been entitled to pensions under the scheme.

4. The Committee of Management of the Seamen's National Insurance Society decided that the money could be most effectively used in payment of pensions. Special circumstances existing at that time made it desirable, however, to suspend action pending the accumulation of sufficient funds to warrant the establishment of a permanent scheme.

5. Approximately four-fifths of the total number of non-domiciled seamen employed in the British Mercantile Marine are Lascars, and the bulk of the income of the Fund is, therefore, derived from contributions paid in respect of this class of seamen. It is from this fact that the Fund became commonly known under its present title.

6. As a result of recommendations made by the Departmental Committee on Approved Society Finance and Administration which sat in 1916, the Fund was reconstituted and established on its present basis. (National Health Insurance Act, 1918, section 27 (1) (c) and National Health Insurance Act, 1924, section 64.)

7. The Governing Body consists of three representatives of shipowners nominated by the Board of Trade, and six representatives of insured persons, being persons serving, or who have served, in the British Mercantile Marine or in the British Sea

Fishing Fleets, or being persons on the Committee of Management of an Approved Society other than persons appointed on such Committee to represent shipowners. The representatives of insured persons are selected from the following seamen's Approved Societies:—

- (1) Three members of the Seamen's National Insurance Society.
- (2) Two members of the National Sailors and Firemen's Union.
- (3) One member of the National Sailors and Firemen's Union or the Trinity Provident Approved Sick Club, as may be agreed between the two Societies.

The Governing Body hold office for three years. There are three Trustees of the Fund nominated by the National Health Insurance Joint Committee in whose names all investments are held on behalf of the Fund.

8. In 1922 the Ministry of Labour decided to transfer to the Fund the contributions paid by shipowners in respect of non-domiciled seamen under section 39 of the Unemployment Insurance Act, 1920. This had the effect of increasing the contribution income of the Fund to about three times its former amount.

9. With the exception of a yearly grant of £500 to seamen's hospitals, the benefits of the Fund are for the present, at any rate, restricted to pensions for old seamen. For Class A pensions only seamen who are members of Approved Societies are eligible, but a pension once granted is not forfeited because a seaman thereafter ceases to be a member of such a society. For Class B pensions it was originally provided that only seamen who were insured under the Unemployment Insurance Acts were eligible, but this latter requirement has recently been abolished.

Three hundred pensions (150 Class A and 150 Class B) are offered on the 1st January and on the 1st July of each year to seamen between 65 and 70 years of age. The selection from the applicants is made by a system of marking proportionate to the length of sea service, preference being given to seamen who have served in the foreign trade. The value of each pension is, at present, 10s. a week, and a pension ceases when the pensioner reaches the age of 70 years. In view of the want of reliable information as to the probable number of applicants and the uncertainty regarding the future contribution income of the Fund, the arrangements provide for a considerable balance being carried to investment each year. It is hoped by conservative administration to accumulate sufficient funds to enable a pension to be given to every seaman domiciled in

Great Britain and in Northern Ireland who has served approximately thirty years in the British mercantile marine or in the British fishing fleets.

10. The following particulars may be of interest:—

(1) Number of pensions awarded since the Fund came into operation in 1922: Class A, 982; Class B, 474: total, 1,456.

(2) Number of pensions current at the present time: Class A, 679; Class B, 416: total, 1,095.

(3) Investments: Health Account, £339,366. Unemployment Account, £238,090. Total, £577,456.

(4) Approximate annual income of the Fund from contributions and investments, £130,000.

11. The statutory requirement that applicants for Class A pensions shall be members of Approved Societies has been found to disqualify many deserving old seamen who for various reasons are no longer or never have been members of such societies. The corresponding qualification with regard to Class B pensions is not imposed by Statute, and, recognising the position, the Minister of Labour has recently sanctioned its deletion from the scheme governing the award of those pensions.

12. The members of the Governing Body, who are representative of all classes—owners, officers and seamen—connected with the shipping industry, are unanimously of opinion that length of sea service should constitute the chief claim to a pension. They, accordingly, suggest that the pensions (Class A) derived from health insurance contributions should be open to all seamen domiciled in Great Britain, including Northern Ireland, who are serving, or have served, in the British mercantile marine or in the British fishing fleets.

13. It is also suggested that the cost of administering the Fund which is now payable up to the prescribed amount by Approved Societies having members entitled to the benefits of the Fund, shall be paid by the Fund. Up to the present the necessary regulations dealing with the matter have not been made, as it is felt that the requisite arrangements would be almost impossible in their application. It might be added that Mr. Wheatley, when Minister of Health, agreed that, when an opportunity occurred, legislation should be introduced to give effect to the foregoing suggestions.

APPENDIX XXXIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE COVENTRY INSURANCE COMMITTEE, BY MR. H. W. WALE, CHAIRMAN, AND MR. J. C. LEE GORDON, CLERK. See Minutes of Evidence of the Twenty-second Day, Questions 12,237 to 12,451.

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I.—PROPOSALS ALREADY ADOPTED BY THE COVENTRY INSURANCE COMMITTEE.

SCOPE OF MEDICAL BENEFIT.

1. Section 15 (6) of the National Insurance Act of 1911 contemplated that the Insurance Committee and Approved Societies having members in their area should negotiate as to the cost of the medical benefit of the Societies' members, and that the Committee were to be paid accordingly. The Insurance Commissioners took this bargaining power away from the Insurance Committees, and on 27th April, 1914, the Coventry Insurance Committee adopted the following rider to a resolution authorising the Commissioners to fix the price:—

"That this Committee, whilst seeing no present alternative to the agreement through the Commissioners with Approved Societies for payments by them as in the foregoing, record that they are of the opinion that the extent of the medical benefit hitherto provided by the Committee has been unduly restricted both by the regulations made by the Commissioners and by the apparent limitation of the sum available to Approved Societies for the provision of medical benefit; and further that, seeing that by section 15 (2) of the National Insurance Act, 1911, it is enjoined upon the Commissioners that arrangements shall be made such as to secure

to insured persons adequate medical attendance and treatment, this Committee are of opinion that amending regulations should be made so as to secure the provision by Insurance Committees of

- (i) such treatment in hospitals as appears to be needed by insured persons recommended for this by their doctor;
- (ii) further facilities for modern means of exact diagnosis;
- (iii) The services of trained nurses where recommended by the doctor in charge of the case;
- (iv) Provision of such further appliances as are shown to be needed."

2. The Budget speech made by the Chancellor of the Exchequer in 1914 stated that provision would be made for further extensions of clinical and other services. On 29th June, 1914, the Coventry Insurance Committee adopted a memorandum on the subject, in which it was stated (par. 6):—

"It would seem desirable that a definite proportion of the Public Health Grant should be allocated to the (Insurance) Committees, thereby placing them in a position to arrange with local and hospital authorities for medical and other treatment of insured persons. . . . Insurance Committees are responsible for the provision of medical treatment with a view generally to the promotion of public health and incidentally of safeguarding the funds of approved societies; and neither object can satisfactorily be achieved until arrangements such as these can be made." Another important factor in the provision of an adequate medical treatment is the addition of nursing, without which, the Chancellor of the Exchequer stated, 'any system of doctoring is hopelessly inefficient.'"

3. On this memorandum the Insurance Committee passed the following resolution:

"That this Committee, being of opinion that individuality of control by Insurance Committees is essential to an efficient administration of medical benefit in the best interests of insured persons, and in view of the budget statement of the Chan-

cellor of the Exchequer that grants will be made available in the current year for the further provision of hospital beds, the further treatment of tuberculosis, for nursing, medical referees and consultants, and for clinics and the scientific diagnosis of disease, represents to the Chancellor of the Exchequer (etc., etc. . . .) that in the view of the Committee it is of the highest importance that adequate proportions of these grants shall be placed at the disposal of Insurance Committees for the purpose indicated."

4. It is pointed out that only a limited medical referee grant, and a certain subsidy for the treatment of tuberculosis has materialised up to the present.

NURSING.

5. In 1913 and 1914 the Insurance Committee took active steps in conjunction with the Association of Approved Societies to review the need for a nursing scheme. On 30th March, 1914, the Committee passed the following resolution:—

"That the Committee have considered the draft outline scheme for the provision of nursing to insured persons presented by the Association of Approved Societies and accords its entire approval of this proposal towards rendering an adequate medical benefit to insured persons; and that this Committee are desirous of taking all steps such as lie within their power to bring the same into effect."

The draft scheme thus adopted states:

"Inasmuch as nursing attendance on a sick person is an essential part of medical treatment, it follows that it forms a natural part of medical benefit. The administration, therefore, of sick nursing will naturally be by and through the Insurance Committees or whatever bodies are from time to time charged with the administration of medical benefit."

6. The Coventry Insurance Committee attempted in 1921 to bring about a scheme whereby the Approved Societies providing nursing as an additional benefit would use their local machinery which, by various resolutions, they placed at general disposal. No progress was made, and notwithstanding continuous enquiry from the public, the Insurance Committee have no information as to the societies providing this benefit nor of the nature of their schemes. In a report adopted by the full Committee on 10th November, 1921, the following occurs:—

"... most committees have thoroughly overhauled and investigated the position, and are ready and willing to take their share in investigating any such nursing scheme which is necessarily ancillary to the medical treatment of the insured. It is also plain that the larger societies are holding their hand at present in order to see whether the Government will take what is the only possible course, that is, the promotion of a national scheme."

TREATMENT OF TUBERCULOSIS.

7. When sanatorium benefit was discontinued and the institutional treatment of tuberculosis made the subject of eligibility of application by all local residents, the Committee found occasion on 29th March, 1920, to adopt the following resolution:—

"That the fullest safeguards should be provided whereby the standard hitherto attained for the provision of treatment amongst the insured community shall in no way suffer or be regarded as a maximum condition; and that the necessary financial provision should be made whereby such medical supervision, medicines and nourishment, as may be essentially requisite and not otherwise obtainable by the individual shall be made available in co-operation with the Insurance Committees for the domiciliary treatment of the disease."

8. It is nevertheless a fact that no provision whatever is made for the domiciliary treatment of tubercu-

losis amongst the uninsured; whilst it can be demonstrated that since the co-operation of Insurance Committee members has been removed considerably less cases receive relief from the local tuberculosis authority under the shape of extra nourishment (an important part of the treatment of tuberculosis). The criterion is a comparison of the appropriate expenditure of the Insurance Committee with that of the Local Authority who have not at their disposal the special interest which Insurance Committee members devoted to the efficiency of the treatment which it was their duty to administer.

DISPENSING.

9. On 10th November, 1921, the Committee passed the following resolution:—

"That in this Committee's opinion the provision of the National Insurance Act, 1911, whereunder the dispensing of medicines for the insured community is undertaken by the pharmacist wherever available, has been fully justified by experience; and that the current arrangements should be continued and developed."

ADDITIONAL BENEFITS.

10. The following is a minute of the Committee's Medical Benefit Sub-committee, adopted by the Insurance Committee on 26th September, 1921:—

"The National Health Insurance (Additional Benefits) Regulations, 1921, were received from the Ministry of Health. These provided the following benefits as being 'additional benefits' to those set out by Part 2 of the Fourth Schedule of the 1911 Act:—

- (15) Payments to hospitals or convalescent homes;
- (16) Payment of whole or part of medical and surgical appliances;
- (17) Payment of whole or part of optical treatment and appliances;
- (18) Payment of whole or part of the cost of the provision of nurses for members.

"The Fourth Schedule, Part 2, of the principal Act also prescribes as an additional benefit 'The payment of the whole or any part of the cost of dental treatment'

"The Sub-committee noted that section 14 (1) of the 1911 Act provided that additional benefits are to be administered by the society or branch of which persons entitled are members, except where such benefits are in the nature of medical benefits, in which case they are to be administered by and through the Insurance Committees."

"The Ministry had not, up to the date of the meeting, declared any of the foregoing to be in the nature of medical benefits."

11. It appears that none of the additional benefits at present being provided for insured persons is in the nature of medical benefits, seeing that none is administered by and through Insurance Committees.

ADMINISTRATION.

12. On 30th July, 1917, the Insurance Committee passed the following resolution bearing on the establishment of a Ministry of Health, setting out its views as to the organisation of local control:—

"That for the purpose of local organisation in connection with the proposed Ministry, this Committee are of the opinion:

- (a) that the country should be divided into administrative areas, consisting of such existing local government areas or combinations thereof as will require the services of wholtime administrative medical officers, both clinical and preventative;
- (b) that for each such area there should be a local administrative Health Committee, consisting of representatives of

the Rating Authority, Education Committee, contributors to the Health Insurance scheme and others, and the medical profession, together with representatives of such other persons or organisations as may be directly affected by the administration of the Health Committee:

- (c) that the principal medical officers of such Health Committees should be two, each of equal status, viz., the Chief Clinical Officer who should advise on all questions of medical treatment including the administration of treatment centres and all special clinics, etc., and the Medical Officer of Health, whose duties would be those connected with vital statistics and preventative medicine generally;
- (d) that the medical staff of such Authority should consist of (i) those engaged exclusively in duties of administration and inspection, (ii) those employed as resident officers of institutions, or as officers in charge of special clinics; and (iii) pathologists; and (iv) practitioners engaged in giving advice and treatment to individual persons;
- (e) that such local administrative Health Authority should arrange for the recognition or establishment in the area of hospitals, clinics, or treatment centres where persons entitled to treatment under the public or national scheme may obtain treatment or special services on the recommendation of their medical attendant.
- (f) that other duties of such Authority should be such as might by statute, regulation or order of the Ministry devolve upon them."

The foregoing was sent to the Prime Minister, the Government Departments and all Insurance Committees in England.

13. On 28th October, 1918, the Insurance Committee passed a resolution bearing further upon the establishment of a Ministry of Health, going on to deal with local organisation in the following terms:

"and that for the purpose of local administration under such Central Authority, provision should be made for the establishment in each County and County Borough local government area, of an administrative Health Committee, directly representative of all parties partaking in or affected by Health Services, which should co-ordinate and administer all local services relative to health whether preventative or clinical."

In this latter case the Chairman and Vice-Chairman were expressly authorised to take all steps at their discretion to give the necessary publicity to the Committee's views on this subject.

14. On 29th March, 1920, the Committee expressed as follows their views of the need of co-ordinating the experience gained in the administration of the clinical treatment of tuberculosis with the Local Authority to which a part of this responsibility was transferred:

"That in view of the important part taken by members of Insurance Committees in the initiation, development and administration of local schemes for the institutional treatment of tuberculosis, and of the special administrative and general experience of the diseases thereby gained, provision should be made by amendment of section 4 of the National Insurance Amendment Bill (1920) or by regulation to be made thereunder, whereby close administrative connection shall be maintained between the Insurance Committees and the Local Authority responsible for the treatment of this disease."

15. No such provision has been made, and Insurance Committees as such are entirely excluded from any share in this work; except so far as concerns domiciliary treatment for the insured, where the Tuberculosis Officer is the only link.

INQUIRIES INTO CAUSES OF EXCESSIVE SICKNESS, ETC.

16. Section 63 of the 1911 Act (section 107 of the Act of 1924) provides for certain action by the Approved Society or the Insurance Committee where the allegation is that excessive sickness has taken place amongst the persons for the administration of whose sickness or disablement benefits the society or committee is responsible. This definition confines the Committee to a policy of inaction, as it is impossible to prove excessive sickness amongst an artificially segregated portion of the local population, i.e., the deposit contributors. It is suggested that on account of their local character, the Insurance Committees should be entrusted with the whole of the responsibility under the section, and the following specific recommendation was made by the Committee on September 29th, 1913:

"That (the National Association of Insurance Committees) should press for such an amendment of section 63 of the 1911 Act as will provide for action being taken by Insurance Committees to recover from persons or Local Authorities the cost of treatment of tuberculosis amongst insured persons where it can be shown to the satisfaction of the Local Government Board that the disease has been contracted or propagated by conditions of occupation or dwelling."

II.—CERTAIN OF THE COMMITTEE'S ADMINISTRATIVE ACTIVITIES.

MAKING OF REPORTS AND PUBLICATION OF HEALTH INFORMATION.

17. Section 60 of the 1911 Act lays down that the Insurance Committee shall make such reports as to the health of insured persons in the locality and provide such returns regarding local health conditions as the Ministry may prescribe. Nothing has been prescribed or called for by the Commissioners or the Ministry.

The same section lays on Committees the duty of publishing information on questions relating to health at its discretion.

18. The Coventry Insurance Committee has published posters bearing on tuberculosis and has had handbills with appropriate information delivered at every house in the city. It has prepared and published up and down the country newspaper articles bearing upon the prevention, diagnosis and treatment of common ailments. It has prepared a statistical memorandum of the local housing shortage and presented this to the Local Authority, the same having been extensively quoted from at meetings of the Council. It circulates handbills on health topics at the office.

DEPOSIT CONTRIBUTORS.

19. The average number in Coventry in 1923 was 1,218, out of an insured population of some 57,000 (registration figures). These appear a healthy and respectable class, whose claims are dealt with by the Committee without difficulty or friction. The punctual certification and prompt payment through London obviously conduces to this. In 1923 an average of 302 weeks' sickness benefit was claimed. This gives 208 days' sickness in the year per contributor in the area. The Committee has communicated through the post with every deposit contributor in the area at the date urging the importance of joining an Approved Society.

CONSUMPTIVE PERSONS' RATION CARDS.

20. During the rationing period of the War, the Insurance Committee entered into arrangements with the local Food Control Committee whereunder a special dietary and ration card was made available for every consumptive person residing in the area, insured or non-insured. The card obtained priority of entry to the shop for the insured. It had a special currency, and the dietary recommended by the doctor on a scale furnished by the Panel Committee was endorsed on the card up to a maximum period of three

months, when the card was exchanged at the Committee's offices. Over three thousand cards were issued by the Committee altogether, and the expense was nil, apart from the cost of providing the cards.

EXTRA OFFICE ROUTINE.

21. Daily inquiries on subjects outside the official administration of the Committee are dealt with by their staff at the offices. These enquiries are numerous in nature, and range from elementary questions as to the duties of employers and employed under the Acts, to individual difficulties of insured persons in obtaining benefits they believe to be due, or details concerning their Approved Society—its address, etc. This considerable volume of work falls upon the Committee's staff owing to the presence of some 60,000 insured persons within a radius of three miles, and is absolutely unavoidable and probably a great public convenience.

REGISTRATION.

22. The general work of registration connected with the issue of medical cards is mainly complicated by the current operations (not so numerous as formerly) to procure deflation of the index-register of insured persons. The work of issuing and recalling medical cards and the registration of persons on doctors' lists and the keeping of those lists proceeds without difficulty or any considerable expense. So far as the Committee is concerned, there is no delay in establishing insured persons in the benefits which they are entitled to receive through the Insurance Committee. Where delays occur in connection with the issue of a medical card or the recall of the same, the difficulty is straightway to be traced to the inherent difficulties of a system whereunder many hundreds of Approved Societies—many of whose administrative offices are situated far from the area—are charged with the initiation of the necessary steps bearing upon insured persons' title to benefit.

III.—SOME GENERAL INFERENCES OF FACT.

23. The Insurance Act enjoins that insured persons shall receive adequate medical attendance and treatment from the medical practitioners with whom arrangements are made. The regulations have narrowed the criterion of adequacy so that specialist and consultant services are not available. In Coventry all the general practitioners but three are on the list. But there are no specialists under contract, nor consultant services. Laboratory means of diagnosis are not available nor institutional treatment (apart from venereal disease and tuberculosis) except as to limited categories through the Local Authority and generally through private, poor-law or charitable agencies.

24. The general practitioner service is adequate and the Committee have only dealt with fifteen complaints against doctors under the provisions of the regulations since its inception in 1912.

25. The insured persons experience no difficulty in obtaining the free services of an insurance practitioner owing to the geographical nature of the

administration. The freedom and promptitude with which a medical card can be obtained from the Committee if necessary on production of evidence as to insurability, is conducive to this.

26. It is believed that the dispensing service is adequate and popular—practically no complaints arise.

27. If medical benefit were extended to the dependants of the insured—say elderly parents dependent or wife and children under sixteen—it would appear that arrangements could be carried out by the Insurance Committee with slight excess administrative cost by means of extra provision for the registration with a doctor of such persons appearing upon the insured person's medical card. The same machinery by which a fresh choice of doctor is at present exercised would suffice to register the dependants upon doctor's lists; and in regard to the doctor's credits, special loading could be adopted until such time as it is actuarially demonstrated that all dependants are registered on a list.

28. Further available benefits of the nature of medical benefits would undoubtedly be best administered by and through the Insurance Committee. The Coventry Insurance Committee has received over forty verbal enquiries in the course of three months regarding dental treatment, but has no knowledge at all regarding the societies which provide this and analogous benefits, or of the schemes under which they are provided or the persons eligible. A local scheme for the administration of such benefits for all insured (or other) persons would co-ordinate very economically and simply with the administration of medical benefit; the endorsement by the practitioner on a medical certificate as to the treatment or appliance required would link up the medical service with one analogous to the present clinical service. The insured persons would know where to look for their benefit.

29. Nursing is undoubtedly required, and the local voluntary and private units could be utilised and strengthened upon lines adapted to what is demonstrated to be local needs. One local authority only is necessary for this general adaptation.

30. The Insurance Committee's current organisation is such that it can immediately and with considerable economy be utilised for extended administrative work, or brought into organic relationship with the local authority on the lines suggested. Arrangements can be directly concluded with all professional classes and negotiations carried out with various local or other institutions for additional clinical facilities for the insured, their dependants and others.

31. In the above connection it is worth pointing out that section 15 (7) of the 1911 Act (S. 85, 1924 Act) could be made operative for the first time in this connection; the Insurance Committee (reorganised or otherwise) could prepare an annual budget covering the extra clinical provision for non-insured so that, subject to Treasury and Ministry of Health consent, the cost over and above that borne from the insurance funds could be shared equally with the Government and the Local Authority.

APPENDIX XXXIV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE INSURANCE COMMITTEE FOR THE COUNTY PALATINE OF CHESTER, BY MR. GEORGE WRIGHT, CHAIRMAN, AND MR. FRANK TREHARNE WEST, CLERK. See Minutes of Evidence of the Twenty-second Day, Questions 12,452 to 12,659.

PERSONS GIVING EVIDENCE.

Pursuant to Resolution passed at a Meeting held 22nd October, 1924, Evidence will be Submitted on behalf of the Insurance Committee for the County Palatine of Chester by GEORGE WRIGHT, J.P. of "Brantwood," Sandbach, Cheshire, Chairman of the Committee since 1920, previously vice chairman 1913 to 1919, General Secretary of the National United Order of Free Gardeners Approved Society No. 162; and FRANK TREHARNE WEST, of 28, Nicholas Street, Chester, Clerk to the Insurance Committee since its inception.

NATURE OF EVIDENCE TO BE SUBMITTED.

SECTION A.—As to the Detailed Administrative Work of a County Insurance Committee
SECTION B.—As to the Development of the Service and the Grounds upon which the Insurance Committee for the County Palatine of Chester bases its Contention that the Present Form of Administration should in the Main be Continued and Extended on Similar Lines, and Envisaging the Potentialities Lying within the Administrative Machinery of Insurance Committees
SECTION C.—As to the Application to a County Area of an Attendance System of Remunerating Insurance Practitioners

Prefatory Note.

(i) In the evidence already given before the Royal Commission on National Health Insurance by Sir Walter Kinnear, K.B.E., Controller, Insurance Department, Ministry of Health, on the First and Second Days (16th and 23rd October, 1924), and by Mr. L. G. Brock, C.B., Assistant Secretary, Ministry of Health, and Dr. J. Smith Whitaker, M.R.C.S., L.R.C.P., Senior Medical Officer, Ministry of Health, on the Third and Fourth Days (30th October and 6th November, 1924), general reference has been made to the subjects upon which it is the wish of the Insurance Committee for the County Palatine of Chester to give particular or more detailed and specific evidence.

(ii) *Section A.*—In requesting to be permitted to give evidence on the individual experience of an Insurance Committee as distinct from that based on the experience of Insurance Committees generally, the Cheshire Committee is actuated by a desire to place in the possession of the Royal Commission a more intimate knowledge of the detailed administration of an Insurance Committee and of certain aspects of its work than would appear to be within the scope and possibilities of a general statement applicable to all Insurance Committees irrespective of the varying conditions, geographical, industrial and administrative, under which such work is respectively carried out in the whole country.

(iii) The area administered by the Cheshire Insurance Committee comprises almost every type of geographical, industrial and administrative condition.

(iv) Within its boundaries are found both densely and sparsely populated areas. The average density of population (1921 Census) is one person to one acre; the density varies from 21.3 persons per acre in the municipal borough of Crewe, with a total population of 46,497 and a total acreage of 2,154, and in the single parish of Hoole, with an acreage of 37 and a total population of 2,712, or 79.3 persons per acre, to as low as 0.2 in the Tintwistle rural district, and lowest in the large parish of Wildboarclough of 5,066 acres where only 182 people are resident, or an average of nearly 30 acres to a person.

(v) There are numerous districts in which difficulties of access between practitioner and patient exist, arising out of the varying nature of the country in the county.

(vi) Steep gradients obtain on the borders of Derbyshire and Staffordshire where insured persons may be found living at a height of one thousand feet above sea level, and again in the Peckforton and Beeston Castle districts; areas intersected by rivers,

canals and streams, with bridges few and far between, also add to the difficulties of access between patient and practitioner. Other districts are so sparsely populated that the distance between the residence of insured persons is over three miles and sometimes as far as seven or eight miles from the nearest doctor.

(vii) All types of industry, including agriculture, salt and coal mining, cotton and silk spinning and weaving, fustian, woollen, worsted and flax manufacture, cotton printing and dyeing, shipbuilding, extensive chemical and soap works, clothing, hosiery, hat and boot factories; each particular industry carried on under varying conditions and circumstances of employment and differentiations of sex-occupation with a consequential reaction on National Health Insurance administration.

(viii) The following example shows the manner in which units of administration vary:—

Crewe, with a population of 46,497, is a municipal borough, and also Stalybridge, with a population of 25,216, whereas Altrincham has an urban district council with a population of 20,450 and so has Handforth with a population of only 904. Runcorn rural district has a population of 28,934, and Disley with a population of 3,022 is also a rural district. The county borough of Chester has a total population of only 40,802, and yet has a separate Insurance Committee.

(ix) The administrative county of Cheshire therefore may be taken as being typical of the country generally, and is in the opinion of the Cheshire Insurance Committee eminently suitable as a collecting ground for evidence of the work of an individual County Insurance Committee.

(x) A comparison of the administrative work of a County Committee with that of a County Borough Committee has formed the subject at various times of consideration by the Cheshire Insurance Committee, and as the Committee is of the opinion that the differences in administration disclosed are of a nature to justify some differentiation in apportioning between Committees' Administration Funds, it suggests that the matter may receive the attention of the Royal Commission, and has therefore included in its evidence under this section certain particulars relative thereto.

(xi) *Section B.*—In this Section the Committee puts forward its view as to the development of the service and its contention that any considerable departure from the present system of administration will disadvantageously affect the beneficiaries under the present or any extended scheme for the medical and allied treatment of insured persons, especially having

regard to the potentialities lying within the present machinery of Insurance Committees to carry a very largely increased burden of cognate administration at a relatively low additional cost.

(xii) *Section C.*—The Cheshire Insurance Committee's object in requesting to submit evidence as to the practicability of the application to a county area of an Attendance System of remunerating Insurance Practitioners is primarily to demonstrate that if generally acceptable to practitioners there would not be any insuperable administrative difficulties in application.

(xiii) In this connection the Committee in the year 1923 conducted an exhaustive inquiry into the question of applying the Attendance System of remunerating Insurance Practitioners to this area, and although the decisions at which it arrived were not put into operation on account of the vigorous opposition of the County Panel Committee, it feels that the information and data obtained in its examination of the subject may not be without advantage to the Commission if placed before them.

(xiv) The Committee, however, does not now desire to express any definite opinions as to the relative advantages of the respective systems, but at the same time includes in its statement in this Section some desirabilities and some disadvantages which presented themselves to the Committee in the process of its investigation of the matter.

SECTION A. AS TO THE DETAILED ADMINISTRATIVE WORK OF A COUNTY INSURANCE COMMITTEE.

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CHAPTER I.—THE COMMITTEE.

COMPOSITION OF THE COMMITTEE.

1. The composition and powers of a County Insurance Committee are clearly defined in Section "C" of Appendix I to the evidence already given before the Commission as prepared by certain Government Departments, and it is not proposed herein to recapitulate evidence already placed before the Royal Commission.

2. The Cheshire Committee is constituted of the following representatives:—

(a) Directly appointed by Approved Societies.

Friendly Societies ...	2
Industrial Societies ...	7
Collecting Societies ...	—
	9

(b) Elected by Approved Societies.

Friendly Societies ...	5
Industrial Societies ...	1
Collecting Societies ...	1
Trades Union Societies... ..	4
	11

(c) Appointed by Committee to represent Deposit Contributors ...

County Councillors ...	3
Non-County Councillors ...	5
	8

(of whom 3 are Medical Practitioners)

CHESHIRE INSURANCE COMMITTEE.

Statement of Number of Meetings held and Record of Attendances of Members since the inception of the Act, showing also percentage of attendances of separate section of the Committee.

Year.	General.	Sub-Committees.	Total.	Total Attendances.		Percentage of Attendances.	Percentage of Attendances of Separate Classes of Members.			
				Possible.	Actual.		Ministry of Health.	Cheshire County Council.	Medical Committee.	Insured Persons.
1913 ...	14	44	58	1,399	876	63	48	60	66	66
1914 ...	8	39	47	1,052	719	68	61	61	75	72
1915 ...	4	49	53	925	616	67	51	53	70	73
1916 ...	6	49	55	1,080	809	75	69	67	78	78
1917 ...	8	44	52	1,064	646	61	51	50	48	66
1918 ...	5	33	38	791	513	65	44	60	80	69
1919 ...	6	50	56	1,054	587	56	36	43	63	62
1920 ...	4	43	47	876	557	64	57	55	61	67
1921 ...	5	45	50	861	577	67	58	69	41	69
1922 ...	4	29	33	533	372	70	71	55	43	78
1923 ...	6	24	30	566	422	75	87	64	72	77
1924 ...	9	34	43	871	635	73	70	61	50	75
TOTALS ...	79	483	562	—	7,329	—	—	—	—	—
Average per annum ...	6.6	40.2	46.8	—	611	67	58.5	58.1	62.2	71

(e) Appointed by Local Medical Committee 2

(f) Appointed by Minister of Health ... 4

(of whom 1 is a Medical Practitioner)

A total of 35 Members, of whom 6 are Medical Practitioners and Insurance Practitioners.

The number of Members of the Committee prior to its reduction by Section 3 of the National Health Insurance Act, 1921, was 60.

ORIGINAL MEMBERS NOW SERVING.

3. Of the original members of the Insurance Committee as provisionally appointed in 1912 only the following are now members, having retained their membership unbroken for over 12 years, viz.:—

Mr. J. O. Brandrith, J.P.
Mr. Christopher Lamb, J.P.
Mr. W. Eric Smith.
Mrs. Nellie Scott.
Mr. George Wright, J.P.

MEETINGS.

4. The meetings of the Cheshire Insurance Committee and of most of its Sub-Committees are held in the Municipal Borough of Crewe as being the most conveniently situated centre for the County.

The distances travelled by members of the Committee as at present constituted vary from one to 40 miles. The railway facilities generally, however, having regard to the varying places of residence of members, are not very good.

Crewe is also used by the County Council for the majority of its Meetings. Other Sub-Committees are held at the Offices of the Committee at Chester.

5. The meetings are ordinarily held in the afternoon. The number of Meetings of the Insurance Committee in the year has varied from 14 to 4, and the average has been 6.6; and of Sub and Inter Sub-Committees from 50 to 24, the average being 40.2.

During the period from the inception of the Committee to 31st December, 1924, there have been held 79 Meetings of the General Committee and 483 Meetings of Sub and Inter Sub-Committees.

ATTENDANCE OF MEMBERS.

6. The actual attendances varied from 56 to 75 per cent. of the possible attendances of Members, and the aggregate of attendances of Members since the inception of the Committee to 31st December, 1924, is 7,329, as shown by the following Table; the percentages of attendance of the separate sections of the Committee, e.g., Approved Societies, County Council, etc., etc., are also shown, viz.:—

The duration of Meetings has varied from 7½ hours to one hour, and the average duration has been approximately 2½ hours. Members have given voluntarily approximately 18,000 hours in actual attendance at Meetings to the public service in carrying out the National Health Insurance Acts, and this does not include time spent in travelling to and from Meetings or attendance at Conferences, Visitations of Sanatoria; etc., etc.

ADMISSION OF PRESS.

7. The Press is notified of and admitted to all Meetings of the Insurance Committee, being supplied with copies of the Agenda of business to be transacted thereat. The local Press has at all times given due prominence to the work of the Committee and has on many occasions freely and generously helped in the dissemination of information for the benefit of insured persons.

SUB- AND INTER SUB-COMMITTEES.

8. The present sub- and inter Sub-Committees of the Insurance Committee and their duties are as follows:—

Finance and General Purposes Sub-Committee (23 Members).

9. All those duties usually undertaken by the Finance Committee of Public Bodies, which include amongst others the direction, regulation and control of all matters relative to the finance of the Insurance Committee.

10. All accounts, financial returns and abstracts are required to be submitted to this Sub-Committee and recommendations of other Sub-Committees involving expenditure are required to be approved by it before being put into operation.

11. To this Sub-Committee there is submitted, as occasion requires an abstract of the bills and accounts falling due from time to time, and no payment may be made unless with the authority of this Sub-Committee.

12. By resolution of the General Committee it has been agreed that an abstract of bills and accounts from time to time authorised by the Finance Sub-Committee to be paid, and duly signed in accordance with the Insurance Committee's Consolidated Regulations, 1916, by two Members of the Finance Sub-Committee (one of whom as far as possible to be the Chairman of the Sub-Committee) and countersigned by the Clerk to the Committee, will be sufficient authority to the Committee's Bankers to pay out of the Committee's Funds cheques drawn and signed by the Clerk to the Committee in discharge of such bills and accounts duly authorised.

13. This Sub-Committee also is responsible for the administration of the cash benefits and general supervision of Deposit Contributors and members of the Navy and Army Insurance Fund.

14. It is assisted in its administration by an Office Administration Inter Sub-Committee (nine members), which is charged with the consideration of matters particularly connected with Office Administration.

Medical Benefit Sub-Committee (23 Members).

15. Makes arrangements for the provision and administration of Medical Benefit as prescribed by the Medical Benefit Regulations for all insured persons entitled to medical benefit in the Committee's area.

16. Carries out arrangements with medical practitioners, Approved Institutions, persons, firms and bodies corporate for the supply of drugs and appliances, etc., for the provision of medical treatment and medicines to insured persons; prepares and issues in accordance with the Regulations from time to time List of Insurance Practitioners, Approved Institutions, and of persons, firms and bodies corporate contracting to supply drugs and appliances, etc., or both or otherwise.

17. Prepares, in conjunction with the Panel Committee, Schemes for the distribution of the Practitioners' Fund and Mileage Funds available for the area, and schemes for the allocation of insured persons and secures the carrying out of such schemes; frames rules for the control of insured persons in receipt of medical benefit and for the regulation of Sub-Committees specially appointed in connection with medical benefit.

18. It receives and considers all cases arising as to scope of Medical Treatment and the Drug Supply.

19. Considers applications from insured persons desirous of making their own arrangements for medical benefit and from exempt persons or others required to make their own arrangements who have applied for a contribution towards their medical benefit under such own arrangements.

20. It has power to consider and report upon allegations of excessive sickness.

21. It considers, in the first instance, all matters arising in connection with medical benefit administration, except such as stand referred to the Service Sub-Committees.

Health Education Sub-Committee (5 Members).

22. Makes arrangements for the exercise of the Committee's powers under 60 (1) (b) of the National Insurance Act, 1911, for the giving of lectures and publication of information on questions relating to health as the Committee thinks necessary or desirable.

Nursing Inter Sub-Committee (11 Members).

23. Charged with the consideration of proposals and Schemes for the domiciliary nursing of insured persons entitled to medical benefit in the area.

JOINT SUB-COMMITTEES.

24. Medical Service Sub-Committee.—10 members and 10 Deputies therefor, with neutral Chairman and Vice-Chairman, with duties and powers as defined in Article 28 of the Medical Benefit Consolidated Regulations, 1924.

25. Pharmaceutical Service Sub-Committee.—6 Members and 6 Deputies therefor with neutral Chairman and Vice-Chairman, charged with the exercise of the duties and powers as defined in Article 30 of the Medical Benefit Consolidated Regulations, 1924.

26. Joint Services Sub-Committee.—6 members, with neutral Chairman and Vice-Chairman, responsible for the carrying out of the powers and duties under Article 33 of the Medical Benefit Consolidated Regulations, 1924.

27. Allocation Sub-Committee.—6 members and 6 deputies therefor, with neutral Chairman and Vice-Chairman, to give effect to the provisions of the Allocation Scheme made under Article 15 of the Medical Benefit Consolidated Regulations, 1924.

28. Joint Committee for Adequate Pharmaceutical Service—6 members and 6 deputies therefor, with neutral Chairman and Vice-Chairman, responsible for giving effect to the provisions of the Scheme prepared jointly by the Insurance Committee and the Pharmaceutical Committee under Article 9 of the Regulations for securing a proper Pharmaceutical service.

29. Dispensing Sub-Committee appointed under Article 10 (4) of the Regulations.—6 Members with neutral Chairman, responsible for giving effect to the provisions of the Article under which appointed.

30. The Insurance Committee is further represented upon the following bodies:—

South West Lancashire and Cheshire Joint (Prescriptions) Committee (3 Members).

National Association of Insurance Committee (3 Members and the Clerk to the Committee, with 4 deputies therefor).

Cheshire and Flintshire Joint Committee for Diagnostic Facilities. (Chairman and Clerk to the Committee.)

whose duties are indicated by the title of the Committee of which they are representatives.

MINUTES OF PROCEEDINGS.

31. The Committee's administration is recorded in approximately 5,000 pages of printed Minutes of Proceedings, which do not include *in extenso* many documents and reports which have been considered by it.

MEMBERS TRAVELLING EXPENSES, SUBSISTENCE ALLOWANCE AND COMPENSATION FOR LOSS OF REMUNERATIVE TIME.

32. The following Table shows the amount paid by the Committee to Members attending Meetings of the Committee and its Sub-Committees during the period under review:—

CHESHIRE INSURANCE COMMITTEE.

Statement of Amounts paid for Travelling Expenses, Subsistence Allowance and Compensation for loss of Remunerative time—1913-1924.

Year.	Travelling Expenses. Third Class Rail.		Subsistence Allowance.		Compensation for loss of Remunerative Time.		Totals.	
	Amount Paid.	Average cost per Meeting.	Amount Paid.	Average cost per Meeting.	Amount Paid.	Average cost per Meeting.	Amount Paid.	Average cost per Meeting.
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.
1913	167 11 8	2 17 9	22 4 6	0 7 8	10 17 0	0 3 9	200 13 2	3 9 2
1914	94 9 4	2 0 2	60 16 0	1 5 10	33 19 0	0 14 5	189 4 4	4 0 5
1915	103 0 2	1 18 10	69 11 0	1 6 3	48 9 6	0 18 3	221 0 8	4 3 4
1916	112 13 4	2 0 11	64 12 0	1 3 5	47 11 6	0 17 3	224 16 10	4 1 7
1917	111 8 10	2 2 10	60 8 6	1 3 2	43 4 6	0 16 7	215 1 10	4 2 7
1918	98 16 11	2 12 0	44 19 0	1 3 7	26 15 0	0 14 0	170 10 11	4 9 7
1919	98 14 10	1 15 3	65 9 6	1 3 4	43 0 6	0 15 4	207 4 10	3 13 11
1920	117 7 0	2 9 11	71 11 6	1 10 5	41 10 0	0 17 7	230 8 6	4 17 11
1921	113 4 1	2 5 3	61 0 6	1 4 4	40 5 0	0 16 1	214 9 7	4 5 8
Totals, prior to reduction of Committee's Members...	1,017 6 2	—	520 12 6	—	335 12 0	—	1,873 10 8	—
Yearly Average ...	113 0 8	—	57 16 11	—	37 5 9	—	208 3 4	—
1922	91 8 11	2 15 5	42 15 0	1 5 11	8 0 0	0 4 10	142 3 11	4 6 2
1923	76 14 4	2 11 1	41 5 6	1 7 6	10 5 0	0 6 10	128 4 10	4 5 5
1924	101 3 2	2 7 0	55 0 0	1 5 7	14 15 0	0 6 10	170 18 2	3 19 5
Totals subsequent to reductions ...	269 6 5	—	139 0 6	—	33 0 0	—	441 6 11	—
Yearly Average ...	89 15 5	—	46 6 10	—	11 0 0	—	—	—
Total for 12 Years ...	1,286 12 7		659 13 0		368 12 0		2,314 17 7	
Average for 12 Years	107 4 4		54 19 5		30 14 4		192 18 1	

CHAPTER II.—OFFICE ORGANISATION.

APPOINTMENT OF CLERK TO COMMITTEE.

33. On the 31st August, 1912, the Committee appointed Mr. Frank T. West to be Clerk and Cashier to the Committee, and he has so continued.

STAFF (OTHER OFFICERS).

34. The present staff numbers 21 in addition to the Clerk to the Committee, and the following statement shows the number of each grade engaged in each department of the Committee's administration, viz.:—

CHESHIRE INSURANCE COMMITTEE.

Statement of Numbers and Grading of Staff in Each Department.

Department.	Number.	Grade.
Finance and General Purposes (including Deposit Contributors' and Navy and Army Insurance Fund, &c.).	1	E
	1	D
	2	B
Claims	1	Learner

Department.	Number.	Grade.
Registration—Medical	1	C
	3	A
	1	Learner
Registration—Records	1	C
	3	A
Registration—Index	1	C
	4	A
Shorthand Typists	2	B

COST OF STAFF.

35. The cost of staff for the 12 years ending 31st December, 1924, is shown in Table II.

36. The approximate cost shown in amounts and relative percentages of the separate departments of the Committee's administration for the year 1924 is as follows:—

CHESHIRE INSURANCE COMMITTEE.

Approximate Allocation of Administration Expenditure under Heads of Different Departments of Committee's Administration and showing Relative Percentages of Total Expenditure for the year 1924.

Heads of Expenditure	Finance, Accounting, Committee Meetings, General, including Deposit Cont. and N.A. Fund Claims, Pricing Prescriptions, &c.		Index Registration. Issue of Medical Cards on entry. Index Count, &c.		Medical Registration. Medical and Pharm. Lists. Transferred Practices. Allocation, &c.		Medical Records Issue and Recovery. Medical Cards Issue on Acceptance, &c.		Totals.
	Amount.	Per cent. to Col. 6.	Amount.	Per cent. to Col. 6.	Amount.	Per cent. to Col. 6.	Amount.	Per cent. to Col. 6.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	£		£		£		£		£
Remuneration of Staff ...	1,015	33	687	23	560	18	778	26	3,040
Printing, Stationery, &c. ...	366	61	50	8	119	20	69	11	604
Postal Charges ...	160	26	100	16	100	16	250	42	610
Office Accommodation ...	79	23	77	23	81	24	97	30	334
Incidentals, including Travelling Expenses, &c., of Members ...	316	82	30	8	20	5	20	5	386
Pricing Prescriptions...	719	100	—	—	—	—	—	—	719
Totals ...	£2,655	47	944	17	880	15	1,214	21	5,693

BANKING ARRANGEMENTS.

37. On the 24th July, 1912, the following arrangements were made with Parr's Bank, Ltd., Chester (now Westminster Bank), whereby the bank agreed to keep the account on the following terms: Charge no commission and allow interest on all creditor balances of 1 per cent. under bank rate.

As from the 18th October, 1922, in view of additional work in which the bank became involved by the adoption of a new system in connection with the payment of the Committee's accounts, it was agreed that no interest would be payable by the bank on any current balances which may stand to the credit of any accounts of the Committee up to and including but not exceeding an aggregate upon all such accounts of £1,000.

BANK INTERESTS AND INVESTMENT DIVIDENDS.

38. The annual and total amount of interest, etc., earned on balances standing to the credit of the Committee's funds for the past 12 years is shown in the following table:—

CHESHIRE INSURANCE COMMITTEE.

Bank Interest and Dividends on Investments.

Year.	Bank Interest.	Dividends on Investments.	Profit on Redemption of War Bonds.
	£ s. d.	£ s. d.	£ s. d.
1913 ...	156 16 0	—	—
1914 ...	113 3 2	—	—
1915 ...	385 6 9	—	—
1916 ...	253 14 8	—	—
1917 ...	188 9 8	—	—
1918 ...	91 2 3	1 5 2	—
1919 ...	124 13 6	24 5 0	—
1920 ...	348 17 11	24 5 0	—
1921 ...	335 11 8	44 7 6	—
1922 ...	138 13 4	45 1 11	—
1923 ...	122 15 11	54 3 5	9 14 0
1924 ...	158 9 5	22 5 8	11 5 0
TOTALS	2,417 14 3	215 13 8	20 19 0

These sums have been credited to the General Purposes Fund. From time to time balances in the General Purposes Fund have been invested in Government Stocks.

Under the new National Health Insurance (Insurance Committees) Regulations, 1924, no specific provision is made with regard to the disposal of bank interests on creditor balances.

The Committee, however, has been informed that the intention of the Minister is that the interest on such balances shall be credited to the respective funds in respect of which such balances are shown, i.e., the interest earned on monies advanced in respect of the Practitioners' Funds to be credited to that fund, and so in respect of other funds.

OFFICE ACCOMMODATION.

39. The Committee's offices, previously rented, now its own property, having been purchased very advantageously in 1923, are centrally situated, very commodious and capable of housing a much larger administration.

PRINTING AND STATIONERY.

40. The heaviest items of annual expenditure under this heading are as follows:—

Minutes and Agendas of Meetings.
Prescription Books.
Lists of Insurance Practitioners, Chemists, &c.

PRICING PRESCRIPTIONS.

41. Since 1916 Insurance Committees have been responsible for the pricing of prescriptions, whereas up to that year prescriptions were priced by individual chemists, the scripts in turn being checked by the Committee. The check on the Committee's pricing is now performed by the Retail Pharmacists' Union.

The Cheshire Insurance Committee is a constituent of the South West Lancashire and Cheshire Joint (Prescriptions) Committee, by which the pricing of scripts is carried out.

In 1924 a large increase of cost in this connection has arisen primarily by reason of the new arrangements made for the purpose of extracting data necessary to the investigation of alleged or apparent excessive prescribing.

42. The cost of pricing prescriptions since 1915 to date is shown in Table II hereto.

GENERAL.

43. The Committee has incurred and paid to the 31st December, 1924, expenditure exceeding £1,380,000, and has accounted for cash received of approximately a similar amount.

There have been issued during the period over 60,000 cheques, involving separate financial transactions of approximately 75,000.

The Committee has paid in postage during the period the sum of over £6,500 for the issue of documents to insured persons, Doctors, Chemists, other Insurance Committees, &c., aggregating two-and-a-half millions.

Nearly 6,000 pages of Cash Books, Ledgers and Registers have been written up and duly balanced and submitted for audit.

During the whole period no surcharge has been made by the Government Auditor against any expenditure incurred or paid by the Insurance Committee.

TOTAL FUNDS ADMINISTERED AND COST OF ADMINISTRATION.

44. Statements are appended showing:—

TABLE I.

- (a) Total Funds Administered (1912-1924).
- (b) Cost of Administration (1912-1924).
- (c) Percentages of (a) to (b).
- (d) Cost of Administration shown as a rate in the "£" of Funds Administered.

TABLE II.

- (e) Cost of Administration (1912-1924).
- (f) Cost under separate heads of Expenditure.
- (g) Percentages of (e) to (f).
- (h) Sources and Amounts of Income.
- (i) Average Annual Cost per Insured Person.

CHAPTER III.—SANATORIUM BENEFIT.

INTRODUCTORY.

45. In submitting evidence in detail as to the administration by the Cheshire Insurance Committee of Sanatorium Benefit it may appear that to some extent an undue amount of space has been taken and a greater amount of detail shown than would appear to be justified in respect of a department of its administration which does not at the present time form any part of the duties of the Insurance Committee. The object of the Committee, however, in showing in detail the manner in which this work was carried out is primarily to demonstrate its capacity for a type of administration which differs considerably from that which now forms the main work of the Insurance Committee.

In connection with many of the suggested extensions of medical benefit which it is understood the National Association of Insurance Committees proposes to recommend should be administered by the Insurance Committees, the benefit can only be available on specific recommendation of the Committee as was the case in Sanatorium Benefit, and it is for this reason that the work and experience of the Committee in the administration of Sanatorium Benefit, now dead, is set forth so fully.

Further reference to this matter is made in Section B hereof.

MEETINGS OF SUB-COMMITTEE.

46. The Sanatorium Benefit Sub-Committee in the early stages of the operation of the Acts met monthly, subsequently six-weekly, and considered at its Meetings as required every case which had been reported.

APPLICATION FOR BENEFIT.

47. All applications were submitted with the following particulars:—

- Case and Reference Number.
- Name of Applicant.
- Address.
- Age.
- Occupation.
- Name of General Practitioner examining.
- Medical Adviser's Report (Prospect of Treatment—Kind of Treatment—Duration of Treatment—When to be Reconsidered—Special Remarks).
- Estimated Cost of Treatment Recommended.
- Followed by the Resolution of the Committee in each case.

The individual requirements of every case were considered by the Committee, who determined the nature of the treatment to be granted, whether Institutional (Sanatorium or Hospital) Dispensary, Domiciliary with or without accessories of treatment.

Over fourteen thousand separate reports were made upon insured persons, applicants for or recipients of Sanatorium Benefit, and were considered by the Sanatorium Benefit Sub-Committee during the period of its administration.

BEDS IN INSTITUTIONS.

48. It made arrangements for the retention of beds in various private and public Sanatoria, the first of such arrangements being for ten beds in Wensleydale Sanatorium at £90 per bed per annum.

Beds were retained at various times for varying periods in the following private and public institutions:—

Wensleydale Sanatorium.
 Meathop Sanatorium, Westmorland.
 Pinewood Sanatorium, Wokingham, Berks.
 Liverpool Sanatorium, Kingswood, Frodsham.
 King Edward VII. Sanatorium, Midhurst.
 Cranham Lodge Sanatorium, Stroud.
 Crewe Open Air Pavilion.
 Macclesfield Isolation Hospital.
 Ventnor Sanatorium.
 Bowdon Sanatorium.
 Painswick Sanatorium.
 Eryngo Sanatorium, Wallasey.
 Baguley Sanatorium.
 National Sanatorium, Benenden.
 Ashton-under-Lyne Infirmary.
 Royal National Sanatorium, Bournemouth.
 Chester Royal Infirmary.
 Macclesfield General Infirmary.
 East Anglian Sanatorium.
 Royal Southern Hospital Sanatorium.
 Barnes Convalescent Hospital.
 Crossley Sanatorium.
 Manchester Royal Infirmary.
 Grosvenor Sanatorium, Ashford.
 Groesynwyd Sanatorium, Conway.
 Delamere Training Colony.
 Talgarth Sanatorium, Brecon.
 Mill Hill Sanatorium.
 Albert Infirmary, Winsford.
 Hyde Tuberculosis Infirmary.
 Mount Pleasant Hospital, Liverpool.
 Chester Pavilion, Sealand.
 Royal Sea Bathing Hospital, Margate.
 Preston Hall Training Colony.
 Brompton Hospital, London.
 Vale of Clwyd Sanatorium, Ruthin.
 Berks and Bucks Sanatorium.
 White Abbey Sanatorium, Belfast.
 Frimley Sanatorium.
 Shropshire Orthopaedic Hospital.
 Stockport General Infirmary.
 Bradley Wood Sanatorium.
 Cottingham Hospital
 West Hulme, Sanatorium.
 Hull After-Care Colony.

INSTITUTIONAL TREATMENT THROUGH LOCAL AUTHORITY.

49. On the 26th March, 1917, consent was given by the National Health Insurance Commission (England) to an agreement whereby the Cheshire County Council were to provide beds for the Institutional treatment of insured persons suffering from Tuberculosis in lieu of the arrangements which had previously existed under which the Insurance Committee itself engaged and paid for beds in various Institutions. The County Council, however, were not in a position to provide all the beds required under the agreement until 1920. During the interval the Committee itself provided the necessary beds and made similar arrangements to those obtaining prior to the entering into of the agreement with the County Council.

SHELTERS (MOVEABLE).

50. In many cases shelters were provided, where suitable, for the convenience of insured persons who desired to have the benefit of out-door treatment at their own homes.

ACCESSORIES OF TREATMENT.

51. Accessories of treatment included:—

Cod liver oil.
Malt and oil.
Virol.
Spinal supports.
Dental treatment.
Yeo respirators.
Milk.
Eggs.
Beef for beef tea.

In addition a fund was created voluntarily for the supply of underclothing, boots, books, papers, etc., to patients.

PAYMENT OF TRAVELLING EXPENSES OF PATIENTS.

52. Arrangements were also made for payment of third class rail fares to enable insured persons suffering from tuberculosis to travel from their places of residence to any sanatoria and for their return therefrom, and in this connection the voucher system was adopted. The arrangements worked smoothly and well.

Where insured persons were required to attend at dispensaries for dispensary treatment, and who were resident in places not easily accessible to and from the dispensary, arrangements were made for their rail or omnibus fares to be paid by the Committee.

NURSING FOR TUBERCULOSIS CASES.

53. Arrangements were made with the County and other Nursing Associations for the nursing of insured persons suffering from tuberculosis receiving domiciliary treatment on the basis of 6d. per visit.

ADVICE TO PATIENTS APPLYING FOR SANATORIUM BENEFIT.

54. Advice to insured persons undergoing treatment, to applicants for sanatorium benefit, was conveyed by leaflets, personal visitation by the members of the Committee and otherwise, and generally to insured persons by posters and press notices.

In very many cases, in which owing to ignorance or prejudice an insured person refused to accept institutional treatment, members of the Committee interviewed the patient, and in a considerable number of instances secured their acquiescence to undergo the form of treatment recommended.

VISITATION OF SANATORIA, ETC.

55. Members of the Committee on a rota system regularly visited the various institutions to which the Committee from time to time sent insured persons, and reported the result of such visitations to the Committee in writing.

The following extracts from such reports show the value of the regular visitation of sanatoria and of a personal interest in the cases resident therein for whom the Committee was responsible:—

"We came away feeling perfectly satisfied that everything possible was being done for the comfort of all."

"All the patients were separately interviewed. They appeared to be making satisfactory progress and in all instances have gained weight."

"Each one speaks in high terms of the sanatorium and we did not have a single complaint."

"Dr. — takes a great interest in the work generally, also the sterilising of the sputum utensils and the crockery used by the patients."

"One was the case of —, which we were informed by Dr. — was quite a hopeless case, and considering the nature and extent of the disease it seemed a pity that the expense to the Committee of sending the case to an institution was ever incurred or the trouble of travelling imposed on the patient."

"There is also the case of —. This patient has, I understand, twice previously been in the institution, and is, I am afraid, inclined to look upon a visit to the sanatorium as a long holiday at the Committee's expense."

"We were given the opportunity of asking the patients if they were satisfied with the food, etc. All appeared to be well satisfied. One case proved the need of the After Care Committee, a young girl who had been in sanatoria for 11 months, Dr. — stating that unless she was well looked after and found suitable work she would soon relapse, and all the money spent on her would have been wasted."

"There was a deficiency of cloak-room accommodation, but that is to be remedied."

"We closely questioned all the patients resident there, having free access to them, and everyone expressed themselves thoroughly satisfied and full of hope and encouragement that their stay would be of great benefit to them."

"We investigated a general complaint made by several members as to the quality of the food. Dr. — stated that he had interviewed the ringleader in this matter, and in the interests of other patients he had been obliged to discharge him. Since then the ringleader has written a letter apologising to the doctor for his conduct, regretting that he had caused the doctor to take such serious view of the case and offering to come back at his own expense." (The letter written by — was seen by the members of the deputation.)

APPRECIATION OF BENEFIT.

56. The following extracts from letters received from patients further show the manner in which the sanatorium benefit administered by the Insurance Committee was appreciated:—

"I am very thankful for your treatment at — Sanatorium. . . . But for your good treatment I would have been incurable, and I thank you from the bottom of my heart."

"Just a line to say that I am doing very nicely here. I don't think I could be better satisfied anywhere else. So far I have found both the doctor and the staff very nice and attentive. As soon as I arrived here Dr. — gave me a thorough examination, and said that I was an early case and would soon be alright again. He seems a nice and clever man. As regards myself, I feel much better already. Each Tuesday morning the patients are weighed, and this morning I had gained three pounds in weight during the week, four pounds since I came here. The food here is also very good, plain but substantial, and as much as we can eat, the more the better. Of course, the chief foods are bread and milk. We breakfast at eight o'clock, consisting of porridge, bacon,

bread, a pint of milk and a cup of tea. Dinner at one o'clock is a cooked one, usually meat and potatoes with vegetable, pudding and the usual pint of milk. Supper at seven o'clock is also a cooked meal. We have from three to four pints of milk daily. Retire before 8.30 p.m. The country here is also very nice; there are some lovely walks. Our temperature decides our occupation. If fit we usually do a little work in the morning, and a walk in the afternoon. These are arranged by the doctor. My walks so far have included Mouldsworth, Kingsley, Overton, Helsby and Manley, all within a three or four miles radius; so on the whole I have no cause for complaint."

HOUSING CONDITIONS IN RELATION TO TUBERCULOSIS.

57. The Committee were particularly attentive in their consideration of the housing conditions of patients' places of residence, and no opportunity was lost to secure an improvement therein.

The attention of local sanitary authorities and county and local Medical Officers of Health was continually being drawn to these matters, and it is satisfied that the active interest evinced herein did much to achieve an improvement in the conditions.

CONTRIBUTION TOWARDS COST.

58. In no case was application made to the insured person for any contribution towards the cost of any part of his treatment under the Acts where such treatment was recommended by the Committee, whilst the Committee was responsible for the administration of sanatorium benefit.

59. Since the administration was placed in the hands of the Cheshire County Council application is made for payment of contributions by insured persons receiving institutional treatment in tuberculosis sanatoria or otherwise towards the cost of their treatment therein, and the matter has received the very serious consideration of this Committee, and representations have been made to the Cheshire County Council that application to volunteer to contribute should not be made to insured persons.

This Committee is satisfied that no insured person is really in a position to contribute to his treatment during his stay in the sanatorium.

The impossibility of determining the duration of treatment, the uncertainty of the result of that treatment, the consequent handicapping of the patient in after life in connection with his position in the labour market, the need for conservation of any financial reserves which he may have to enable him to obtain the necessary accessories of treatment after discharge from the institution, are considerations which, in addition to the needs of his dependants, if any, cannot be overlooked in deciding whether such an insured person is in a position to contribute or not.

To ask them to volunteer to contribute is to introduce into the mind of the patient a suggestion that unless contribution is volunteered some differentiation of treatment will arise, or, further, that there will be some distinction between his as a non-contributor and some other patient who is a contributor.

It is a differentiation which should not be allowed to occur. These subtle, though disturbing, influences on a tubercular patient may have very serious psychological and physiological effects.

This Committee feels that it should not be forgotten that the acceptance by an insured person of institutional treatment and his voluntarily absenting himself from his ordinary family and social surroundings contributes relatively more to the benefit of the community than to himself as a single member of that community, and that regarded from this point of view alone it seems distinctly unwise to require any insured person or, in fact, any tuberculous person to contribute towards a benefit which in general is more to the advantage of the community than to the contributor individually.

COST OF BENEFIT AND ADMINISTRATION.

60. The total cost incurred and paid by the Committee on Sanatorium Benefit, including the treat-

ment of Tuberculous Discharged Sailors and Soldiers, amounted to £101,052, and the sums debited against the Fund for administration amounted to £7,086 or 7 per cent. on the amount administered.

SUMMARY AND RESULTS OF TREATMENT.

61. The Committee accorded institutional treatment to 2,519 separate individual cases of insured persons suffering from tuberculosis. Of these 136 were not proceeded with owing to their title not being established or that pending investigation they had removed into other areas, or for other reasons were not eligible or available to be treated.

The recommendations of the medical adviser were in the majority of instances approved by the Committee, but not invariably, as local knowledge and other medical opinion made it in some cases advisable to take other steps.

Of the above 2,519 applications, 1,068 were received from insured persons resident in municipal boroughs, 1,023 from urban districts, and 423 from rural districts. 1,804 were male applicants and 716 female applicants.

On the 25th May, 1921, of these applications 851 had been restored to or kept at working capacity, 906 were not working, i.e., continuing under treatment either institutional or domiciliary, and the remaining 762 had been officially notified as having died.

A total of 35,144 weeks of treatment was afforded in institutions to tuberculous insured persons during the eight and a half years sanatorium benefit was administered by the Insurance Committee.

62. In the Report of the Chairman of the Sanatorium Benefit Sub-Committee on the Insurance Committee ceasing to be responsible for the administration of this benefit he stated, *inter alia*, "the result is very far short of what we had confidently hoped to achieve. At the same time we must confess that it is extremely difficult to measure the degree of success which has attended our efforts."

"Eight and a half years is too restricted a period of time in which conclusively to prove the fruitfulness or otherwise of our labours, but signs are not altogether wanting that the road which we have so laboriously and often despondently and hesitatingly followed will ultimately lead to the realisation of our ideal—the complete eradication from mankind of the tubercle bacilli as a health and life destroyer."

"We, who have come into close personal touch with so many cases by visitation at sanatoria, hospitals and otherwise, have had painfully and deeply impressed upon our minds the consciousness of the great amount of human suffering and loss which has been inflicted by this terrible white scourge."

63. "There can be no doubt that the efforts which have been made in the past eight and a half years with regard to treatment of tuberculosis in insured persons have not been lost, and that the education in hygiene and treatment which sanatorium benefit cases have received has been a considerable help in the prevention of the spread of the disease, and that by greater enlightenment, better housing conditions and a higher standard of living, our hopes of a total stamping out of the disease are not altogether unfounded."

"Your Committee feels that the nation has sacrificed on the altar of administrative convenience and expediency to the spirit of bureaucracy a very vital and living force embodied in the Sanatorium Benefit Sub-Committees of Insurance Committees."

SOME CONCLUSIONS.

64. The Committee holds that the constant personal touch which was kept by Members of Insurance Committees with insured persons resident in the particular area in which the Member lived had a very considerable bearing on the constancy and humanity with which this part of the Committee's administration was carried out.

It further holds that this personal touch has been lost since the administration was transferred to the County Council, as the whole matter would appear to have become almost entirely one of departmental routine.

65. The Committee here desires to aver that the work of the Insurance Committee during the period when they were responsible for the administration of Sanatorium Benefit has been one of the main contributing causes of the very marked decrease in Tuberculosis mortality, which is one of the outstanding features of the Fifth Annual Report of the Ministry of Health 1923-1924.

66. It further desires to express the opinion that the administration of the treatment of tuberculous persons should be restored forthwith to Insurance Committees, and that amending legislation should be introduced to enable all medical and allied treatment of insured persons to be carried out under the direct control of Insurance Committees.

CHAPTER IV.—MEDICAL BENEFIT.

TERMS OF SERVICE WITH PRACTITIONERS.

67. The terms and conditions under which insurance practice is carried on in this Committee's area do not differ from those set out in the First Schedule to the Medical Benefit Consolidated Regulations, 1924, except in so far as those terms are amplified by the Allocation Scheme made under Article 15 and the Distribution Scheme made under Article 23.

In both these Schemes some variations from the models suggested by the Minister of Health have been made with the approval of the Minister. Reference to these modifications will be made later herein.

MEDICAL LIST.

68. The Committee's Medical List at the 1st January, 1925, contained the names of 368 Insurance Practitioners and of 19 Assistants to Insurance Practitioners. Of the former 140 are in partnership together, although partnership accounts are only rendered in the case of 55 practitioners. In no instance does the partnership consist of more than three practitioners. The names of five assistants to Insurance Practitioners are not included in the list. Included in the above are 12 women Insurance Practitioners (11 Principals and 1 Assistant).

Over one thousand changes have taken place in the list during the past twelve years.

Of the Practitioners included in the Medical List 129 (125 Principals, 4 Assistants) are not resident in the area of the Committee, although practising therein. Such are they who are resident in the Cheshire County Boroughs and in the adjoining Counties.

The estimated total number of medical practitioners engaged in general practice and resident in Cheshire as far as can be ascertained at the 1st January, 1925, was 398, of whom 258 were Insurance Practitioners (243 principals, 15 assistants). The proportion of practitioners engaged in Insurance practice therefore to the whole estimated active and available body of the profession in the County is 76 per cent.

In addition, the districts bordering on other Counties and County Boroughs are served by Practitioners resident in such Counties and Boroughs.

With the Medical List the Committee also publish full information of the arrangements made for medical benefit.

TERMS OF SERVICE WITH CHEMISTS, ETC.

69. The conditions for the supply of drugs and appliances in this area are in conformity with the Terms of Service of Insurance Chemists as set out in the Third Schedule to the Medical Benefit Consolidated Regulations except in so far as they are amplified by the Scheme made under Article 9 thereof, to which reference is made later.

LIST OF CHEMISTS, ETC.

70. The Committee's list of persons, firms and bodies corporate at 1st January, 1925, contained the names of 210 who are entitled to dispense medicines, and four not so entitled. The number of separate shops is 252. During the twelve years over 350 material changes have been made in the list of Chemists, etc.

ADEQUATE PHARMACEUTICAL SERVICE.

71. The Committee and the Pharmaceutical Committee through a Joint Committee appointed under the Scheme made under Article 9 of the Regulations have prepared rotas showing the chemists' shops open in various districts for one-half hour after the usual evening surgery hours, and of those open in such districts on Sundays, Public Holidays, and weekly half-holidays, in respect of 22 separate districts in which there are more than two chemists' shops.

These rotas are issued for a period of six months and regularly revised from time to time.

RURAL DISPENSING.

72. A Dispensing Sub-Committee has been appointed under Article 10 (4) of the Regulations. Difficulties are dealt with which may from time to time arise in connection with the dispensing for insured persons in rural areas or otherwise where, by reason of distance or inadequacy of means of communication trouble has arisen in the obtaining by insured persons of any necessary Drugs or Appliances from a chemist.

APPROVED INSTITUTIONS.

73. Only one Approved Institution for the provision of medical treatment and drugs operates now in the area of this Committee, since the transfer of the Post Office Medical System, the number of persons included in the list of this Institution at the 1st January, 1925, being 27. The tendency is for this number annually to decrease, for at the 1st January, 1914, the number was approximately 61. The following shows the movement in membership and cost for the twelve years under review:—

MEDICAL INSTITUTIONS.

Warrington Amalgamated Friendly Societies' Medical Association.

Year.	Cheshire Membership Mean No.	Amount Paid.
		£ s. d.
1913	50.62	22 12 0
1914	46.75	19 16 9
1915	46.00	20 0 9
1916	45.50	20 3 9
1917	48.75	21 12 0
1918	51.50	24 6 10
1919	55.25	25 7 5
1920	47.25	24 14 0
1921	34.00	21 16 5
1922	30.50	15 15 9
1923	24.00	12 15 8
1924	28.00	13 17 2
	508.12	£242 18 6

	£ s. d.
Average Cost per year	20 4 10
Average Cost per Member	0 9 6

Post Office Medical System.

Year.	Cheshire Membership Mean No.	Amount Paid.
		£ s. d.
1913	208.75	78 4 7
1914	152.75	59 8 6
1915	125.00	47 15 9
1916	99.25	38 7 11
1917	84.75	32 12 6
1918	75.75	29 2 2
1919	77.50	29 16 11
	823.75	£315 8 4

	£ s. d.
Average Cost per year	45 1 2
Average Cost per Member	0 7 7

NUMBER ENTITLED TO BENEFIT.

74. The number of insured persons entitled to medical benefit in the area of the Cheshire Insurance Committee was at the 1st January, 1925, 243,736. Of this number 232,186 or 95.26 per cent. were included in Practitioners' Lists, leaving 11,550 or 4.74 per cent. who had not chosen or been accepted by an Insurance Practitioner.

NUMBERS INCLUDED IN DOCTORS' LISTS.

75. The subjoined Statement shows the extent to which insured persons have been accepted by Insurance Practitioners by the numbers included in Practitioners' Lists and the relation in percentages thereof to the insured population in the area over the period 1912 to 1924:—

Year.	Mean Count of Register of Insured Persons.	Mean No. included in Practitioners' Lists.	Percentage of Col. 2 to Col. 1.	Total Practitioners in Medical List.	Average of Col. 2 to Col. 1.
(1)	(2)	(3)	(4) Per cent.	(5)	(6)
1913...	200,382	182,555	91	384	476
1914...	213,717	184,923	86	357	518
1915...	212,143	187,567	88	351	534
1916...	208,289	189,370	91	346	547
1917...	209,435	192,666	92	342	563
1918...	212,599	196,699	92	337	584
1919...	230,620	202,207	87	330	613
1920...	244,778	218,879	89	321	682
1921...	249,509	225,626	90	335	673
1922...	248,194	227,590	92	341	667
1923...	245,503	226,432	92	348	651
1924...	244,710	230,602	94	354	651
Averages ...	227,407	205,426	90	345	595

MEDICAL CARDS.

76. In 1914 the present form of buff medical card was issued to approximately 220,000 insured persons replacing the old Pink medical ticket. Since that date over 340,000 medical cards have been issued in respect of new entrants, removals from other areas, or transfers as between Practitioners or otherwise.

OWN ARRANGEMENTS.

77. Application has been made to the Committee since the inception of Health Insurance from approximately 1,000 different persons requesting to be allowed to make their own arrangements, the numbers of the different classes of the applications being as follows:—

- From members of staffs of Institutions entitled to medical attendance from the Medical Officer of such Institution, approximately 350.
- From private persons, approximately 650.

In all cases where the Committee were satisfied that proper medical attendance would be forthcoming claims under (a) were invariably allowed.

Every individual private application under (b) was very carefully considered by the Insurance Committee. Only 45 applications were allowed. In one case the applicant appealed to the National Health Insurance Commissioners (England) against the decision of the Committee. The appeal, however, was dismissed and the action of the Committee confirmed.

The following table shows the amounts paid between 1913 and 1923 in respect of insured persons allowed

or required to make their own arrangements for medical benefit, viz.:—

Year.	No. of Persons allowed or required to make their own arrangements during year.	Amount Paid.
		£ s. d.
1913 ...	137	55 6 11
1914 ...	134	59 3 4
1915 ...	120	53 8 8
1916 ...	127	56 13 9
1917 ...	128	48 0 0
1918 ...	127	54 11 1
1919 ...	121	70 10 0
1920 ...	144	89 13 4
1921 ...	129	84 11 11
1922 ...	151	86 16 7
1923 ...	150	88 9 8
		£747 5 3

In cases where such persons did not arrange for a fixed rate per annum equal to the capitation fee payable to Insurance Practitioners, the accounts incurred by these persons receiving treatment and the amounts paid were as follows:—

For the whole period—

Total of accounts submitted for treatment received, including drugs and appliances ...	£218
Total amount paid by the Committee ...	£149

showing that such accounts had been discounted in the sum of £69 or by 31.5 per cent.

SPECIAL INCOME LIMIT.

78. The Committee has fixed no special income limit.

LIMITATION OF PRACTITIONERS' LISTS.

79. The limits to be placed on the number of insured persons who may be included in the list of an Insurance Practitioner have been determined at the maximum laid down in Article 15 (2) of the Regulations. In one case only has it been necessary for the Committee to request an Insurance Practitioner to reduce his list owing to his having exceeded the prescribed limit.

The Committee are satisfied that it would be unwise in the present circumstances to reduce the limit further in so far as its own area is concerned, for it is clear that in the cases where high lists obtain they are not caused by any scarcity of Insurance Practitioners but rather by the choice of a predominating number of insured persons for a particular Practitioner.

(Complaints of neglect or of unsatisfactory treatment have been almost non-existent, and the few cases of complaint which have been received have been against Doctors with small lists of insured persons and not against Doctors with large lists.)

80. This is particularly demonstrated in one area where out of a total of 3,812 insured persons on the lists of the two Doctors practising in that area there were prior to reduction under the limit clause of the Allocation Scheme at the 1st April, 1924, 2,668 included in the list of one of such Practitioners. A further reduction of the limit would probably result in the Committee being required to assign insured persons to Practitioners whom the insured person would not voluntarily approach for acceptance, and the further probability is that such insured persons would, were they so assigned, continue to be treated by the Doctor of their choice as private patients.

81. On this point it desires to state that further provision should be made to cover the case where an Insurance Practitioner proposes to absent himself from his practice and makes arrangements for the conduct thereof during his absence with another Insurance Practitioner practising in the same area, whereby the combined lists of the two Practitioners

concerned exceed the limits imposed by the Allocation Scheme.

The distribution of insured persons in relation to Practitioners' Lists at 1st January, 1926, is as follows:—

Variations in Lists of Insurance Practitioners.

Range of Numbers of Insured Persons included in Practitioners' Lists at 1st January, 1926.		No. of Practitioners.
With "Nil" Lists	...	9
Less than 50	...	101
More than 50 less than 100	...	20
" 100 "	100	10
" 150 "	200	14
" 200 "	250	14
" 250 "	300	12
" 300 "	500	31
" 500 "	750	39
" 750 "	1,000	35
" 1,000 "	1,500	38
" 1,500 "	2,000	24
" 2,000 "	2,500	10
" 2,500 "	3,000*	8
" 3,000 viz.—	3,091*	1
	3,135*	1
	3,190*	1

* These Practitioners have Partners or Assistants.

TRANSFERRED PRACTICES.

82. The Allocation Scheme provides that in the case of transferred practices a period of eighteen months shall elapse before assignment of the insured persons previously included in the list of the deceased or retiring practitioner.

83. The provision under the Regulations whereby the Insurance Committee is required on request of the representatives of a deceased practitioner or by a retiring practitioner to notify insured persons of the arrangements made for carrying on the practice where a successor proposes to carry on such practice, has involved this Committee in a very large amount of additional work.

84. During the past two years 33 practices have been transferred under these conditions involving the Committee in the notification of 27,220 insured persons, and the practitioners in the return of resigned medical cards and the issue by the Committee of new cards to replace those bearing the name of the previous practitioner. Medical records also require to be renamed and redistributed. Further, 571 insured persons, not having made a selection in the prescribed time, were again notified of proposed assignment to certain practitioners.

85. The Committee is of the opinion that, as insured persons may change as they will, from day to day if necessary, and in view of the experiences of the past two years that insured persons generally choose the successor to the practice as shown by the fact that out of 27,220 insured persons involved in transferred practices up to the present only 1,645, or 6 per cent., have chosen a doctor other than the successor, and even on assignment after the expiration of the time allowed under the Regulations for choosing another doctor, out of 571 concerned, only 13 objected to the assignment and chose a practitioner other than the one to whom they had been assigned under the allocation scheme, there would appear to be reasonable grounds for a modification of this requirement, and it suggests that insured persons should be notified that, unless application was made for acceptance within a month, they would be placed on the list of the successor to the practice.

86. This modification would result in a very considerable reduction of clerical work and the saving of considerable sums in postages. It would not ordinarily result in an unfair distribution of the local Practitioners' Fund inasmuch as it has, in the past, in this area, been the practice to add the unaccepted residue to the successor in the practice as representing the additional responsibility for treatment under the transferred practice, until assignment is made by the Allocation Sub-Committee at the expiration of the prescribed periods. In the case of every practice, assignment is made of the individuals included in the list of the retiring practitioner, and in no case has the Allocation Sub-Committee assigned insured persons in bulk to any successor in a practice or other practitioner.

87. The name of every insured person ceasing to be on the list of a practitioner by reason of the death, retirement or withdrawal of an insurance practitioner is submitted to the Allocation Sub-Committee and assigned individually; the Committee taking into consideration the question of residence and any other factors which may have been brought to its notice to which it considers regard should be had.

CHANGE OF DOCTOR.

88. The numbers of (a) insured persons who annually during the past seven years have exercised the right of change of practitioner under the old Regulations by giving notice before the 1st June and 1st December and under the present Regulations at any time, and (b) who have been removed at practitioner's request, are shown in the following table:—

Year	(a) At Insured Person's Request.		(b) At Doctor's Request.		Ratio Percentage of Col. 4 to Col. 2.
	Number.	Percentage to Total in Doctors' Lists.	Number.	Percentage to Total in Doctors' Lists.	
(1)	(2)	(3)	(4)	(5)	(6)
		Per cent.		Per cent.	Per cent.
1918...	756	·4	28	·015	3·7
1919...	841	·4	20	·010	2·4
1920...	910	·4	25	·011	2·8
1921...	1,232	·6	17	·008	1·4
1922...	2,013	·9	35	·015	1·7
1923 (half-year) ...	900	·8	21	·020	2·3
Above are under Old Regulations					
1924... Under New Regulations	3,315	1·5	78	·034	2·5

ANÆSTHETISTS' FEES CLAIMS.

89. For the five years ending 31st December, 1924,

which represents the period of operation of the provision for the payment of anæsthetists' fees, 238 claims have been made by practitioners, of which

207 have been allowed by the Panel Committee and 31 disallowed, as follows:—

Anæsthetists' Fees.

Year.	No. of Claims.	Amount.		
		Allowed.	Disallowed.	
		£ s. d.	£ s. d.	£ s. d.
1920 ...	18	18 18 0	18 18 0	—
1921 ...	50	52 10 0	36 15 0	15 15 0
1922 ...	34	35 14 0	29 8 0	6 6 0
1923 ...	49	51 9 0	44 2 0	7 7 0
1924 ...	87	91 7 0	88 4 0	3 3 0
Totals	238	249 18 0	217 7 0	32 11 0

Emergency Treatment.

Year.	No. of Claims.	Amount of Claims.		Allowed.	Disallowed.	Amount deducted from Practitioner Fees.	Charged to Drug Fund.	Priority Charge.
		£ s. d.	£ s. d.					
1920 ...	4	6 3 6	3 9 6	2 14 0	3 6 0	3 6	—	
1921 ...	4	3 19 2	3 8 8	0 10 6	3 8 0	0 8	—	
1922 ...	—	—	—	—	—	—	—	
1923 ...	2	4 9 6	4 9 6	—	—	—	4 9 6	
1924 ...	12	10 6 6	7 1 0	3 5 6	—	—	7 1 0	
Totals ...	22	24 18 8	18 8 8	6 10 0	6 14 0	4 2	11 10 6	

TEMPORARY RESIDENTS.

91. Over 5,000 insured persons have received treatment in the area of this Committee during the past 12 years as temporary residents, and approximately 200 travellers' vouchers have been issued by the Minister of Health or the National Health Insurance Commissioners to persons frequently moving from place to place; the annual averages, respectively, being 440 and 17.

EXPENSES OF PANEL COMMITTEE.

92. The expenses of the Panel Committee have been met by a voluntary levy, advantage not having been taken of the provisions of Section 86 of the 1924 Act in this connection; the Clerk to the Insurance Committee having been authorised separately by each insurance practitioner to make the necessary deduction each quarter from his remuneration.

The amounts actually deducted and paid to the Panel Committee during the operation of the arrangements totalled £6,880 0s. 3d.

The following table shows the rates imposed and the amounts deducted for each year of the period under review, viz.:—

Year.	Amount.	Rate of Deduction.	
		£ s. d.	Per cent.
1914...	297 16 0	—	½
1915...	282 15 6	—	½
1916...	266 8 5	—	½
1917...	310 4 3	—	½
1918...	287 5 6	—	½
1919...	318 10 3	—	½
1920...	1,054 19 10	—	1
1921...	1,164 13 11	—	1
1922...	1,018 3 6	—	1
1923...	996 17 11	—	1
1924...	882 5 2	—	1
Final settlement amount not included.	£6,880 0 3		

EXPENSES OF PHARMACEUTICAL COMMITTEE.

93. The expenses of the Pharmaceutical Committee are met by a levy made under Section 86 (Section 33 (2) 1913 Act).

The following statement shows the amounts deducted from chemists' accounts and paid over to the

CLAIMS FOR EMERGENCY TREATMENT.

90. Twenty-two claims have been made by practitioners for emergency treatment given to insured persons. Twenty-two were allowed, and £6 14s. was deducted from the remuneration of the insurance practitioner in whose list the insured person was included, and £11 10s. 6d. has been charged in priority against the Practitioners' Fund.

Pharmaceutical Committee for its administration expenses for the years under review:—

Year.	Amount.		Rate Per Cent.
	£	—	
1914 ...	31	—	0.17
1915 ...	72	—	0.43
1916 ...	332	—	2.55
1917 ...	169	—	1.38
1918 ...	316	—	1.91
1919 ...	244	—	1.37
1920 ...	400	—	1.67
1921 ...	189	—	0.78
1922 ...	250	—	1.04
1923 ...	270	—	1.07
1924 ...	270	—	0.90

The Committee has conducted an examination of the accounts each year for the purpose of satisfying itself that the money has been expended in accordance with the Act.

CALCULATION OF LISTS—NOTIFICATIONS OF ADDITIONS TO AND REMOVALS FROM PRACTITIONERS' LISTS.

94. The system adopted by the Cheshire Insurance Committee differs from that of other Insurance Committees.

Every acceptance of an insured person by the signing of the medical card either in part "A," "B" or "C" is acknowledged by the transmission of an "IN" Schedule to the Practitioner, and every death, suspension, removal or transfer is likewise notified to the Practitioner through a form of "OUT" Schedule. These Schedules are issued weekly or fortnightly as occasion requires. They are prepared in duplicate, one copy being retained by the Committee and the other transmitted to the Practitioner. The Schedules show the name and address of the insured persons, Approved Society and membership number, whether credited for treatment, dispensing, emergency drugs, mileage or special mileage, and the number of units respectively credited, and are totalled at the foot.

95. These weekly or fortnightly totals of additions or deletions are carried to a quarterly summary which also shows the number at the commencement of the quarter and, after additions of "INS" and deductions of "OUTS" the number at the commencement of the following quarter, which forms the basis of the calculation of the distribution of the Fund.

96. It is found after three years' experience that this system has very considerably contributed to a solution of the difficulties in connection with the title

to benefit of insured persons as it affects the Insurance Practitioner on the following grounds:—

- (a) It provides the practitioner with a complete and up-to-date list of insured persons for whom at any time he is ordinarily entitled or required to give treatment, irrespective of the possession by him of a medical record envelope or not.
- (b) It enables the Insurance Practitioner by easy reference to ascertain whether the applicant for medical benefit is ordinarily entitled to treatment by him, or whether on production of evidence he is to be treated otherwise
- (c) It further provides Insurance Practitioners at the end of each quarter with a ready and convenient means of checking the accuracy of the numbers upon which his quarterly credit is based, thereby removing the apprehension which had for some time existed in the minds of Insurance Practitioners as to the fairness of the distribution of the areal pool.

97. "IN" Schedules, further, act as a notice of transmission of medical records or that such records are to follow.

The "OUT" Schedules also constitute a request for the return of the records and the perforated portion provides an instrument whereby a practitioner may notify the Committee of the return of such records or otherwise as to their disposal.

DISPENSING PATIENTS.

98. The following statement shows the number of insured persons included in doctors' dispensing lists and the sums paid therefor during the period 1913-1923, from which it will be seen that the sum of £30,689 has been paid during that period to insurance practitioners in this connection:—

Year.	Mean of Practitioners' Lists. Totals.		Percentage of Col. 3 to Col. 2.	Amount paid to Practitioners.	Percentage of Col. 5 to Total Cost of Drugs, &c.
	All Patients.	Dispensing Patients.			
(1)	(2)	(3)	(4)	(5)	(6)
			Per cent.	£	Per cent.
1913 ...	182,555	30,558	16.7	2,993	15.6
1914 ...	184,923	29,369	15.9	2,476	14.0
1915 ...	187,567	29,389	15.7	2,425	14.0
1916 ...	189,370	29,324	15.5	2,325	14.6
1917 ...	192,666	29,462	15.3	2,324	16.0
1918 ...	196,699	30,045	15.3	2,472	13.0
1919 ...	202,207	30,767	15.2	2,622	12.6
1920 ...	218,879	32,468	14.8	3,247	11.9
1921 ...	225,626	32,610	14.5	3,261	12.2
1922 ...	227,590	32,828	14.4	3,283	12.0
1923 ...	226,432	32,606	14.4	3,261	11.3
Totals...	—	—	—	30,689	—
Average	203,137	30,857	15.2	2,790	13.1

PAYMENTS TO INSURANCE PRACTITIONERS.

99. Payment to insurance practitioners of capitation fees due in respect of treatment and, where due,

Year.	No. of Prescriptions Dispensed and Charged.	Total Charge therefor.	Amount Allowed.	Average Cost per Prescription.	Mean Number of Insured Persons included in Practitioners List excluding Dispensing Patients.	Average cost per Insured Person.	
						s.	d.
1913...	485,791	16,163	16,163	7.98	151,997	2	1.5
1914...	478,356	17,818	15,151	8.93	155,554	2	3.3
1915...	460,386	16,918	14,167	8.81	158,178	2	1.7
1916...	470,076	12,988	12,988	6.63	160,046	1	7.5
1917...	431,061	12,284	12,284	6.84	163,204	1	6.1
1918...	487,678	16,523	16,523	8.13	166,654	1	11.9
1919...	474,334	17,789	17,789	9.0	171,440	2	0.9
1920...	509,642	23,984	23,984	11.29	186,411	2	6.9
1921...	523,269	23,362	23,362	10.72	193,016	2	5
1922...	588,681	24,004	24,004	9.78	194,762	2	5.6
1923...	652,163	25,445	25,445	9.36	193,826	2	7.5
Totals ...	5,561,437	207,278	201,860	—	—	—	—
Averages ...	505,585	18,843	18,351	8.71	172,281	2	2.3

dispensing is made quarterly, except in three instances paid monthly.

Since 1920 cheques have without exception been issued to practitioners on the last day of the quarter in respect of which the money was due.

Table III shows the Distribution of the Practitioners' Funds, etc.

The following table shows variations in the Income from Insurance sources for the year 1923 of Insurance Practitioners, excluding those whose names are included in the Insurance Medical Lists of other committees:—

Range of Income.		No. of Practitioners.	Percentage.
£	£		
More than 5	Less than 5	5	3.43
" " 10	" " 10	10	0.00
" " 50	" " 50	12	6.86
" " 100	" " 100	12	6.86
" " 250	" " 250	30	17.15
" " 500	" " 500	46	26.28
" " 750	" " 750	37	21.14
" " 1,000	" " 1,000	14	8.00
" " 1,100	" " 1,100	3	10.28
" " 1,200	" " 1,200	4	
" " 1,300	" " 1,300	3	
" " 1,400	" " 1,400	1	
" " 1,500	" " 1,500	6	
" " 1,500	" " 1,500	1	—

Total sums paid ...£81,531 175 Average income £466

ISSUE OF MEDICAL RECORDS.

100. Medical records were issued in 1920 to insurance practitioners in respect of all insured persons included in their lists, and this involved the preparation and transmission of some 213,000 medical records. Since that date 150,000 have been issued and 130,000 withdrawn, representing changes from time to time taking place in the movement in and out of insurance and of the population geographically and of transfers from practitioner to practitioner or otherwise.

SUPPLY OF DRUGS, APPLIANCES, ETC., BY CHEMISTS, ETC.

101. Approximately six million prescriptions issued to insured persons have been included in chemists' accounts and paid by this committee. Chemists' accounts are paid monthly.

The prescriptions dispensed during any given month, together with a statement of their number, are required to be transmitted to the Pricing Bureau by the 4th of the month following.

They are duly priced, and the certified accounts are transmitted to and received by the Insurance Committee approximately on the 6th of the following month and usually paid within four or five days of their receipt by the Insurance Committee.

Annual statistics for eleven years, 1913-1923, as to numbers of prescriptions dispensed, total cost of drugs, the average cost per prescription and per insured person are shown below.

The expenditure incurred in the checking or pricing of such prescriptions is shown in Table II.

102. The following Table shows varying incomes from insurance funds received for the year 1923 by Chemists included in the Committee's list:—

Range of Income.		No. of Chemists, &c.	
Less than £1	...	...	12
More than £1 and less than £5	...	...	28
" 5	"	10	14
" 10	"	15	7
" 15	"	25	9
" 25	"	50	16
" 50	"	75	16
" 75	"	100	15
" 100	"	150	18
" 150	"	200	13
" 200	"	250	8
" 250	"	350	15
" 350	"	500	10
" 500	"	750	3
" 750	"	1,000	2
" 1,000	...	...	3—1—£1,010.
			1—£1,202.
			1—£1,226.

SCRUTINY OF PRESCRIPTIONS.

103. Scrutiny of the issue of prescriptions is carried out with a view to the prevention of improper charges on the Committee's Drug Fund under the following heads:—

- (i) Issue of prescriptions to persons not entitled to Medical Benefit;
- (ii) Issue of prescriptions to persons entitled to treatment through another committee;
- (iii) Issue of prescriptions to insured persons in cases where the practitioner is himself required to supply the drug or appliance ordered.

This is an important section of the Committee's work, especially in a county area, but unfortunately owing to lack of necessary staff has only been very indifferently carried out in the past. With the present very limited staff of the Committee there is little prospect of the work being properly performed.

INVESTIGATION OF ALLEGED EXCESSIVE PRESCRIBING.

104. Very great help could be given to the broader question of investigation of alleged excessive prescribing if committees were financially able efficiently to carry out the scrutiny, as in the process, valuable information becomes available as to the prescriptions issued to individual insured persons. "Frequency" of prescribing for individual insured persons is readily ascertainable as distinct from "frequency" calculated on the total number of insured persons included in the practitioner's list in a given period.

For example:—

Dr. "A's" "frequency" figure is shown by the Pricing Bureau Statement for the months of March and June, 1924, as 40 and 16 respectively—yet in the process of checking prescriptions against the doctor's list of insured persons the information is elicited that during March the frequency for 31 patients was 5.30, and for 10 of these a rate as high as 7.20 was disclosed, and in one instance the Committee paid for 11 prescriptions issued to the same insured person during the month of June.

The total number of prescriptions actually dispensed issued by Dr. "A" for the eight months, February to September, 1924, was 2,098 in respect of 630 different insured persons, a "frequency" rate of 3.33.

The total number of insured persons included in Dr. "A's" list, excluding dispensing patients, at the 1st October, 1924, was 1,353.

Real knowledge of the prescribing of practitioners can only be obtained by a detailed examination from month to month of the prescriptions dispensed, and this could, if Insurance Committees had the staff, be carried out *pari passu* with its present procedure of scrutiny for the specific purposes indicated herein.

DRUGS, &c., FORMULARY.

105. A Formulary issued by the Committee in conjunction with the Panel and Pharmaceutical Committees and known as the Pharmacopœia Cœstriensis was issued in 1917, a revised edition being issued in 1924. It contains 353 formulæ ordinarily considered to meet the average needs of the different departments of practice.

It has been found of great benefit to Insurance practitioners in the area.

DOMICILIARY NURSING OF INSURED PERSONS.

106. In 1921 and 1922 the Committee made a very great effort to inaugurate a scheme of nursing in conjunction with the county and other nursing associations operating in the administrative area for the nursing of insured persons, but owing to the introduction of schemes arranged between certain Approved Societies and the Queen Victoria Jubilee Institute for Nurses for the provision of nursing out of valuation surpluses, it was found impossible to proceed.

As far as the County of Cheshire is concerned, the joint schemes of the Queen Victoria Jubilee Institute have failed.

107. The Committee, however, desires particularly to state that it should not be assumed that the lack of utilisation of the services under such Queen Victoria Jubilee Institute schemes indicates the absence of a need for nursing of insured persons. This is clearly evidenced by the position in Cheshire where, during the first year of the operation under the Joint Schemes, the County Nursing Association had received less than £100 for an area in which approximately 250,000 insured persons were resident, and yet the local nursing associations affiliated with the County Association had at the same time rendered a very considerable number of visits to insured persons without reference to the scheme.

This Committee is still of the opinion that nursing is a very necessary and vital adjunct to medical benefit, and urges that it may be incorporated as an integral part of medical benefit to be administered by the body responsible for the administration of medical benefit.

RURAL DISPENSING DIFFICULTIES.

108. From time to time the Committee has determined questions and settled difficulties arising in rural areas in connection with the supply of drugs and appliances to insured persons.

At present it is satisfied that no district of the Committee's area is inadequately served in this respect, although in one instance a special grant is annually made for the collection of prescriptions and delivery of medicines.

MILEAGE.

109. In an area where so many varying conditions of country arise, the difficulty of the equitable distribution of the fund made available for mileage is considerable.

Its preliminary schemes in this connection were to a very large extent tentative, but in 1920 a more complete and equitable method of distribution was arrived at, and the scheme adopted by the Committee then would appear to have been justified, inasmuch as the model scheme issued by the Ministry of Health in July, 1924, so closely approximated thereto that it was not necessary to make any serious modifications in the Committee's Scheme.

Practitioners in the county are satisfied that the scheme secures a fair distribution of the available funds.

110. The funds available are distributed in the following manner:

(a) Ordinary Mileage Fund.

- (i) The Committee with the Panel Committee determines in the first instance the area in which mileage shall be payable.
- (ii) A practitioner, when accepting an insured person resident in such areas, indicates the mileage claimed on the medical card in a place provided for the purpose.

- (iii) In calculating the credit to each practitioner, the following table is employed:
In respect of each person included in the statement who is distant—
- Over two miles but under three miles —1 unit.
Over three miles but under four miles —2½ units.
Over four miles but under five miles —4 units.
Over five miles but under six miles —6½ units.
Over six miles but under seven miles —9 units.
Over seven miles but under eight miles —12½ units.
Over eight miles but under nine miles —16 units.
Over nine miles but under ten miles —20½ units.
Ten miles and over—25 units.
- (iv) The fund is distributed in proportion as the individual practitioner's units bear to the aggregate of units of all Insurance Practitioners.
- (v) Subsidiary units are credited in certain instances for walking distances.

(b) *Special Mileage Fund.*

- (i) The areas are determined as in (a) (i) above.

- (ii) A Practitioner at the time of signing a medical card of a person indicates that he desires to claim against the Special Mileage Fund, by marking upon the medical card, in the space provided, the letters "S. M." and the number of units claimed calculated in the manner hereinafter set out:—

(a) In respect of each person resident in a place accessible only by excessively steep gradients a Practitioner is entitled to claim one unit for every mile measured from the commencement of such gradient and continued for such distance during which such conditions exist, and lying along the nearest road from the residence of the Practitioner to the residence of such person, provided that no distance is taken into account where there is a lower gradient than one in ten, and where such steep gradient averages less than one-quarter mile in length in every mile of the whole distance.

(b) In respect of each person resident in a place accessible only by walking or riding on horseback over moorlands, mountain paths, bridle paths, or by boat or vehicle over inlets or tidal streams to islands or islets, a Practitioner is entitled to claim one and one-half units for every quarter of a mile measured from the point at which such conditions of travel commence up to the point where normal conditions obtain, and lying along the nearest road or way between the residence of the Practitioner and such person.

111. The sums distributed in mileage during the period under review are shown in Table I.
The following statements show variations in amounts received by Doctors during 1923:—

ORDINARY MILEAGE, 1923.

Number of Doctors who received less than £5 ...	55
Number of Doctors who received more than £5 and less than £10 ...	26

Number of Doctors who received more than £10 and less than £20 ...	38
Number of Doctors who received more than £20 and less than £50 ...	24
Number of Doctors who received more than £50 and less than £100 ...	14
Number of Doctors who received more than £100 and less than £150 ...	2
	<hr/> 158

Amount distributed, £3,003.
Average for each Doctor, £19 0s. 1518d.

SPECIAL MILEAGE, 1923.

Number of Doctors who received less than £5 ...	16
Number of Doctors who received more than £5 and less than £10 ...	6
Number of Doctors who received more than £10 and less than £20 ...	4
Number of Doctors who received more than £20 and less than £50 ...	3
Number of Doctors who received more than £50 and less than £100 ...	1
Number of Doctors who received more than £100 and less than £150 ...	Nil
	<hr/> 30

Amount distributed £322.
Average for each Doctor £10 14s. 8d.

112. The Committee feels that the "Mileage Fund" has to some extent compensated the rural Practitioner for the inequality which arises between him and the urban Practitioner when payment is based solely on the capitation fee without regard to the difficulties of access involving expenditure and time in travelling which is placed upon the rural Practitioner.

In no case, however, has a rural practice lapsed since the inception of the Acts.

In this connection the following table, showing the number of insured persons included in the list of purely rural doctors and of their income from Insurance sources for the year 1923 and some variations therefrom, may be interesting, viz:—

STATEMENT AS TO RURAL PRACTICES.

Number of Insurance Practitioners practising in purely rural areas—	
Principals ...	23
Assistants ...	1
	<hr/> 24
Number of Separate Practices—	
Singlehanded ...	14
Partnership ...	4
With Assistant ...	1
	<hr/> 19
Number of single-doctor areas included above ...	11
Number of Insured Persons included in Lists of such Practitioners ...	15,333
Average Number per Practitioner ...	667

Income of such Rural Practitioners for year 1923:—

	Aggregate.	Average.	Percentage of Total Income.
Treatment ...	£	£	75.0
Dispensing ...	7,242	313	14.0
Ordinary Mileage	1,324	58	10.8
Special "	1,044	45	0.2
	24	1	
	<hr/> 9,634	<hr/> 417	<hr/> 100.0

102. The following Table shows varying incomes from insurance funds received for the year 1923 by Chemists included in the Committee's list:—

Range of Income.	No. of Chemists, &c.
Less than £1	12
More than £1 and less than £5 ...	28
" 5 " 10 ...	14
" 10 " 15 ...	7
" 15 " 25 ...	9
" 25 " 50 ...	16
" 50 " 75 ...	16
" 75 " 100 ...	15
" 100 " 150 ...	18
" 150 " 200 ...	13
" 200 " 250 ...	8
" 250 " 350 ...	15
" 350 " 500 ...	10
" 500 " 750 ...	3
" 750 " 1,000 ...	2
" 1,000	3—1—£1,010. 1—£1,202. 1—£1,226.

SCRUTINY OF PRESCRIPTIONS.

103. Scrutiny of the issue of prescriptions is carried out with a view to the prevention of improper charges on the Committee's Drug Fund under the following heads:—

- (i) Issue of prescriptions to persons not entitled to Medical Benefit;
- (ii) Issue of prescriptions to persons entitled to treatment through another committee;
- (iii) Issue of prescriptions to insured persons in cases where the practitioner is himself required to supply the drug or appliance ordered.

This is an important section of the Committee's work, especially in a county area, but unfortunately owing to lack of necessary staff has only been very indifferently carried out in the past. With the present very limited staff of the Committee there is little prospect of the work being properly performed.

INVESTIGATION OF ALLEGED EXCESSIVE PRESCRIBING.

104. Very great help could be given to the broader question of investigation of alleged excessive prescribing if committees were financially able efficiently to carry out the scrutiny, as in the process valuable information becomes available as to the prescriptions issued to individual insured persons. "Frequency" of prescribing for individual insured persons is readily ascertainable as distinct from "frequency" calculated on the total number of insured persons included in the practitioner's list in a given period.

For example:—

Dr. "A's" "frequency" figure is shown by the Pricing Bureau Statement for the months of March and June, 1924, as 40 and 16 respectively—yet in the process of checking prescriptions against the doctor's list of insured persons the information is elicited that during March the frequency for 31 patients was 5.30, and for 10 of these a rate as high as 7.20 was disclosed, and in one instance the Committee paid for 11 prescriptions issued to the same insured person during the month of June.

The total number of prescriptions actually dispensed issued by Dr. "A" for the eight months, February to September, 1924, was 2,098 in respect of 630 different insured persons, a "frequency" rate of 3.33.

The total number of insured persons included in Dr. "A's" list, excluding dispensing patients, at the 1st October, 1924, was 1,353.

Real knowledge of the prescribing of practitioners can only be obtained by a detailed examination from month to month of the prescriptions dispensed, and this could, if Insurance Committees had the staff, be carried out *pari passu* with its present procedure of scrutiny for the specific purposes indicated herein.

DRUGS, &c., FORMULARY.

105. A Formulary issued by the Committee in conjunction with the Panel and Pharmaceutical Committees and known as the Pharmacopœia Cestriensis was issued in 1917, a revised edition being issued in 1924. It contains 353 formulæ ordinarily considered to meet the average needs of the different departments of practice.

It has been found of great benefit to Insurance practitioners in the area.

DOMICILIARY NURSING OF INSURED PERSONS.

106. In 1921 and 1922 the Committee made a very great effort to inaugurate a scheme of nursing in conjunction with the county and other nursing associations operating in the administrative area for the nursing of insured persons, but owing to the introduction of schemes arranged between certain Approved Societies and the Queen Victoria Jubilee Institute for Nurses for the provision of nursing out of valuation surpluses, it was found impossible to proceed.

As far as the County of Cheshire is concerned, the joint schemes of the Queen Victoria Jubilee Institute have failed.

107. The Committee, however, desires particularly to state that it should not be assumed that the lack of utilisation of the services under such Queen Victoria Jubilee Institute schemes indicates the absence of a need for nursing of insured persons. This is clearly evidenced by the position in Cheshire where, during the first year of the operation under the Joint Schemes, the County Nursing Association had received less than £100 for an area in which approximately 250,000 insured persons were resident, and yet the local nursing associations affiliated with the County Association had at the same time rendered a very considerable number of visits to insured persons without reference to the scheme.

This Committee is still of the opinion that nursing is a very necessary and vital adjunct to medical benefit, and urges that it may be incorporated as an integral part of medical benefit to be administered by the body responsible for the administration of medical benefit.

RURAL DISPENSING DIFFICULTIES.

108. From time to time the Committee has determined questions and settled difficulties arising in rural areas in connection with the supply of drugs and appliances to insured persons.

At present it is satisfied that no district of the Committee's area is inadequately served in this respect, although in one instance a special grant is annually made for the collection of prescriptions and delivery of medicines.

MILEAGE.

109. In an area where so many varying conditions of country arise, the difficulty of the equitable distribution of the fund made available for mileage is considerable.

Its preliminary schemes in this connection were to a very large extent tentative, but in 1920 a more complete and equitable method of distribution was arrived at, and the scheme adopted by the Committee then would appear to have been justified, inasmuch as the model scheme issued by the Ministry of Health in July, 1924, so closely approximated thereto that it was not necessary to make any serious modifications in the Committee's Scheme.

Practitioners in the county are satisfied that the scheme secures a fair distribution of the available funds.

110. The funds available are distributed in the following manner:

(a) Ordinary Mileage Fund.

- (i) The Committee with the Panel Committee determines in the first instance the area in which mileage shall be payable.
- (ii) A practitioner, when accepting an insured person resident in such areas, indicates the mileage claimed on the medical card in a place provided for the purpose.

(iii) In calculating the credit to each practitioner, the following table is employed:
In respect of each person included in the statement who is distant—

Over two miles but under three miles	—1 unit.
Over three miles but under four miles	—2½ units.
Over four miles but under five miles	—4 units.
Over five miles but under six miles	—6½ units.
Over six miles but under seven miles	—9 units.
Over seven miles but under eight miles	—12½ units.
Over eight miles but under nine miles	—16 units.
Over nine miles but under ten miles	—20½ units.
Ten miles and over	—25 units.

(iv) The fund is distributed in proportion as the individual practitioner's units bear to the aggregate of units of all Insurance Practitioners.

(v) Subsidiary units are credited in certain instances for walking distances.

(b) *Special Mileage Fund.*

(i) The areas are determined as in (a) (i) above.

(ii) A Practitioner at the time of signing a medical card of a person indicates that he desires to claim against the Special Mileage Fund, by marking upon the medical card, in the space provided, the letters "S. M." and the number of units claimed calculated in the manner hereinafter set out:—

(a) In respect of each person resident in a place accessible only by excessively steep gradients a Practitioner is entitled to claim one unit for every mile measured from the commencement of such gradient and continued for such distance during which such conditions exist, and lying along the nearest road from the residence of the Practitioner to the residence of such person, provided that no distance is taken into account where there is a lower gradient than one in ten, and where such steep gradient averages less than one-quarter mile in length in every mile of the whole distance.

(b) In respect of each person resident in a place accessible only by walking or riding on horseback over moorlands, mountain paths, bridle paths, or by boat or vehicle over inlets or tidal streams to islands or islets, a Practitioner is entitled to claim one and one-half units for every quarter of a mile measured from the point at which such conditions of travel commence up to the point where normal conditions obtain, and lying along the nearest road or way between the residence of the Practitioner and such person.

111. The sums distributed in mileage during the period under review are shown in Table I.

The following statements show variations in amounts received by Doctors during 1923:—

ORDINARY MILEAGE, 1923.

Number of Doctors who received less than £5 ...	55
Number of Doctors who received more than £5 and less than £10 ...	26

Number of Doctors who received more than £10 and less than £20 ...	38
Number of Doctors who received more than £20 and less than £50 ...	24
Number of Doctors who received more than £50 and less than £100 ...	14
Number of Doctors who received more than £100 and less than £150 ...	2
	<hr/>
	158

Amount distributed, £3,003.
Average for each Doctor, £19 Os. 1:518d.

SPECIAL MILEAGE, 1923.

Number of Doctors who received less than £5 ...	16
Number of Doctors who received more than £5 and less than £10 ...	6
Number of Doctors who received more than £10 and less than £20 ...	4
Number of Doctors who received more than £20 and less than £50 ...	3
Number of Doctors who received more than £50 and less than £100 ...	1
Number of Doctors who received more than £100 and less than £150 ...	Nil
	<hr/>
	30

Amount distributed £322.
Average for each Doctor £10 14s. 8d.

112. The Committee feels that the "Mileage Fund" has to some extent compensated the rural Practitioner for the inequality which arises between him and the urban Practitioner when payment is based solely on the capitation fee without regard to the difficulties of access involving expenditure and time in travelling which is placed upon the rural Practitioner.

In no case, however, has a rural practice lapsed since the inception of the Acts.

In this connection the following table, showing the number of insured persons included in the list of purely rural doctors and of their income from Insurance sources for the year 1923 and some variations therefrom, may be interesting, viz:—

STATEMENT AS TO RURAL PRACTICES.

Number of Insurance Practitioners practising in purely rural areas—	
Principals ...	23
Assistants ...	1
	<hr/>
24	
Number of Separate Practices—	
Singlehanded ...	14
Partnership ...	4
With Assistant ...	1
	<hr/>
19	
Number of single-doctor areas included above ...	11
Number of Insured Persons included in Lists of such Practitioners ...	15,332
Average Number per Practitioner ...	667

Income of such Rural Practitioners for year 1923:—

	Aggregate.	Average.	Percentage of Total Income.
Treatment ...	£	£	75.0
Dispensing ...	7,242	313	14.0
Ordinary Mileage	1,324	58	10.8
Special "	1,044	45	0.2
	24	1	
	<hr/>	<hr/>	<hr/>
	9,634	417	100.0

COMPLAINTS.—MEDICAL SERVICE, ETC., COMMITTEES.

113. Table IV gives information as to the cases considered by the respective services Sub-Committees, the nature of the complaints, the decisions of the Committee, and in cases of appeal the result of such appeals.

The very small number of cases of complaint must not in itself be taken to justify a conclusion that the medical service generally is satisfactory, but the Committee are satisfied nevertheless that in an area where the educational standard is relatively high, where the conditions of living are good, and where freedom of expression is not unduly restrained, that had there been any serious or persistent ground of complaint against the service the Committee would not have been kept in ignorance of it. It reasonably concludes therefore on the foregoing premises that the service has generally given satisfaction and that the number of complaints does represent the measure of discontent.

INSURANCE PRACTITIONERS. DISCIPLINARY ACTION.

114. On the question of disciplinary action in relation to Insurance Practitioners generally, the Committee does feel that where an Insurance Practitioner is alleged to have or has failed or neglected to comply with the terms of service applicable to him, such cases should in every instance, prior to action by the Minister of Health under Article 36 of the Medical Benefit Regulations or otherwise, be submitted to the Insurance Committee for reference for the purpose of investigation by the Medical Service Sub-Committee of the Insurance Committee.

It seems contrary to the accepted practice in such matters that the Minister should have power to take disciplinary action against and impose penalties upon Insurance Practitioners without reference to one of the principal parties to the contract and the body responsible for the administration of the service which such Practitioners contract to render, *i.e.*, the Insurance Committee, and the Committee claims that it should have an opportunity of considering any such question arising prior to final action by the Minister,

CHARGING OF FEES BY PRACTITIONERS.

Notices under Clause 7 (2) of Terms of Service.

115. All cases where a practitioner has held that a service has been without the scope of medical benefit and has given notice to the Committee of his intention to charge the insured person, on Form G.P.11, or otherwise, in accordance with Clause 7 (2) of his Terms of Service, have been submitted as a matter of unofficial routine to the Panel Committee and afterwards considered by the Insurance Committee.

116. A statement is appended showing particulars as to the cases so submitted for the period from 1st January, 1922 to the 31st December, 1924, the nature of the services rendered, the decisions of the Panel Committee, and the action of the Insurance Committee therein. (*See Table V.*)

SURGERY ACCOMMODATION AND HOURS.

117. This subject has engaged the attention of the Committee from time to time as necessity arose. In one case action was taken to secure the resignation of an Insurance Practitioner whose surgery accommodation was inadequate and unsuitable.

In another case where the body of Practitioners in a particular area desired to change the evening surgery hours, a member of the Committee resident in the district undertook to make the necessary enquiries as to whether such a change would inconvenience insured persons. On his report the Committee decided that no hardship would be inflicted on insured persons, and permitted the change to be made.

GENERAL.

118. A large number of questions raised in connection with the Acts and Regulations and on various other matters appertaining to different

aspects of the Committee's administration submitted by Insurance Practitioners and Chemists and insured persons are dealt with daily.

During the past two years the Committee has replied to over 300 enquiries in connection with the following subjects:—

- Provision of Dental Treatment.
- Provision of Convalescent Home Treatment.
- Accounts rendered by non-insurance Practitioners.
- Duty of Insurance Practitioners in relation to Confinements.
- Anæsthetists' Fees in connection with confinements.
- The dispensing of prescriptions issued by R.A.M.C. Officers to the Territorial Army.
- Claims under the Workmen's Compensation, &c., Acts.
- Certification in cases of misconduct and of accident.
- Specialist treatment.
- The cost of Blood Sugar Estimation in Insulin Treatment.
- The provision of optical appliances.
- Vaccination and certificates in relation thereto.
- Provision of appliances not included in the list.
- Giving of anæsthetics in dental treatment.
- Prescribing of proprietary drugs and other vaccines.
- Supply of autogenous and other vaccines.

119. Over two hundred applications for dental or optical treatment have been received from insured persons during the past two years. In the same period over 700 enquiries from insured persons and employers, with reference to insurability, sickness benefit, &c., of members of Approved Societies, have been referred by this Committee to the proper quarter.

120. The Insurance Committee has become the Reception Bureau and Clearing House for a very large number of enquiries which do not lie within the province of its administration. Such enquirers have in every instance been promptly put in touch with the responsible authorities.

It is to the Insurance Committee that insured persons apply when they are labouring under any sense of injustice as to treatment from Doctors, Approved Societies, and even employers. The deserted wife applies to the Insurance Committee for particulars of her wandering husband, and the pursuer of the fugitive not infrequently applies to be allowed to consult the Insurance Committee's Register of insured persons. No information of any kind whatever, however, is given unless it is solely for purposes in connection with the National Health Insurance Scheme.

CHAPTER V.—REGISTRATION.

THE INDEX REGISTER.

121. In 1912 the count of index slips representing insured persons in respect of whom the Committee was responsible for the administration of medical and sanatorium benefit numbered 210,000, which at the 1st January, 1925, had increased to 243,736, representing insured persons entitled to medical benefit.

For the twelve years during which the register has been maintained over 560,000 transactions involving additions to or abstractions from the register have taken place, and this total does not include a very large number of alterations of addresses, names, Society particulars, &c., &c.

Table VI shows the mean annual count of the Register and transactions thereon since the inception of the Act, and further shows the variations during the period 1912 to 1924 in the numbers of Deposit Contributors and Exempt Persons and from 1916 to 1924 of members of the Navy and Army Fund.

NUMBER OF APPROVED SOCIETIES AND THEIR MEMBERSHIP IN COUNTY.

122. At the 1st January, 1925, the total number of Approved Societies having members resident within the area of the Cheshire Committee was 543; the

following table shows the variations in memberships of Societies:—

Members resident in the area.		No. of Societies.
Not exceeding 5 Members ...	...	298
Over 5 but not exceeding 10 members	52	
" 10 " 50 "	66	
" 50 " 100 "	32	
Total Societies having less than 100 Members, 448.		
" 100 " 250 "	32	
" 250 " 1,000 "	32	
Total Societies having less than 1,000 Members, 512		
" 1,000 " 2,500 "	14	
" 2,500 " 5,000 "	9	
" 5,000 " 10,000 "	6	
" 10,000 " 20,000 "	1	
" 20,000 " 30,000 "	3	
" 30,000 " 40,000 "	1	

Total Members 240,503 in 546 Societies, or an average of 440 Members.

A considerable number of the Societies having members in the area have lodges or branches acting as an administrative unit under the Scheme. It is estimated that in addition to the above 546 separate Societies there are a very large number of Branches or Lodges having separate administrative autonomy in connection with the Scheme.

ANNUAL VARIATIONS IN MEMBERSHIP.

123. Table VII shows the annual variations which have taken place in the numbers of members of a selection of the larger Approved Societies for the years 1912 to 1924.

REGISTER TRANSACTIONS, &C.

124. Cross references and registration between the medical register and the index register and in connection with the association of an index slip with a medical slip in a Practitioner's list have involved approximately one and a half million transactions.

DISTRICT INSURANCE COMMITTEES.

Summary of Committees and Analysis of Representation.

DISTRICT	No. of Members.	Analysis of Representation.						Total Agreeing with Column 2.
		Insurance Committee.	Ches. C. Council.	Local Authorities.	Insured Persons.	Medical Committee.	Chemists' Committee.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 Congleton Borough ...	24	4	2	2	14	1	1	24
2 Crewe " ...	30	4	2	5	17	1	1	30
3 Dukinfield " ...	26	4	2	3	15	1	1	26
4 Hyde " ...	28	4	2	4	16	1	1	28
5 Macclesfield " ...	28	4	2	4	16	1	1	28
6 Stalybridge " ...	28	4	2	4	16	1	1	28
7 Altrincham and Bowdon District ...	30	4	2	5	17	1	1	30
8 Ashton-under-Lyne and Stockport District ...	38	4	2	9	21	1	1	38
9 Bebington and Neston District ...	32	4	2	6	18	1	1	32
10 Chester Area District ...	26	4	2	3	15	1	1	26
11 Congleton Area District ...	30	4	2	5	17	1	1	30
12 Hoylake and West Kirby District ...	26	4	2	3	15	1	1	26
13 Knutsford and Wilmalaw District ...	26	4	2	3	15	1	1	26
14 Lymm and District ...	24	4	2	2	14	1	1	24
15 Macclesfield and Hayfield District ...	34	4	2	7	19	1	1	34
16 Nantwich Area District ...	30	4	2	5	17	1	1	30
17 Northwich and District ...	28	4	2	4	16	1	1	28
18 Runcorn Rural District ...	26	4	2	3	15	1	1	26
19 Runcorn Urban District ...	26	4	2	3	15	1	1	26
20 Sale and Ashton-on-Mersey District ...	28	4	2	4	16	1	1	28
21 Tarvin District ...	28	4	2	4	16	1	1	28
22 Malpas District ...	26	4	2	3	15	1	1	26
23 Winsford and Middlewich District ...	28	4	2	4	16	1	1	28
Totals ...	650	92	46	95	371	23	23	650

N.B.—Of the Representatives of the County Insurance Committee, as per Column 3, at least Two in each District were women.

During the period under review, hand-counts of the index register have been made on three occasions, the last of these being in May, 1922. At the 1st January, 1925, the difference between the figures of the Central Index Committee and the Insurance Committee was 1,439, or 0.59 of the total Register.

On the occasion of the last hand-count it was possible to associate index slips with a large number of suspense slips, and at present the total number of suspense slips is only 1,583, the majority of these being of very recent date.

A system has been adopted for the weekly checking of a section of the index register with a view to the detection of errors in placing index slips incorrectly in Societies, incorrect arrangement as to name and other particulars, and for the purpose of keeping down the suspense register.

NUMERICAL ARRANGEMENT OF REGISTERS.

125. In 1922 an experiment was tried of arranging certain Societies' slips in order of membership number as distinct from name arrangement, but in those Societies where membership numbers run into seven figures and in other Societies having Lodge as well as membership numbers, when an index slip was misplaced, as was not infrequently the case, it was found owing to the above conditions that it was almost impossible unless the whole of the register for that Society was searched to trace the misplaced slip. Further, much more difficulty was experienced in cases where an insured person failed to give membership number to trace that person in the index register, most cases requiring to be again communicated with. The experiment proved to the Committee conclusively that name arrangement of the index register is much more administratively satisfactory, and this arrangement has been continued.

CHAPTER VI.—DISTRICT INSURANCE COMMITTEES.

APPOINTMENT AND MEMBERSHIP.

126. On the 15th day of March, 1913, there was completed a Scheme for the appointment of 23 District Insurance Committees, with a total membership of 650 members. The following Table gives details:

MEETINGS, PROCEDURE AND END.

127. During the year 1913 meetings of all the District Insurance Committees were held and were well attended.

Each District Committee appointed Sub-Committees and made Standing Orders and determined generally their procedure, and each appointed some person to act as Clerk to the District Committee. In no case, however, did District Sub-Committees meet more than three times, and as the work which the County Insurance Committee was empowered to delegate to District Committees to perform had been so restricted by the Regulations issued by the Commissioners, District Insurance Committees in a very short time ceased to function, their Meetings and activities falling into complete abeyance. Such was the state of things until their appointment was discontinued.

The limitation of powers and the lack of the necessary finances to enable them to become active bodies may be attributed as the causes of their failure to become a valuable administrative unit under the Scheme of National Health Insurance.

CHAPTER VII.—DEPOSIT CONTRIBUTORS.

NUMBERS AND VARIATIONS.

128. The number of Deposit Contributors entitled to medical benefit during the 12 years under review is shown in Table VI.

CLAIMS AND PAYMENTS OF CASH BENEFITS.

129. Over 6,000 separate claims have been received during that period and approximately £4,250 has been paid in respect of such claims for sickness and maternity benefit and refundments under various sections of the Act.

Table VIII gives statistics as to claims, &c., from 1913 to 1924.

An analysis of the claims of Deposit Contributors for Sickness and Maternity Benefit for the two years 1923 and 1924 showing number of claims met in full, met in part, and not met, and certain percentages, &c., &c., is summarized in Table IX.

FUTURE OF DEPOSIT CONTRIBUTOR CLASS.

130. An exhaustive analysis has been made in connection with the membership of the Deposit Contributors Fund with a view to ascertaining to what extent the contributors under the National Insurance Acts utilise the Deposit Contributors Fund as a permanent instrument of Insurance or merely as a vestibule or waiting room to an Approved Society.

An examination has been made of the index slips of the Deposit Contributors Fund, the General Federation of Trades Union Approved Society No. 110, the Prudential Approved Societies 136 and 137 (portions), and the National Order of Free Gardeners Approved Society, No. 162, and the result of that examination is shown in the following Table:—

Statement showing a comparison between Membership in Cheshire of certain Approved Societies and of the Deposit Contributors Fund on the following points.

Year of entry into Membership of Insured Persons who were members at the 1st January, 1925.

Relative Percentages of Members of varying length of Membership to the whole Membership at 1st January, 1925.

Numbers who had selected Doctors.

Percentages to Total Number of Members.

Year of Entry or Establishment.	G. Federation T.U.A.S. 110. All Members in Cheshire.				N.O. Free Gardeners A.S. 162. All Members in Cheshire.				Prudential A.S.'s 136 and 137 Portion only of Members.				Average Percentages of Preceding Figures.		Members of Deposit Contributors Fund.				
	MEN.		WOMEN.		MEN.		WOMEN.		MEN.		WOMEN.				MEN.		WOMEN.		
	No.	Percent- age to Total.	No.	Percent- age to Total.	No.	Percent- age to Total.	No.	Percent- age to Total.	No.	Percent- age to Total.	No.	Percent- age to Total.	MEN.	WOMEN.	No.	Percent- age to Total.	No.	Percent- age to Total.	
																	No.	Percent- age to Total.	No.	Percent- age to Total.
1912-1914	1,446	84.0	342	65.5	1,342	72.9	226	46.2	702	49.4	380	24.7	70.0	37.2	83	5.0	32	3.9	
1915... ..	22	1.3	3	0.6	19	1.0	15	3.1	11	0.8	64	4.2	1.0	3.2	25	1.5	9	1.0	
1916... ..	13	0.8	16	3.0	36	2.0	25	5.1	32	2.3	65	4.2	1.6	4.2	22	1.3	17	2.0	
1917... ..	20	1.1	10	2.0	43	2.3	25	5.1	41	2.9	93	6.0	2.1	5.0	37	2.3	15	1.8	
1918... ..	32	1.9	11	2.0	51	2.8	15	3.1	41	2.9	87	5.7	2.5	4.4	46	2.8	40	4.9	
1919... ..	35	2.0	16	3.0	67	3.6	26	5.2	119	8.4	114	7.4	4.5	6.1	190	11.5	56	6.8	
1920... ..	30	1.7	27	5.2	42	2.3	20	4.1	107	7.5	134	8.7	3.6	7.2	191	11.5	94	11.5	
1921... ..	55	3.2	24	4.6	53	2.9	29	6.0	80	5.6	133	8.7	3.8	7.3	140	8.5	95	11.6	
1922... ..	20	1.1	27	5.1	52	2.8	25	5.1	100	7.0	156	10.2	3.4	8.2	215	13.0	109	13.3	
1923... ..	26	1.5	25	5.0	65	3.5	30	6.1	93	6.6	140	9.1	3.7	7.6	366	22.2	190	23.2	
1924... ..	23	1.3	21	4.0	71	3.9	53	10.9	94	6.6	171	11.1	3.8	9.6	332	20.4	160	20.0	
TOTALS	1,722	100.0	522	100.0	1,841	100.0	489	100.0	1,420	100.0	1,537	100.0	100.0	100.0	1,647	100.0	817	100.0	
Number of above who are in- cluded in Doctors lists... ..	1,571	91.2	488	93.5	1,653	89.8	425	86.9	1,210	85.2	1,350	84.6	89.0	88.8	868	52.7	447	54.7	

131. It is clear from this Table that the Deposit Contributors' Fund is not a permanent domicile for insured persons.

It is much more difficult to prove, however, whither go these birds of passage.

132. A further investigation was made of approximately 1,800 suspensions of members of the Deposit Contributors Fund during the two years 1923 and 1924, as shown by the orange slips received from the Ministry of Health.

The reasons given on such orange slips for suspension from medical benefit were as follows:—

Reasons for Suspension.	Number of Persons Suspended.	Percentage to whole number Suspended.
(a) Transfer to Approved Societies.	395	22
(b) Cessation of Contributions.	830	46
(c) Insufficiency of Balance	520	29
(d) On becoming Exempt Persons.	19	1
(e) On permanent removal from United Kingdom.	16	1
(f) On joining His Majesty's Forces.	7	1
(g) Death	13	
Totals... ..	1,800	100

Of the above 1,800 insured persons suspended from medical benefit, only 530, or 30 per cent., had actually been included in practitioners' lists, and it may be assumed that the others had taken no steps to secure the services of a medical practitioner.

133. It is extremely difficult to draw any precise conclusions from the foregoing data, but it is clear that there is an appreciable number of insured persons who fail to obtain the benefits to which they are entitled by reason of indifference or ignorance of procedure, and that those responsible for the acceptance of the contributions should take some action to secure that these persons who fail to appreciate their privileges should be made more fully aware of them seems to be desirable.

134. In June, 1923, the Committee conducted an enquiry with the object of obtaining information in connection with the matter. A questionnaire was sent to 250 deposit contributors resident in different parts of the county, and where varying conditions of employment obtained. 127 replies were received; 19 letters were returned marked "Gone; left no address."

The following statement shows an analysis of the replies received:—

STATEMENT OF ANALYSIS OF 127 REPLIES RECEIVED TO QUESTIONNAIRE ADDRESSED TO 250 DEPOSIT CONTRIBUTORS.

Question.	Nature of Reply.	Numbers.		
		Men.	Women.	Totals.
1. Has the Deposit Contributor ever applied to become a member of an Approved Society?	1. Yes	18	17	35
	2. No	48	36	84
	3. No information	5	3	8
2. If rejected, on what grounds?	1. Ill health	—	1	1
	2. Physical Deformity— (i) Caused by war... ..	1	—	1
	(ii) Other causes	2	—	2
	3. Intermittent employment	1	1	2
	4. Age	5	4	9
3. If no application made, the reason why?	5. Not disclosed	5	3	8
	1. Ignorance	2	—	2
	2. Indifference	5	2	7
	3. Intermittent employment	2	3	5
	4. Hostility to Acts	2	1	3
	5. Disinclination	4	3	7
	6. Ill health	3	—	3
	7. Misapprehension as to position of A.S. member	1	4	5
	8. Deliberate choice	—	—	—
9. Uncertainty in choice of A.S.	—	—	—	
4. Previously a member of an Approved Society?	1. Yes	9	6	15
	2. No	62	50	112
5. If previously a member, reason for cessation of membership?	1. Unemployment	3	3	6
	2. Suspended	2	2	4
	3. Voluntary resignation	1	1	2
	4. Enlistment	2	—	2
	5. Not stated	1	—	1
6. Application for membership pending?	—	6	2	8
7. Desires now to become an A.S. member?	1. Yes	40	29	69
	2. No	24	20	44
	3. Not stated	7	7	14
8. Number who had gone and left no address.	—	—	19	

OCCUPATIONS OF DEPOSIT CONTRIBUTORS WHO REPLIED TO SUCH QUESTIONNAIRE.

Nature of Occupation.		Nature of Occupation.	
Men.	No.	Women.	No.
Labourers	5	Office Workers	8
Farm Workers	13	Domestics	13
Craftsmen	11	Charwomen and Office	
Roadmen	2	Cleaners	11
Gardeners	3	Nurses	3
Nurseryman	1	Textile Operatives ...	7
Greenkeepers	1	Lady Gardener	1
Chemist's Assistant ...	1	Chemists Assistant ...	1
Travellers' Agents ...	3	Teachers	2
Shop Workers	1	Shop Workers	2
Office Workers	12	Other trades	3
Textile Workers	2	Not stated	5
Mechanics	14		
Not stated	2		
	71		56

135. From an examination of the analysis the Committee found it difficult to form any general conclusions as to the underlying causes of such persons having become Deposit Contributors.

It will be seen, however, that of the number who replied, more than one half desired at the time to become members of Approved Societies, and that of those who had applied for membership and been rejected, and where the cause of the rejection was disclosed, the greatest number was on the grounds of age.

136. The Committee is of the opinion that the present position of the deposit contributor class is unsatisfactory, and considers that the time is ripe after twelve years' experience for some action to be taken.

SUGGESTIONS.

137. The Cheshire Committee are strongly opposed to the creation of a separate society for deposit contributors independent of control by Approved Societies. They consider that every person becoming insured should be required to apply for membership to an Approved Society, and failing application or acceptance by an Approved Society should be assigned to Approved Societies under Regulations made by the Minister of Health or otherwise.

The Committee are aware that the rules of certain Approved Societies would probably present an obstacle to the operation of such regulations and, furthermore, that societies would not agree to relinquish their present right of expulsion of members for misconduct or otherwise. There is no reason, however, why such difficulties cannot be surmounted, and where the society refuses to accept its quota of rebels or rejects, that society should nevertheless be called upon to bear its share of any financial burden which might be involved by the acceptance by societies with less rigid rules of such persons.

It cannot of course be assumed that the Deposit Contributor class as an insurable proposition is not sound (See Table IX.).

It is recognised that it is difficult to value the class as an insurance proposition in view of the fact that immediately an individual contributor's balance is exhausted, sickness, disablement and medical benefit cease, whereas such of course is not the case with a member of an Approved Society. Should, however, it be found after an experimental period of treatment of this class on an Insurance basis that the class was a less sound proposition than the general class of insured persons in Approved Societies, the necessary adjustment between those societies accepting and those not accepting could be made in terms of financial considerations.

138. As an alternative it might be found administratively practicable that Approved Societies themselves should form a Joint Approved Society for the

absorption of Deposit Contributors, and the Committee would favour such a solution if Approved Societies represented were given complete control in a joint capacity.

NAVY AND ARMY FUND.

139. The Committee have received and dealt with 4623 claims from members of the Navy and Army Fund and approximately £3,000 has been paid in cash benefits.

CHAPTER VIII.—DIAGNOSTIC FACILITIES (VOLUNTARY SCHEME).

140. For some years past the Committee has felt the need of the provision for the benefit of insured persons of bacteriological and pathological laboratory services as aids to Insurance Practitioners in the diagnosis and treatment of disease.

After considerable negotiations it was, last year, able to achieve in part its objective.

A scheme has been prepared and is now in operation for the provision of diagnostic facilities to insured persons, their dependants, widows and orphans, whereby the services of the Pathological Department of the Chester Royal Infirmary are available on a contributory basis at rates approximately one half of those usually charged.

A copy of the scheme and of the schedule of fees is attached. (See Sub-Appendix A.)

141. Up to the present time the Scheme is working very satisfactorily. Practitioners are daily taking greater advantage of the facilities. The free outfits issued to every Insurance Practitioner in the Committee's area and the area of the Chester and Flintshire Committees have done much to facilitate the reference of specimens, &c., to the laboratory. During the short period of the operation of the Scheme 150 reports have been made on specimens submitted and 10 autogenous vaccines prepared.

Difficulties with regard to payment of fees and other matters of a professional, technical and administrative nature have now been overcome, and the Committee looks forward to the Scheme serving a very useful purpose and supplying a very urgent need.

It recognises, however, that it is only a step on the road to a complete medical service.

CHAPTER IX.—MISCELLANEOUS.

GRANTS UNDER SECTION 26 (21 OLD ACT).

142. The only grant made by the Committee under Section 26 has been the sum of £100 to the Chester Royal Infirmary.

HEALTH, AND HYGIENE EDUCATION AND PROPAGANDA. UNDER SECTION 50 OF ACT (s. 60, 1911 ACT).

143. The Committee has from time to time taken action in connection with Health and Baby Week Propaganda, but it is not satisfied that spasmodic efforts of this description are the best means of educating the community in matters relating to health and hygiene. It has recently further considered the matter fully and has made the following proposals which it is hoped with the co-operation of the Cheshire County Council Education and Public Health Committee and the Local Medical and Panel Committees to give effect to.

- (1) That the following be the respective sections of the public to whom the programme of Health and Hygiene education should separately and/or collectively be applied:
 - (a) Children of school age (methods and nature of instruction to be varied according to age and sex).
 - (b) Insured persons—minors.
 - (c) Insured persons—adults.
 - (d) The general public.

- (2) That such education should comprise:—
- (a) Instruction in the principles and practice of hygiene.
 - (b) Knowledge of the human body and its functions.
 - (c) Food in its relation to the body.
 - (d) Causation and conveyance of disease.
 - (e) Prevention of disease.
 - (f) Remedies and cures.
 - (g) The recognition of simple symptoms in common complaints, e.g., measles, fever, whooping cough, influenza, mumps, rheumatism.
 - (h) Health insurance (contributions, benefits, procedure).
- (3) That the methods of imparting such education should include:—
- (a) The instruction of elementary and other school teachers by medical men and otherwise by lectures, &c.
 - (b) Addresses, if possible as part of the ordinary school curriculum and supplemental of Article 2 of the Elementary Education Provisional Code, 1922, preferably by teachers who had taken advantage of the facilities to be provided under (3) (a) hereof.
 - (c) Adult lectures run in connection with existing health bodies and other organisations in Municipal Boroughs and other well populated areas.
 - (d) The issue of press articles, posters, pamphlets, periodicals, etc.
 - (e) Cinema shows and demonstrations.
- (1) That for the purpose of securing a full and complete educational and propagandist effect it is essential for the Health and Education forces of the County to be united in close and cordial co-operation, and it is suggested that the administration of the Scheme be carried out by a Joint Committee comprised of representatives of the County Public Health and Housing Committee, the County Education Committee, the County Panel Committee, and the County Insurance Committee.

STATISTICAL, &C., INFORMATION FROM MEDICAL RECORDS.

144. Considerable attention has been given by the Committee to the question of the utilization of the data entered by Insurance Practitioners upon medical record envelopes.

It desires to remind the Commission of the purposes for which medical records are being kept by Insurance Practitioners.

145. The Inter-departmental Committee on Insurance Medical Records, the majority of whose sittings was under the Chairmanship of Sir Humphry D. Rolleston, after a very careful investigation of the whole matter determined that the purposes of the records should be (a) Clinical, (b) Administrative and (c) Statistical, and in so far as it was necessary to give precedence to any one of these purposes, precedence must be given to the clinical objects.

It is, however, primarily with the statistical objects of the records that this paragraph is concerned, and in Para. 43 of the Inter-departmental Committee's Report the following is found:—

“One kind of routine tabulation from the records themselves is indeed practicable, viz.:— from the records of insured persons who have died, or gone out of benefit, and whose cards would under the arrangements proposed be returned eventually to the Central Department.

“As regards other periodic tabulation, a routine examination of the records of all insured persons would be in any case an operation of such magnitude that the labour and expense might not be justified by the results; but a systematic tabulation, annually or at other fixed

periods, of selected portions of the records of a large and clearly defined class of persons, e.g., those of all insured persons who are certified as incapable of work, might as regards labour and expense be a practicable operation, and might yield valuable administrative and statistical results.”

Further, Para. 11 of Memorandum 274/O.C. states that the maintenance by Insurance Practitioners of a continuous record will in itself automatically make it possible to collate a number of important facts and to prosecute certain enquiries, either by direct examination of the continuous record itself or by the preparation of special returns and summaries.

146. Illustrations of such uses of the records mentioned by the Inter-departmental Committee are investigations into the sickness experience of a number of persons of a particular age or ages, or engaged in a particular occupation, and inquiries with a view to the assessment of the diagnostic and prognostic significance of various symptoms occurring in diseased conditions.

147. Clause 12 proceeds further to state that such investigations may have an important bearing on the progress of medical science, and the necessary data cannot be obtained except by the co-operation of general practitioners in the careful compilation of the records.

Again reverting to the Inter-departmental Committee's Report we find in Para. 38 that data of visits and surgery attendances may be required as an aid when any revision of general remuneration or wider questions of development or re-organisation of services are contemplated.

148. Since the 1st January, 1921, which saw the effective employment of the new form of medical record, there have been returned to this Committee in respect of insured persons who have died, ceased to be entitled to benefit, removed into other areas, or into another part of Cheshire, approximately 150,000 records. Of this number it is estimated that between forty and forty-five thousand contained data. Of that number about sixteen thousand records are at present in the possession of the Committee arranged in Society order and alphabetically according to the name of the insured person, representing insured persons who have been suspended from medical benefit.

149. The proposal is submitted that Insurance Committees should be empowered to extract data from all records coming into the hands of the Committee, whether they are subsequently to be re-transmitted to other Committees or Insurance Practitioners, or retained in the Offices of the Committee. Provided the form in which the information should be collated and analysed as determined by the Minister were not unduly exhaustive, it is not anticipated that any very considerable addition to staff would be necessary to perform this current work, and it must be recognised that the work accomplished would have gone far to facilitate any future operations which might have to be taken in connection with the statistical or other purposes of the records.

150. Further, geographical, geological and climatic conditions have an undoubted bearing on questions connected with the health of the people, and it is reasonable to suppose that the collection of data on a County or County Borough basis would go far to show the effect of these conditions, and probably other local conditions, upon the health of the people.

151. Unless this procedure were followed it might not be possible otherwise, owing to the continuous nature of the record and the many changes of residence of the insured person, to arrive at reliable data as to the particular diseases and ailments occurring in any specified part of the country.

During the collation and analysis of this data there will probably come to the knowledge of Insurance Committees very valuable information on various aspects of the medical benefit of insured persons, and this would undoubtedly be a very great help in dealing with questions such as are contemplated by Sections 50 and 107 of the Act (Sections 60 and 63 of the Old Act).

152. Had Insurance Committees from the commencement been given the necessary instructions, and supplied with the requisite funds to carry out this work, the question of the extension of medical benefit could then have been approached from a much more enlightened point of view, and it might have been that the Committee which enquired into the remuneration of Insurance Practitioners would have had available more precise knowledge as to their work and responsibilities.

It is admitted that it would be quite impossible, having regard to the necessity of a continuous record being kept by the Doctor, that the records in his possession should be periodically collected and retained by Insurance Committees to enable the information to be abstracted therefrom, but inasmuch as over a sufficiently long period the records of most insured persons would pass through the hands of the Insurance Committee, there does appear to be no objection to the continuous and current extraction of data from such records as they come in the ordinary way into the hands of the Insurance Committee by reason of suspense, removal, death, or otherwise.

LOCAL MEDICAL AND PANEL COMMITTEES AND PHARMACEUTICAL COMMITTEE.

153. It has been the practice of the Committee in connection with all matters in which the Panel and Pharmaceutical Committees may through their members be concerned invariably to consult such Committees, not only when required so to do by statutory regulations or otherwise, but in other instances where the special knowledge of such Committees was considered to be helpful, that help has been requested and in the main most readily given.

The Local Medical and Panel Committees have consistently supported the Committee in its action with regard to the provision of Nursing; its agitation against the Cheshire County Council's collection of contributions from insured persons suffering from Tuberculosis receiving Institutional Treatment; the Panel Committee is a party to the Joint Scheme for the provision of Diagnostic Facilities, and is agreeable to be represented on a Joint Health and Hygiene Education Sub-Committee; its representatives on the Medical Service Sub-Committee have invariably acted in accordance with the best traditions of the profession, and its attitude on questions affecting Insurance Practitioners has been generally free of prejudice.

The members of the Panel Committee take a very active interest in the work of the Insurance Committee, the Chairman, Secretary and Treasurer of the Panel Committee being members of the Committee and of several of its Sub-Committees; the Chairman of the Panel Committee being also Vice-Chairman of the Medical Benefit Sub-Committee and Chairman of the Nursing Inter Sub-Committee.

The Vice-Chairman of the Pharmaceutical Committee is a member of the Insurance Committee, and the former Committee also has on every occasion acted in full co-operation with the Insurance Committee in all matters which have arisen between them. Particularly is this the case in connection with the arrangement of Rotas under the Scheme prepared under Article 9 of the Medical Benefit Regulations.

The cordial co-operation of these bodies with the Insurance Committee presents a combination of forces in administration which, directed primarily to the furtherance of the interests and benefit of insured persons, has done a great deal towards the improvement of the Service.

The Local Medical Committee although identical in personnel with the Panel Committee deals with a very considerable number of matters unconnected with National Health Insurance, and generally exercises a supervision of the interests of the profession in its relationship with Local Authorities, Voluntary Organisations, etc., etc.

COMPARISON WITH COUNTY BOROUGH COMMITTEES.

154. In presenting for consideration by the Royal Commission a few points which suggest themselves as being desirable to be taken into consideration in

the comparison of the administrative work of a County Committee with that of a County Borough Committee it would appear to be necessary that the Commission should have cognisance of certain additional responsibilities of County Insurance Committees.

It is not proposed in this statement to submit at length these matters, but briefly to bring these points before the Commission so that they may not be overlooked.

155. A County Insurance Committee is responsible in addition to the ordinary duties which are common to both types of Committee, for the following:—

Dispensing in Rural Areas.

Distribution of Mileage Fund and the collection of the necessary statistics relative thereto.

Except in the possible instance of rent of premises, a County Insurance Committee is under a relatively larger cost of Administration in respect of the following:—

Travelling Expenses, Subsistence Allowance, and Compensation for Loss of Remunerative Time of Members attending Meetings of the Committee.

Increased postages and cost of staff arising out of greater correspondence inasmuch as a very large bulk of enquiries in a County Borough Office are answered in personal interviews.

Extensive additional detail work of registration, correspondence and accounting arising out of the distribution of the Mileage Fund and payment of rural dispensing fees.

A relatively greater number of Panel Practitioners and of Chemists on County Lists.

Heavy costs in connection with the transmission to and from Practitioners of medical records, certificate and prescription books.

This Committee considers therefore that in proportioning the funds between County Borough and County Insurance Committees regard should be had to these additional burdens of County Committees.

CONCLUSION.

156. The Committee has in the whole of this work been kept regularly informed.

Many hours have been spent in consultation with other bodies and otherwise in connection with the preparation of Schemes for the distribution of the funds available for medical benefit, etc., etc. It has conducted enquiries into questions relating to almost every aspect of the medical treatment of insured persons. Its officials have taken no action without the previous or later approval therein of the Insurance Committee.

It may be held that a very large amount of the work of which report is made herein is of a detailed nature, and to those who are unaware of the intricacies of the system might not unreasonably be considered unnecessary, but so long as medical treatment is available to insured persons on individual title thereto by reason of being a member of an Approved Society, Deposit Contributor, or otherwise, so long as payment is made to Insurance Practitioners on the basis of responsibility in accordance with his acceptance of individual insured persons, and so long as chemists are paid on the basis of prescriptions dispensed, so long will it be necessary for this intricate detailed administration to be carried out.

The work of the Insurance Committee has at times been carried out under very difficult conditions. During the War, when shortage of Doctors, Chemists, Drugs and Appliances had become a very serious and pressing problem, the Insurance Committee was from day to day and week to week continually involved in making arrangements and adjustments of the service for the provision of the necessary treatment to insured persons.

The Committee has administered the large funds at its disposal in such a way during the whole period as to have given general satisfaction to all parties concerned.

The happy and cordial relations at present existing between the Insurance Committee, Insurance Practitioners, Chemists, and other bodies with whom from time to time the Insurance Committee has had dealings is an indication of a true appreciation of its

responsibilities to all those with whom the Acts and Regulations have brought them into contact.

The cost of this intricate and detailed administration is less proportionately than the cost of the administration of any other Public Body.

TABLE I.

CHESHIRE INSURANCE COMMITTEE.

Statement of Expenditure from 1912 to 1924 on Benefits and Administration.

Period Covered.	Sanatorium Benefit.	Medical Benefit Including War Grants to Drs. etc.	Mileage Fund.	Deposit Contributors' Benefits.	General Purposes Fund.	Total Sums Administered.	Net Cost of Administration.	Percentage of Col. 8 to Col. 7.	Rate in £ of Col. 8 to Col. 7.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	£	£	£	£	£	£	£		s. d.
15th July to 11th Jan., 1914	9,888	83,039	393	—	—	93,320	5,821	6.23	1 3
12th Jan., 1914 to 31st Dec., 1914	11,270	75,512	394	—	23	87,199	6,430	7.37	1 5½
1915	13,761	71,604	407	—	46	85,818	4,921	5.73	1 1½
1916	13,148	68,005	400	—	10	81,563	4,609	5.65	1 1½
1917	10,738	74,580	568	—	36	85,922	4,612	5.37	1 1
1918	11,545	77,261	568	—	30	89,404	5,157	5.77	1 2
1919	11,991	95,798	568	—	119	108,476	6,461	5.96	1 2½
1920		119,465	4,333	7	41	123,846	8,607	6.96	1 4½
1921	18,377	124,614	3,522	2	35	146,550	7,031	4.79	0 11½
1922		135,851	3,522	4	35	139,412	5,412	3.86	0 9½
1923	334	135,450	3,325	2	38	139,149	*6,495	4.67	0 11½
1924	—	†126,507	†1,894	7	39	128,447	5,693	4.43	0 10½
Totals ...	£101,052	£1,187,686	£19,894	£22	£452	£1,309,106	†£71,249	5.44%	1 1

* Including Purchase of Offices. † Incomplete figures.

‡ Approximately £450 was received in respect of sundry receipts and deducted from Gross Expenditure shown in Table II.

TABLE II.

ADMINISTRATION OF BENEFITS.

Statement of Income and Expenditure since the inception of the National Health Insurance Act.

Heads of Expenditure.	1913.	1914.	1915.	1916.	1917.	1918.	1919.	1920.	1921.	1922.	1923.	1924.	Totals.	Percentage of Whole Cost.	Average Annual Cost.	Average Annual Cost per Insured Person.
	£	£	£	£	£	£	£	£	£	£	£	£	£	Per cent.	£	d.
Remuneration of Staff ...	2,220	2,518	2,287	2,247	2,211	2,502	3,770	5,251	4,433	3,271	2,856	3,040	36,606	51·06	3050	3·25
Stationery and Printing ...	1,871	1,138	1,092	513	616	1,034	703	1,133	596	443	470	604	10,213	14·25	851	0·91
Postages ...	377	944	453	479	422	372	514	719	672	518	456	610	6,536	9·12	545	0·58
Office Accommodation ...	715	1,193	293	258	282	294	359	396	370	330	1,893	334	6,717	9·37	560	0·59
Incidental Expenses ...	470	424	586	368	235	242	224	165	84	90	57	110	3,055	4·26	255	0·27
National Health and Un-employment Insurance.	—	—	30	31	29	28	33	50	68	104	108	106	587	0·82	49	0·05
Travelling Expenses of Members.	168	94	103	113	112	99	99	117	113	92	77	101	1,288	1·79	107	0·11
Subsistence Allowance ...	22	61	70	65	60	45	65	72	61	43	41	55	660	0·92	55	0·06
Compensation for loss of Remunerative Time.	11	34	48	48	43	27	43	41	40	8	10	15	368	0·51	31	0·04
Pricing Prescriptions ...	—	—	—	487	625	572	648	730	821	547	521	718	5,669	7·90	472	·50
TOTAL EXPENDITURE ...	5,854	6,406	4,962	4,609	4,635	5,215	6,458	8,674	7,258	5,446	6,489	5,693	71,699	100·00	5,975	6·36
														Percentages of whole Income.	Average Annual Income.	Average Annual Income per Insured Person.
<i>Income.</i>																
From Statutory and Central Sources.	6,598	2,485	2,246	2,613	2,679	2,676	2,834	6,447	6,961	5,958	5,706	5,495	52,698	73·73	4,391	4·68
Ordinary Grants ...	—	713	735	1,235	1,735	2,085	2,497	500	—	—	—	—	9,500	13·29	792	0·84
Special Grants...	1,520	1,313	884	868	500	500	500	500	500	—	—	—	7,085	9·91	590	0·63
Sanatorium Benefit Transfer																
Total from Central Sources ...	8,118	4,511	3,865	4,716	4,914	5,261	5,831	7,447	7,461	5,958	5,706	5,495	69,283	96·93	5,773	6·15
From Cheshire Insurance Committee General Purposes Fund.	—	—	—	—	1,000	—	—	710	—	—	485	—	2,195	3·07	183	0·19
TOTAL INCOME ...	8,118	4,511	3,865	4,716	5,914	5,261	5,831	8,157	7,461	5,958	6,191	5,495	71,478	100·00	5,956	6·34
Year-End Balances ...	Cr. 2,264	Cr. 369	Dr. 728	Dr. 621	Cr. 658	Cr. 704	Cr. 77	Dr. 440	Dr. 237	Cr. 275	Dr. 23	Dr. 221	Dr. 221			

TABLE III

CHESHIRE INSURANCE COMMITTEE.

Statement showing amounts of Practitioners Funds &c. for the period 1913 to 1923.

Period.	Mean of Practitioners' Lists.*	Total of Practitioners' Funds.	Nominal Capitation Fee upon which Fund based.	Actual rate per Insured Person included in Practitioners' Lists.
From 15th January, 1913, to 11th January, 1914.	179,244	£ 66,939	3/3 of 7 0 = 6 11·3	s. d. 7 5·6
To 31st December, 1914 ...	184,923	61,683	3/3 of 7 0 = 6 9·5	6 8·1
1915	187,567	58,413	7 0	6 2·3
1916	189,370	55,391	7 0	5 10·3
1917	192,666	63,780	7 0	6 7·5
1918	196,699	59,298	7 0	6 0·4
1919	202,207	65,871	7 0	6 6·2
1920	218,879	118,733	11 0	10 10·2
1921	225,626	124,619	11 0	11 0·2
1922	227,590	108,326	9 6	9 6·2
1923	226,432	106,462	9 6	9 4·9

* No allowance is made for Inflation in these figures.

TABLE IV.

CHESHIRE INSURANCE COMMITTEE.

Summary of Cases investigated by the Service Sub-Committees during the period 1914 to 1924.

No. of Cases.	Nature of Question arising.	How raised.	Against whom raised.	Whether Hearing held.	Action of the Committee.	Subsequent action (if any).
<i>By Medical Service Sub-Committee.</i>						
19	Alleged irregular certification.	By Approved Societies.	Insurance Practitioner.	With hearing (10). Without hearing (9).	Insurance Practitioner warned. (12.) Dismissed. No action. (5.) Practitioner mulcted in costs. (1.) Representation made to M. of H. (1.)	M. of H. impose fine of £5 each (2.) M. of H. after hearing issues warning. (1.)
1	Alleged irregular remarks on certificates.	By Approved Society.	Insurance Practitioner.	With hearing.	Dismissed	Nil.
9	Refusal to treat ...	By insured persons.	Insurance Practitioners.	With hearing (7). Without hearing (2).	Dismissed. (4) ... Transfer to other doctor. (1.) Found that doctor had failed to treat, but doctor allowed to resign. (1.) Resignation of doctor accepted, and expenses charged to him. (1.) Warned. (1.) Doctor to pay cost of treatment. (1.)	On appeal when additional evidence was produced. Practitioner was exonerated.
7	Alleged failure to give proper treatment.	By insured persons.	Insurance Practitioners.	With hearing (5). Without hearing (2).	Dismissed. (6.) Doctor to pay cost of treatment. (1.)	
4	Alleged charging of fees	By insured persons.	Insurance Practitioners.	With hearing (4).	Dismissed. (4.)	
6	Failure to return medical records.	By Insurance Committee.	Insurance Practitioners.	With hearing (6).	Fine recommended. (4.) No action. (2.)	Fined £9 (1) £8 (1). £5 (1)
1	Alleged refusal to issue certificates, and assault.	By insured person.	Insurance Practitioner.	With hearing (1).	Dismissed, but insured person allowed to change doctor.	
1	As to conduct of insured person under treatment.	By Insurance Practitioner.	Insured person.	With hearing (1).	Insured person transferred to another doctor.	
<i>By Pharmaceutical Service Sub-Committee.</i>						
2	Alleged irregular dispensing.	By district Local Medical Committee and an Insurance Practitioner.	Insurance Chemist.	With hearing (2).	Warned. (1.) Dismissed. (1.)	
<i>By Joint Services Sub-Committee.</i>						
1	Alleged restriction by Insurance Practitioner of right of insured person to free choice of chemist.	By Insurance Chemist.	Insurance Practitioner.	With hearing (1).	No action. Misunderstanding between parties. Agreement arrived at.	

TABLE V.

Summary of cases arising between 1st January, 1922 and 31st December, 1924, notified in accordance with Clause 7 (2) of the Terms of Service of Insurance Practitioners' 1st Schedule Medical Benefit Regulations, 1924 (9(2) 1920 Regs.).

(a) Cases in which the Panel Committee and the Insurance Committee have agreed that notice was requisite and that the service was without the scope of Medical Benefit.

Nature of Service.	No. of Cases notified.
1. Appendicectomy	80
2. Operations for various types of hernia ...	18
3. Operations for removal of hæmorrhoids ...	9
4. Tonsillectomy and for removal of adenoids...	9
5. Ophthalmascopy and Retinoscopy ...	8
6. X-ray treatment for various purposes ...	14
7. Radical cure of Hydrocele	8
8. Removal of Tubercular Glands of neck ...	2
9. Mastoidectomy	2
10. Excision of Tumour from breast	5
11. Operation for intestinal obstruction ...	1
12. Operation for rectal abscess	1
13. Uterine Curettage and Dilatation for various complaints	5
14. Exploratory Laparotomy, Inoperable carcinoma of cæcum	1
15. Operation for Otitis Media	1
16. Removal of Bone, Nasal disease	2
17. Removal of Cystic Kidney	1
18. Operation for Strangulated Richter's Hernia	2
19. do. Hammer-toes	1
20. do. Gastric Ulcer	4
21. do. Duodenal Ulcer	3
22. Removal of Sebaceous Cyst from neck ...	1
23. Removal of Large Tubercular Lumbar Abscess	2
24. Operation on L. Knee joint	1
25. Cholecystotomy	1
26. Amputation of R. Breast, Mastitis	1
27. Operation for Subinvolved uterus	1
28. Operation for hour-glass stomach	1
29. Excision—epithelioma lower lip	1
30. Plastic Operation, Rectum. Excision of Fibrous structure	1
31. Pathological examination and report ...	1
32. Removal of Fibroid Uteri	2
33. Hæmatocele of Tunica Vaginalis, Incision and drainage	1

Nature of Service.	No. of Cases notified.
34. Supra-pubic Cystotomy and Prostatectomy...	1
35. Uterine Polypus, Curettage removal of growth	2
36. Operation for Urethral obstruction	1
37. Operation for removal of diseased tibia ...	1
38. Operation on upper jaw, removal of segment of alveolus, etc.	1
39. Resection of rib, drainage, empyema ...	1
40. Operation for fistula in ano	1
41. Colporrhaphy and perineoplasty	1
42. Amputation of Leg	1
43. Epithelioma of floor of mouth, etc.	1
44. Carcinoma of Lower Lip. Excision, removal of adjacent glands	1
45. Removal of Cancerous growth from neck ...	1
46. Ovariectomy	1

Total Cases under (a) ... 205

(b) Cases in which Panel Committee have held that notice was not necessary nor a fee chargeable as the service was held to be within the scope of Medical Benefit, and in which opinion the Insurance Committee concurred.

Nature of Service.	No. of Cases notified.
1. Removal of Cystic Growth from L. Arm (under local anæsthetic)	1
2. Excision of Cyst of Forehead	1
3. Amputation of both forefingers	1

Total Cases under (b) ... 3

(c) Cases in which the Panel Committee have held that notice was necessary and a fee chargeable as the service was outside the scope of Medical Benefit, but in which opinion the Insurance Committee did not concur—

Formally submitted to Local Medical Committee under Art. 38, Med. Benefit Regulations, 1924.

Opinion of Local Medical Committee not yet received.

Nature of Service.	No. of Cases notified.
1. Compound Fracture of Leg ... Case under (c)	1

TABLE VI.

CHESHIRE INSURANCE COMMITTEE.

The Index Register of Insured Persons showing Annual Statistics and Transactions, 1912-1924.

Year.	Annual Mean Count.					Annual Transactions on the Register.			Percentage of Col. 9 to Col. 6, showing movement of Insured Person.
	Members of Approved Societies.	Deposit Contributors.	Exempt Persons.	Members of Navy and Army Fund.	Total.	In.	Out.	Totals.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1912	207,051	2,767	Nil	Nil	209,818	Original	Count	—	—
1913	197,431	2,806	145	Nil	200,382	11,508	24,700	36,208	18·01
1914	210,263	2,859	595	Nil	213,717	21,605	26,097	47,702	22·27
1915	209,033	2,578	509	23	212,143	25,457	27,270	52,727	24·8
1916	205,272	2,463	470	84	208,289	27,541	28,122	55,663	26·7
1917	205,056	2,717	453	209	208,435	23,124	18,962	42,086	20·19
1918	208,892	2,830	454	423	212,599	40,351	19,789	60,140	28·29
1919	225,979	3,461	404	776	230,620	42,207	30,106	72,313	31·35
1920	239,246	3,904	573	1,025	244,778	27,625	23,536	51,161	20·9
1921	244,718	3,396	585	810	249,509	17,380	18,111	35,491	14·22
1922	244,372	2,673	508	641	248,194	25,551	26,164	51,715	20·83
1923	241,939	2,507	502	555	245,503	19,380	21,616	40,996	16·69
1924	241,168	2,559	504	479	244,710	27,268	25,777	53,045	21·67
Total transactions						308,957	290,250	599,247	

TABLE VII

Statement showing Annual Variation in the Membership in Cheshire of a Selection of Approved Societies over the Period 1912 to 1924. (Mean Annual Count.)

Approval No.	Name of Approved Society.	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	Increase or Decrease at 1924 over 1912.	
															Number.	Percentages.
110	General Federation of Trade Unions ...	2,759	2,796	2,836	2,497	2,433	2,165	2,098	2,212	2,475	2,482	2,459	2,328	2,256	- 503	- 18
113	Grand United Oddfellows ...	6,796	6,898	7,129	7,123	6,762	6,211	6,024	6,508	7,369	7,560	7,333	7,168	7,214	+ 418	+ 6
115	Hearts of Oak ...	3,387	3,484	3,837	3,777	3,461	3,237	3,198	3,471	3,904	3,966	4,097	4,136	4,447	+ 1,060	+ 31
122	Loyal Order Ancient Shepherds ...	3,822	3,839	3,962	4,113	4,281	4,245	4,278	4,640	5,188	5,279	5,265	5,360	5,548	+ 1,720	+ 45
123	Independent Order Oddfellows, M.U. ...	18,484	18,621	19,223	19,541	19,223	18,944	19,232	20,643	22,658	23,303	22,769	22,240	21,734	+ 3,250	+ 18
125	National Amalgamated ...	25,195	26,861	29,579	30,594	31,997	31,930	32,806	33,948	34,334	37,435	37,830	38,207	36,256	+ 11,061	+ 44
135	Ancient Order Druids ...	3,943	3,998	4,321	4,213	4,017	3,976	3,983	4,257	4,773	4,965	4,907	5,111	5,169	+ 1,226	+ 31
136	Prudential (Men) ...	18,128	18,880	20,065	20,487	18,675	18,175	17,893	18,809	22,198	23,861	24,572	24,860	25,328	+ 7,200	+ 40
137	" (Women) ...	13,118	13,960	15,166	15,902	17,124	18,911	21,254	22,060	22,059	22,368	22,606	21,874	21,249	+ 8,131	+ 62
199	" (Domestics) ...	6,349	6,835	7,252	7,581	7,625	7,645	7,643	7,383	6,771	61,30	5,663	5,370	4,876	- 1,473	- 24
150	Independent Order of Rechabites ...	3,975	3,905	4,075	4,333	4,390	4,388	4,460	4,808	5,179	5,440	5,489	5,674	5,770	+ 1,795	+ 45
152	Ancient Order of Foresters ...	13,174	13,118	13,797	13,876	13,573	13,683	13,898	14,750	16,248	16,476	16,664	16,775	16,868	+ 3,704	+ 28
162	United Order of Free Gardeners ...	1,385	1,414	1,456	1,403	1,383	1,501	1,510	1,666	1,833	2,127	2,199	2,222	2,351	+ 966	+ 70
214	Co-Operative Wholesale ...	5,194	5,211	5,592	5,424	5,273	5,219	5,152	5,680	5,981	6,160	6,397	6,531	6,705	+ 1,511	+ 29
215	Sons of Temperance ...	2,882	2,928	3,126	3,108	2,827	2,750	2,715	3,045	3,595	3,796	3,632	3,697	3,794	+ 912	+ 32
239	National Union of Railwaymen ...	1,245	1,293	1,328	1,364	1,370	1,381	1,419	1,510	1,719	1,818	1,946	1,986	2,074	+ 829	+ 67
245	Royal Liver ...	4,596	4,840	5,212	5,424	5,120	4,905	4,944	5,158	5,461	5,736	5,704	5,800	5,858	+ 1,262	+ 27
1111	Amalgamated Weavers ...	5,510	5,669	5,902	5,677	5,376	5,145	4,987	5,106	5,349	5,182	5,098	5,022	4,793	- 717	- 13
1144	Amalgamated Cotton Spinners ...	1,926	1,987	2,084	2,016	1,784	1,415	1,213	1,546	1,981	2,121	2,246	2,286	2,308	+ 382	+ 20
1265	Amalgamated Card and Blowing Room Operatives.	3,282	3,339	3,622	3,379	3,188	3,178	3,209	3,434	3,676	3,718	3,853	3,830	3,630	+ 348	+ 11

Average percentage Increase ... 31

TABLE VIII.

DEPOSIT CONTRIBUTORS CASH BENEFITS.

Statement of Claims received, Paid or otherwise in respect of the Period 1913-1924.

Year.	Mean Membership of Fund.	Sickness Benefit.								Maternity Benefit.								Other Payments.		
		No. of Claims received and approved.	Record as to payment of such Claims.						No. of Claims received and forwarded.	No. of Claims due to be paid.	Record as to Payment of such Claims.				Amount Paid.	Refundments, &c. under various Sections. 42 (f), 42 (g), 44 (4), 1911 Act.				
			Claims paid in full.	Owing to insufficiency of Balance.		Amount Paid.	Claims paid in full.	Owing to insufficiency of Balance.												
				Paid in part only.	Not Paid.			Paid in part only.			Not paid.									
No.	Per-centage.	No.	Per-centage.	No.	Per-centage.	£	No.	Per-centage.	No.	Per-centage.	No.	Per-centage.	No.	Per-centage.	£	No. of Claims.	Amount. £			
1913 ...	2806	250	199	79.6	38	15.2	13	5.2	91	49	48	12	25.0	36	75.0	—	0.0	54	13	5
1914 ...	2859	318	257	80.8	44	13.8	17	5.3	154	55	43	35	81.4	7	16.3	1	2.3	56	25	14
1915 ...	2578	269	222	82.5	40	14.9	7	2.6	140	44	41	28	68.3	11	26.8	2	4.9	54	10	9
1916 ...	2463	303	271	89.4	25	8.3	7	2.3	146	53	48	33	68.8	14	29.2	1	2.0	64	11	7
1917 ...	2717	357	311	87.1	30	8.4	16	4.5	173	32	26	16	61.5	7	27.0	3	11.5	33	10	11
1918 ...	2830	314	250	79.6	33	10.5	31	9.9	164	40	35	22	62.9	13	37.1	—	0.0	47	4	4
1919 ...	3461	459	381	83.0	24	5.2	54	11.8	249	72	61	49	80.3	11	18.1	1	1.7	85	34	42
1920 ...	3904	433	321	74.1	35	8.1	77	17.8	271	116	99	88	88.9	11	11.1	—	0.0	153	17	26
1921 ...	3396	486	327	67.3	64	13.2	95	19.5	376	98	88	78	88.6	6	6.8	4	4.6	162	8	16
1922 ...	2673	592	425	71.8	60	10.2	107	18.0	372	85	77	57	74.0	16	20.8	4	5.2	133	2	4
1923 ...	2507	641	462	72.1	59	9.2	120	18.7	401	79	69	49	71.0	15	21.7	5	7.3	120	4	11
1924 ...	2559	771	549	71.2	77	10.0	145	18.8	423	74	68	54	79.4	13	19.1	1	1.5	128	10	20
Totals ...		5,193	3,975	76.6	529	10.2	689	13.2	2,960	797	703	521	74.1	160	22.8	22	3.1	1,089	148	169

TABLE IX.

CHESHIRE INSURANCE COMMITTEE.

Statement showing certain Statistics and Data as the result of an Analysis of all Claims received from Deposit Contributors for Sickness and Maternity Benefit for the period 24th December, 1922, to 15th December, 1924.

Heads of Information.	Sickness Benefit.					Maternity Benefit.				
	Men.	Per cent. of Total.	Women.	Per cent. of Total.	Totals.	Men.	Per cent. of Total.	Women.	Per cent. of Total.	Totals.
1. Total mean Count for 1923-1924 of Deposit Contributors under 70 years of age.	1,720	67.9	813	32.1	2,533	1,720	67.9	813	32.1	2,533
2. Total claims received and approved for payment subject to sufficiency of balance standing to credit of contributor.	—	—	—	—	1,384	112	81.8	25	18.2	137
3. Number of individual contributors claiming.	259	65.2	138	36.8	397	109	81.3	25	18.7	134
4. Number of days claimed (excluding waiting period).	7,864	60.4	5,158	39.6	13,022	—	—	—	—	—
5. Average period of incapacity where claimed (days).	30	—	37	—	35	—	—	—	—	—
6. Percentage proportion of Claimants per annum to total Contributors for the two years 1923-1924.	7.5%	—	8.5%	—	7.8%	3.2%	—	0.7%	—	2.6%
7. Payment of claims:—										
Paid in full:										
Claimants	175	69.7	76	30.3	251	86	86.0	14	14.0	100
Days paid	2,670	65.9	1,384	34.1	4,054	—	—	—	—	—
Paid in part owing to insufficiency of balance:										
Claimants	73	56.2	57	43.8	130	21	75.0	7	25.0	28
Days paid	1,964	56.8	1,493	43.2	3,457	—	—	—	—	—
Days not paid owing to insufficiency of balance.	2,800	55.9	2,211	44.1	5,011	—	—	—	—	—
Not paid owing to insufficiency of balance:										
Claimants	11	68.8	5	31.2	16	2	33.3	4	66.7	6
Days not paid... ..	43C	86.0	70	14.0	500	—	—	—	—	—
8. Percentage proportion to total Claimants and total days claimed:—										
Percentage of Claimants paid in full.	67.6%	—	55.1%	—	63.2%	78.9%	—	56.0%	—	74.6%
Percentage of Claimants paid in part.	28.2%	—	41.3%	—	32.8%	19.3%	—	28.0%	—	20.9%
Percentage of Claimants not paid.	4.2%	—	3.6%	—	4.0%	1.8%	—	16.0%	—	4.5%
Percentages of Days paid in full.	58.9%	—	55.8%	—	57.7%	—	—	—	—	—
Percentages of Days not paid.	41.1%	—	44.2%	—	42.3%	—	—	—	—	—
9. Cash Payments. Total for two years 1923-1924.	£ 557 0	67.6	£ 267 0	32.3	£ 824	£ 210	84.7	£ 38	15.3	£ 248
Average per annum ...	278 10	67.6	133 10	32.3	412	105	84.7	19	15.3	124
10. Average annual cost per head of total Deposit Contributors.	s. d. 3 3	—	s. d. 3 3½	—	s. d. 3 3	s. d. 1 2½	—	d. 5½	—	d. 11½
11. Estimated cost per head if all Claims made had been met in full.	s. d. 5 6	—	s. d. 6 11	—	s. d. 5 7½	s. d. 1 3½	—	d. 7½	—	s. d. 1 1
12. Estimated Annual Cost of Sickness and Maternity Benefits						s. d. 6 9½	—	s. d. 6 6½	—	s. d. 6 8½

SUB-APPENDIX "A."

Revised 1925.

SCHEME FOR THE UTILISATION OF THE SERVICES OF THE PATHOLOGICAL DEPARTMENT OF THE CHESTER ROYAL INFIRMARY ON BEHALF OF INSURED PERSONS.

PRELIMINARY.

It may be desirable in the first instance to point out that the aids to diagnosis referred to in this Scheme are not services to which an insured person is entitled as part of medical benefit under the National Insurance Acts.

The Insurance Committee has no power to pay out of its funds any charges which may be incurred by patient or practitioner by reason of the employment of such aids to diagnosis.

Should, however, the Laboratory be called upon to supply any vaccine, autogenous or otherwise, for administration by the practitioner attending an insured person, the cost of such preparation would be met by the Insurance Committee as being a proper charge against the Committee's Drug Fund; the procedure in such cases being for the practitioner to pay the charge due to the Laboratory and claim reimbursement in the prescribed manner from the Insurance Committee. The hospital not being under contract with the Insurance Committee, no payment may be made direct by the Insurance Committee to the hospital for vaccines supplied.

The Insurance Committee cannot make any payment for vaccines supplied to persons who are not insured.

The primary object of the Scheme is to secure, on favourable terms, for insured persons, their dependants, widows and orphans, etc., the unquestionable benefit of these services by encouraging insurance practitioners to make full use of the facilities for pathological and bacteriological examinations and of other aids to diagnosis which are available at the Pathological Department of the Chester Royal Infirmary.

As a first step to the achievement of this object, the Infirmary Board have agreed to issue free of charge to all practitioners practising in the area in which it is proposed to arrange for this Scheme to operate, a complete outfit for the collection and transmission of material.

The Board have further agreed to accept very substantially reduced charges for the services which it provides, and will give every facility for the attendance of such persons and the use of beds for the collection of material for examination in the diagnosis and treatment of disease.

ADMINISTRATIVE ARRANGEMENTS.

A joint Committee of representatives of the following bodies of each of the administrative areas included in the Scheme shall be appointed, viz.:-

The Insurance Committee Two Representatives
The Local Medical and
Panel Committee ... Two Representatives

with three Representatives of the Chester Infirmary Board.

The duties of the Committee shall be to administer the Scheme.

The Clerks to the respective Insurance Committees will supply the Pathological Department with the names of the Insurance Practitioners practising in the area, and such practitioners will be supplied free of charge with a complete outfit for the collection and transmission of material; also with forms for submission of enquiries. The Pathological Department will send reports of the result of the examinations to the practitioner.

From time to time the character and quality of the service given by the Pathological Department will come under review by the Committee, and it shall have power to make suggestions to the Board for modification, improvement or extension of its work.

The fees chargeable for services under the Scheme shall be in accordance with a scale to be determined by the Joint Committee.

Practitioners, or Local Medical and Panel Committees on their behalf shall be entitled to draw attention of the Committee to any matter in connection with the service which they were of opinion should be considered, and the Committee shall in turn, if thought desirable, draw the attention of the Pathological Department to the representations made.

All fees shall be paid direct to the Pathological Department of the Infirmary, and the Department shall be responsible for all expenses in connection with the Scheme.

The Joint Committee shall accept no responsibility for the payment of any fees in connection with this Scheme.

F. T. WEST,
Hon. Secretary.

February, 1925.

MEMO.

The undermentioned bodies have intimated their agreement to enter the Scheme, and have appointed the following members as representatives of the Joint Committee:—

County of Cheshire.

Insurance Committee:

George Wright, Esq., J.P.
Frank T. West, Esq.

Local Medical and Panel Committees:

Dr. J. Hedley Marsh, J.P.
Dr. Lionel J. Picton, O.B.E.

County of Flintshire.

Insurance Committee:

F. Llewellyn Jones, Esq., M.A.
W. D. Forber, Esq., J.P.

Local Medical and Panel Committees:

Dr. J. Humphrey Williams, J.P.
Dr. J. Owen Jones, J.P.

County Borough of Chester.

Insurance Committee:

J. H. Hopley, Esq.
David Hughes, Esq.

Local Medical and Panel Committees:

Dr. A. G. Hamilton, O.B.E.

Chester Royal Infirmary Board.

Dr. J. George Taylor.
Major W. G. Townsend Currie.
J. R. Mitchell, Esq.

The Joint Committee has made the following appointments:—

Chairman: George Wright, Esq., J.P.
Vice-Chairman: Dr. J. Humphrey Williams, J.P.
Hon. Secretary: Frank T. West, Esq.

SCALE OF FEES.

Nature of Service.	Fee.
Diphtheria swabs—including telegraphic or telephonic report	0 2 6
Examination of sputum for Tubercle bacilli Section and report on morbid tissues for cancer, etc.	0 2 6
	0 5 0
<i>Urine:</i>	
General examination, including microscopical examination of the centrifuged deposit	0 2 6
Cultural examination	0 5 0

Urine:—continued.

Nature of Service.	Fee.
Examinations for Tubercle bacilli ...	0 5 0
Ditto by animal inoculation ...	0 10 6
Quantitative examination for urea ...	0 2 6
Quantitative examination for sugar ...	0 2 6
Quantitative examination for urea in the blood ...	0 10 6

Cerebrospinal Fluid:

General examination, chemical, cytological and direct bacteriological, not including cultures ...	0 5 0
Ditto, including cultures ...	0 7 6
Wassermann test (carried out on Wednesdays) ...	0 7 6
Lange's colloidal gold test ...	0 10 6

Test Meals:

Ordinary ...	0 7 6
Fractional ...	0 10 6
Qualitative test for occult blood ...	0 2 6

Fæces:

Cultural examination for Typhoid bacilli	0 10 6
Total bacteriological examination, including tubercle bacilli ...	0 15 0
Occult blood ...	0 2 6
Intestinal parasites or their ova ...	0 5 0

Blood:

Total count and estimation of Hæmoglobin ...	0 10 6
Cultural, if blood sent to Laboratory ...	0 5 0
Examination of films for parasites ...	0 6 0
Widal test for Typhoid Fever, including telegraphic and telephonic report ...	0 2 6
Test for Paratyphoid A. and B. Fever and Widal test for Typhoid, including telegraphic or telephonic report ...	0 7 6
Wassermann test (carried out on Wednesdays) ...	0 7 6
Examination of pus for Gonococci ...	0 2 6
Examination of hairs for Ringworms ...	0 2 6
Examination of serum for Spirionema pallidum ...	0 5 0
Stock vaccines ...	1 1 0
Autogenous vaccines ...	2 2 0

SECTION B.—AS TO THE DEVELOPMENT OF THE SERVICE AND THE GROUNDS UPON WHICH THE INSURANCE COMMITTEE FOR THE COUNTY PALATINE OF CHESTER BASES ITS CONTENTION THAT THE PRESENT FORM OF ADMINISTRATION SHOULD, IN THE MAIN, BE CONTINUED AND EXTENDED ON SIMILAR LINES, AND ENVISAGING THE POTENTIALITIES LYING WITHIN THE ADMINISTRATIVE MACHINERY OF INSURANCE COMMITTEES.

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CHAPTER I.—THE NATURE AND EXTENT AND THE PROSPECT IN PRIORITY OF REALISATION OF THE SUGGESTED DEVELOPMENTS OF THE SERVICE TO INSURED PERSONS.

CONSULTANT AND SPECIALIST SERVICES, INCORPORATING DIAGNOSTIC FACILITIES AND HOSPITAL (IN-PATIENT, TEMPORARY) TREATMENT.

1. It would appear that the first consideration in approaching this subject should be directed to the nature of and co-relation between the services mentioned and the manner in which they could be made available for the benefit of insured persons.

It is recognised that Bacteriological and Pathological Laboratories have to a very appreciable extent taken the place of the consultant as an aid in the diagnosis of disease, which Service has thereby become less a quality of personal possession and more a branch of exact science administered along definitely discernible lines.

It further must be remembered that the great advance in the direction of modern equipment of General and Cottage Hospitals and the much more general use of the facilities therein, and the very marked raising of the standard, particularly in surgery, of the capacity of the ordinary general Practitioner are factors which go far to simplify the solution of a problem which some years ago would have bristled with difficulties.

The services of consultants and specialists are so closely associated with the services of Pathological and Bacteriological Laboratories and Hospitals, in so far as they represent the apparatus for treatment, that it does appear that the subject of these services must be approached as a whole.

The Regional Medical Services of the Ministry of Health forms in itself the nucleus of a very valuable contribution to this extension. The very large number of cases referred to them by Approved Societies and Insurance Practitioners, in which doubt exists as to capacity for work or otherwise, provide a field of experience from which in a relatively short period of time Regional Medical Officers will be able to reap an experience second to none, and of infinite value in the extension of the service in this direction.

Their completely independent and disinterested position as Civil Servants would be not the least important factor in the administration of such a Scheme.

2. It is suggested that the Commission's consideration would ordinarily be applied at the outset to the question of the potentialities lying within the medical and pharmaceutical personnel already under contract for services under the present Scheme, and to the extent by which the additional services suggested herein are capable of being rendered by that personnel.

It is clearly shown by the returns of services rendered by insurance practitioners to insured which have been held by those practitioners not to be within the content of Medical Benefit (*vide* Table V. Section "A" hereof) that a considerable proportion of Insurance Practitioners are capable of and have the necessary qualification for performing services outside the present content, which content must from time to time become greater. The Cheshire Committee is of the opinion that insurance practitioners are capable of playing a considerable part in this particular extension of the service.

3. Where in any case the extent of that service is reached and the treatment required by the insured person is beyond the capacity of that service it is the practice for insured persons to have recourse to the wider facilities available through Hospitals.

Many of such services are rendered by visiting consultants and specialists and especially in medical surgery can such services only effectively be rendered under Hospital conditions.

4. It becomes apparent therefore that hospital (In-patient, Temporary) Treatment forms an integral part of consultant and specialist treatment. Further, the Hospital service would be requisitioned in treatment requiring special apparatus, *i.e.*, X-Ray, Radium Heat, Electrotherapy.

Pathological and Bacteriological Laboratories are almost invariably associated with Hospitals and become part to a very large extent of the Hospital Service.

It may be concluded therefore that the provision of consultant and specialist services, diagnostic facilities, services of Laboratories, Clinics and Hospitals (In-patient, Temporary) Treatment could be provided from the services which in the past have been and at present are being utilised by insured persons, and there would at any rate for the immediate present be no call to requisition the services of the specialists and consultants in their, at present, private capacity.

5. It is suggested that the most suitable method of payment for this service would be as follows:—

(a) To Insurance Practitioners rendering services outside the present content of medical benefit, remuneration on an attendance basis at an agreed scale subject to an areal pool limit, and

(b) To hospitals on the basis of cases treated or services rendered by grants in aid—

(i) Of general services including Pathological, &c., Services;

(ii) Seasonal services of Consultants and Specialists.

It is estimated on the basis of returns from general practitioners previously referred to, and of services rendered by the Chester Royal Infirmary and from the Committee's experience of the operation of the Joint Voluntary Scheme for Diagnostic Facilities, that the approximate annual cost for the area of the Committee of the foregoing services would be

	£
To General Practitioners—Fees ...	3,500
To Hospitals—Grants in Aid ...	4,000
	<hr/>
	7,500

6. Should such a service be found practicable, very much would have been done to remove the impression, still not uncommon, that "Panel Doctoring" is not quite so good as that received as a "private patient."

DENTAL TREATMENT.

7. The provision of this treatment, held by the medical profession to be one of the most important factors in the question of national health, is one which has already engaged a large part of the time and consideration of the Commission.

The Committee do not desire to elaborate the evidence already given in the matter, but is strongly of the opinion that a uniform service should be available to all insured persons irrespective of the existence

of valuation surpluses or otherwise, and that at least a minimum service sufficient to secure the insured person against the ill-health consequent on defective teeth should be made available to insured persons without contribution specifically therefor on their part.

8. Except in a few rural areas where general Practitioners occasionally make extractions, dental treatment and the provision of dentures would require the men and materials of a new service.

This service is already available to some extent to the members of certain Approved Societies as an additional benefit out of valuation surpluses, but the very marked variations in the value of the benefit to the recipient, in the method of its administration, and the absence of any real Ministerial control over the expenditure thereon, calls for its inclusion as an integral part of the Medical Benefit Scheme.

9. The Committee recognises that the cost of extension in this direction will for the first few years be high, but having regard to the operation of the school dental service it feels that the cost in this direction would after some years be of regularly diminishing quantity.

In the absence of any data the Committee regrets it is unable to submit any estimate as to the probable annual cost, but feels nevertheless that a very considerable improvement in the general health of the community would result, with a consequent diminution in calls against sickness and disablement benefit funds.

ADDITIONAL APPLIANCES.

10. The most called for appliances not at present included in the list of appliances available for insured persons are found on experience to be the following:—

- (i) Trusses.
- (ii) Abdominal Belts.
- (iii) Elastic Stockings and Knee Caps.
- (iv) Capsicum Wool.
- (v) Burney Yeo's Inhalers.
- (vi) Eye Shades.
- (vii) Finger Stalls.
- (viii) Minor Appliances for the application of preparations prescribed by Practitioners:—

Glass Nasal Douches.
Eye Baths.
Small Syringes.
Throat Brushes.
Eye Droppers.

The inclusion of the foregoing appliances would in the opinion of the Committee occasion only a small additional cost on the Drug Fund.

NURSING AND MATERNITY SERVICES.

11. The Committee feels that general domiciliary nursing and maternity nursing should not be considered as two separate subjects.

Nurses to-day with very few exceptions have the necessary qualifications for both branches of their profession. Both should form an integral part of medical benefit.

Further reference to this matter is made in Chapter II. hereof.

The service would be relatively easy to organise, and the machinery for dealing with difficult maternity cases is already provided under the Midwives Act, 1918, at present administered by Local Authorities, and which could in respect of insured persons be transferred to the body responsible for the administration of Medical Benefit.

12. Remuneration of the General Nursing Service might be made in any of the following ways:—

Insured Population Basis.

Alternative (a)

In respect of each year to each Nursing Association an amount bearing the same proportion

to the total available fund for that year as the number of Insured Persons ascertained to be resident in the area or areas covered by each such Association bears to the aggregate of Insured Persons resident in the administrative area to whom Nursing Services under the Scheme are available.

Total Population Basis.

Alternative (b).

In respect of each year to each Nursing Association an amount bearing the same proportion to the total available fund of that year as the population (1921 census) of the area or areas covered by each such Association bears to the total population of the administrative area to which the Scheme, at the time, applies

Visits paid Basis.

Alternative (c).

Each Nursing Association within ten days of the close of each quarter to submit a statement of the number of visits paid by its Nurse or Nurses to Insured Persons within the area covered by such Nursing Association, and payment be made in respect of each year to each Association an amount bearing the same proportion to the total Fund for that year as the aggregate of the quarterly totals of visits paid by the Nurse or Nurses of each Association bears to the aggregate of visits paid to Insured Persons within the administrative area to whom Nursing Services under the Scheme are available.

Voluntary Income Basis.

Alternative (d).

In respect of each year to each Nursing Association an amount bearing the same proportion to the total available Fund for that year as the total of voluntary donations and subscriptions of each such Association bears to the aggregate of such donations and subscriptions of Associations within the area to which the Scheme, at the time, applies.

Total Expenditure Basis.

Alternative (e).

In respect of each year to each Nursing Association an amount bearing the same proportion to the total available Fund for that year as the expenditure of each Association bears to the aggregate expenditure of Associations within the area to which the scheme, at the time, applies; provided that in arriving at the amount of expenditure no account should be taken of grants made by any Nursing Association to any central organisation or to any other Nursing Association.

13. On the basis of the returns from the County and other Nursing Associations operating in the Committee's area at a flat rate of 6d. per visit, and 20/- per maternity case, the estimated cost of the provision of a Domiciliary Nursing Service would be as follows:—

	£
General nursing	1,000
Maternity nursing	13,000
	<hr/>
	£14,000

(See Chapter II., Para. 34).

HOSPITAL (EXTENDED IN-PATIENT) AND CONVALESCENT HOME TREATMENT.

14. The provision of hospital extended in-patient and convalescent home treatment is already available to insured persons in other ways out of voluntary contributions, and although it is recognised that this service is not by any means adequate to meet the needs of the population it is nevertheless felt that by

reason of the relief which would accrue to hospitals through the grants administered under Paragraph 5 hereof, further facilities would become available to meet this need.

In considering the question regard should of course be had to the services already provided out of public funds for hospital treatment in cases of certain specified diseases, i.e., infectious fevers, tuberculosis, &c., &c.

15. The cost to hospitals and convalescent homes of of the treatment of insured persons could be met by a series of grants in aid in respect of the individual cases treated, on the basis of services rendered.

It is again difficult in the absence of any precise data to form any reliable estimate of the cost of this extension of the service, and until such data are available it might be desirable as an experiment to place at the disposal of Insurance Committees a limited sum for administration as was the case with sanatorium benefit. After a few years' experience it would be found to what extent the amount available had met the need, and the necessary adjustment could then, if found practicable, be made.

OPTICAL TREATMENT AND APPLIANCES.

16. The Committee is of the opinion that the increasingly greater care exercised at the birth of children and the greater appreciation of the value of early medical treatment in all affections of the eyes have done much to reduce the urgency of the need for the provision generally of this treatment.

The number of applications received by the Committee during its administration have been relatively few in comparison with the applications for dental treatment, and the benefit of the school medical service has very largely contributed to satisfying this need.

It is known that a number of general practitioners are capable of rendering ophthalmic treatment, and payment could be made to such practitioners on the basis of services rendered, and a minimum range of optical appliances might be made available for insured persons.

For reasons similar to those indicated in connection with dental treatment the Committee is not in a position to submit an estimate of the probable cost of this extension.

ORDER OF PRIORITY.

17. Should it be found impracticable to give effect to the whole of the foregoing extensions at the same time, the Committee suggests that the order of priority should be that in which they are dealt with in this memorandum, except that (1) and (2) be taken together.

CHAPTER II.—THE EXTENSION OF MEDICAL BENEFIT AND A MATERNITY SERVICE TO THE DEPENDANTS OF INSURED PERSONS.

GENERAL CONSIDERATIONS.

18. On the general question of the desirability of extending Medical Benefit to the dependants of insured persons, the Committee desires to offer the following observation:—

The household should be the unit for medical service. It is unusual and ordinarily undesirable that more than one medical Practitioner should be in attendance on members of the same family. The family doctor should ordinarily be available for advice and treatment of a family from the cradle to the coffin.

It is recognised that the seeds of disease and disability are to a very large extent sown in the years prior to the age of insurability under the National Insurance Act.

A medical practitioner's knowledge of the childhood of an insured person should, and does generally, form a very reliable and valuable guide to his treatment of that person in adolescence and later life.

When the head of a household engages a baker or butcher to supply his needs, those needs are expressed in the terms of the family and not in the terms of the needs of the head of the family alone.

19. The present system which differentiates between the wage-earner and his responsibilities in the person of his wife and children fails in justification on the following grounds:—

- (i) That there is seldom if any provision made for the sickness of the members of his family; when that sickness does come it makes a call upon his meagre resources usually unexpected and unprovided for. Chemists must be paid and doctors, too, in time; the invalid may require special diet and additional comforts and nurses may have to be found. These all represent charges upon the wage-earner, for which in very many cases little or no provision has previously been made.
- (ii) Friendly Societies have to some extent attempted to deal with the problem through their private adult and juvenile sections, but it is well known that the system of separate Society bargaining with the medical profession has in many cases forced Friendly Societies to abandon the provision of medical treatment to their private members.
- (iii) The present limited method of meeting the needs of the dependants of insured persons through Friendly Societies has failed primarily because of the absence of a standardised, controlled and organised service.

Under Poor Law Administration the family is recognised as the unit for relief and otherwise.

DEPENDENT WIDOWS AND ORPHANS.

20. Many widows and orphans dependent upon pensions, annuities, or supported by voluntary or other charitable organisations, although not technically dependent upon insured persons, would, had their husbands or fathers lived, have been the dependants of insured persons. In many thousands of cases their widowhood and orphanhood arises through the War, and it would be only just and right that they should look to the State to act as husband and father, and be included in any Scheme for the extension of Medical Benefit to the dependants of insured persons.

GENERAL RECOMMENDATION.

21. The Committee holds that medical benefit should be extended to the dependants of insured persons, their widows and orphans, and in so far as the present content of Medical Benefit is extended to include the additional services mentioned in Chapter I, they likewise should be available, and is further of the opinion that in any Scheme of extension proposing to include the dependants of insured persons it is desirable that maternity

service should be included whether the other extensions referred to be included or not.

22. The provision under a National Scheme of Medical Benefit for the dependants of insured persons cannot in any sense be termed a charitable action on the part of the nation as a whole, and exception is taken to the allegation made already in the evidence that the people in this country are not in a position to provide Medical Benefit for their dependants.

Medical Benefit would be provided for the dependants of insured persons by the contributions of the insured persons, and it is not suggested herein that any other method of raising the necessary sums for the benefit or its administration should be adopted.

Already in connection with many collieries and works in different parts of the country a medical service for the man and his family is provided and maintained by weekly deductions from the men's wages irrespective of whether they are married or not; in these cases the Works' Service and contribution would cease if a service under the Insurance Acts was provided; this would provide a better and more complete service without any extra burden on the worker; while in other instances the dependants of insured persons would be provided for by a weekly contribution in place of the present arrangement which often burdens the man with big doctor's bills.

The Committee do realise, however, that very few insured persons are in a position, if suddenly called upon, to find relatively large sums to pay doctors and chemists when illness falls upon the household, and that it is the right and proper thing that a nationally controlled and safeguarded system of weekly payments is the only satisfactory manner in which these services can be provided and the health of the nation secured.

It should not be forgotten that it is not only the health and welfare of the individual which is at stake, but also the general health and prosperity and progress of the race.

The voluntary system has failed in this case as it failed in the case of the worker, and it is for the nation to secure by a system similar to that applied in the case of the worker that the future workers shall be cared for when medical care and nursing is requisite.

23. As such a service would not involve any question of reserve values or require the building up of balances to meet future contingencies, no very serious difficulty should be experienced in arriving at the cost of the extension of Medical Benefit to dependants of insured persons for the whole country.

THE ESTIMATED NUMBER OF DEPENDANTS OF INSURED PERSONS, WIDOWS AND ORPHANS.

24. The following statement, based on information extracted from the Census Returns, 1921, County Series, County of Chester, and the Annual Report of Dr. Meredith Young, Medical Officer of Health for the County of Chester, and from other sources, shows the approximate number of dependants of insured persons resident in the County of Chester with its associated County Boroughs:—

STATEMENT "A."

An Estimate of the Number of Dependants, including Widows and Orphans where dependant, of Insured Persons resident in the County of Chester (and for convenience of calculation with Associated County Boroughs) at the 1st January, 1925.

(Marginal notes refer to Returns, Reports, &c., from which data has been abstracted.)

Ref.	Population of County including associated County Boroughs of—										
Census 1921.	Birkenhead	} 1,025,724
County of	Chester	...	...	...	...	...	...	...	...	...
Chester.	Stockport	...	...	...	...	...	...	...	...	...
	Wallasey	...	...	...	...	...	...	...	...	...
County Medical Officer of Health.	Estimated Increase for 3½ years (2.60 per cent.) to 1st January, 1925										26,265
	(a) Estimated Population in round figures at 1st January, 1925										1,052,000

Insurance Committee's Returns.	Number of Insured Persons as shown by Count of Registers to be resident in the Area :—									
	County (Administrative) 243,736									
	County Boroughs of—									
	Birkenhead 54,617									
	Chester 15,995									
	Stockport... .. 56,080									
Wallasey 26,584										
<hr/>										
Royal Comm. Evidence. Para. 2090.	Less Estimated Inflation 7 per cent. 397,012									
<hr/>										
Net Total Insured Persons 27,791										
<hr/>										
(b) or in round figures, or 35% of total Population 369,221										
<hr/>										
Census. Chester County. Table 18, p. 82.	Occupied Persons :—									
	Employees :—									
	Males 295,561									
	Females 138,110									
	<hr/>									
	433,671									
	Employers :—									
	Males 18,662									
	Females 2,414									
	<hr/>									
	21,076									
	Workers on own account :—									
Males 17,720										
Females 9,347										
<hr/>										
27,067										
Table 16 (p. 58). Table 18 (p. 82).	Total Occupied Persons 481,814									
	Retired Unoccupied :—									
	Males 10,362									
	Females 1,866									
	<hr/>									
	12,228									
Less 50 per cent. estimated as not being self-supporting 6,114										
<hr/>										
6,114										
Total Occupied and Independent Retired Persons as 1921 Census 487,928										
Add estimated natural increase to 1st January, 1925, on basis of increase in population. 12,400										
<hr/>										
(c)	Estimated total Occupied and Independent Retired Persons at 1st January, 1925, in round figures. 500,000									
<hr/>										
Distributed as follows :—										
Insured Persons 370,000										
Uninsured Persons 130,000										
<hr/>										
Total Unoccupied and Dependent :—										
Total Estimated Population as shown at (a) 1,052,000										
Less Occupied, &c., as shown at (c) 500,000										
<hr/>										
552,000										
(d)	Total Unoccupied and Dependent 552,000									
<hr/>										
Distribution of Dependants between Insured Persons and Uninsured Persons :—										
(e)	Insured = $\frac{370,000}{552,000}$ of 552,000 = 408,480									
(f)	Uninsured = $\frac{130,000}{552,000}$ of 552,000 = 143,520									
Expressed as a ratio =										
(g)	Insured Persons' Dependants are to Insured Persons as 1.1 is to 1.									

SUMMARY.

(h)	Total Insured	... ..	370,000
(i)	Total Insured Dependants (say)	... ..	410,000
(j)	Total Affected by Extension of Scheme (say)	... ..	780,000
= 73 per cent. of total population			

NOTE.—The proportion of insured persons to the total population in Cheshire is 35 per cent., being 2 per cent. higher than the proportion in the country generally, and probably this will to some extent account for the fact that the ratio of dependants is less than that generally put forward by other witnesses in this connection.

ESTIMATE OF SCHOOL CHILDREN.

25. The following further statement gives an estimate of the number of children of age 14 or under, dependent on insured persons resident in the like area, attending educational institutions :—

STATEMENT "B."

An Estimate of the number of Children of age 14 or under, dependent on Insured Persons resident in the like area, attending Educational Institutions.

Census, 1921. Table 15, p. 57.	Children attending Educational Institutions. Number up to 14 years of age. Whole Time... .. 163,296									
	Add estimated increase (2.6 per cent.) to 1st January, 1925 4,245									
<hr/>										
Estimated Total in round figures 168,000										
Proportion in same ratio as shown in Statement A. Dependent on Insured Persons :—										
(k)	Insured	$\frac{370,000}{552,000}$ of 168,000 =	... ..	124,690					
(l)	Uninsured	$\frac{130,000}{552,000}$ of 168,000 =	... ..	43,810					
(m)	Total Insured Persons, children of age 14 or under =	... ..	... ..	124,690					

ESTIMATE OF INFANTS.

26. The following statement "C" shows the

number of infants who may be deemed to be beneficiaries under Maternity and Child Welfare Schemes:—

STATEMENT "C."

An Estimate of the number of Infants under one year of age, dependent on Insured persons resident in the like area.

Census, 1921.	Total number of Infants under one year of age	...	...	...	...	20,127
County of	Proportion in same ratio as shown in Statement "A":—					
Cheshire.	(n) Insured $\frac{11,888}{20,000}$ of 20,000 =	...	...	...	...	14,800
Table 13, p. 50.	(o) Uninsured $\frac{8,112}{20,000}$ of 20,000 =	...	...	...	...	52,000
	(p) Total Insured Persons' infants under one year of age =	...	...	...	...	14,800
	Or in round figures	...	...	...	...	15,000

ESTIMATED NUMBER OF BIRTHS.

27. It is estimated that the number of births

occurring in the like area for the year ended 31st December, 1924, allocable to insured persons is as follows:—

STATEMENT "D."

An Estimate of the Number of Births occurring in the like area for the year ended 31st December, 1924, and showing the allocation to Insured and Uninsured Persons.

Estimated Births for the year 1924 in the Administrative County based on figures submitted by the County Medical Officer of Health—approximately	...	...	...	...	11,000
(Representing a rate of 17·15 per 1,000 of estimated population.)					
Add estimated births for Cheshire County Boroughs at same rate per 1,000—approximately					7,000
Total estimated births	...	...	...	...	18,000
Proportion in ratio as above to insured persons:—					
(q) Insured $\frac{13,320}{18,000}$ of 18,000 =	...	...	...	...	13,320
(r) Uninsured $\frac{4,680}{18,000}$ of 18,000 =	...	...	...	...	4,680
(s) Births allocable to insured persons in round figures	...	...	...	...	13,500

AVAILABLE PUBLIC SERVICES AND THEIR VALUE.

28. Having determined, approximately, on the data available, the number of dependants of insured persons who would be brought into the Scheme for the extension of Medical Benefit, the next consideration is as to its cost, and in attempting to estimate in this connection, regard in the first place must be had to the services which are at present available to the dependants of insured persons from Public sources.

Perhaps the most important of such services are those made available under—

- (a) Medical Inspection of School Children.
- (b) Maternity and Child Welfare Schemes.

In connection with the former the Act of 1921 makes it compulsory upon Education Authorities to provide for the inspection and treatment, where necessary, of all children attending elementary and higher elementary educational institutions.

In the latter, Maternity and Child Welfare Centres with advice and treatment, are available to all upon application, irrespective of status.

29. Some idea of the extent of these services may be formed from the amount of expenditure which is involved in the administrative County of Chester, with an estimated population of 640,000, excluding the County Boroughs.

The estimated expenditure from 1st April, 1924, to 31st March, 1925, as shown by the County Council "Budget" for these services is as follows:—

School Medical Service	...	£10,875
Maternity and Child Welfare	...	£14,190
		<u>£25,065.</u>

and the County Scheme in this connection does not include all the Schemes of Maternity and Child Welfare.

Further, for the provision of the services under the Mental Deficiency Act; Venereal Diseases; Blind Persons Act; Isolation Hospitals Act; Children's Act, 1908; Public Vaccinators; Defective Children; Deaf, Blind and Epileptic; an expenditure of approximately £20,000 is estimated for the same period.

For Tuberculosis alone it is estimated that an expenditure of £40,000 will be incurred, although this

latter service may perhaps not have so great a bearing on the cost of treatment of dependants of insured persons as would those services previously enumerated.

30. A further indication of the extent to which the public services at present supply the needs of the community in this connection may be gauged by the following details taken from the Report of the Medical Officer of Health for the County of Chester for the year 1923:—

MATERNITY AND CHILD WELFARE.

Visits paid by lady assistant Medical Officer of Health Visitors during 1923:—

First Visits to infants under one year	...	6,742
Revisits to children under one year,		
Ophthalmia	...	35,575
Revisits to children over one year	...	40,655
Still Birth and Death enquiries	...	648
Visits to Midwives	...	881
Visits to expectant mothers	...	1,372
		<u>85,873</u>

In addition approximately 30,000 attendances were made at Maternity and Child Welfare Centres. 362 Midwives notified their intention to practise in the County area during the year 1923, a number corresponding closely with the number of medical practitioners included in the Cheshire Medical List.

AN ESTIMATE OF A CAPITATION FEE FOR PRACTITIONERS, &c.

31. The present payment *per capita per annum* in respect of insured persons is 9s. to the Insurance Practitioner, but this fee covers the issue of medical certificates for the purposes of sickness and disablement benefit, &c., &c.

It is estimated that the number of certificates issued to the twelve-and-a-half millions insured persons in England is approximately twenty millions annually, or eight to every five persons. At only 2d. each the saving of this obligation to dependants would amount to over 3d. in the capitation fee.

Allowing for this consideration alone it might be contended that a capitation fee of 8s. 9d. would be a fair remuneration for the dependants of insured persons other than school children, to whom the provisions of Part VII. of the Education Act, 1921, and Maternity and Child Welfare Schemes apply.

32. In addition, having regard to the foregoing provisions affecting children and infants, it is very necessary in attempting to arrive at the cost of the Medical Benefit of such to have some regard to the extent by which such publicly-provided services as indicated above would either be relieved by the Scheme or alternatively relieve the Scheme of certain costs, and it would therefore appear reasonable that a considerably lower capitation fee might be deemed equitable in respect of infants and children up to fourteen attending educational Institutions.

On the basis of Statement "B" as to the number of children attending Educational Institutions, i.e., 125,000, and of Statement "C" as to the number of infants under one year of age, i.e., 15,000, a total is disclosed of persons who benefit directly by such public services of, say, 140,000 persons.

Assuming that the costs of the School Medical Service and Maternity and Child Welfare Schemes are in similar proportion in the Cheshire County Boroughs, it may be estimated that the total annual cost of these services for the whole county is as follows:—

	£
School Medical Service	18,000
Maternity and Child Welfare	24,000
Total	£42,000

Assessing such services and the value of the consequent relief of work to the Practitioner at one-half of the cost of Medical Inspection and one-third of the cost of Maternity and Child Welfare Schemes, a total sum of approximately £17,000 is shown, equal to a capitation rate of 2s. 5d. Thus it is shown that capitation rates as follows would appear to represent, in comparison with the rate for insured persons fair remuneration for Practitioners, viz.:—

	Per Annum.
	s. d.
Dependants (other than School Children)	
and Infants	8 9
School Children and Infants	6 4

COST OF DRUGS, ETC.

There are no special considerations which would vary the cost of Medicines under this Scheme, and 2s. may be concluded to represent a fair maximum capitation rate upon which to assess this cost.

ESTIMATED COST OF MEDICAL BENEFIT.

33. The following is an estimate of the cost of the extension of Medical Benefit (present content) to the Dependants of Insured Persons, having taken into account the foregoing considerations, viz.:—

Estimated Annual Cost of Extension of Medical Benefit (present content) to the Dependants. Widows and Orphans of Insured Persons in the County of Cheshire (with, for convenience of calculation, the Associated County Boroughs).

Total Estimated Dependants as shown at	
(i) in Statement "A" hereof	410,000
i.e.—	
Dependants, &c. (other than School Children and Infants)	270,000
School Children and Infants	140,000
Capitation Fees to Insurance Practitioners:—	
s. d.	£
270,000 x 8 9 = (say)	119,000
140,000 x 6 4 = (say)	45,000
Payments for Drugs and Appliances:—	
410,000 x 2 0 =	41,000
Administration 1s. per insured person (say)	21,000
Estimated Annual Total Cost for County of Chester	£226,000

Or an additional contribution by 370,000 Insured Persons of £226,000—

Per head per annum of 12s. 2½d.
Per week of 2½d.

ESTIMATED COST OF MATERNITY SERVICE.

34. In determining the cost of Maternity Service on the basis of a treatment benefit and taking into account the services in this connection receivable under Maternity and Child Welfare Schemes, which may be assessed at one-sixth of the cost to the public funds of such Schemes, viz., £3,500, it may be taken that the following statement presents a reasonable estimate in connection with this service:—

An Estimate of the Annual Cost of a Maternity Service for Insured Persons and their Dependants for the County of Chester including the County Boroughs.

Number of Births as shown in (s) of Statement "D" hereof	13,500
	£
Fees of Midwives and Practitioners—	
Midwives, at £1 per case	15,000
Practitioners, at £2 per case }	15,000
Add special fees for unusual cases, 10 per cent.	1,500
Total	£16,500
Less Value of services of Maternity and Child Welfare Schemes	3,500
Estimated Annual Net Cost for County of Chester	13,000

Or an additional contribution by 370,000 Insured Persons of £13,000.

Per head per annum of 5½d.
Per week of (say) one-eighth of a penny.

SOURCE OF INCOME.

35. The estimated additional contribution required per insured person to meet the cost of a Maternity Service and of Medical and Maternity Services of Dependants of insured persons would therefore be—

Per annum, 12s. 8½d.,

Or in round figures 3d. per week,

which the Committee recommend should be contributed as to ¾ths. by the Insured Person and as to ¼ths. by the State.

CHAPTER III.

ADMINISTRATION OF THE SERVICE.

Wherein it is contended that the present form of administration by Insurance Committees should in the main be continued and extended on similar lines, and envisaging the potentialities lying within the administrative machinery of Insurance Committees to administer the extensions referred to herein.

CONSTITUTION AND CAPABILITIES OF COMMITTEES.

36. The composition, duties and experience of the Insurance Committee is shown, and its usefulness and capacity demonstrated by the evidence submitted in Section A of this Statement.

It is clear that the Insurance Committee is capable of administering benefits to the insured community in general on a basis of common right as exemplified in its administration of medical benefit, and of administering selected benefits on recommendation after consideration of specific cases, as shown in its administration of sanatorium benefit.

COMPARISON WITH OTHER PUBLIC BODIES.

37. The composition of Insurance Committees differs from the composition of some other public bodies inasmuch as it directly represents (or at any rate the Act of 1911 pre-supposed that such would be the case) and includes in its membership the beneficiaries under the Scheme.

This cannot be said of the Poor Law Guardians, for the receipt of Poor Law Relief is in itself a disqualification for the office of guardian.

In the case of County Councils, Municipal, Urban and Rural District Councils, the benefits are primarily communal as distinct from individual, so that the same need of personal touch with the body of constituents is not so essential.

This feature of Insurance Committees which is so important and vital a factor in dealing with large masses individually, where thousands of persons are daily brought into touch with the Committee and its Officers, should be very carefully safeguarded.

There is a tendency at the present time for this to be lost.

MODIFICATION IN ELECTION OF REPRESENTATIVES OF INSURANCE COMMITTEES.

38. It is important that Insurance Committees should truly represent the interests of the persons for the administration of whose benefits they have been appointed.

It might not be without profit to consider a proposal whereby in every County and County Borough area elections should take place for the representatives of insured persons by direct appeal to the beneficiaries. Members of the Committee could be appointed for a period corresponding with the period of valuation, viz., five years.

Elections could be carried out by a postal vote, nomination papers and voting papers being sent to a local centre under the control of a local Returning Officer. It is conceivable that were such a method adopted, insured persons themselves would take a much greater interest in Health Insurance which would undoubtedly be to the greater benefit of the Scheme.

39. The proportion of insured persons' representatives upon the Committee should be increased, and if it were found necessary to reduce any section of the Committee it would appear that the section having least interest in the Scheme are representatives of the County and County Borough Councils.

It is understood that representation to such bodies was originally given primarily, so that these new Committees should have the advantage of the experience and knowledge of members who were versed in Public Administration. This need has practically disappeared.

These modifications of the present constitution, it is thought, would add strength to Insurance Committees, make them more truly representative of the interests which they have been appointed to administer, and give a greater power of control by the beneficiaries.

It would further awaken a greater interest amongst the insured, and generally enable the opinions of insured persons more truly to be expressed.

SUITABILITY OF INSURANCE COMMITTEE TO ADMINISTER EXTENDED BENEFITS.

40. In considering the question whether the machinery of Insurance Committees as modified above would be suitable for the administration of the extensions of Medical Benefit suggested herein, it may be desirable in the first instance to form an estimate of the work which would be involved.

Of the foregoing extensions many could be administered in the same manner as medical benefit is at present administered, i.e., on the basis of the right of the insured persons to such benefits without question.

Certain sections of Specialist and Consultant Services, provision of dentures and optical appliances and the more expensive of specialist medical and

surgical appliances, and of Hospital and Convalescent Home (extended) treatment, should only be available to insured persons after consideration by and on the specific recommendation of the Insurance Committee of the area.

The action of the Insurance Committee would, to a very large extent, be determined on the advice of its medical and specialist advisers who would be required to be retained in a part-time advisory capacity by the Committee for that purpose, although a considerable amount of the advice which Committees would need could be made available through the Divisional and Regional Medical Officers.

41. The ideal of such an administration should be the maximum of central financial control with the minimum of interference with local autonomy. Such an administration would ensure absolute control over Insurance Funds, which would not appear to be the case at present, in view of the almost unlimited power which Approved Societies have to make grants under Section 28 (Section 21, Old Act) to Hospitals, &c.

It is known that this power is being exercised in a way not contemplated at the time it was originally granted.

When it is remembered that approximately twelve million insured persons are affected by additional benefits available out of valuation surpluses it does appear that the matter calls for some system which shall secure uniformity of administration of the benefits available.

42. The very close connection between domiciliary medical treatment and the above named extensions would appear to justify the contention that administration of these benefits should be under the control of the same body; and this view was evidently held by Parliament when the 1911 Act was passed which by Section 14 (1) provided that "where such (additional) benefits are in the nature of medical benefit . . . they shall be administered by and through the Insurance Committees."

43. The Committee therefore contends that the Insurance Committee as modified in the manner suggested herein would by constitution and experience form the most suitable instrument of administration of such an extended Scheme, inasmuch as such Committee so constituted and so empowered would direct its efforts solely to the administration of the medical and allied benefits of insured persons and their dependants, having no other purpose or objective.

44. County or County Borough Councils, whether directly or through their Public Health Committees or through a Committee constituted on the lines of the present Education Committees, would be unsuitable administrative instruments, on the grounds that it is held that the benefits of insured persons and their dependants should be administered by their duly appointed representatives, and that the action of such representatives should not be subject to the veto of County or County Borough Councils, who, as such, contribute at present nothing towards the cost of the benefits administered.

45. The Committee considers that, with over 8,000 separate Administrative Units, Approved Societies, of which for example 546 have members in the Committee's area, and whose rules of membership and conditions of admission and expulsion vary, and where control by the members in the larger Societies has up to the present been practically a dead letter, are not the instruments for the administration of a uniform system such as is contemplated in this memorandum.

46. The Committee looks with no favour on the creation of a new *ad hoc* authority charged with the administration of all matters affecting health. It considers that the cost, confusion, redistribution of duties and general upheaval is not warranted at the present time, nor is it in the Committee's opinion at present necessary or desirable.

NATIONAL MEDICAL SERVICE

47. On this point the Committee considers that it would perhaps not be out of place to make reference

to proposals which have been submitted, having as their object the establishment of a National Medical Service:—

In attempting to apply such a Scheme to the County of Cheshire one is confronted with the following difficulties which are almost insuperable:—

- (1) In a very large number of districts the population who would come under the Scheme would be proportionately to the whole population of that district so large as to make it economically impossible for any other Practitioner to practise in the district, with the result that the residue of the population in that particular district would be without any medical service of any kind. The National Medical Practitioner would be precluded as a whole-time officer from engaging in private practice.
- (2) In sparsely populated rural areas the numbers of insured persons would be so small as not to warrant the employment of a whole-time medical officer.
- (3) Choice of doctor would practically be abolished and this would without doubt have a very bad psychological effect upon the beneficiaries.

The relationship between a Practitioner and his patient is of such a nature that unless the most perfect and uninterrupted, non-compulsory, entirely voluntary conditions obtain, both on the part of the patient and the Practitioner the treatment must lose to a very large extent its efficacy.

Under a whole-time National Medical Service the beneficiaries would be compelled to obtain treatment without the choice of a particular doctor. The result would be that many would be forced to obtain treatment from some Practitioner in whom they had little or no faith.

This would strike at the very root of successful medical service. Unless beneficiaries were actually allocated to particular Practitioners, the probability is that the clever and painstaking Practitioner would be overburdened whereas his less capable colleague would have nothing to do, and yet probably both Practitioners would be drawing the same salary as a state medical officer.

MACHINERY OF INSURANCE COMMITTEES.

48. The present office machinery of Insurance Committees is readily adaptable for carrying the additional burdens suggested.

The Committee itself has for twelve years been closely associated with the personnel of the service.

The additional personnel of Dentists, Midwives, Nurses and Hospital Staffs are already closely related to the personnel with which the Committee is at present associated.

49. The regulations governing the service of Insurance Practitioners; the Schemes for the distribution of Funds; the payments of services rendered by specialists, nurses and midwives; pricing and payment of appliances in connection with dental, optical and surgical treatment; the assessing of grants to Hospitals; the arrangements for admission and discharge and conveyance and otherwise in connection with patients to Convalescent Homes or Hospitals; in fact, the whole of the detailed work in connection with such an extended Scheme, presents no feature which has not at one time or another formed a part of the administration of Insurance Committees. Its system of registration is easily capable of extension to include the dependants of insured persons.

GENERAL CONCLUSION AND RECOMMENDATION.

50. The opinion is held, and supported generally throughout the country and by all those connected

with National Health Insurance, that Insurance Committees have efficiently and economically carried out their duties, and it may be reasonably anticipated that such would be the case were those duties and responsibilities increased.

This Committee feels that to scrap the machinery of Insurance Committees or to make it a subsidiary part of a greater machine would be disastrous to insured persons.

The Insurance Committee for the County Palatine of Chester therefore holds that it has justified its existence, and now contends for a continuance and enlargement of its duties and responsibilities, feeling that it is without question the most suitable instrument for the administration of medical and all allied treatment benefits.

CO-ORDINATION OF HEALTH SERVICES.

51. The Committee is prepared to advocate a Scheme of full co-ordination of the various statutory and voluntary Health Services operating in its area, provided that in the main the present units of administration were continued.

If desired by the Commission the Committee is prepared to submit the benefit of an exhaustive investigation of the matter which it carried out in 1920 and further developed in 1924.

SECTION C.—AS TO THE APPLICATION TO A COUNTY AREA OF AN ATTENDANCE SYSTEM OF REMUNERATING INSURANCE PRACTITIONERS.

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GENERAL OBSERVATIONS.

1. The variations in the conditions of practice in a large County area where in many districts difficulties of access arise, not only between Practitioners and their patients but also between Insurance Practitioners and the County Panel Committees and the Insurance Committee, represent briefly the obstacles which would be encountered in attempting to determine the practicability of the application of an Attendance System of Remunerating Insurance Practitioners to a County area.

2. Of these, the two main difficulties resolve themselves into the following concrete forms:—

- (a) An assessment of the value of the service and a determination of the available funds in respect of the different types of districts representing varying conditions of practice, and
- (b) The setting up of a system of medical record keeping which will secure to the insured person the benefit of the continuous record of his treatment.

3. In attempting to resolve these difficulties, the Committee, much as it desires to avoid unduly burdening this section of its memorandum of evidence, feels that the Commission should be made acquainted of the inherent differences of the respective systems and for this purpose it will be necessary to review the procedure at present being carried out in Cheshire on a Capitation basis and in Manchester and Salford representing the two areas in which practical experience of the Attendance System is obtainable.

Much of the data submitted herein was obtained during the Committee's investigation of the matter in 1923, and is abstracted from a Report of a Special Sub-Committee which was appointed for the purpose.

4. It will be seen therefrom that to a very large extent the difficulties with respect to the distribution of the various funds available to practitioners could be met with satisfaction to the participants.

5. With reference to the keeping of medical records centrally, it is recognised that to a certain extent Practitioners are debarred from the benefit of the knowledge of the previous medical history of new patients, but this could probably be overcome by an arrangement whereby the records of insured persons treated for the first time in any quarter should be transmitted to the Practitioner for his information.

This would, of course, not apply to old patients, inasmuch as the Day Sheets could be made to show the necessary clinical notes and medical history at the time treatment was accorded.

ADVANTAGES OF THE ATTENDANCE SYSTEM.

6. At the time the matter was under consideration by the Committee the insured persons under the Capitation System were required to give notice of intention to change their doctors before the 1st June or 1st December in each year, i.e., the opportunity of change was restricted to twice a year, and then subject to notice according to the prescribed procedure.

To-day this disadvantage of the Capitation System has been removed, and insured persons have the power to change their doctor at any time.

7. Another consideration which at the time inclined the Committee to the Attendance System was that it secured payment for services rendered as distinct from payment for responsibility accepted, and the third advantage, which the Committee considered the most important, was that the remuneration for treatment of insured persons more closely approximated to the system of payment in private practice, and that as a Practitioner would not be paid except for services rendered, he might be inclined more readily to render that service being aware that unless he did, no payment would accrue to him.

This approximation to the conditions of private practice would no doubt have a considerable effect in removing the impression which still remains amongst a section of insured persons that Practitioners are paid capitation fees irrespective of the services which they may be called upon to render.

8. It is possible that in effect the Attendance System of remunerating Practitioners would not in the aggregate materially affect the remuneration of individual Practitioners in the County, but on the basis of the foregoing conclusions it might be that a better spirit, arising out of the establishment of a clearer understanding on the part of insured persons that for every service the Practitioner performed a specific fee would be attached, might ensue amongst

insured persons, for whose contentment and satisfaction with the service, above all, the Insurance Committee is primarily responsible.

DISADVANTAGES.

9. The disadvantages of the system have no doubt been felt in Manchester and Salford, and steps have been taken to remove them.

The difficult question of over-attendance is one which has required the creation of a somewhat elaborate machinery to overcome. This would, of course, be accentuated in a County area where many more variations of conditions of practice—factors would require to be taken into account, i.e., incidence of disease, length of treatment required, availability of Hospital and other facilities, etc., etc.

10. The question of Drug Supply, already found to present difficulties under the Attendance System, would in a County area be further complicated by the necessity of certain Practitioners dispensing for their patients.

As stated in the reference to this section in the preface to this Memorandum, the Committee does not now desire to submit any expression of opinion as to the relative merits of the two systems.

CHAPTER I.—THE PRESENT SCHEME, &c.

POWERS UNDER THE REGULATIONS.

11. Article 23 of the Medical Benefit Consolidated Regulations, 1924, provides as follows:—

"The Committee and Panel Committee shall jointly prepare a Scheme in accordance with the provisions contained in Part II of the First Schedule to these Regulations, and the provisions of these Regulations with regard to the joint preparation, or, in default of agreement, to the determination by the Minister, of the Allocation Scheme and to its approval by the Minister, method of amendment, and incorporation in the terms of service for Practitioners, shall apply in all respects to any scheme to be made under this Article."

12. Part II of the First Schedule to the Regulations provides, *inter alia*:—

- (a) Any one of the following methods of remuneration may be adopted in the Scheme relating to the remuneration of Insurance Practitioners.
- (b) A Capitation System, that is to say, payment by reference to the number of insured persons included in the Practitioner's list.
- (c) An Attendance System, that is to say, payment by reference to the attendances given and services rendered by a Practitioner to insured persons.
- (d) A Combined System, that is to say, payment by Capitation except in respect of special classes of service for which payment is made by reference to the services actually rendered.
- (e) Such other combination or modification of the above-mentioned Systems, or any of them, as the Minister may approve.

13. The Scheme provides for the following matters, *inter alia*:—

- (a) Payment to Practitioners in respect of the supply of drugs and appliances.
- (b) Payment in respect of Mileage.

14. The Regulations referred to in Article 23 with regard to the joint preparation, &c., of the Allocation Scheme, and which, by Article 23 are applicable *mutatis mutandis* to the Scheme of Distribution (System of Remuneration) provide as follows:—

Art. 15—(5) In the event of the Committee and Panel Committee failing to agree on any provision of the Allocation Scheme, the matter shall be referred to the Minister, whose determination shall be final.

Art. 15—(6) The provisions of the Allocation Scheme shall be subject to the approval of the Minister, and, if so approved, shall be incorporated in and form part of the Terms of Service of Insurance Practitioners.

Art. 15—(7) Subject to the approval of the Minister, the Allocation Scheme may from time to time be amended jointly by the Committee and Panel Committee, or in default of agreement between the two Committees, by the Minister, and the provisions of the Scheme for the time being in force shall form part of the Terms of Service for Practitioners.

Art. 15—(8) If the Committee and the Panel Committee fail to submit an Allocation Scheme to the Minister within a reasonable time, the Minister may determine a Scheme and such Scheme shall have effect within the area of the Committee, as though it had been agreed by the Committee and the Panel Committee and approved by the Minister.

SCHEMES ADOPTED BY THE COMMITTEE.

15. At a General Meeting of the Insurance Committee held 21st January, 1920, a Scheme of Remuneration of Insurance Practitioners on the Capitation Basis prepared jointly by the Committee and the Panel Committee and approved by the Minister of Health, was adopted, and has remained in force, with slight modifications to date.

This Scheme also provides for the payment on a Capitation Basis to Insurance Practitioners of fees due to them in respect of Dispensing Patients.

16. A Scheme prepared jointly by the Committee and the Panel Committee for the distribution on a Unit-Capitation basis of the Mileage Fund (Ordinary Portion and Reserved Portion) was adopted by the Insurance Committee at a Meeting held 19th January, 1921, and has remained in force with slight modification to date.

17. STATISTICAL INFORMATION RELATIVE TO THE DISTRIBUTION OF THE FUNDS FOR THE FIVE YEARS, 1920 TO 1924.

Heading.	1920.	1921.	1922.	1923.	1924.
(a) Number of Insured Persons resident in area	244,778	249,509	245,194	245,503	244,710
(b) Number included in Practitioners' Lists ...	218,879	225,626	227,590	226,432	230,602
(c) Amount distributed in Capitation Fees ...	£118,733	£124,619	£108,326	£106,462	£103,004
(d) Rate of Capitation Fee per Insured Person on Practitioners' Lists ...	10s. 10·2d.	11s. 0·2d.	9s. 6·2d.	9s. 4·9d.	8s. 11·2d.
(e) Total distributed on Capitation Basis for Dispensing ...	£3,247	£3,261	£3,283	£3,261	£3,142
(f) Number of Dispensing Patients ...	32,468	32,610	32,828	32,606	31,421
(g) Average fee per Dispensing Patient ...	2s.	2s.	2s.	2s.	2s.
(h) Amount of Ordinary Mileage Fund ...	£3,953	£3,200	£3,200	£3,003	£3,127
(i) Number of Insured Persons to whom Ordinary Mileage is Applicable ...	20,387	21,006	21,363	22,020	22,307
(j) Amount of Special Mileage Fund ...	£380	£322	£322	£322	£376

CHAPTER II.—A COMPARISON OF THE ADMINISTRATION OF THE CAPITATION SYSTEM AND THE ATTENDANCE SYSTEM AS IN OPERATION IN MANCHESTER AND SALFORD.

TERMS OF SERVICE.

18. The Terms of Service in Cheshire, Manchester and Salford are substantially the same, except in the following instances: Whereas under the Capitation System an Insurance Practitioner is supplied with a list of insured persons for whose treatment he is responsible, no such list is in existence in Attendance System areas, and consequently references to such list in the Terms of Service do not apply in Manchester and Salford.

19. The Allocation Scheme made under Article 15 and the Scheme of Remuneration made under Article 23 of the Medical Benefit Consolidated Regulations, 1924, form part of the Terms of Service, and it is in these two schemes that the main differences between Capitation and Attendance Systems arise.

ACCEPTANCE OF INSURED PERSONS.

Procedure in Cheshire.

20. Each insured person is provided with a medical card, which he is not compelled to present to an Insurance Practitioner unless requiring treatment. If he desires to be accepted by an Insurance Practitioner, he presents his medical card to the Doctor of his choice, who, if he be willing, signs and transmits the medical card to the Committee. The insured person is included in the Doctor's List as from the commencement of the quarter succeeding the date of acceptance, the medical card is returned to the insured person, and the insured person remains upon

the Doctor's list until he is removed in any of the following ways:—

- By removal out of the area of the Doctor's Practice, and acceptance by a Doctor in his new area of residence.
- By making application any time by presenting his medical card to another Practitioner for acceptance by that Practitioner. (Change of Doctor).
- At request of the Insurance Practitioner.
- By being accepted by or assigned to another Practitioner owing to the death, withdrawal or removal from the Medical List of the Insurance Practitioner in whose list he was included.

Procedure in Manchester and Salford.

21. Each insured person is provided with a medical card, which differs from that used in Cheshire in that provision is made therein for the holder to be accepted from time to time by any Practitioner, should the insured person wish to change. The medical card may be taken at any time to an Insurance Practitioner, who will sign it or not, in accordance with his desire to accept or otherwise the insured person. If he accepts the insured person, he signs the card and hands it back forthwith to the insured person. No record is made of this acceptance, but if at the same time the insured person requires treatment, or subsequently requires treatment, particulars of the insured person, i.e., name, address, Society particulars, age, sex, etc., and details of any treatment given are entered by the Doctor on a "Day Sheet." If, after the first visit, the insured person is not satisfied with his treatment, even if it be on the same day, he is entitled to go to another Practitioner, have his card signed a second time, and thereupon become entitled to obtain treatment from that Practitioner.

Free Choice.

22. Under the Cheshire, Manchester and Salford System, the Insured Person has free choice of Doctor and the Doctor free choice of patient, except in so far as the Allocation Scheme may require in any instance where an insured person has been refused acceptance that the Allocation Committee shall assign him to such Practitioner as it thinks fit.

REMUNERATION OF PRACTITIONERS.

Cheshire Procedure.

23. Every acceptance of an insured person by an insurance practitioner is notified to the Committee by the transmission of the medical card duly signed by the practitioner to the Committee, and the person so accepted is included in the practitioners list.

Removals out of the area, suspensions, deaths, etc., of insured persons included in such lists are from time to time notified to the Practitioner by the Committee, and his quarterly lists adjusted accordingly. The net figure at the commencement of any quarter is the "Practitioner's List" for that quarter.

24. Distribution of the Practitioners' Fund for the area amongst Practitioners is made in proportion as the number of insured persons included in each Doctor's list bears to the aggregate of insured persons on all Doctors' lists in the area, e.g. :—

Dr. A. B. at the 1st January, 1922 had upon his list 1,850 insured persons.

The total number of insured persons on all Doctors' Lists at that date was 228,078.

The total sum available out of the Practitioners' Fund for the area for that quarter was £27,074 3s.

The share to which Dr. A. B. is entitled is represented by the following fraction;

$$\frac{1850}{228,078} \text{ of } £27,074 \text{ 3s. 0d.}$$

25. The only priority charge against the Fund is in respect of Anaesthetists' Fees where claimed by an Insurance Practitioner in cases where the services of a second Practitioner are required, and in certain cases where emergency treatment is given. Up to the present these claims have been negligible.

Manchester and Salford System.

26. Every service rendered to an insured person is entered by the Practitioner on a Form known as a "Day Sheet."

For each of these services, according to its varying nature, a fee based on a "Scale of Fees" is credited, and at the end of each quarter the aggregate amount of the fees claimed by each Practitioner is ascertained.

The Day Sheets are submitted to the Panel Committee for scrutiny, primarily, with a view to the prevention of over-attendance by Practitioners. The methods respectively adopted by Manchester and Salford in this connection are detailed later.

The sum of the totals of the fees credited to each Insurance Practitioner in the area, after allowing for any deduction made therefrom by the Panel Committee after their investigation, represents the aggregate credit upon which the distribution of the available fund is made; for example:—

27. Dr. C. D. submitted the following account for the quarter commencing 1st January, 1922:—

Nature of Services.	Sale of Fees.
	£ s. d.
Surgery attendances, 180, say at 3s.	27 0 0
Visits to patient's house, 75, say at 4s.	15 0 0
Special visits, 20, say at 5s.	5 0 0
Night visits, 14 say at 10s.	7 0 0
Surgical Operation requiring local anaesthetic, 8, say at 10s. 6d.	4 4 0
Fracture or reduction of dislocation, 4, say at £2 2s.	8 8 0
Administration of general anaesthetic, 8, say at £1 1s.	8 8 0
Total Credit	75 0 0

The total of such credits for all Practitioners in the area for the same quarter amounted to £50,000.

—The total available out of the Insurance Practitioners' Fund for the Area for the quarter amounted to £43,000.

Amount due to Dr. C. D. may be shown by the following fraction:—

$$\frac{43,000}{50,000} \text{ of the sum of } £75 \text{ 0s. 0d.}$$

The amount which Dr. C. D. therefore receives is £64 10s. or 86 per cent. of his credit based on the Scale of Fees.

PREVENTION OF OVER-ATTENDANCE.

28. Machinery has been devised whereby the general body of insurance practitioners are secured against over-attendance on insured persons by any member of the body. There does not exist in Capitation Areas any similar machinery for securing under-attendance on the part of any practitioner.

VARIATION OF PROCEDURE BETWEEN MANCHESTER AND SALFORD IN CONNECTION WITH THE PREVENTION OF OVER-ATTENDANCE BY INSURANCE PRACTITIONERS.

Procedure in Manchester.

Quotation from a Report by the Clerk to the Manchester Committee.

29. "The value of each doctor's services for the quarter at the scale rates having been calculated, his average charge (at scale rates) per patient for the quarter is then ascertained. Similarly the general average charge per patient is ascertained from the total figures of all Doctors' accounts for the quarter. The accounts with this information are then placed at the disposal of the Panel Committee.

DISALLOWANCES BY PANEL COMMITTEE.

30. "The Panel Committee, by virtue of their powers under the Distribution Scheme, may make disallowances, and they usually carry out their powers by applying averages—any special circumstances in an individual case being taken into account. A value per patient approximating to the general average charge above referred to is adopted by the Panel Committee as a basis for disallowances, and all accounts which show that the average scale charge per patient is in excess of the amount allowed by the Panel Committee are reduced by an amount equivalent to the excess. Accounts with an average charge of less than the amount allowed are, of course, not increased. In addition special deductions may be made where warranted by exceptional circumstances, e.g., a charge for an 'operation' may not be justified, in the opinion of the Panel Committee, and the charge would accordingly be reduced to, say a 'visit.'

31. "The following typical examples may make the foregoing explanation clear. The accounts of the whole of the Doctors in the area in a recent quarter showed 70,476 patients treated during the quarter, and the scale fees for the treatment of these patients amounted to £47,170 resulting in a general average cost of 13s. 5d. per patient for the quarter. The Panel Committee adopted 13s. 6d. as the basis for disallowances during that quarter. Dr. A's accounts contained the names of 673 patients who received treatment varying from one attendance (3s.) to 43 visits (£8 12s.) the total of his account amounting to £473 11s. at scale rates, and his average cost per patient was therefore 14s. 1d.

"The value of the account as passed by the Panel Committee, was £454 5s. 6d. which represents 673 times 13s. 6d.

"Dr. B's account amounted to £434 11s. for 657 patients, showing an average of 13s. 3d., which was less than the amount adopted by the Panel Committee; thus no disallowances were made in this instance.

"There were no special circumstances in either of these cases to cause the Panel Committee to vary the application of the general 'cost per patient' amount adopted.

Procedure in Salford.

Quotation from Memorandum by Clerk to Salford Committee:—

32. "The insured persons treated during the year being definitely ascertained are classified as

- (1) Whole-time Patients, *i.e.*, those who have received treatment from only one doctor; and
- (2) Part-time Patients, *i.e.*, those who have received treatment from two or more doctors. Part-time Patients are about 6 per cent. of the total number of insured persons treated. The cost of attendance per insured person is limited to a figure which approximately represents the average cost of the majority of the practitioners.

"The average cost for treatment of the whole of the practitioners for Whole-time Patients in 1921 was approximately 22s. per insured person treated. The limit allowed was 19s. per insured person treated. The average cost for treatment of the whole of the practitioners for 1921 for Part-time Patients was approximately 36s. per insured person treated.

"The limit allowed was 50s.

"The limit is higher for Part-time Patients, as they have been found legitimately to require more service.

"Having determined these 'limits,' the accounts are adjusted as follows:—

"Where a practitioner's cost per Whole-time patient is at or below the 'limit,' he is credited with his actual cost, but where his cost is above the limit the account is reduced to the 'limit' and credit given accordingly. Where the practitioner's cost per Part-time Patient is at or below 50 per cent. of the 'Part-time Limit' (*i.e.*, 15s.) he is credited with his actual cost, but if his cost is above this percentage, it is reduced thereto and credit given accordingly."

(*Note.*—As the Part-time Limit requires to be proportionately credited to two or more practitioners, the basis of 50 per cent. is adopted, as from experience it is ascertained that on the average but a fraction over two practitioners are concerned in the treatment given to a Part-time Patient.)

CHAPTER III.—PROCEDURE REQUIRED TO BE FOLLOWED IN CONNECTION WITH A CHANGE OVER TO AND SUBSEQUENT ADMINISTRATION OF AN ATTENDANCE SYSTEM OF REMUNERATING INSURANCE PRACTITIONERS IN CHESHIRE.

ACTION BY THE INSURANCE COMMITTEE.

IN RELATION TO THE AMENDMENT OF THE SYSTEM OF REMUNERATION.

PRACTITIONERS' FUND.

33. From Article 23 of the Regulations it is clear that any amendment of the Scheme of Remuneration would require to be made *jointly* by the Committee and the Panel Committee, and, in default of agreement between the two Committees, by the Minister. As the Minister, therefore, might possibly at some stage in the proceedings be called upon to act as arbitrator between the Insurance Committee and the Panel Committee, neither party would feel justified until the stage of default of agreement had actually been arrived at in approaching him for an expression as to the relative merits of its case and of any aspect of the same.

34. Should agreement between the Committees on the method of Distribution not be arrived at, and the scheme be determined by the Minister, such a scheme would then form part of the Terms of Service of Insurance Practitioners for the Cheshire Area, notwithstanding that either the Insurance Committee or the Panel Committee had not agreed thereto.

35. Notice of any alterations in the Terms of Service of Insurance practitioners must be given to

practitioners by the Insurance Committee, and except in the case of an alteration which results from the coming into operation of any new Regulation, Order, Order in Council, or Act of Parliament, the alteration shall not come into operation within a period of three months from the date of the issue of the notice.

36. Should the Terms of Service accepted by practitioners provide for remuneration on an attendance basis, some modification of the manner in which the system is applied in Manchester and Salford might be considered desirable by Insurance practitioners.

37. If the opinion generally was formed that a flat application of the Attendance System would in practice seriously disadvantage the rural practitioner in comparison with the urban practitioner, the Committee could devise a method of crediting which would remove such a disability were it found to exist. The following suggestions are made:—

Alternative Method "A."

38. The Insurance Committee and the Panel Committee would, in the first instance, decide into which classification each of the districts in which any practitioner practises in the area of the Committee should fall, whether rural, semi-rural, or urban, or might reduce the classification solely to rural and urban. The Committee could then, by reference to the present Medical List, ascertain the relative numbers of insured persons falling into the different classifications, and the Capitation fees in respect of the aggregate of such insured persons in each of such classifications would represent the total available fund against which attendances upon insured persons in such classifications would represent the total available fund against which attendances upon insured persons in such classifications should fall, *e.g.*:—

39. Assuming that the Total Practitioners' Fund for the area—240,000 insured persons at 9s. = £108,000.

Assuming further of this total it is ascertained in the manner indicated above that there are:

(a) Urban Insured Persons—180,000 at	
9s.	£81,000
(b) Semi-rural Insured Persons—40,000	
at 9s.... ..	£18,000
(c) Rural Insured Persons—20,000 at	
9s.	£9,000
	£108,000

there would then be three distinct Funds—the Urban Practitioners' Fund, the Semi-rural Practitioners' Fund, and the Rural Practitioners' Fund.

40. The charges against each such Fund would be the aggregate of the attendances, after submission and certification by the Panel Committee, upon insured persons in each of the three classifications. Doctors would indicate on their "Day Sheets" the classification of each patient treated, or keep separate Day Sheets for each classification.

This would secure the Rural and Semi-rural Practitioner against loss of remuneration by reason of absence of easy access by the distant insured person to the Practitioner in comparison with the reverse in Urban areas. In other words, for the purpose of remuneration the area would be divided into three distinct distribution districts.

Alternative Method "B."

41. By adopting a different Scale of Fees in each of the types into which insured persons would be classified, thus raising the credit rates in respect of services to insured persons in Rural and Semi-rural areas in comparison with those in Urban areas.

Alternative Method "C."

42. By the allocation in priority of an aggregate sum for distribution on an Attendance credit basis to Rural and Semi-rural Practitioners.

43. Any of the foregoing methods are administratively practicable, and although the initial work in

connection with any of them or of a combination of two or more of them would be considerable, the recurrent work would not be difficult.

The necessary subsequential modifications, not of a very serious nature, would, of course, be made in the Allocation Scheme.

MILEAGE FUND.

44. Amended arrangements for the distribution of the Mileage Fund would also require to be made. The present system is explained in paras. 109 to 112 of Section A of this Memorandum.

The following suggestions are made:—

Alternative Method "A."

45. By the addition in equitable proportion of the Mileage Fund to the Semi-rural and Rural Practitioners' Funds referred to in para. 39 hereof.

The distribution of the fund being based on the mileage travelled by the practitioner in actual attendance on his patients as recorded in his "Day Sheets," or by increasing the scale of fees payable for attendance on insured persons resident in certain scheduled areas without regard to the actual mileage travelled in each case.

Alternative Method "B."

46. By a distribution of the Fund on the basis of Practitioners' Returns of all mileage travelled daily, after allowing for proportionate deductions for private patients and insured patients resident in areas to which the Fund did not apply.

DISPENSING PATIENTS.

47. The method of payment of practitioners for the supply of drugs and appliances to insured persons where they are at present required or permitted to dispense would also need modification.

DETERMINATION OF THE FUND.

48. As no record would, in the absence of Practitioners' lists be available whereby the number of persons for whom Practitioners were responsible for dispensing could be determined, the main difficulty of the Committee would be in determining the amount of the "Dispensing Fund." It might be based on the experience gained during the past twelve years on the capitation system, or on Returns to be rendered by Insurance Practitioners of their "dispensing" patients, or it might be based on the number of insured persons treated who were resident in certain scheduled areas on a case value system.

49. The following suggestions for the distribution of the Fund when determined would be practicable:—

Alternative Method "A."

By a flat rate of payment in respect of each case where the insured person was actually supplied with drugs and/or appliances, supplemented by special payments in cases where drugs and appliances of an expensive nature were provided, the latter to rank as a charge in priority against the "Dispensing Fund."

Alternative Method "B."

50. By the submission of claims by practitioners quarterly based on the actual drugs and appliances used in the treatment of their dispensing patients to be met by the Committee in so far as the available fund would allow.

ACTION BY THE COMMITTEE IN RELATION TO INSURED PERSONS.

51. Adopt a new form of medical card for issue to new entrants and where old one is surrendered for exchange, etc.

ACTION BY THE COMMITTEE IN RELATION TO INSURANCE PRACTITIONERS.

52. Arrange for issue to Practitioners of—

- (a) Forms of Day Books with full instructions as to mode of entering up services, disposal at quarter's end, etc.
- (b) Form of Prescriptions for use in Rural areas where Practitioners dispense, if a flat rate system for drugs and appliances supplied be not adopted.

53. Arrange, in conjunction with the Panel Committee, for all medical records in hands of Insurance Practitioners to be withdrawn, collected and arranged in order for issue to Panel Committee Central Office, and discontinue issue of medical records to individual Insurance Practitioners and requests for return of same.

ACTION OF THE COMMITTEE IN RELATION TO OFFICE PROCEDURE.

54. The initial procedure in a change over from the Capitation System to the Attendance System would, of course, involve the Committee in a considerable amount of work; which would be determined to a very large extent by what the Committee would consider necessary as far as the insured person was concerned. If every person had to be notified of the change over, and also provided with a new form of medical card such as that used in Salford and Manchester, the work of the office would be very considerable.

55. It might not, however, be thought necessary to issue a new form of medical card to all insured persons at present on the lists of Doctors, for it may reasonably be assumed that under the new system most insured persons would, when requiring treatment, ordinarily apply to the Doctor by whom they had been accustomed to be treated in the past. In such case, therefore, the new form of medical card need only be issued to new entrants or to insured persons who desire to change their Doctor.

The Minister of Health, however, might consider it necessary for the Committee to notify individually all Insured Persons.

56. Practitioners would be required to be supplied with the form of Day Book on which to record particulars of their daily services to insured persons, and the accounting arrangements of the Committee would, of course, need amendment.

57. The present Practitioners' Lists would be abolished, but it is not thought that there would be any difficulty in transferring part of the staff at present engaged in the Medical Registration and Medical Record Departments to the work of calculating out the Practitioners' Day Sheets and other accounting work incidental thereto.

At present, under the Capitation System, medical records are kept individually by the Practitioners in whose lists the insured person to whom the record refers is included.

58. Under the Attendance System, as insured persons would not be included in any Practitioners' List, the records would have to be kept centrally by the Panel Committee, and entered up from time to time from the Day Sheets received from Insurance Practitioners. This is the procedure in Manchester and Salford.

The Committee would require to apply for, collect and arrange all such Medical Records for issue when required by the Panel Committee's Central Office.

59. Further, if either of the alternative methods "A" or "C" of Distributing the Practitioners' Fund and "A" and "B" of the Mileage Fund referred to herein were adopted, it would be necessary for the Committee to ascertain *ab initio* by some means the relative disposition of insured persons in the various classifications adopted, i.e., Urban and Rural, or Urban, Semi-rural and Rural.

The following are suggested:—

- (a) By an analysis of the present "Practitioners' Lists" of insured persons to show the aggregate numbers of insured persons shown by such lists to be resident in each of the "classifications."
- (b) By reference to the ordinary population (Census Return 1921).

60. By whichever of the foregoing means the relative funds were determined it is highly improbable that any considerable variation would be found to be necessary, say, within five years, as until the provision of houses proceeds at a greater rate, the disposition of the population must remain stable and the proportional distribution of the Funds constant.

61. The subsequent current procedure of the Committee would be to

- (a) Prepare, print and issue day books to Insurance Practitioners and arrange for collection at end of quarter.
- (b) Transmit Medical Records as required to Panel Committee's Central Office.
- (c) Collect Medical Records of insured persons who remove, die, cease Insurance, &c.
- (d) At end of each quarter analyse and summarise Day Sheets for purpose of a provisional advance to Practitioners.
- (e) Transmit Day Sheets to Panel Committee for scrutiny. Only in those cases where average cost per insured person is exceeded would it be ordinarily necessary to do this.
- (f) Make a careful current analysis of the operation of the adopted system of remuneration in its separate application to various types of practices, *i.e.*:—
 - (a) Rural;
 - (b) Semi-rural;
 - (c) Urban;
 - (d) Industrial;
 - (e) Residential, &c., &c.

ACTION OF INSURANCE PRACTITIONERS.

62. The only modifications necessary in connection with the change would be:—

- (a) Medical cards of all new acceptances to be signed and returned by the Doctor to the insured person, and not, as at present, sent to the Insurance Committee for registration.

- (b) All records of treatment to insured persons, differentiating between those resident in Urban, Semi-rural and Rural areas, including particulars of Dispensing, Mileage, &c., in Rural areas to be entered on Day Sheets.
- (c) Medical Records no longer kept by individual Practitioners.
- (d) Day Sheets to be sent in at end of each quarter to the Insurance Committee.

ACTION OF PANEL COMMITTEE.

63. Set up Central Office for the following purposes:—

- (a) Writing up of Medical Records from Doctors' Day Sheets.
- (b) Transmission of Records to Insurance Committees upon insured persons' removal, suspension or death.
- (c) Preparation of information in cases requiring to be investigated by the Panel Committee on the grounds of unduly high claims by Insurance Practitioners against Practitioners' Funds.
- (d) Certification of Accounts in such cases for payment by Insurance Committee.

CHAPTER IV.—ESTIMATED COST OF "CHANGE OVER."

64. In attempting to estimate the initial cost to the Committee of the change over from the Capitation System to the Attendance System, much would depend upon whether the Committee would consider it desirable to issue the new form of medical card to all insured persons, or whether the alternative submitted above would meet the case, and, further, as to whether it would be necessary, and, if so, what means were adopted to arrive at the relative proportions of the Funds.

65. Once the alteration had taken place there would be very little difference between the cost of running the present system and that of the new system.

APPENDIX XXXV.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE LEICESTERSHIRE INSURANCE COMMITTEE IN RELATION TO HEALTH PROPAGANDA, BY ALDERMAN CHAS. GOODACRE, J.P., AND MR. T. CREW, CLERK. See Minutes of Evidence of the Twenty-second Day Questions 12,660 to 12,695.

INTRODUCTORY.

1. This statement being that of a constituent Insurance Committee is intended to supplement the evidence submitted by the Federation Committee of the English, Scottish and Welsh Associations of Insurance Committees in relation to Health Propaganda as provided for under the provisions of the National Health Insurance Acts.

2. Under section 50 of the Act, it is distinctly laid down that it is the duty of Insurance Committees (a) to make reports as to the health of insured persons within their area, and (b) to make provision for the giving of lectures and the publication of information on questions relating to health, and for that purpose to make arrangements with local educational authorities, universities, and other institutions.

3. This provision was accepted by the Leicestershire Insurance Committee in the broadest spirit with a view to the prevention of disease. While recognising that their primary duty was the arrangement for the provision of medical treatment it was also felt to be equally important that efforts should be con-

centrated upon Health Propaganda in various forms in order to enlighten the insured and their dependants upon the necessity of right living and to urge them to take advantage of the services of the doctor at the earliest possible moment of symptoms of ill-health arising.

4. This then was the guiding spirit of the members of the Committee at the commencement of their duties under the Act, and while they endeavoured to establish an efficient medical service for the treatment of insured persons, they felt that preventive measures should be undertaken in closest relationship with the practitioner.

5. Therefore, since the commencement of medical benefit in 1913 various methods of disseminating sound information on health matters have been consistently pursued in the towns and villages of Leicestershire. In the light of the valuable experience gained in this phase of work, it has been suggested that the Leicestershire Committee would be a fitting body to present tangible evidence of the useful work performed by many Insurance Committees in this direction.

HEALTH POLICY.

6. The chief course of action by the Committee has been to emphasise (a) the appalling total of unnecessary suffering and loss of life; (b) the need for its prevention and the ease with which it can be prevented; (c) the truth that each person's health is mainly in his own hands; and (d) the pleasure and power of perfect health.

7. References to the activities of the Committee were made by Sir George Newman in his recent valuable Memorandum on "Public Education in Health," in which he specifically stated "that the Leicestershire Insurance Committee have disseminated information on health subjects of general interest, such as avoidance of minor ailments, the awakening of a civic sense of sanitation, and the importance of personal hygiene."

Undoubtedly, the greater the advance made in propaganda work undertaken by Insurance Committees the greater is the amount of money now spent on minor maladies which could be saved. The Leicestershire Committee too endeavoured to obtain, with much success, the assistance of the insurance practitioners in reaching insured persons and impressing upon the latter the importance of good health and the necessity for noting the invaluable advice given by the Committee as well as by the practitioners, on health matters.

8. The importance of promoting sound views on health is beginning to claim the attention it deserves, particularly of manual workers. Health and Disease belong to all classes, and the art of Health Propaganda is to make the subject of sound health attractive—so attractive that it will become a personal as well as a public ideal.

9. The more mental imagery is employed in the use of simple posters and literature—in appealing to the pleasant emotions—the more is Health Propaganda forwarded. The actual point to be illustrated should be developed in a striking form so as to invite and compel the attention of those appealed to.

10. The Right Hon. D. Lloyd George, M.P., (then Chancellor of the Exchequer) in presenting the National Health Insurance Bill in 1911, called attention to the important provision for the giving of lectures and the publication of information on questions relating to health. He said "this is an important power, because there is an appalling ignorance of the most elementary conditions of health, diet, light, and fresh air, especially light, and the danger of the excessive use of alcohol and narcotics. All these questions affect the health of the community."

CONSTITUTION.

11. The Insurance Committee is admirably constituted to engage in Health Propaganda, as the majority of its members, notably the representatives of Approved Societies are in direct touch with the insured persons and their dependants. It is to this class of person—the insured—to whom greater effort must be made to impart sound information on public and personal hygiene; to constantly focus attention on vital matters of health, and to arouse a keen sense of the individual responsibility for health.

12. The majority of the Approved Society representatives are engaged in active administration of the National Health Insurance Acts, which brings them into personal touch with insured persons and their dependants. A vital force in the counsels of the Insurance Committee is the insurance practitioner, whose duties under the Act are of inestimable value, particularly in respect of advice given on personal hygiene to the insured patient. This side of the panel services is apt to be lost sight of, and yet it is of daily application. Its value cannot be overestimated and the personality of the doctor brings in its train effective results which cannot be expressed. Truly "every panel doctor is a missionary hygienist." Undoubtedly the purpose of preventive medicine is not only the diminution of disease and the extension of life, but the strengthening of the health of the individual, and raising the standard of physical well-being.

13. Then the representatives appointed by the Council of the County or the County Borough, who

in many cases having also magisterial experience are an added force to the usefulness of Committees. Their intimate knowledge of the administration of public health is of extreme value in determining the form of public education in harmony with the effective discharge of public health services. The Council as part of their representation must appoint a lady who has been or is associated with a nursing organisation and her services are of great benefit to the Committee.

14. The Minister of Health also appoints a consultant practitioner, who is independent of the panel doctors, and a lady of experience associated with nursing and maternity services.

15. Another factor in the effective administration of the National Health Insurance Acts is the work performed by the Clerk to the Committee, who initiates, co-ordinates, and knits together the various interests and ideas of the Committee in the general application of preventive measures in the area.

16. So far as the Leicestershire Committee is concerned, they have taken always advantage from the beginning of the personal services of H.M. Divisional Inspector attached to the Ministry of Health. In the early days Committees were encouraged to consult with such officers upon the many difficult and complicated conditions arising in their respective areas. This has been done with beneficial results, and we would suggest that this link between the Ministry and Insurance Committees should be strengthened in the future.

17. Sub-section 2 of section 50 of the Act reads: "For the purpose of assisting insurance committees in the exercise and performance of their powers and duties under this part of the Act, and with a view to promoting co-operation between such committees and the councils of counties, boroughs, and urban and rural districts, any medical officer of health may, at the request of an insurance committee, and with the consent of the council by whom he is appointed attend meetings of the committee, and give such advice and assistance as is in his power."

18. The Committee endeavoured at the outset to obtain the presence of the Medical officer of Health at their meetings, but while agreeing to such official giving all possible assistance in this direction, the Local Council could not see its way to sanction his attendance. The invitation was repeated last year, and it is gratifying to record that the Council gave consent to the Medical Officer to attend meetings of the Health Propaganda Sub-Committee, which had been specially constituted by the Finance and General Purposes Sub-Committee to consider ways and means in respect of Health Propaganda. In our opinion it is extremely essential that the Medical Officer of Health should be in the closest relationship with the Insurance Committee in order that the health and sanitary administration should be in complete harmony with the dissemination of Health Information among the community.

HEALTH CONDITIONS.

19. When the National Health Insurance Act was passed by Parliament, the general trend of opinion was in the direction of securing that Insurance Committees should be more than organisations for the administration of medical benefit. They were not to concern themselves only with the routine work of arranging and administering treatment benefits, but to consider also the maintenance of the health of the insured population in their areas. There was thus conferred on Committees a statutory duty, and the funds of Approved Societies, obviously are materially affected to a lesser or higher degree by the efforts made in the preventive measures. This responsibility has since been emphasised by the British Medical Association who have stated "that they view the insurance medical service as having been set up not merely to assure medical attendance on certain wage-earners when they become ill, but to promote the national health by having regard to preventive as well as consultative methods, by facilitating research into the beginnings of disease (for which the service obviously offers unrivalled facilities) and by making investigations and reports."

20. Following upon section 50 dealing with further education on health matters, the Committee have concentrated upon section 107, and again with the valuable assistance of the panel practitioner, special enquiries have been made as to Health Conditions of the area. These have recently included an enquiry into the Incidence of Rheumatism in Leicestershire area, and the results indicate more than ever the necessity for increased and better housing and improved sanitary accommodation, as well as concentrated efforts to impart sound information to the masses on hygiene.

21. When one realises the vast number represented in the 14 millions of insured persons it becomes an important duty of a Committee to deal with preventive and curative measures. The clarion call to-day is to urge more than ever the individual responsibility for health, which is nine-tenths of the battle against disease.

22. Insurance Committees should be enabled to undertake to a greater degree Health propaganda in its direct form, on the ground that they represent the industrial life of the country where the greatest need for instruction is required. An essential feature in the administration of medical benefit is that the insured person is in general association with the panel practitioner, and one of the reasons of the success of the panel service is that the insured patient goes to the doctor at the earliest symptom of illness, a course to be encouraged to the fullest degree.

23. Therefore in combination with the enquiry into health conditions with the aid of skilled and discerning practitioners, the Insurance Committees with their representatives of Doctors, Chemists, Approved Societies, Local Authorities and others, are undoubtedly taking an important part in promoting practical Health Propaganda in ordinary life.

FINANCE.

24. It may be well to recapitulate the provisions which enabled Insurance Committees to carry out the provisions of section 60 of the National Health Insurance Act, 1911 (now section 50) in respect of Health Propaganda.

25. Under section 12 (2) (b) of the National Insurance Act, 1911, Committees were entitled to apply for the transference of the sickness or disablement benefit payable to an insured person, without dependants, who was in receipt of institutional treatment at a sanatorium. During the period of treatment as an inmate the benefit accruing was claimed and credited to the General Purposes Fund of the Committee.

26. This was the chief source of income to this Fund, and the amounts received varied in proportion to the insured population in the area, and to the number of persons accepted for treatment.

27. Consequent upon the repeal in 1918 of section 12 (2) (b) the chief source of income ceased. Many Committees continued various forms of health propaganda in a modified form and in due course this fund was reduced to a very low state in the majority of areas, and in the case of Leicestershire exhausted.

28. It was understood in 1917 and 1918 that this loss of income would be made good to Committees. The Civil Service Supplementary Estimate of 1914-15, which was duly passed by Parliament, whereby a sum not exceeding £20,000 was to be applied to meet the cost of health lectures and the publication of information on questions of health, was suspended owing to the War and has not been renewed.

29. Realising the extreme importance of the development of a National Health Policy for the instruction of the great mass of the people in the principles and practice of hygiene the Leicestershire Insurance Committee have in the past urged the Ministry of Health to consider seriously the whole question of providing additional monies. The Committee is strongly of the view that a definite sum should be realised and placed to the credit of a Central Health Propaganda Fund, and distributed *pro rata* according to the insured population in each area.

30. It is felt that this would be a wise expenditure and would result in an ultimate saving in the payments of sickness benefit by Approved Societies. The great underlying principles of the Acts in the prevention of disease, the saving of life, and the creation of a better state of affairs, mentally and bodily, might then be carried into effect.

A TYPICAL CAMPAIGN.

31. In order to indicate the usefulness of an Insurance Committee in directing and conducting a Health Campaign, a resumé of the work done by the Leicestershire Committee in the year 1922 is given:—

(1) The campaign was conducted on the following lines:—

Distribution of small artistic posters.
Descriptive notices and paragraphs in the Local Press.

Appeal to the Clergy, Sunday Schools, and Adult Schools to co-operate during Health Week.

Illustrated Health Lectures to school children.

(2) In connection with posters, the Committee realised that for effective publicity purposes, these should be of a simple and yet artistic character as simplicity and boldness must be predominant in order to appeal to the passer by. Too much subject matter does not secure that close attention necessary to impress the mind of the individual. Bearing this point strongly in mind, the Committee decided on the following "Twelve Health Hints" as being the most suitable to be printed on the blue posters:—

Open windows day and night.

Let Sunlight into your rooms.

"Kill that Fly"—Carrier of Disease.

Keep milk cool in a covered vessel.

Avoid worry, cultivate a cheerful disposition.

Moderation in all things; avoid alcohol.

Personal cleanliness essential.

Clean your teeth and mouth regularly.

Eat slowly and masticate your food well.

Regular exercises improve mind, strength and digestion.

Clean thoughts lead to clean actions.

Pure water, best tonic and blood purifier.

(3) The next procedure was to procure the distribution of these posters in the homes of the people and other places. Outside publicity was secured by the co-operation of the chemists and cinemas, who posted the bills outside their buildings, and of newsagents, sub-libraries and motor conveyances. The Panel Practitioners and Employers of Labour, also placed the posters in their surgeries and factories. Advantage was, however, taken of the school-children attending the Committee's Lectures at the various cinemas, and they were each given a health poster to take home. The fact that approximately 10,000 of these posters reached the homes of the people will readily be appreciated as fruitful of results that cannot be fully estimated.

(4) The local daily Press (2) and the County Weekly Papers (5) again gave valuable assistance to the Committee in the form of suitable paragraphs relating to Health Week, and also inserted daily a series of Health Hints (24 in all) in their issues, the first four being as follows:—

(5) Health Week Hints.

God's remedies: Fresh air, moderate exercise, plain food, regular sleep and kind thoughts will heal you of your ailments.

Breathe deeply of God's Great Out-of-Doors. It is all free and so far no monopoly has ever clutched the ozone.

Make a business of being happy at all times and in all places, and you have one of the secrets of Health. The sure recipe for this abiding happiness is the effort to secure it for others.

A person who eats too fast is likely to eat too much.

- (6) The Committee followed up these daily Hints by placing a small but distinctive advertisement in the press as follows:—

Health Week.

The Leicestershire Insurance Committee recommend that the dominant idea for 1922 should be "Self-Help in Health," and the consideration of what an individual can do for himself and his neighbour in securing a healthy life.

Regular Exercise, Personal Cleanliness and Moderation in all Things are Sound Health Commandments.

- (7) Clergy, Sunday Schools and Adult Schools generally responded to the Committee's invitation to observe Health Week, and suitable subject matter was supplied to them for their discourse or discussion as the case might be.

- (8) Much of the effort of Health Propaganda was concentrated during Health Week (October 8th-15th, 1922) and a feature was the presentation of illustrated lectures to school children at the various cinemas in the chief centres of the County. In the first place, the generous co-operation of the cinema proprietors was secured for afternoon lectures, and the Leicestershire Education Committee willingly agreed to support the efforts of the Insurance Committee in this direction. Consequently it was arranged for children over the age of nine years to attend the lectures as part of the education curriculum. Realising that there was possible danger in the transference of large numbers of children from the schools to the cinema, arrangements were made with the Chief Constable for the County for the necessary police supervision, and this was given gratuitously.

- (9) A series of about fifty lantern slides were shown on the screen, and the lecturer made simple comments, although many of the slides being suitably illustrated and coloured, explained themselves. The subjects referred to were various, and covered the following points:—(1) Physiology, (2) Brain, Nerves, and Stomach, (3) Good Posture, (4) Value of Sunlight, Fresh Air and Water, (5) Exercise, (6) Milk, (7) Flies, (8) Training Rules, (9) Smoke and Dust, (10) Overwork, (11) Good Habits, (12) Personal Cleanliness, (13) Breathing Exercise (14) Health Rays, etc.

- (10) In the presentation of such lectures to children one fully realised the value of saying as little as possible and the necessity of securing their personal co-operation as frequently as possible, by inviting them to read out aloud some of the slides, which contained thereon pertinent Health Maxims. This was a happy inspiration, and contributed greatly to the success of the lectures. Simplicity and a happy atmosphere must be the key-notes to any lecture in order to be successful in its application to the younger mind. Upon leaving the cinema, neat Health cards were presented to each child, and these

were eagerly accepted as a kind of prize to take home:—

Ten Health Commandments.

Keep the Teeth clean and sound.

Drink pure water, eat plain and wholesome food and eat slowly.

Breathe fresh air.

Breathe through the nose, not through the mouth.

Keep windows open day and night.

Be clean.

Take daily open-air exercise in the sunshine when possible.

Do not spit.

Cultivate punctuality.

Laugh when you can.

Follow the Rules. Play the Game of Health.

- (12) The Health Propaganda Sub-Committee feel that their strenuous activities have been amply repaid by the response made to the wide dissemination of the laws of Health regularly among the masses, including the children of this area.

OTHER VIEWS.

32. The Insurance Committee desire to submit the following statements with respect to their work:—

- (1) *Mr. C. J. Bond (Leicester)*: "In my opinion the Health Propaganda work which you and your Leicestershire Insurance Committee have undertaken for some time past has been of real service in spreading knowledge concerning the principles which underly the 'Healthy Life.' I think the lectures and demonstrations to school-children and the young population have been especially valuable, and a very important factor in preventive work. Such propaganda work is very valuable on the educational side by favouring enquiry, and a healthy discontent with the present way of living, and this is the first step to any reconstruction of our national habits and the amelioration of the conditions under which life is lived in many working class and other homes. Your motto that Prevention is better than Cure is undoubtedly a sound one."

C. J. BOND, C.M.G., F.R.C.S.,

Hon. Cons. Surgeon, Leicester Royal Infirmary.
Vice-Chairman Medical Consultative Council,
Ministry of Health.

Acting Chairman of the Industrial Fatigue
Research Board.

Dr. Bond lectured on behalf of the Committee to school-children in the County of Leicester and also presented illustrated Health Lantern Slides.

- (2) *Dr. R. Pratt (Leicester)*: As the late Representative of the Ministry of Health on the Leicestershire Health Insurance Committee, and the Chairman of its Health Propaganda Committee, I have been much struck by the need for a better education of insured persons and their dependents in the elementary laws of health. In the N.H. Insurance Act power is given to the various Insurance Committees to do this, but so far not much progress has been made, owing to varying circumstances.

From our experience in Leicestershire there can be no doubt that such teaching is heartily welcomed, and indeed longed for, by the insured. It is especially necessary to reach the younger generation whose minds are more receptive of new suggestions than are those of older persons. In Leicestershire we have for several years made a great effort during Health Week to appeal to school-children by means of film and lantern lectures, and where these are not available, by special Health Talks in school hours by local doctors and teachers, who have responded splendidly to our appeals for help by them. In some cases prizes have been given by friends of the movement, to those children who on examination have grasped the principles sought to be inculcated. Efforts must not be confined to Health Week, but continued throughout the year. Our

experience with evening lantern lectures in the villages has proved conclusively that the people are willing to come. The difficulty is that a County Insurance Committee cannot itself hope to cover such a large area as a County. I am convinced that the wisest plan is to enlist the help of Urban Rural District and Parish Councils, so that a good deal of the work can be delegated to them, the Insurance Committee being the channel for supplying them with information, etc. This was done here during the last Health Week, with very gratifying results. Such members thereon are influential in their respective districts, and it is important to obtain their assistance. I am sure they will at any time be ready to give it. Of course this presupposes that the Local Medical Practitioners will be willing to give their valuable help, and I think there need be no hesitation on that ground. The Panel Practitioners of our area have shown their keen interest in health matters affecting their neighbours by the great number and fullness of the replies to a Questionnaire on Health Conditions in their districts which we have sent them, in many of which valuable suggestions were made; in fact our experience has been that both doctors and insured persons are very keen on the subject of Health Propaganda. The Approved Societies might well be appealed to for help in this work. It is so obviously to their advantage that the health of the community should be improved that they would no doubt welcome and assist any movement for the better education of the insured class in health matters.

All the above suggestions are founded upon actual experience, but I must insist again that all the detail work is beyond the capacity of any one Committee, and that the success of Health Propaganda must ultimately depend upon the hearty co-operation of the local doctors, Local Councils, and other interested persons, with the Insurance Committee as the connecting link of these forces.

REGINALD PRATT.

M.D. Lond., M.R.C.P., Lond.

(3) *Mr. Joseph Cave (Leicester)*: In my view one of the most valuable benefits under the N.H.I. Act is the dissemination amongst insured persons and the public generally, especially the young, of information regarding the attainment and maintenance of Good Health.

The Health Propaganda of the Leicestershire Insurance Committee in the form of lectures to adults and school-children emphasizing the simple laws of health in personal habits, in the home, the workshop or factory, is bound to result in a generally improved standard of health amongst the people and will in time tend to the diminution of sickness incidence under N.H.I. There is no organisation better fitted to carry on this beneficent work than the Insurance Committees as now established, comprised as they are of representatives of insured persons in whose interest this work is carried on, the medical profession with the knowledge and skill they possess and are willing to impart, and representatives of Local Authorities who are interested in the general health conditions of the area, the housing and sanitary conditions and water supply so essential to the health of any community.

My experience of the administration of Health Propaganda on the Leicestershire Insurance Committee is, that there is a growing interest in this important phase of health work both amongst the members of the Committee and also the general public, and I am strongly convinced that if more money could be found for this purpose it would be money usefully spent and would be fulfilling the first principles of the N.H.I. Act, viz., the prevention of sickness. To

this end a small flat rate payment to Insurance Committees out of the present contribution, say, of one halfpenny per member per year would go a long way towards providing the necessary funds.

JOSEPH CAVE.

High Chief Ruler I.O. Rechabites
Approved Society (No. 150)
Member of Consultative Council
of Approved Societies of the
Ministry of Health,
Chairman of Medical Benefit Sub-
Committee of the Leicestershire
Insurance Committee.

(4) *Dr. T. Robinson (Leicestershire)*: It is impossible for any individual, however healthy born, to avoid disease and the dangers to health, unless he has some general knowledge of the nature of such diseases and is trained in the simple methods of living to enable him to steer clear of such danger. Up to the last few years the health of the community has been the care and responsibility of the Local Sanitary Authority, and such standards of sanitation, etc., have been attained as have been proved to give the best results. Thus the community has been protected as far as possible, but in almost complete ignorance; and it was not thought necessary to seek the help of the individual.

The individual must now be taught. Propaganda is, in my opinion, one of the most valuable weapons we have in promoting the health of the people and teaching the individual. There is a growing desire on the part of the individual to learn. Whether it is by the child in the school, the mother at the baby centre, the man or father at his association or "school," or the girl at her "guild" or class, there is always a keenness and interest shown in all matters relating to health; and this enthusiasm must be encouraged and satisfied by a systematic and properly organised scheme of instruction. The health propaganda work carried out by the Leicestershire Insurance Committee during the last few years has been most valuable and reflects great credit on that Committee. The great appreciation of their efforts must be very gratifying to them. During each succeeding (annual) Health Week a more and more extensive and attractive programme has been carried out. The results must be good, and no doubt will be clearly shown in the next few years to come. On occasions I have myself lectured, and can most confidently state that I have always derived a great satisfaction and pleasure in so much as I have invariably "felt" the earnest attention of my audience, a proof of the desire to learn and interest in the subject.

The subjects chosen by the Leicestershire Insurance Committee, whether for child or adult, whether for a lecture or cinema film, have always been most suitable and instructive. The co-operation with the Education Committee and Local Authorities has been cordial and most effective and the head teachers have shown their appreciation by giving their whole-hearted support. Essays written by children afterwards have proved the value of the lesson. There can be no doubt as to the value of health propaganda; but at the same time there can be no doubt that there must be an organised co-operation of all bodies interested—the Insurance Committees, County Councils, Local Authorities, Education Committees etc.—each has a branch or department which can be usefully employed. There must be no dual control or overlapping. The scattered rural parishes must be provided for as well as the towns. The expense need not be great as much of the existing machinery can be usefully employed.

T. ROBINSON. M.R.C.S., L.R.C.P.,
D.P.H. (Camb.).
County Medical Officer of Health,
Leicestershire.

CONCLUSION.

33. In the light of the foregoing statement, it will be understood that there is a wide sphere of useful activity on the part of Insurance Committees to engage in further Health Propaganda, and we earnestly urge that additional facilities and monies should be provided to continue this work. The

results achieved in Leicestershire and in many other areas justify greater efforts being made in the future. A factor that should not be lost sight of is that Committees are in a position to disseminate daily health information in a very effective way, by the issue of medical cards and other notices to insured persons. This method of propaganda is a feature which is attended with good results in many areas.

APPENDIX XXXVI.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE FEDERATION COMMITTEE OF THE ENGLISH, SCOTTISH AND WELSH ASSOCIATIONS OF INSURANCE COMMITTEES, BY THE REVEREND WILLIAM DENNIS YOWARD (Vice-Chairman of the Federation Committee, and Ex-President of the National Association of Insurance Committees); MR. EDWIN POTTS, B.LITT. (Hon. Secretary of the Federation Committee and of the National Association of Insurance Committees); MR. WILLIAM MARCHBANK MARSHALL, Solicitor, (Ex-Chairman of the Federation Committee, and Hon. Secretary of the Scottish Association of Insurance Committees); and MR. FREDERICK LLEWELLYN JONES, B.A., LL.B., Solicitor, (Chairman of the Federation Committee, and Past President of the Association of Welsh Insurance Committees). See Minutes of Evidence of the Twenty-Third Day, Questions 12,696 to 13,142.

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CHAPTER I.—INSURANCE COMMITTEES AND ASSOCIATIONS.

THE ESTABLISHMENT OF INSURANCE COMMITTEES.

1. Insurance Committees were established under section 59 of the National Insurance Act, 1911, subsection 1 of which provided for an Insurance Committee to be constituted for every county and county borough in England and Wales. There are 128 Committees in England and 17 in Wales. The areas differ in Scotland, and the number of Committees there is 54.

2. The National Insurance Bill contemplated the creation of Local Health Committees for certain purposes. The intention at the time of the introduction was undoubtedly to continue and extend the arrangements for medical attendance and treatment by and through the existing Friendly Societies and other Societies to be approved under the Act, on lines similar to those obtaining at the time—mainly by the appointment of medical practitioners on agreed terms. The acceptance of amendments by Parliament transferred the

administration of medical benefit to the Local Health Committees, under the new name of Insurance Committees, which were to be set up to undertake the administration of sanatorium benefit in counties and county boroughs, or, in Scotland, burghs containing a population of over 20,000.

3. Uniformity of method in the area of each Committee became possible, and the scheme was saved from the acerbity of conflicting interests and the diversity of arrangements which would inevitably have resulted in grave dissatisfaction to all parties if the original plan had been adopted. The number of Approved Societies in England alone in 1912 was 2,208, and there were 12,438 branches, making a total of 14,646 administrative bodies, whose members were so distributed amongst the 121 Insurance Committees in the country that even in the smallest Insurance Committee area there were members—often a single member—of a large number of societies and branches.

The number of societies represented by members in every Committee area was, and still is, considerably greater than was anticipated, and experience has justified the acceptance by Parliament of the amendment handing over the administration of medical benefit to the Insurance Committees, although the action may fairly be attributed to the anxiety to secure the loyal and hearty co-operation of the medical profession.

4. It was soon found necessary to adopt special procedure to provide for persons temporarily absent from home and for persons frequently changing their place of residence, and to meet the necessities of accidents and other emergencies; and apart from the complexities due to the number of societies, the creation of local committees must have ultimately been necessary through the difficulties attendant upon the migratory character of the insured population for whom medical benefit has to be provided at any time and in any place throughout the length and breadth of the country.

THE CONSTITUTION OF INSURANCE AND ALLIED COMMITTEES.

5. The constitution of Insurance Committees under section 48 of the 1924 Act provides that a majority of the members—three-fifths—are to be appointed in such a manner as may be prescribed by regulations of the Insurance Commissioners (now the Minister of Health) so as to secure representation of the insured persons resident in the county or county borough who are members of Approved Societies and deposit contributors. One-fifth (including not less than two women) are appointed by the Council of the county or county borough, and the remaining fifth comprises practitioners, part elected on a representative basis, and part appointed by the Council and the Minister of Health, and other persons, at least two of whom must be women, appointed by the Minister. The membership varies between 20 and 40 in England and Wales, and in Scotland between 30 and 80. Before the Act of 1921, Committees in England and Wales comprised from 40 to 80 members; no similar reduction occurred for Scottish Committees.

6. The appointment of representatives to the extent of one-fifth of the members of the Insurance Committee by the Council for the county or county borough was of the greatest value to Committees at the outset, mainly because of their experience in the local administration of Acts of Parliament. They were a valuable link between the Committee and the Council, and aided materially in the arrangements between the two bodies in connection with the administration of sanatorium benefit. The representation of the Council may under section 48 (4) of the Act be proportionately increased if the Council has undertaken to defray any part of the cost of medical benefit or sanatorium benefit or of the administration thereof under section 85 (1) of the Act where the expenditure exceeds the amounts available to the Insurance Committee from other sources. In fact, though the same Authorities did bear considerable expenditure in relation to the provision of sanatorium benefit, in no case is the Association aware of any Council's contributing towards the cost of medical benefit or

administration. Jointly, expenditure has occasionally been incurred in health propaganda.

The representatives of Approved Societies are either appointed by the larger societies, or elected by the smaller societies; the deposit contributors' representative is, in the absence of an Association, appointed by the Insurance Committee.

The number of medical practitioners usually is not less than ten per cent. of the membership of an Insurance Committee; chemists and nurses are frequently included amongst the members appointed by the Minister.

Insurance Committees accordingly represent many diverse interests, but there is little, if any, real conflict amongst the members, and they work together harmoniously in a genuine effort to further the work of the Insurance Committee, and to bring about improvements in the services available to insured persons.

7. Insurance Committees are required to appoint a Finance Sub-Committee, and they usually appoint other Sub-Committees in connection with their principal duties, including, as a rule, a Medical Benefit Sub-Committee. The practice amongst local authorities is closely followed, and certain powers and duties are delegated to the sub-committees. A woman must be included in every sub-committee dealing with the administration of any benefit. Sub-committees, other than the Finance and the Services Sub-Committees, may include persons other than members of the Committee. The Medical Benefit Sub-Committee has generally delegated to it the powers and duties in connection with the administration of medical benefit. There is in many cases similar delegation to a sub-committee for dealing with deposit contributors. Special sub-committees are appointed for various purposes from time to time, and some of these have rendered efficient service in the arrangements for health propaganda.

8. There are several joint sub-committees appointed either under the Medical Benefit Regulations or under schemes made thereunder. Any question arising between an insurance practitioner and a patient in respect of treatment or any question raised by a society with regard to medical certification stands referred to the Medical Service Sub-Committee, and any appropriate matter relating to the administration of medical benefit may be referred to it for investigation.

Any complaint made by an insured person against a chemist in respect of the supply of drugs or appliances falls to be investigated by the Pharmaceutical Service Sub-Committee, which may also have referred to it for investigation any appropriate matter relating to the administration of medical benefit.

There is also a Joint Services Sub-Committee, which deals with any question involving a practitioner and a chemist and any appropriate matter in connection with the administration of medical benefit may be referred direct to it by the Insurance Committee.

These sub-committees include a like number of representatives of insured persons, insurance practitioners, and chemists, and a neutral chairman.

They display a keen desire to ensure justice amongst the parties concerned, and by their care and impartiality they indicate a full recognition of the semi-judicial capacity in which they must act.

The Regulations also provide for the appointment of sub-committees under the Allocation Scheme, under the Scheme for securing an adequate Pharmaceutical Service, and if necessary, to deal with the arrangements for dispensing by doctors or chemists in rural areas, and in fact in any case where the insured person resides more than a mile from a chemist's shop.

9. There are certain statutory committees with which an Insurance Committee is concerned, viz., the Local Medical Committee, the Panel Committee, and the Pharmaceutical Committee. Any question arising as to whether an operation or other service is within the range of medical service must be referred to the Local Medical Committee, and in the event of disagreement, the matter must be submitted to referees appointed under the regulations for decision. The Local Medical Committee may also investigate any

complaint made by one insurance practitioner against another, involving any question of the efficiency of the medical service.

10. Local Medical and Panel Committees are to be consulted with regard to the Terms of Service for Practitioners, and they appoint the medical members of the Medical Service Sub-Committee.

The Insurance Committee and Panel Committee have the joint duty of preparing the Allocation Scheme under article 23 of the Regulations. Panel Committees have also important duties in the investigation of excessive prescribing, and determining whether an excess in quantity or otherwise has been incurred by an insurance practitioner. They also examine claims for fees in respect of emergency treatment and the administration of anaesthetics.

11. The Pharmaceutical Committee is to be consulted with regard to the Terms of Service for chemists and other persons supplying drugs and appliances, and acts jointly with the Insurance Committee in preparing a scheme for securing a proper pharmaceutical service.

It appoints the chemists' representatives on the Pharmaceutical Service Sub-Committee.

It is also empowered to consider complaints made to it by any person supplying drugs or appliances against another, involving any question of the efficiency of the service of supplying drugs and appliances to insured persons.

12. Insurance Committees (with the exception of London, Lancashire, Manchester and Salford) have entered into agreements under which Joint Committees, consisting of representatives of the several Insurance Committees in the group, undertake their duties in connection with the pricing of prescriptions and the determination of the amounts payable in respect of the supply of drugs and appliances to insured persons in accordance with the tariff. These Joint or Pricing Committees also undertake duties in connection with the preliminary investigation of prescribing in their areas.

13. The meetings of Insurance Committees are held at least once every quarter, but some Committees meet every six weeks, whilst others have monthly meetings. The Finance Sub-Committees, which are required to be appointed by regulation, generally meet once a month. It has already been stated that Insurance Committees may also appoint other sub-committees, and may delegate certain powers and duties to them. The effect of this is that the Insurance Committee may meet at longer intervals, since the duties in connection with finance and the administration of medical benefit can be and are expeditiously performed through the Finance and Medical Benefit Sub-Committees, and the duties in connection with deposit contributors, etc., by the appropriate sub-committee.

The Medical Service Sub-Committee meets quarterly, but in the case of the largest Committees, meetings are necessarily held more frequently. The Pharmaceutical Service, Joint Services, Allocation, Dispensing and Hours of Service (for Chemists) Sub-Committees only meet as may be necessary.

Insurance Committees are also represented at meetings of Joint Pricing Committees. Members of Committees are appointed, when necessary, to meet representatives of the Local Medical and Panel Committee for consultation, particularly with regard to the preparation of schemes which have to be prepared jointly under the regulations.

It is the common experience that members are regular in attendance at meetings of the Insurance Committee and of the sub-committees, notwithstanding the fact that the powers and duties originally intended by the Act to have been performed by Committees have not been possible of fulfilment in practice.

THE POWERS AND DUTIES OF INSURANCE COMMITTEES.

14. The powers and duties of Insurance Committees are very wide. These Committees are in the first place to be responsible for the administration of medical benefit for the whole of the insured persons, whether members of Approved Societies, or not, resident in their area, and for any members of a society which becomes approved, who were

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The number of medical practitioners usually is not less than ten per cent. of the membership of an Insurance Committee; chemists and nurses are frequently included amongst the members appointed by the Minister.

Insurance Committees accordingly represent many diverse interests, but there is little, if any, real conflict amongst the members, and they work together harmoniously in a genuine effort to further the work of the Insurance Committee, and to bring about improvements in the services available to insured persons.

7. Insurance Committees are required to appoint a Finance Sub-Committee, and they usually appoint other Sub-Committees in connection with their principal duties, including, as a rule, a Medical Benefit Sub-Committee. The practice amongst local authorities is closely followed, and certain powers and duties are delegated to the sub-committees. A woman must be included in every sub-committee dealing with the administration of any benefit. Sub-committees, other than the Finance and the Services Sub-Committees, may include persons other than members of the Committee. The Medical Benefit Sub-Committee has generally delegated to it the powers and duties in connection with the administration of medical benefit. There is in many cases similar delegation to a sub-committee for dealing with deposit contributors. Special sub-committees are appointed for various purposes from time to time, and some of these have rendered efficient service in the arrangements for health propaganda.

8. There are several joint sub-committees appointed either under the Medical Benefit Regulations or under schemes made thereunder. Any question arising between an insurance practitioner and a patient in respect of treatment or any question raised by a society with regard to medical certification stands referred to the Medical Service Sub-Committee, and any appropriate matter relating to the administration of medical benefit may be referred to it for investigation.

Any complaint made by an insured person against a chemist in respect of the supply of drugs or appliances falls to be investigated by the Pharmaceutical Service Sub-Committee, which may also have referred to it for investigation any appropriate matter relating to the administration of medical benefit.

There is also a Joint Services Sub-Committee, which deals with any question involving a practitioner and a chemist and any appropriate matter in connection with the administration of medical benefit may be referred direct to it by the Insurance Committee.

These sub-committees include a like number of representatives of insured persons, insurance practitioners, and chemists, and a neutral chairman.

They display a keen desire to ensure justice amongst the parties concerned, and by their care and impartiality they indicate a full recognition of the semi-judicial capacity in which they must act.

The Regulations also provide for the appointment of sub-committees under the Allocation Scheme, under the Scheme for securing an adequate Pharmaceutical Service, and if necessary, to deal with the arrangements for dispensing by doctors or chemists in rural areas, and in fact in any case where the insured person resides more than a mile from a chemist's shop.

9. There are certain statutory committees with which an Insurance Committee is concerned, viz., the Local Medical Committee, the Panel Committee, and the Pharmaceutical Committee. Any question arising as to whether an operation or other service is within the range of medical service must be referred to the Local Medical Committee, and in the event of disagreement, the matter must be submitted to referees appointed under the regulations for decision. The Local Medical Committee may also investigate any

complaint made by one insurance practitioner against another, involving any question of the efficiency of the medical service.

10. Local Medical and Panel Committees are to be consulted with regard to the Terms of Service for Practitioners, and they appoint the medical members of the Medical Service Sub-Committee.

The Insurance Committee and Panel Committee have the joint duty of preparing the Allocation Scheme under article 23 of the Regulations. Panel Committees have also important duties in the investigation of excessive prescribing, and determining whether an excess in quantity or otherwise has been incurred by an insurance practitioner. They also examine claims for fees in respect of emergency treatment and the administration of anaesthetics.

11. The Pharmaceutical Committee is to be consulted with regard to the Terms of Service for chemists and other persons supplying drugs and appliances, and acts jointly with the Insurance Committee in preparing a scheme for securing a proper pharmaceutical service.

It appoints the chemists' representatives on the Pharmaceutical Service Sub-Committee.

It is also empowered to consider complaints made to it by any person supplying drugs or appliances against another, involving any question of the efficiency of the service of supplying drugs and appliances to insured persons.

12. Insurance Committees (with the exception of London, Lancashire, Manchester and Salford) have entered into agreements under which Joint Committees, consisting of representatives of the several Insurance Committees in the group, undertake their duties in connection with the pricing of prescriptions and the determination of the amounts payable in respect of the supply of drugs and appliances to insured persons in accordance with the tariff. These Joint or Pricing Committees also undertake duties in connection with the preliminary investigation of prescribing in their areas.

13. The meetings of Insurance Committees are held at least once every quarter, but some Committees meet every six weeks, whilst others have monthly meetings. The Finance Sub-Committees, which are required to be appointed by regulation, generally meet once a month. It has already been stated that Insurance Committees may also appoint other sub-committees, and may delegate certain powers and duties to them. The effect of this is that the Insurance Committee may meet at longer intervals, since the duties in connection with finance and the administration of medical benefit can be and are expeditiously performed through the Finance and Medical Benefit Sub-Committees, and the duties in connection with deposit contributors, etc., by the appropriate sub-committee.

The Medical Service Sub-Committee meets quarterly, but in the case of the largest Committees, meetings are necessarily held more frequently. The Pharmaceutical Service, Joint Services, Allocation, Dispensing and Hours of Service (for Chemists) Sub-Committees only meet as may be necessary.

Insurance Committees are also represented at meetings of Joint Pricing Committees. Members of Committees are appointed, when necessary, to meet representatives of the Local Medical and Panel Committee for consultation, particularly with regard to the preparation of schemes which have to be prepared jointly under the regulations.

It is the common experience that members are regular in attendance at meetings of the Insurance Committee and of the sub-committees, notwithstanding the fact that the powers and duties originally intended by the Act to have been performed by Committees have not been possible of fulfilment in practice.

THE POWERS AND DUTIES OF INSURANCE COMMITTEES.

14. The powers and duties of Insurance Committees are very wide. These Committees are in the first place to be responsible for the administration of medical benefit for the whole of the insured persons, whether members of Approved Societies, or not, resident in their area, and for any members of a society which becomes approved, who were

members before the passing of the Act, and are disqualified by age or incapacity for work from becoming insured persons. For this purpose they must make arrangements to the satisfaction of the Minister of Health with a sufficient number of duly qualified medical practitioners to ensure to all those persons adequate medical attendance and treatment, or must take such other steps as may be necessary for the purpose; and they must provide for the supply of proper and sufficient drugs and medicines, and such appliances as the Minister of Health may prescribe. In each case they are required to prepare and publish lists of medical practitioners and chemists who are willing to undertake the work at the remuneration authorised and upon the terms and conditions of service approved by the Minister of Health. Except with the consent of the Minister of Health, the arrangement for the supply of drugs and medicines must not be made with medical practitioners. Insurance Committees are required to consider questions arising between medical practitioners and chemists on their lists and insured persons as to matters affecting attendance and treatment, including the supply of medicines, and between medical practitioners and Approved Societies in regard to the issue of certificates of incapacity for work.

15. Secondly, Insurance Committees administer sickness, disablement, and maternity benefits for deposit contributors and members of the Navy and Army Insurance Fund within their area.

16. Beyond their duties in connection with the administration of benefits, there are certain matters of a general character which the Insurance Committees may, by statute, undertake, *e.g.*, to collect information and statistics of health with regard to the insured persons in their area, for which purpose they may obtain the assistance of medical officers of health; to make reports and returns for the information of the Minister of Health, these reports when made to be forwarded to the councils of the counties, boroughs, urban or rural districts affected by them; in particular, to collect information with a view to the analysis and classification of the deposit contributors in their area; and in addition to collecting information, to disseminate it by means of lectures and publications, for which purpose they may make arrangements with local and other educational authorities.

17. Insurance Committees were also entrusted with the administration of sanatorium benefit from the 15th July, 1912, and this formed an important part of their duties until this benefit ceased on the 1st May, 1921.

18. Insurance Committees have taken a very deep interest in the work entrusted to them, and much of the success of the National Health Insurance Scheme is due to their efforts in making, locally, the arrangements for medical attendance and treatment, and for the supply of drugs and appliances. The fact that there is a local Committee readily available to insured persons, doctors, chemists, and others, for the solution of any difficulty as it emerges, is of enormous advantage, and the offices of Committees have been utilised to a very considerable extent, not only for the elucidation of matters strictly within their province, but for the supply of information upon all sorts of questions relating to National Health Insurance which strictly fall to be dealt with by Approved Societies or by the Ministry of Health and its officers. The small number of complaints that occur gives some indication of the thoroughness of Committees in performing their duties, and also speaks for the good relationships which prevail amongst the various interests concerned in, or affected by, the administration of the Act.

Beyond these duties, Committees have to consider applications from insured persons desiring or required to make their own arrangements for medical attendance and treatment; to consider applications for and to recommend the granting of travellers' vouchers to people frequently moving about the country; to deal with claims in respect of emergency

treatment, and of the administration of anaesthetics; to consider notices that certain services are claimed to be outside the scope of the doctor's agreement; to see that the provisions for deputies and assistants are observed; to issue and collect medical records; to make arrangements for the supply of medicines by chemists especially outside their ordinary business hours (by rota or otherwise); to undertake the testing of medicines; to see that surgeries are adequate and in every way satisfactory, and to ensure that the hours of attendance are observed.

Although there is no absolute right of entry on the part of Insurance Committees, inspection of surgeries is usually agreed upon and carried out by representatives of Insurance and Panel Committees jointly; but even before direct attention was drawn to this aspect of the matter at the beginning of 1924, many Committees had already interested themselves in it, and had undertaken the inspection of surgeries, and, where necessary, had arranged for improvements as to adequacy, lighting, heating, and ventilation, and in those cases in particular in which the doctor was not resident, steps were taken to provide for resident caretakers at branch surgeries, and for telephones, etc., at both surgery and residence.

Committees have fully recognised the importance of their responsibilities in the matter of the proper issue of medical certificates of incapacity for work, and have striven to secure the strictest compliance on the part of insurance practitioners with the rules relating thereto. They appreciate the necessity for safeguarding the funds of Approved Societies against unnecessary and unjust demands due to any carelessness or irregularity in the issue of medical certificates, which play so important a part in the administration of sickness and disablement benefits.

During the war the services of Insurance Committees were utilised in connection with the recruiting of doctors and chemists, and in many cases made arrangements, with the assistance of Panel Committees, for the conduct of the practice of a doctor during his absence on service with H.M. Forces. Similarly, arrangements have frequently been made for the conduct of a practice where it has become necessary owing to absence of the doctor on account of illness, or in consequence of the doctor's decease.

Pricing Committees have rendered extraneous service in compiling information relating to the use of dangerous drugs, and in pricing prescriptions for the Ministry of Pensions, and recently they have been specially requested by the Minister of Health to undertake duties in connection with the investigation of prescribing.

Insurance Committees have displayed an active interest in all matters pertaining to national health. They have taken a large share in health propaganda, particularly in National Health Week campaigns; they have endeavoured to provide or to improve the provision of nursing services, and they have taken their part in local health administration through representatives appointed upon Committees of the County or County Borough Council, *e.g.*, Tuberculosis, Maternity and Child Welfare, and Venereal Diseases; and also on Pensions and other Committees.

19. The staffs of Insurance Committees were largely recruited, at the inception of the Act, from the ranks of local authorities. In England most of the Clerks of Committees are whole-time servants, but in Scotland and Wales a considerable number of part-time Clerks are engaged. The previous experience gained by members of the staffs in the local government service has been of much advantage, and the further experience gained during the past twelve years in the service of Insurance Committees has resulted in an efficiency which is of the greatest value in the administration of National Health Insurance.

NATIONAL ASSOCIATION OF INSURANCE COMMITTEES.

20. The National Association of Insurance Committees was established at a Conference held on the 15th August, 1913, and the objects of the Association, which are approved by the Minister of Health under

section 37 of the National Health Insurance Act, 1924, are in the following terms, viz. :—

- (1) To confer on matters relating to the National Insurance Act, 1911, and any amending Act, in order that Insurance Committees may have the benefit of the practice and procedure of one another in matters of difficulty and doubt, as well as in the general administration of National Health Insurance and the various regulations, etc., issued by the Insurance Commissioners, and to take such steps as may from time to time appear advisable to obtain amendments which experience may show to be desirable.
- (2) To watch over and protect the general interests of Insurance Committees as they may be affected:—
 - (a) By legislation of general application to Insurance Committees and their areas;
 - (b) By the administration of the various Departments of the Government, which may exercise jurisdiction over the work of National Health Insurance; and
- (3) To take action generally in relation to any subjects in which Insurance Committees may be interested.

21. The membership in February, 1914, included 37 (of the 49) counties, and 58 (of the 73) county boroughs. These numbers steadily increased until at the present time 122 (of the 128) Insurance Committees in England are represented. General meetings of the Association are held annually, and special general meetings may be held at other times, but only two or three special meetings have been necessary. Insurance Committees usually send from two to four representatives to these meetings. The administrative power of the Association is vested in an Executive Council consisting of the officers (five in number), and 16 members elected by the representatives at the Annual Meeting, together with two members appointed by the London Insurance Committee. Meetings of the Executive Council are held as may be necessary; there have been five or six meetings in the course of a year.

22. The discussions at the Annual Meetings and Conferences have been extremely valuable in the development of the National Health Insurance Scheme; they have included every subject within the purview of Insurance Committees, including the relationship of their work to the Central Health Departments and local bodies as well as voluntary organisations interested in health matters. The Executive Council have taken suitable action to give effect to important resolutions passed at the meetings of the Association or at their own meetings, and have made representations in writing and by deputation to the Government, the Insurance Commissioners, the Local Government Board, and, later, to the Ministry of Health, with beneficial results not limited to insured persons and their dependants.

Frequent representations have been made with respect to the development of medical benefit and the ultimate provision of a complete medical service for insured persons and their dependants, and to measures appertaining to the treatment of tuberculosis, to maternity and child welfare, to pensions, and generally on matters relating to the prevention and cure of sickness.

Useful pamphlets and leaflets relating to the National Health Insurance Scheme, including medical and sanatorium benefits, health propaganda, nursing, etc., have been published.

Similar Associations of Insurance Committees were formed in Scotland and Wales, and later in Ireland, and, as will be shown, were federated with the English Association.

The National Association in conjunction with the federated Associations played a conspicuous part in the negotiations which preceded the introduction of the Bill to establish the Ministry of Health.

23. The National Association, the Scottish Association and the Welsh Association are recognised by the Government Departments as representative of the views of Insurance Committees, but certain matters are now dealt with through the National Joint (Whitley) Council for Insurance Committee Services for England and Wales, which was established on the 19th March, 1920, with the approval of the Minister of Health and the Minister of Labour.

NATIONAL JOINT COUNCIL.

24. The Scheme for the National Joint Council for Insurance Committees' Administrative, Technical and Clerical Services was prepared at a preliminary meeting held in London on the 19th March, 1920. At the first meeting of the Council, on the 21st May following, it was reported that the Minister of Health and the Minister of Labour were prepared to approve the scheme, and it was formally adopted and approved.

The objects were defined generally as follows:—

- (1) To secure the largest possible measure of joint action between employers and employed for the development of Insurance Committee administration, and for the improvement of the conditions of all engaged therein.

The more specific objects included consideration of the following matters:—

- (2) The provision of machinery for the regular consideration of remuneration, hours and conditions of service, including superannuation, tenure of office, and other matters affecting the service.
- (3) Measures for regularising the service and employment therein.
- (4) The encouragement of the study of methods of administration with a view to improvements affecting the service.

The Council consists of 26 members, one-half representative of the employers and the other half of representatives appointed by Officers' Associations, viz. :—

Representatives of Employers.

National Association of Insurance Committees	10
London Insurance Committee	1
Association of Welsh Insurance Committees	2
	—
	13

Representatives appointed by Officers' Associations.

Association of Insurance Committee Officers	9
National Association of Clerks to Insurance Committees	3
Welsh Association of Clerks to Insurance Committees	1
	—
	13

The Council is re-appointed annually and elects its own officers.

The Council has prepared certain scales of minimum salaries for officers in the service which, with the approval of the Minister of Health, have been circulated amongst Insurance Committees for adoption.

The Council has devoted considerable time to the preparation of a contributory Superannuation Scheme, and has endeavoured to obtain a statutory scheme. A voluntary scheme was submitted to the Minister of Health, but he determined that the consideration of the matter must be deferred pending the report of the Royal Commission on National Health Insurance. In consequence of the decision of the Minister, the Scheme was initiated without any contribution towards the benefits by Insurance Committees who will, however, contribute towards the cost of administration of the Fund. The Scheme came into operation on the 1st September, 1924, but the time for applications from existing officers has been extended to the 31st March, 1925. Insurance and Pricing Committees throughout the country

have unanimously passed resolutions in favour of the establishment of a joint contributory scheme of superannuation.

The Council has also undertaken a certain amount of educational work, and has obtained modifications in the syllabus for certain examinations suitable for Insurance Committee officers.

Representatives are sent by the Council to the meetings of the Association of Joint Industrial Councils.

FEDERATION COMMITTEE OF ASSOCIATIONS OF INSURANCE COMMITTEES.

25. The National Association entered into correspondence with the Scottish, Welsh, and Irish Associations of Insurance Committees with a view to joint action on matters of common interest, and on the 27th March, 1914, the Executive Council passed the following resolution:—

“That a Federation Committee be formed consisting of five representatives from each of the four Associations in the United Kingdom for purposes of common interest connected with the National Insurance Acts, and embraced within the Objects of the Association as set forth in Rule 2, the English members to act as may be directed by the Executive Council.”

The first meeting of the Federation Committee of the English, Scottish, and Welsh Associations was held on the 3rd July, 1914, and the representatives of the Scottish and Welsh Associations joined the members of the English Association in a deputation to the Chancellor of the Exchequer, the Right Hon. David Lloyd George, M.P., at the Treasury the same day.

The constitution of the Federation Committee was adopted at a meeting held on the 10th December, 1914, and under it each Association is entitled annually to appoint four members who, together with the President and Secretary, represent the Association on the Committee.

The objects of the Committee are:—

- (1) To confer and act upon all matters of common interest remitted to the Committee from the respective Associations or their Executive Councils.
- (2) To consider, from time to time, proposals either legislative or administrative, affecting the general interests of Insurance Committees, and make recommendations thereon to the constituent Associations.

The constitution provided for an Executive Committee consisting of the Chairman and Secretary and three other members, a representative of each Association to be included.

Regular meetings of the Committee and the Executive Committee have been held, and joint action has been taken on many occasions, *e.g.*, deputation to the President of the Local Government Board, the Right Hon. The Lord Rhondda, on the 13th April, 1917; deputation to the Prime Minister on the 11th October, 1917; in giving evidence before the Court of Inquiry into the Remuneration of Insurance Practitioners in January, 1924; and in taking action with respect to amending legislation affecting National Health Insurance. The Associations have been consulted by the Department thereon and in framing regulations connected with the work of Insurance Committees.

CHAPTER II.—MEDICAL BENEFIT.

THE STATUTORY PROVISIONS RELATING TO MEDICAL BENEFIT.

26. Medical benefit came into operation in January, 1913. It is defined in section 24 of the National Health Insurance Act, 1924, as “medical treatment and attendance, including the provision of proper and sufficient medicines, and such medical and surgical appliances as may be prescribed” by regulations.

The National Health Insurance (Medical Benefit) Consolidated Regulations, 1924, define and delimit the

“medical attendance and treatment” to be provided by insurance practitioners and the “provision of all proper and sufficient medicines” and prescribe the list of medical and surgical appliances to be supplied to insured persons. These regulations also set out the terms and conditions of service for insurance practitioners and chemists.

THE ORIGINAL SCHEME FOR MEDICAL TREATMENT AND ITS DEVELOPMENT.

27. The original scheme provided for local negotiations with doctors and chemists in order that Insurance Committees might make arrangements, with the approval of the Insurance Commissioners, for medical benefit to be made available to insured persons, and for this purpose to prepare lists of doctors and chemists who were willing to undertake service upon agreed terms and conditions, including rates of remuneration. It was also provided for Insurance Committees to enter into agreements with Approved Societies with respect to the sums to be paid to them to meet the cost of medical benefit and of its administration. It was found impracticable under the circumstances to carry through the local negotiations, as the central negotiations with the doctors had not resulted in general agreement, particularly with respect to the remuneration offered for services, and negotiations by Insurance Committees with large numbers of Approved Societies and branches could not even be attempted. After several conferences between the Government, the Insurance Commissioners and the Chairman and Clerks of Insurance Committees, the Commissioners were appointed to act as the agents of all Insurance Committees and Approved Societies, and in the result a single agreement was effected.

28. The doctors, however, were unwilling to accept service unless a higher rate of remuneration were offered than that upon which the finance of the National Insurance Bill was based, and the decision of the Government to ask Parliament to provide an additional sum of 2s. 6d. per insured person, and to set aside 6d. per head from the Sanatorium Benefit Fund for the domiciliary treatment of tuberculous insured persons also failed to find acceptance.

29. The Insurance Committees conducted prolonged and difficult local negotiations with the doctors, and in December, 1912, they issued letters of invitation to the doctors practising in their areas, setting out the amount of remuneration available, but leaving the method of remuneration for further negotiations. It was with considerable satisfaction that Insurance Committees were able to report their arrangements to the Chancellor of the Exchequer on the 2nd January, 1913. The successful initiation of the panel system was ensured, and within seven days the number of panel doctors had increased to 15,000.

The capitation system of payment was adopted by nearly all Insurance Committees and it is the system now in operation in all areas with the exception of Manchester and Salford.

30. The negotiations with doctors and chemists are now mainly conducted centrally, and only minor matters are dealt with under Schemes to be prepared by Insurance Committees either jointly or in consultation with the Local Committee representative of doctors and chemists.

The procedure whereby agreements were necessary between Insurance Committees and Approved Societies with respect to the cost of medical benefit and its administration, was terminated by section 7 of the National Health Insurance Act, 1920, which provided for definite payments to Insurance Committees out of the funds out of which benefits are payable under the 1911 Act. The special supplementary Grants-in-Aid provided by the Exchequer, were replaced by the provision of further moneys under the National Health Insurance (Cost of Benefits) Act, 1924, which remains in force until the 31st December, 1926.

31. Although the terms of service for doctors and chemists are agreed centrally after discussion between the Minister of Health, the Insurance Acts Committee of the British Medical Association, and

the Retail Pharmacists' Union, these terms, subject to approved local modifications, form the basis of the contract between the Insurance Committee and those doctors and chemists who apply to be and are included in the lists prepared by the Committee.

Insurance Committees however, have not been parties to the central negotiations with doctors and chemists, but the Associations are invariably consulted by the Departments when the terms and conditions of service (apart from remuneration) are under review. The Associations would urge that they should be directly represented, on behalf of Insurance Committees, on any body or conference negotiating the terms and conditions of service and other arrangements connected with the administration of medical benefit.

MEDICAL TREATMENT IN PRE-INSURANCE DAYS.

32. Until the National Health Insurance Scheme was introduced at the end of the year 1912, with its arrangements for providing medical attendance and treatment for the large body of workers in this country, there was no extensive organised medical system and a very large number had to make their own arrangements with the doctors. A considerable proportion, however, had their needs to some extent provided for under the arrangements made by Friendly Societies, Works Clubs, Medical Aid Societies and Provident Dispensaries, while in a limited number of areas Private Clubs and Public Medical Services were organised for them by members of the medical profession.

The Friendly Societies, according to the Report of the Registrar of Friendly Societies for 1911, had a membership of a little over six millions in England and Wales, and about half a million in Scotland; and it may be rightly inferred that medical treatment was provided for a large number of workers and through some of the societies for the wives and families of members. The members' rates of subscription varied considerably, but the average was about 4s. per member per annum, or a penny per week, with lower rates in respect of dependants.

The Works Clubs and Private Clubs provided medical treatment for the next largest section of the workers, and, as a rule, for their families also. They, like the Friendly Societies, made arrangements on the contract system, under which treatment (including medicine) was provided by a doctor to the members and their families within a defined district, usually extending not more than three miles from the doctor's surgery, on payment of a weekly sum averaging threepence per week. These sums were either deducted from the wages of the worker or handed to a collector, and they were weekly or fortnightly passed on to the doctor.

The Provident Dispensaries, where they existed, provided treatment for those who were not entitled or were unwilling to receive medical relief under the Poor Law, but who were considered unable to pay the full cost of treatment as private patients. These dispensaries were, therefore, to some extent charitable institutions.

The numbers receiving treatment as medical relief under the Poor Law were not considerable, and this method was never popular—rather the reverse.

33. There can be no doubt that the large majority of people were left to make their own arrangements, or to pay the usual fees charged by doctors to persons of the class to which they happened to belong; and although the well paid worker, enjoying good health himself, and with steady employment, might not regard the matter so seriously, there was always a reluctance to consult the doctor, and a tendency to keep down the treatment to a minimum, for fear of incurring a liability difficult, indeed at times impossible, to meet, owing to the demands upon the household budget. Apart from cases of unpaid or part-paid bills, gratuitous treatment was necessary for patients in straitened circumstances.

34. The growth of the contract system was naturally to be expected, but there were defects in it, already showing themselves unmistakably. Amongst these was the absence of free choice of doctor; the

members of societies, clubs, etc., begrudged the payment of their regular contributions if they were from any cause led to seek the services of another doctor. Then the scope of the service was restricted and usually there were fees for such services as night visits and minor operations. Appliances and expensive medicines were not included in the contract. These defects, combined with the difficulties in coming to terms as to the proper contract fee, led to much dissatisfaction, and to the formation, here and there, of medical associations by groups of Friendly Societies for the purpose of securing better treatment and better terms.

It was in these circumstances that the National Health Insurance Act was passed, and immediately the number of persons receiving medical treatment under arrangements made for them was doubled or trebled, although the old systems continued for the non-insured members of the workers' families, but not unaffected by the Insurance Medical Service.

MEDICAL TREATMENT AVAILABLE NOW.

35. Insurance Committees must include in their "Medical Lists" all practitioners who make application unless they have been removed from the list of an Insurance Committee by the Minister of Health. Insurance practitioners are no longer required to enter into formal agreements with Insurance Committees, but a medical practitioner may make formal application to an Insurance Committee and express his desire to undertake service upon the terms for the time being in operation in the area. These terms, it has already been stated, are set out in the Medical Benefit Regulations and in the Schemes made thereunder.

36. The numbers of insurance practitioners included in the Medical Lists of Insurance Committees represent a very large proportion of the general practitioners practising in their areas. From the estimates furnished by Insurance Committees it appeared that 97 per cent. of the general practitioners in counties and 83 per cent. in county boroughs were also insurance practitioners. In every Committee area a satisfactory medical service is available to insured persons, and is steadily improving. From returns obtained from a large number of county and county borough Committees, it appeared that there was an increase of 8 per cent. between January, 1920, and January, 1924. The names of insurance practitioners frequently appear on two or more County Medical Lists, but the Ministry have ascertained that there are 12,000 individual insurance practitioners. Considerable service is also rendered by other medical practitioners in the capacity of deputy or assistant.

Not only has there been a gradual increase in the number of insurance practitioners throughout the country, but the increase is particularly noticeable in the areas where some reluctance to join the panel was shown. There have, of course, been difficulties in a limited number of rural districts in arranging for an adequate service, but suitable provision is now made to meet the necessities of the case. Several Insurance Committees report increases in the numbers of residential doctors in congested areas.

37. Attention has been directed to the ease with which a medical practitioner may obtain admission to the medical list of an Insurance Committee, and to the criticism—never with any justification and now seldom voiced—that insurance service is only undertaken by the less competent practitioners. It is, however, the definite desire of all parties that an insurance practitioner should be recognised as one who is reasonably competent to undertake the duties. There is already a sound safeguard in the disqualification of a practitioner from undertaking service by reason of his name having been removed, after inquiry, from any medical list in Great Britain, but it would be an advantage if there were similar powers of exclusion as exist in the case of a chemist. It should also be made a condition of admission to the medical list that the proposed surgery and waiting-room accommodation and the proposed arrangements for the conduct of practice should be satisfactory to the Insurance Committee.

38. The general definition of the range of service now available is contained in clauses 8 and 9 (6) of the First Schedule to the Medical Benefit (Consolidated) Regulations, 1924.

Clause 8 defines the range of service as "treatment comprising 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 scope of the service includes either the administration of an anæsthetic or assistance at an operation performed on an insured person by another practitioner, whether or not the operation is within the scope of the service, except in cases where the administration of the anæsthetic or the assistance, as the case may be, is in itself a specialist service. Treatment in respect of a confinement is specifically excluded from the scope of the contract. In an emergency, whatever services are in the best interest of the patient under the circumstances are required to be rendered.

39. The definition of the range of service differs from that contained in the previous regulations in that it is intended to define more closely the scope of treatment comprised in medical benefit. Under the old regulations practitioners were not under an obligation to assist at operations performed by other practitioners, or to provide for the giving of anæsthetics in operations which were not within the scope of the contract. Further, the new definition lays down that where a service has been actually rendered to an insured person, the doctor, in order to be entitled to claim payment from the patient, will be required to show by certain criteria laid down in the regulations, that he possesses the special skill requisite for the performance of the service. In all such cases it will be necessary for him to show either:—

- (1) That he has held hospital or other appointments affording special opportunity for acquiring the special skill necessary, and that he has had recent practice in performing the services rendered; or
- (2) that he has had special academic or post-graduate study of a kind which comprises the services rendered and has had actual recent practice; or
- (3) that he is generally recognised by his professional colleagues as having special experience in the performance of the service rendered.

The present formula was arrived at by the Minister of Health after protracted discussions at conferences with representatives of Insurance Committees, Practitioners, and Societies, but it is still not possible under it to say immediately and with certainty whether any particular service rendered by a practitioner is within the contract of service or not.

40. If the patient's condition requires special treatment which is outside the range of medical benefit, the doctor is required to advise him as to the steps to be taken to obtain such treatment and himself to take such steps as may be necessary to secure that the patient receives full advantage from the provision of any services provided by the Local Health Authority. In the case of patients suffering from tuberculosis, the doctor is required to furnish periodical reports, in a specified form, as to the patient's progress, etc., and, if required, to consult with the tuberculosis officer.

41. Insurance Committees have no means of ascertaining to what extent insured persons are advised by insurance practitioners as to the steps which should be taken in order to obtain necessary treatment which is not within the scope of the practitioner's obligations under the Terms of Service, neither are they aware of the extent to which insurance practitioners consult with the tuberculosis officers with respect to patients suffering from tuberculosis. As both insured persons and tuberculosis officers may make complaints to the Insurance Committee on these matters and there has been a relatively small number of con-

plaints, it may be assumed that, generally speaking, satisfactory service is being given.

42. The regulations define the range of service due to insured persons as part of medical benefit, but it has frequently been urged that the provision falls short of the "medical attendance and treatment" to be given under section 10 (1) of the National Health Insurance Act, 1924, or the "adequate medical attendance and treatment from the medical practitioners" with whom arrangements were to be made by Insurance Committees under section 24 of the Act. The Association desires to emphasise the urgent necessity for a complete medical service with ancillary services, which should include the services of consultants and specialists co-ordinated with the general practitioner service, satisfactory diagnostic and treatment facilities, and a full maternity service by doctors and midwives.

DISPUTES AS TO RANGE OF SERVICE.

43. Insurance Committees have always recognised that until a complete medical and surgical service is made available to insured persons, questions as to whether they are entitled to a particular operation or service are bound to be raised by them. Under a complete service, questions of this sort will still arise, but they will concern the insurance practitioner rather than the insured person, and it will merely fall to be decided whether a particular service is to be given by an insurance practitioner or by a specialist or consultant, or by some other branch of the service.

44. All questions arising with respect to the range of service are dealt with by the Insurance Committee and the Local Medical Committee, and their decisions are reported to the Minister of Health, with a statement whether they have agreed or disagreed upon the matter. The Minister must in the event of disagreement, and may in other cases, refer the case to referees to be appointed in accordance with the regulations, and their decision is final.

45. The Ministry of Health, however, publishes the decisions in all such cases, and the total number of references up to June, 1924, was 18. Only one case in which the Local Committees were agreed that the service was within the scope was referred, and their decision was confirmed by the referees. In one only out of four cases did the referees confirm the local agreement that the service was not within the scope. Out of 13 cases where the Insurance Committee disagreed with the opinion of the Local Medical Committee that the service was not within the scope, the referees decided in six of them in favour of the Insurance Committee's opinion, and in the remaining seven cases in favour of the Local Medical Committee's opinion. Having regard to the continuance, development and extension of the range of service, to the varying local customs, and to the practice of referring every disagreement to referees, the small number of such cases actually referred indicates that in practice there is no real difficulty in the interpretation of the definition of the insurance practitioner's duties.

46. Insurance Committees certainly have no evidence that any unfair advantage is taken by insurance practitioners of their right to claim that certain services are beyond the range of service. As insurance practitioners must notify every case in which it is proposed to charge the insured person a fee, and notices given to Committees are infrequent, and as there were few real disputes to be settled, it may be assumed that a generous service is given.

It may further be assumed from the number of claims made by insurance practitioners for the special fee for the service of anæsthetists, that little attempt has been made to restrict the range of service. In a single county area there were 420 cases in which this fee was payable during the year 1924, but only 46 questions were raised during that year that any service rendered by a practitioner was not within the scope, and these were all agreed by the Insurance and Panel Committees with one exception, where the service was agreed to be within the scope.

MEDICAL CERTIFICATION.

47. Insurance practitioners are required to observe general rules governing the issue of certificates of incapacity for work. Briefly stated, these rules require that initial certificates must be issued to a patient at his request on his becoming incapable of work owing to mental or bodily disease or disablement, and thereafter intermediate certificates must be issued weekly at the request of the patient if the incapacity continues. A final certificate must be given as soon as the practitioner finds the patient is capable of work.

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48. There are special provisions governing the issue of intermediate convalescent certificates, covering a period of absence from home up to 14 days and special intermediate certificates in chronic cases, covering a period of not more than four weeks.

49. The Certification Rules were amended in 1924 so as to include certain new provisions. A form of "voluntary" or "optional" certificate strongly advocated by representatives of Insurance Committees, was provided for use on any occasion on which a doctor might wish to issue a certificate of any kind (which he is not required to give) for the assistance of an insured person in claiming sickness benefit, when any of the forms required to be given would be inappropriate.

50. The attention of Insurance Committees has been called to the anomalous position in which an insurance practitioner is under an obligation to make a recommendation with regard to the provision of dental and other treatment benefits only when he is required to issue a certificate of incapacity for work, and has been informed by the Approved Society that under its Scheme of Additional Benefits payments may be made. It not infrequently happens that an insured person is capable of following his ordinary employment, although it has become apparent that he requires dental or other treatment, and the Federated Associations strongly recommend that provision be made for the issue of recommendations by insurance practitioners under such circumstances.

51. Insurance practitioners are now required to certify as to the fact of death of an insured person who may have been under treatment and incapable of work.

52. The Association has no information as to the number of cases requiring medical certificates of incapacity, nor as to the number of such certificates issued annually, but it can safely be computed that many millions are issued every year, since the annual expenditure on sickness and disablement benefits is approximately ten million pounds. In 1924, these benefits were paid in respect of over twenty million weeks of incapacity for work.

53. It is the duty of the Medical Service Sub-Committee to investigate any question raised by a society as to the action of a practitioner with regard to any medical certificate which he is required to furnish to a member of the society. This matter will be dealt with in connection with the work of the Medical Service Sub-Committee, but it may be reasonably inferred from the small number of cases in which the Ministry have inflicted monetary penalties on doctors for grave irregularities in certification, the number for 1923 being 22 as against 16 for the previous year, that the service in this respect is generally satisfactory.

54. The requirement that a final certificate may not be issued after the insured person has resumed work has often been a source of difficulty, and insured persons have not yet become acquainted with the rule to this effect. This is the more to be regretted as sickness benefit is often withheld in respect of the last few days of incapacity, and this militates against the harmonious relationship which should exist between doctor and patient. There is perhaps, however, no greater problem in connection with medical certificates than that of determining what is meant by the term "Incapacity for work." Although official explanations have been issued for the guidance of insurance practitioners, difficulty persists. It is often found that the insured person is not likely to

be able to resume his ordinary occupation, and the question of his fitness for light work leads to differences of opinion between the doctor and the Approved Society. Occasionally when the doctor gives a certificate of incapacity a contrary opinion is given by the regional medical officer; the insurance practitioner must, however, continue to issue certificates if he considers the patient incapable of work. Societies generally allow a reasonable period for an insured person in such circumstances to fit himself for and to obtain other work. It is probable that this difficulty will continue so long as the Act does not make provision for payment of benefits during partial incapacity.

55. There are also problems in connection with certification during convalescence and during periods of hospital treatment. The rules preclude a doctor from issuing a special certificate covering a longer period of absence from home during convalescence than 14 days, and if the insured person does not return home at the end of a fortnight it becomes necessary for him to consult another doctor; and this he occasionally fails to do. Insurance practitioners are clearly not in a position to give certificates to a patient during his stay in a hospital or other institution, and insured persons cannot always obtain a certificate from the medical officer or any other responsible officer of the institution, and difficulty arises when treatment is resumed by the insurance practitioner. If, however, a certificate is obtained from an institution, its issue is not safeguarded in the same manner as with certificates given by insurance practitioners.

Where insured persons on their lists are receiving out-patient treatment at institutions, insurance practitioners are not relieved from the responsibility of giving certificates of incapacity if the patient presents himself for examination.

56. Although many improvements have been effected in the system of medical certification of incapacity for work, Insurance Committees hold the view that further simplification in the system is desirable.

The form of voluntary certificate has proved useful in many directions, but there are limitations under the rules which it does not satisfactorily meet, nor does it provide the ordinary forms for the use of the insured person in giving notice of sickness or a declaration as to continued incapacity for work.

MEDICAL RECORDS.

57. Insurance practitioners are required to keep records of the diseases of their patients and of their treatment of them in such form as the Minister may determine. The form of record in use was adopted by the Minister on the advice of an expert committee, mainly medical in its constitution and presided over by Sir Humphry Rolleston, Bart., K.C.B. The practitioner is furnished by the Insurance Committee with a medical record envelope in respect of each patient on his list, and he is required to record thereon attendances given, visits paid, diagnosis of illnesses, and to enter clinical notes.

The medical record envelope must be returned to the Insurance Committee either on request or on the death of the patient. The medical records serve a dual purpose, as they also form the list of the insured persons on the doctor's list. The medical records are inspected from time to time by the regional medical officer, and occasionally penalties are imposed upon practitioners in respect of delays in transmission or failure to keep the medical records adequately.

The present system is incomplete, inasmuch as no medical records are kept in respect of insured persons receiving treatment from persons or bodies other than insurance practitioners or approved institutions. It is desirable that arrangements should be made for the medical records to include the records of the treatment of tuberculosis patients.

The Association of Insurance Committees in 1921 expressed the opinion that in order to secure an adequate medical service it is essential for insurance practitioners to continue to keep records of the treatment given to insured persons.

58. The Inter-Departmental Committee on Insurance Medical Records laid down that the purposes of the records should be (a) clinical, (b) administrative and (c) statistical.

Insurance Committees, having regard to their duties under section 50 of the National Health Insurance Act, 1924, to make provision for the publication of information relating to health, and to make arrangements for that purpose with local education authorities, universities and other institutions, are of the opinion that valuable statistical information might be extracted from these medical records for publication.

The following resolution on this subject was passed at the last Annual Meeting of the Association:—

“That Insurance Committees be made acquainted with the manner in which the information and data, statistical and clinical, at present in their possession, and from time to time becoming available to them, in the form of medical records received from insurance practitioners and otherwise, may be analysed, summarised and collated, with a view to the same serving, in whole or part, any of the purposes contemplated in sections 60 and 63 of the 1911 Act, or otherwise.”

The Associations desire to urge that arrangements be made for Insurance Committees to be in a position to take advantage of the information contained in the medical records kept by insurance practitioners, and to undertake the compilation of statistics and the extraction of information therefrom as to the causes and incidence of sickness. Hitherto the only effective use which has been made of the records was the partial use of them in connection with the preparation of reports relating to rheumatic and venereal diseases, apart from the compiling of certain statistics for presentation to the Court of Inquiry into the Remuneration of Insurance Practitioners and for use in connection with the reports of the Chief Medical Officer of the Ministry of Health.

SIZE OF DOCTORS' PANEL-LISTS.

59. The maximum limit for the list of an insurance practitioner is 2,500 or 3,000 in the case of a partnership, with a limit of 5,000 for two partners. The limit of 2,500 may be raised to 4,000 in the case of a practitioner who employs, with the consent of the Insurance Committee, a whole-time permanent assistant, and a corresponding addition may be made in respect of any additional permanent assistant whose employment may be sanctioned. These are, however, maximum figures, and the local Insurance and Panel Committees have power to agree upon a lower limit if, in their opinion, the circumstances of the area so require. In the event of disagreement between these two Committees, the limit is fixed by the Minister.

Under the early regulations there was no limit to any panel doctor's list, but in the 1920 Regulations a maximum of 3,000 was prescribed for a single-handed doctor, but no limit was determined to be applicable to partners or assistants, though the Allocation Schemes prepared under these regulations generally restricted the allowance in respect of the employment of assistants.

60. The power for fixing a lower limit where the Insurance and Panel Committees consider the circumstances of the area require this to be done is important, but care has had to be taken to preserve, as far as possible, the right of “free choice.” Insured persons are now permitted to transfer at any time to any practitioner who will accept them, or to whom they may be assigned, if necessary, by the Insurance Committee. This has diminished the importance of the limitation of lists, although the power is valuable inasmuch as it tends to the employment of a partner or an assistant in large practices. Consideration is also given to the proportion which the insurance practice bears to the complete practice as this varies widely, but it has been estimated to be on the average nearly one-half. The proportion of insured persons receiving treatment in the course of a year, or under treatment during any given period, and the increase in the latter during epidemics, are other important factors.

61. The average number on the lists of insurance practitioners is approximately 1,000, but the average is higher in towns and industrial areas, and is correspondingly lower in country practices. In half of the insurance practices the total number on the lists is below 900.

From information received from a number of Insurance Committees it appeared that 77 per cent. of the whole number of insurance practices were single-handed. An examination of the sizes of these practices showed that the number on the list of a single-handed practitioner was under 1,500 in seven practices out of every eight, and in practices of all kinds it was under 1,500 in three practices out of every four.

As insurance practitioners may have insured persons on their lists for more than one Insurance Committee area, it is necessary to aggregate their numbers in the different areas, and Insurance Committees are required to confer with one another in dealing with the limitation of lists of doctors practising in more Committee areas than one. The Ministry have ascertained from time to time the numbers for all Insurance Committee areas, and have compiled the aggregate number of insured persons for whom each doctor is responsible. Mr. L. G. Brock, O.B., Assistant Secretary to the Ministry, showed in his evidence that in 85 per cent. of cases the number on the lists of individual doctors is less than 1,200; in over half of them, less than 600, and that in only 14 per cent. of the cases did the number on the list exceed 2,000, the majority of these relating to doctors employing an assistant or more than one.

62. Insurance Committees have found that while there are obvious advantages in fixing a limit to the number of insured persons who may be included in the list of an insurance practitioner, there are certain disadvantages which arise from an attempt to confine the list within a definite numerical limit. A practitioner may thereby be prevented from accepting an insured person, although he is not only an insurance practitioner, but the family practitioner, and this is regarded as unnecessary interference with the right of free choice. It is suggested that the practitioner should be permitted to exceed the maximum numerical limit within a reasonable margin, but not to go beyond a fixed financial limit.

The usual procedure under several approved Allocation and Distribution Schemes is that a practitioner is required to reduce his list by giving notice to the number of insured persons in excess of the maximum that they must select another practitioner. Where, however, the remuneration is limited to the capitation fee multiplied by the maximum number, notwithstanding that the number on his list is in excess of that number a doctor is able to adjust his list by declining further acceptances until it is in order without disturbing any of the persons included in it.

DEPUTIES, ASSISTANTS, AND PARTNERS.

63. Insured persons are entitled to the personal services of the insurance practitioners in whose list their names are included, but this general statement is subject to certain modifications, under which services may be rendered by deputies, assistants, and partners. Service by deputy may be given when the personal services of the practitioner are not available on the ground that he is attending to other patients, or is absent on leave, or incapacitated by illness; or arrangements may be made with another practitioner to undertake certain services, e.g., minor surgery. The practitioner must notify the Insurance Committee of his standing deputising arrangements.

64. The insurance practitioner may employ an assistant with the consent of the Insurance Committee, or, if sanctioned also by the Ministry, more than one assistant, but patients may, if they wish, have the personal services of the principal. There is no doubt that the employment of an assistant is often an advantage to the patient; it makes a second opinion available, and affords an increased service at all times. The system also possesses the merit of enabling duly qualified practitioners to obtain ex-

perience of general practice which would tend to ensure a high standard of service.

65. In the case of practitioners in partnership, treatment may be given by either partner, but, in the patient's interest, proper steps must be taken to ensure continuity of treatment.

66. Insurance Committees have made arrangements with Panel Committees for ensuring the collective responsibility of insurance practitioners, and treatment may be obtained in emergency from any insurance practitioner.

SURGERY AND WAITING-ROOM ACCOMMODATION.

67. Insurance practitioners are required to provide proper and sufficient surgery and waiting-room accommodation for their patients, having regard to the circumstances of their practice.

Greater accommodation is required where more than one doctor is undertaking the treatment of patients than would be deemed sufficient in the case of a single-handed practice. Separate consulting rooms should at least be provided for doctors engaged at the same time.

68. It is not permissible for a practitioner to carry on insurance practice elsewhere than at his place of residence, except upon such conditions as appear to the Committee to be such as to enable his obligations, especially as regards the visiting of patients, to be adequately carried out. Thus an urban doctor who keeps a lock-up surgery some distance away from his place of residence, is required to take such measures as will ensure that patients are able to obtain his services, when required, at times when the surgery is not open. These include the provision of telephonic communication between the surgery and the doctor's residence, and the appointment of a resident caretaker in suitable cases.

69. It is usual where an Insurance Committee has received a complaint from any quarter, or has any reason to question whether adequate surgery and waiting-room accommodation is provided, either in specific cases or generally in its area, to undertake jointly with the Panel Committee an investigation. If the accommodation is not satisfactory, or, within a reasonable time, suitably improved, or if any of the arrangements for the conduct of the practice are unsuitable or inconvenient, the Insurance Committee usually refers the matter to the Medical Service Sub-Committee for a report to be made to them. The Insurance Committee may notify any deficiencies to the Ministry of Health, with a recommendation that some monetary or other penalty be inflicted. It is usually found, however, that every effort is made by practitioners to carry out any suggestions made to them by the Insurance and Panel Committees, and that the same facilities are afforded to insured as to other patients.

As indicated previously, many Committees have undertaken a systematic review of the surgeries within their areas, and as a result have had improvements effected where necessary, and telephones and caretakers installed in those cases in which the practitioner is non-resident. Generally speaking, surgeries and consulting rooms can now be regarded as satisfactory, but it is considered that admission to the medical list should be conditional upon the surgery and waiting-room accommodation being satisfactory, instead of the present necessity for proving their inadequacy or unsatisfactory character after admission to the list.

SELECTION OF DOCTOR AND CHARGING OF FEES.

70. An insured person has been, since the 1st January, 1924, at liberty to change his doctor at any time by a simple procedure. He was previously required to give notice during specified periods at yearly and later at half-yearly intervals. The Association advocated this alteration, and also urges that similar freedom should be allowed to insured persons on the list of an Approved Institution, or making their own arrangements, to change their method of treatment at any time, which at the present time is restricted to half-yearly intervals, notice having to be given before the 1st June or

the 1st December, respectively. The Insurance Committees have always regarded as of extreme importance the right on the part of any insured person under section 24 of the Act to select the doctor by whom he wishes to be attended, subject to the consent of the doctor.

71. The delay, which insured persons are warned against, in making any selection of doctor at all, has occasionally led to difficulties with respect to the charging of fees for treatment before the name of the patient was included in the practitioners' list, and similar difficulties have arisen where emergency treatment has been rendered without any evidence that it is an insurance practitioner's service that is being given. A practitioner is now permitted in doubtful cases to charge a fee by way of deposit, or to render an account or give notice that he intends to render an account during the course of treatment. The insured person may send the receipt or notice to the Insurance Committee, and if he is found to be entitled to medical benefit the amount is refunded to the patient and deducted from the practitioner's remuneration. The "deposit system" has been resorted to pretty freely in some areas, while in others little use has been made of it. From inquiries which have been made it appears that where the freest use has been made of the "deposit system," the persons applying for treatment have in practically all cases been found, upon investigation, to be entitled to it. It has already been mentioned that practitioners are required to give notice to the Insurance Committee where they intend to charge fees for services not within the scope.

72. Any question raised with respect to the improper charging of fees stands referred to the Medical Service Sub-Committee, and it is evident from the diminishing number of such cases calling for inquiry that these improvements in the machinery—the extension of the freedom of choice, the institution of the deposit system, the collective responsibility of practitioners (including the arrangements for emergency treatment)—have increased the efficiency of the medical service, and materially reduced the occasions for complaint by insured persons. The Association believes that the extended freedom of choice has obviated many complaints which would have fallen to be dealt with by the Medical Service Sub-Committees; the former restriction which prevented an insured person from changing his doctor when he might wish to do so as frequently occurs, at the beginning or during the course of an illness, was often a source of dissatisfaction to him.

REPORTS AND CONSULTATIONS.

73. A service of regional medical officers has been established by the Minister, and one of their functions is to act as referees in cases of insured persons referred by their Approved Societies or by insurance practitioners on the question whether or not they are "incapable of work" within the meaning of the National Health Insurance Act, and, consequently, whether they are entitled to the payment of sickness and disablement benefit.

74. Practitioners are required to furnish to the regional medical officers reports as to the state of health and treatment given, etc., to patients who have been certified by them as incapable of work, and have been referred for examination by their societies.

75. It is also the duty of practitioners to furnish to the Tuberculosis Medical Officers periodical reports as to the progress of patients suffering from tuberculosis.

76. Consultation references to regional medical officers may only be made under restricted conditions, and the Associations have expressed to the Ministry their opinion that insurance practitioners should be at liberty to make such consultation references at any time that they may consider it in the best interests of their patients, and that regional medical officers should have available more extensively the services of consultant specialists in

dealing with any references that render such course desirable.

MILEAGE.

77. Insurance Committees have from the outset recognised the necessity for some differentiation in the rates of payments for practitioners in urban or industrial areas and those whose practices are in rural areas where the patients are scattered, the means of communication difficult, and the homes of certain patients almost inaccessible.

The offer of the Government to the doctors included the provision of a special mileage fund of £50,000, and this was distributed amongst Insurance Committees who submitted details of the specially difficult parts of their areas. The local distribution was undertaken by the Insurance Committee, in conjunction with the Panel Committee. A suggestion that Insurance Committees and Panel Committees might agree in certain areas to allot a portion of the capitation fee (say twopence) for mileage purposes, did not materialise, and there is no doubt that the grant for special mileage was a real inducement to the country doctor to undertake insurance practice, although it was not sufficient to compensate him; he had a small panel-list as compared with the urban doctor, and on the average considerably greater expense and time were involved in visiting the widely scattered patients than in the more compact practices.

78. Many rural doctors have fewer than 500 insured persons on their lists, and the average for all doctors claiming mileage in England and Wales in 1923 was 697, whereas the average number on the lists of all urban doctors was 1,200. The average insurance payments to doctors claiming mileage in 1923 was £353, whereas the corresponding average for urban doctors was £540. But apart from financial considerations, country practice is generally less attractive than urban practice, although there are certain doctors to whom country life has a strong appeal.

The problem of maintaining an efficient medical service in certain parts of county areas early claimed the attention of Insurance Committees, and various methods were adopted in accordance with the circumstances.

79. The grants were substantially increased in 1917, and in 1919 it was agreed that a Central Mileage Fund be set up for the purpose of providing additional payments to doctors with rural practices, and payments out of this fund were based not only on the expense of visiting patients, but also on the time involved in travelling, in so far as it was in excess of the average time occupied by an urban doctor in visiting his patients.

80. The Central Mileage Fund for 1920 based upon a report of the Distribution Committee, amounted to £300,000 for England and Wales, but of this sum £34,900 was to be distributed in special mileage grants for the benefit of doctors engaged in practices of exceptional difficulty. There have since been reductions in the amount of the Central Mileage Fund, and the determination of the amount, as well as the distribution of the Fund amongst Insurance Committees, has been undertaken by the Minister, after considering reports made by the Distribution Committee.

81. The amount of the Central Mileage Fund for 1924 was fixed at £250,000, with an understanding that sparse practices should receive more favoured treatment. The special mileage fund amounted to £34,600, and a further sum of £10,000 was specially allocated to meet claims arising in necessitous practices; the remainder available for ordinary mileage for 1924 was £205,300. It has been estimated that this represented an addition of 1s. 1½d. to the capitation fee in respect of all persons on the aggregate lists in practices receiving mileage payments, or an amount of approximately 5s. per "mileage patient." Of the latter sum 1s. 10d. was the cost of travelling, and the balance of 3s. 2d. was in respect of extra time and other considerations. Although these mileage payments are in the aggregate very consider-

able—representing about 4½d. per head of the total insured population—the country doctor remains at a disadvantage in the matter of average income; and to bring him up to the level of the urban doctor an amount three or four times greater than the present mileage payments would probably be required.

82. Insurance Committees and Panel Committees have jointly prepared the schemes for the distribution of the local Mileage and Special Mileage Funds. It has been generally recognised that a flat rate basis is inapplicable, and that it is essential to have local knowledge of the prevailing conditions of practice, of the nature of the roads and other means of communication, and, further, of the distribution of the patients. The schemes differ considerably in character; some are complicated, others are very simple. They have, however, all worked out well in practice, and experience has shown that the Insurance Committees and Panel Committees in consultation are best qualified to undertake the distribution within their areas.

SPECIAL ARRANGEMENTS.

83. The ordinary method of arrangements for medical treatment by Insurance Committees has been described, but there are two other methods open to insured persons. They may make their own arrangements with medical practitioners, either individually, or collectively as members of a group of persons employed in a hospital or similar institution; again, they may elect to obtain their medical attendance and treatment through a system or institution approved by the Insurance Committee, and by the Minister of Health, under section 24 (4) of the Act.

84. Insured persons may be allowed in certain circumstances to make their own arrangements, but there are some classes of insured persons who may be required by Insurance Committees to make their own arrangements. These latter comprise Exempt Persons whose total income from all sources exceeds £160 a year, and those insured persons who may exceed the income limit, if any, which may have been fixed by the Insurance Committee in accordance with the provisions contained in the Fourth Schedule to the Medical Benefit Regulations.

85. The number of cases in which insured persons have been allowed or required to make their own arrangements is relatively small, but the Association favours the continuance of this method, although there is now a diminished necessity for it, owing to the adequacy of the ordinary arrangements of Insurance Committees.

86. The Association has considered the effect of clause 3 (6) of the Fourth Schedule to the Regulations, which prevents any accumulations in the Special Arrangements Funds, and it is of opinion that any savings in this way might be utilised, or, alternatively, the General Medical Benefit Fund should be made available to meet claims arising in subsequent years, or to meet certain expenses inadvertently incurred by insured persons in obtaining emergency treatment or drugs or appliances otherwise than from doctors or chemists on the lists of Insurance Committees.

APPROVED INSTITUTIONS.

87. Approved Institutions are limited to those systems or institutions which were in existence at the date of the passing of the 1911 Act, and insured persons may elect to receive their medical benefit through them. They are mostly associations formed by Friendly Societies, but some provide medical benefit for the employees of certain large firms. The Post Office system has ceased to be approved, and the employees now obtain their medical benefit by any of the methods open to other insured persons. In many Insurance Committee areas there is no Approved Institution.

88. The Association is of opinion that complaints by members of Approved Institutions which are now dealt with under the Rules of the Institutions, should stand referred to Medical Service Sub-Committees

for investigation in the same way as all similar complaints of other insured persons. This would assist Insurance Committees in considering whether approval should continue to be given to an institution, and in satisfying themselves that the services rendered to the members reach the standard required of insurance practitioners. They further consider that the provisions as to investigations, disputes, appeals, etc. contained in Parts V. and VI. of the Medical Benefit Regulations, 1924, in so far as they relate to witnesses and the awarding of costs, should be made applicable to Approved Institutions.

89. The Association also recommend, as has previously been stated, that members of Approved Institutions should be given the same freedom to transfer to or from an Approved Institution at any time as exists for insured persons on the lists of insurance practitioners.

SUPPLY OF DRUGS AND APPLIANCES.

90. Drugs and appliances are supplied to insured persons by chemists who have entered into contract with the Insurance Committee, but in certain cases arrangements are made for them to be supplied by practitioners.

A practitioner is required to supply a patient with all drugs which are necessarily or ordinarily administered by a practitioner in person, and with any drug or appliance required in an emergency before a supply can be conveniently obtained otherwise.

The Insurance Committee may require a practitioner to supply insured persons with all requisite drugs and appliances when they are satisfied that owing either to the distance of the patient from an insurance chemist, or to inadequate means of communication, serious difficulty and delay to the patient would otherwise arise.

In rural areas an insured person living more than a mile from the nearest insurance chemist may prefer to obtain his drugs and appliances from the practitioner in whose list he is included. In such case, if the practitioner is in the habit of dispensing drugs for his private patients, and the Insurance Committee are satisfied that the insured person cannot obtain his medicine with equal facility from a chemist, they may require the practitioner to supply the requisite drugs and appliances.

TERMS OF SERVICE FOR CHEMISTS.

91. Insurance Committees are empowered by the National Health Insurance Acts and Regulations to contract with persons, firms or bodies corporate, entitled under the Pharmacy Acts to carry on the business of a chemist or druggist (referred to as chemists), who undertake to dispense prescriptions and to supply drugs and appliances. A list of the chemists under contract with them is compiled by the Insurance Committee. Chemists are required to supply to insured persons with reasonable promptness the drugs, etc., ordered by practitioners on insurance prescription forms, and for that purpose are required to keep in stock the drugs and appliances mentioned in the Drug Tariff. All dispensing of medicines must be done by or under the direct supervision of a registered pharmacist. The articles supplied must be of a certain grade or quality corresponding to the standard of the Drug Tariff. The Terms of Service may be altered by three months' notice being given to chemists by the Insurance Committee and a chemist may withdraw from the list by giving proper notice to the Committee.

92. The number of chemists' shops available for the supply to insured persons of drugs and appliances in England was 8,500 at the end of the year 1922 and probably is now increased.

ADEQUATE PHARMACEUTICAL SERVICE.

93. The Insurance Committee and the Pharmaceutical Committee are responsible for maintaining a satisfactory pharmaceutical service in the area and for making arrangements that insured persons may obtain their medicines at all reasonable times. Chemists are required to exhibit a notice at their

places of business stating the name of the Insurance Committee with whom they have contracted, and their hours of business. They are also required, when their places of business are closed, to exhibit a notice informing insured persons of the nearest chemist where medicines may be obtained.

94. Prescriptions issued by a practitioner after the normal closing hour and marked "Urgent" may be dispensed by the chemist if he is resident at his place of business or reasonably accessible; if not, it is the responsibility of the practitioner to supply the medicine himself. 8 p.m. is generally regarded as the normal closing hour, and a double dispensing fee is allowed for each prescription dispensed after that time, provided that the form is endorsed "Urgent" by the prescriber and signed by the chemist with a note of the time when the medicine was actually dispensed.

It is customary for Committees to arrange for a "rota" of chemists in order that no difficulty may arise during the hours when the chemist's shop is closed, particularly on Sundays or early closing days. This, however, is impossible in "single-chemist" areas where it is usually provided under the scheme that a dispensing service shall be available outside the ordinary hours of business to meet the reasonable requirements of insured persons. In practice this arrangement works satisfactorily, and the division of responsibility between the chemist and the doctor gives the insured person an efficient and constant service.

In rural areas there are no arrangements for the conveyance of medicines although it is often necessary, owing to the distance, for medicines to be sent by the doctor or the chemist, and this service is rendered although no charge can be made upon the Drug Fund for it.

PAYMENT FOR DRUGS AND APPLIANCES.

95. All drugs and appliances are supplied free to insured persons, all payments being made by the Insurance Committees.

The Minister of Health, in order that arrangements may be made for the supply of drugs and appliances of proper quality, prepares a statement known as the Drug Tariff, which includes:—

- (1) The prices on the basis of which the payment for drugs and appliances ordinarily supplied by chemists to insured persons is to be calculated,
- (2) The dispensing or other fees payable in respect of the supply of drugs and appliances, and
- (3) The standards of quality for drugs and appliances ordinarily supplied.

While the appliances are limited to those items which are included in the Second Schedule to the Medical Benefit Regulations, the drugs which may be supplied are only limited by the term "proper and sufficient."

The system of pricing now in force in England and Wales is based upon payment for drugs at cost, plus a fee for professional services including a sum for establishment charges.

Insurance practitioners, who undertake to supply all drugs and appliances may, instead of receiving payments in accordance with the Drug Tariff, elect to be paid upon a capitation basis; the present fee is 2s. per "dispensing patient."

PRICING ARRANGEMENTS.

96. The pricing of prescriptions dispensed for insured persons is undertaken by Pricing Bureaux throughout the country.

These Bureaux formed by the grouping of Insurance Committees are controlled by Committees representing the Insurance Committees for the group; eleven of these groups have been formed in England, comprising all the Insurance Committees with the exception of four.

The chemist sends in the National Health Insurance prescriptions which he has dispensed each month to the Pricing Office controlled, directly or jointly, by

the Insurance Committee with whom he has contracted. The prescriptions are then priced and checked and the amount due to the chemist is certified by the Pricing Office to the Insurance Committee who make the payment to the chemist.

The terms of service for chemists in Wales are similar to those in England, and the pricing arrangements are undertaken by a central bureau. The terms of service as regards the basis of payment for drugs, etc., differ in Scotland. The pricing arrangements, as in Wales, are performed by a central bureau.

VACCINES, SERUMS AND INSULIN.

57. Vaccines, serums and insulin may all be supplied to insured persons at the cost of the Drug Fund. In certain areas some serums and vaccines are provided by Public Authorities free of charge; in districts where this free supply is available such serums and vaccines are not paid for from Insurance Funds. The Minister of Health requires Insurance Committees, through their Pricing Bureaux, to furnish him with quarterly returns in respect of serums and vaccines and insulin showing:—

- (1) the total number of prescriptions issued,
- (2) the total number of patients in respect of whom the articles were ordered, and
- (3) the total value of the prescriptions issued.

EMERGENCY DRUGS AND APPLIANCES.

98. As emergency drugs and appliances cannot be conveniently obtained from a chemist, it is the duty of the practitioner to supply them and payment is made to the practitioner either at a capitation rate or by payment for each prescription on the basis of the Drug Tariff. The method of payment depends upon the Distribution Scheme in force in the area of the Insurance Committee. The demand for emergency drugs is usually very small and the general yearly rate of payment is 1s. 3d. per 100 persons on the doctor's list.

STOCK AND REPEAT MIXTURES.

99. "Stock mixture" was the name applied to any liquid medicament prepared and judged to be capable of being stocked in bulk without deterioration, and in respect of it a reduced dispensing fee was payable.

The Drug Tariff which came into force on the 1st April, 1921, abolished these "stock mixtures," and an insured person is now entitled to have all his mixtures freshly compounded and dispensed; this improvement in the service is highly valued by Insurance Committees, who have always regarded "stock mixtures" unfavourably and have made representations to the Department against their use.

When Insurance Committees, through their Joint Pricing Committees, undertook the pricing of prescriptions, considerable difficulty was experienced in dealing with prescriptions ordering "Rep. Mist." In many cases these "repeats" referred to prescriptions issued some months previously. Rules were laid down during the War period regulating the manner in which practitioners might issue repeat orders for medicines, but it was not until 1920 that "Rep. Mist." was entirely abolished, so that a prescription may not now be written so as to necessitate reference by the dispenser to a previous order.

TESTING OF MEDICINES AND APPLIANCES.

100. The dispensing for insured persons is subject to the provisions of the Sale of Food and Drugs Acts in the same manner as all other dispensing. The terms of service for chemists provide that a chemist shall sell to any one of the persons mentioned in section 13 of the Sale of Food and Drugs Act, 1875, 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.

Insurance Committees may arrange for samples of medicines to be obtained from time to time for analysis, and also for samples of appliances to be taken in order to ensure that these are of the standard and quality laid down in the Drug Tariff.

Schemes have been prepared in some areas in conjunction with the Pharmaceutical and Panel Committees with the object of systematically taking samples for testing, and there is now under consideration a scheme intended to apply to the whole country.

INADEQUACY OF LIST OF APPLIANCES.

101. The only appliances that may be ordered for insured persons are those included in the Second Schedule to the Medical Benefit Regulations. This Schedule somewhat rigidly restricts the doctor's choice of appliances and in some areas Insurance Committees receive from their Pricing Office a number of notifications of cases where practitioners have ordered and chemists have supplied appliances not included in the official Schedule. The Pricing Office is therefore unable to pass these prescriptions for payment and it becomes the duty of the Insurance Committee to notify the practitioner.

The Federated Associations recommend that the list of prescribed appliances should be increased and arrangements made for the supply or, in appropriate circumstances, the loan of any appliance requisite in connection with medical treatment.

INVESTIGATION OF PRESCRIBING.

102. In order to secure that an undue charge is not imposed on the Drug Fund owing to needless extravagance in prescribing, it is the duty of the Panel Committee to review from time to time the prescribing of practitioners in the area, and in cases where they are satisfied that there has been such extravagance, to recommend the imposition of a monetary penalty on the practitioner concerned. Except in cases where the Panel Committee apply for and receive permission from the Minister of Health to carry out the whole of the investigation themselves, the preliminary scrutiny of prescriptions is made by the Ministry, with the assistance of the Pricing Offices, and in cases where this scrutiny suggests the possibility of extravagance on the part of the practitioner, he is afforded an opportunity of explaining the reasons for the supposed extravagance to the regional medical officer, who may be accompanied by a member of the Panel Committee appointed for the purpose. After consideration of his explanations, the Ministry decide whether the case should be referred formally to the Panel Committee for adjudication.

103. Both the Ministry and the practitioner have a right of appeal against the decision of the Panel Committee to an independent body of referees, and the Insurance Committee have a right to be consulted as to the penalty, if any, to be imposed.

104. Under previous regulations, the Panel Committee had the duty of deciding whether there had been extravagance, and of recommending to the Insurance Committee the penalty to be imposed. The Ministry were not a party to the earlier proceedings, but a right of appeal lay to the Minister against the decision of the Insurance Committee. The revised arrangements of the 1923 Regulations should result in a more uniform system of scrutinising prescribing, and secure that a practitioner is not penalised for ordering drugs which, though expensive in themselves, are really necessary for the proper treatment of the patients.

105. The duties of Pricing Offices in connection with the investigation of prescribing by insurance practitioners are a considerable addition to their original duties of pricing prescriptions and preparing and certifying chemists' accounts. They are called upon to compile statistical returns and summaries of the prescriptions from each Insurance Committee area showing each month the total number of prescriptions, the total prescription cost, the average cost per prescription, the prescription frequency per insured person, and the average total cost per insured person.

106. The Pricing Office also prepares:—

- (1) Statistical figures and averages as above in respect of prescriptions issued by individual doctors, particulars in respect of approximately one-third of the doctors on the lists of the Bureau being prepared each month, and
- (2) General reports on prescribing, i.e., expensive or unusual prescriptions and large quantities of medicine ordered at one time.

107. From the information supplied on (1) above the Minister of Health asks the Pricing Office to supply full reports on the prescribing of doctors whose monthly averages appear to indicate a tendency towards unduly expensive prescribing. These reports are then dealt with by the Ministry of Health and, if necessary, referred to the regional medical officer for action to be taken on the lines already indicated (in paragraph 102).

108. Insurance Committees have noted from the statistics supplied by Pricing Offices that there has been a steady and, often, a substantial increase during each of the last four years, not only in the total number of prescriptions dealt with, but also in the average number of prescriptions per insured person, or briefly, in the "frequency." The rate of increase is greater than the increase in the number of insured persons entitled to receive prescriptions, and may be due to several causes, e.g., unemployment; the increase in the use of the insurance medical service as the early prejudices disappear and its value is better recognised; the increasing interest of the public in health matters as a result of health teaching and propaganda; the abolition of the "floating sixpence"; and the progress in medical science, diagnosis and treatment.

109. The average costs of drugs and appliances show increases, and there are wide divergencies between the several Insurance Committee areas without any obvious causes.

The occurrence of epidemic sickness from time to time leads to wide fluctuations in the periodic numbers of prescriptions given to insured persons (affecting the "frequency" statistics) and in the total cost of supplying medicines (affecting the statistics with regard to average cost per insured person).

110. The principle headings under which the apparent causes of excessive cost to the Drug Fund may be arranged are:—

- (1) Proprietary preparations.
- (2) Quantities appreciably in excess of quantities normally ordered.
- (3) Unusually expensive mixtures.
- (4) Mixtures containing more than one colouring or flavouring agent.
- (5) Mixtures showing any apparent redundancy in prescribing.
- (6) Mixtures containing many ingredients.
- (7) Expensive liniments.
- (8) Unusually large quantities of liniments.
- (9) Gargles, mouthwashes, injections, paints, etc., unusual as regards quantity, cost or character.
- (10) Prescriptions specifically ordering rectified spirit.
- (11) Unusual quantities of pills, tablets and capsules.
- (12) Unusual or expensive ointments or pastes and large quantities.
- (13) Cost, quantity and frequency of orders for serums and vaccines.
- (14) Quantities (doses, and total) of malt extract, malt and oil, etc.
- (15) Dangerous drugs.
- (16) Lavish ordering of appliances.
- (17) Preparations unusual either as regards the character or amount of the ingredients.
- (18) Prescriptions denoting "two bottles" to be supplied.
- (19) Prescriptions marked "urgent."
- (20) Prescriptions for powders where the principal ingredient is included in the Tariff in pill, tablet or capsule form.

- (21) Prescriptions for non-Tariff preparations similar in composition to a Tariff preparation.
- (22) Prescriptions for Tariff preparations or non-compound liquid drugs directed to be diluted with water.
- (23) Cases where the medicine, etc., has been ordered with a frequency inconsistent with the directions for use.
- (24) Prescriptions ordering large doses of mixture, etc.

111. It also appears from the reports upon prescriptions that there is much diversity amongst insurance practitioners in their methods of prescribing medicines and ordering appliances, and that there have been general changes in the methods of prescribing during recent years, largely due to advances in diagnosis and treatment. There is also evidence of greater care in seeing that prescriptions do not impose an unnecessary charge upon the Drug Fund by noting the anomalies which, if recognised, can bring about considerable economies in ingredient costs and, to an even greater extent, in dispensing fees.

Insurance practitioners have been in doubt as to their duty where a prescription has been given by a consultant or specialist and, although they need not, irrespective of their own opinion, defer to the specialist's view of treatment, they recognise their duty in ordering medicines which offer sufficient prospect of benefit to the patient to be worth trying, and feel that they would not be justified in abstaining from ordering them on the ground of fear of being surcharged. It may safely be said as a result of the examination of the prescriptions and the reference of them to the Insurance Committees' registers that reasonable care is taken in issuing insurance prescriptions to insured persons only, that there is no evidence of abuse, and that improper charges on the Drug Fund are practically negligible.

PROCEDURE FOR DEALING WITH COMPLAINTS.

112. For the purpose of investigating complaints, every Insurance Committee must appoint three standing Committees:—

- (1) A Medical Service Sub-Committee, to deal with questions arising between insured persons and doctors;
- (2) A Pharmaceutical Service Sub-Committee, to deal with questions arising between insured persons and chemists or other persons supplying drugs and appliances; and
- (3) A Joint Services Sub-Committee, to deal with questions involving insured persons and both doctors and chemists.

THE SERVICES SUB-COMMITTEES.

113. These Services Sub-Committees are similarly constituted and include respectively equal numbers of representatives of insured persons and (i.) doctors, (ii.) chemists, and (iii.) doctors and chemists, with a Chairman and Vice-Chairman appointed from the "neutral" members of the Insurance Committee—not including doctors, chemists, insured persons nor officers of Approved Societies. Their procedure is governed by rules made with the approval of the Minister. Their constitution and procedure appear to be such as to secure justice between the parties, and the members, it may be observed, appreciate the judicial or semi-judicial character of their duties.

Insurance Committees have occasionally experienced difficulty in consequence of the restriction of the selection of a Chairman to the "neutral" members of the Insurance Committee, consisting of the members appointed by the County Council and by the Minister, who are not insured persons, officers of societies, practitioners nor registered pharmacists. The Associations consider that there should be a wider field of selection, not only in view of the responsibility appertaining to the office of Chairman, but also the desirability of appointing a person who would be considered to be quite impartial by the Service Sub-Committee, and by all parties coming before it for hearing.

114. Meetings of the Medical Service Sub-Committee are usually held at regular intervals, and meetings of the Pharmaceutical Service and Joint Services Sub-Committees are held whenever necessary. The hearings frequently involve a considerable sacrifice of time and effort on the part of the members, but there are good attendances, and with the arrangements for deputies there is generally little difficulty in forming a quorum.

Insurance Committees have occasionally found that there has been some delay owing to the absence of a quorum when a meeting of a Service Sub-Committee has been convened. The quorum must consist of the Chairman or Vice-Chairman and representatives of both sides or, in the case of the Joint Services Sub-Committee, representatives of insured persons, doctors and chemists. The position has improved since the regulations were amended to permit the appointment of deputies, but the possible absence of any section of the representative members is a real danger to the proper discharge of the important functions of the Services Sub-Committees. The Associations consider that these circumstances call for a review of the constitution of the Services Sub-Committees.

115. After hearing the cases submitted by the complainant and the respondent, who may have lay help, the Sub-Committee are required to prepare a report stating (i.) the relevant facts as established by the evidence, (ii.) the inferences of fact drawn therefrom, and (iii.) a recommendation as to the action which should be taken.

The Insurance Committee are required to accept as conclusive the findings of fact, but they have power to amend or reject any recommendation of the Services Sub-Committees. They may take action of four kinds, viz., (i.) impose a special limit for the doctor's list, (ii.) recover expenses incurred by the insured person, (iii.) make representations to the Minister as to monetary penalties, and (iv.) make representations to the Minister that the continuance of the doctor or chemist on the list would be prejudicial to the efficiency of the service.

The Committee may also impose a penalty upon the insured person in any case where he is found to have been at fault.

NUMBER AND NATURE OF COMPLAINTS.

116. All reports of the Services Sub-Committees have, since April, 1920, been sent by Insurance Committees to the Ministry, and during that period about 1,700 cases have been investigated, the number for 1923 being 411, representing 34 per hundred doctors, or per 100,000 insured persons.

117. The complaints against doctors may be briefly classified as follows:—

- (1) Neglect in treatment, i.e., failing or refusing to visit: unsatisfactory treatment.
- (2) Improperly charging fees.
- (3) Irregularities in certification.
- (4) Unsatisfactory arrangements for conduct of practice.
- (5) Failure to return records.
- (6) Miscellaneous—Failure to order or supply requisite medicines, etc.; irregular prescribing.

118. Complaints against chemists are very rare indeed. These complaints usually relate to inaccurate dispensing, to failure to supply medicines with reasonable promptitude, and to improper supervision of dispensing. Occasionally the Minister has exercised the power of removing a chemist from the list.

119. Insurance Committees frequently find that there is no case for enquiry, or that the complaint is not substantiated, and in many of the complaints with regard to fees, the amount is refunded without any further action. Other decisions require the payment of expenses incurred by patients in obtaining treatment, or take the form of censure. The number of cases in which representations are made to the Minister that a monetary penalty be imposed, or that the doctor be removed from the list, is a small proportion of the total. The number of monetary penalties imposed has never exceeded 150 in a year, and the total number of doctors removed

from the lists of Insurance Committees since the Acts came into operation, including eight doctors who were allowed to resign, is 40, and in some of these cases the doctor has afterwards obtained the permission of the Minister to resume insurance practice.

120. Insurance Committees have sometimes found it difficult to deal satisfactorily with cases without the attendance of persons whose evidence is material, and they have suggested that their powers be strengthened in this respect. Committees have power to pay expenses of witnesses, but the Association holds the view that Services Sub-Committees should have power to require witnesses to give evidence on oath.

Insurance Committees in Scotland already possess this power.

121. The experience of Insurance Committees shows that there is some diffidence on the part of insured persons to make a complaint, or after making it, to attend and give evidence in substantiation. It would also appear that societies are reluctant to raise questions with regard to medical certification. On the other hand, insurance practitioners do not raise many questions against insured persons who have not complied with the Medical Benefit Rules.

122. The experience of the Services Sub-Committees shows that while there are instances of dereliction of duty in individual cases, the Insurance Medical and Pharmaceutical Services can, in the main, be regarded as efficient.

APPEALS TO THE MINISTER.

123. Appeals against the decision of an Insurance Committee may be made by the parties to the Minister, but this right is infrequently exercised. The total number of appeals to June, 1924, was 130, of which 103 were made by doctors and chemists, and 27 by insured persons and societies. In 40 cases the appeal was allowed, and the decision of the Committee was varied in seven cases.

MONETARY PENALTIES.

124. Where an insurance practitioner has (or is alleged to have) failed or neglected to comply with any of the Terms of Service it is desirable that the Insurance Committee should be consulted by the Ministry of Health, and afforded an opportunity of investigating the matter, if necessary through the Medical Service Sub-Committee before any disciplinary action is taken by the Ministry.

125. Penalties recommended by Insurance Committees should not be varied by the Ministry without the Insurance Committee being afforded an opportunity of a hearing, or of making a statement of its views on the matter. This suggested modified procedure is already in operation in Scotland.

COMPARISON OF PRESENT SERVICE WITH THAT OF PRE-INSURANCE DAYS.

126. The medical service available to insured persons is incomparably better than the service which existed prior to the inception of the Insurance Act. In the first place, the insured person to-day has a much wider choice of medical attendant, and he may change his doctor at any time if he is dissatisfied. The present range of service is extensive, and comprises "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." These services include the administration of anaesthetics or the rendering of other assistance at any operation usually performed by a medical practitioner whether the operation is itself within the scope of the practitioner's obligation or not; thus the range of service is greater than that of pre-insurance days.

Insurance practitioners are entitled to a special fee out of the General Practitioners' Fund in each case in which the services of a second practitioner are required for the administration of an anaesthetic. Insurance practitioners are also entitled to make a charge to their patients for services considered to be

beyond the scope of their obligation upon giving notice to the Committee within forty-eight hours, subject to approval by the Local Medical Committee. The claims made in such cases are so few in number compared with the claims made for the administration of anaesthetics that it appears reasonable to assume that, generally speaking, practitioners are not taking a restricted view of their services.

The present medical service is open to an insured person anywhere in the United Kingdom and he has in fact no difficulty in obtaining immediate treatment since the doctors have undertaken a collective responsibility; in pre-insurance days arrangements were for a restricted area and persons removing out of the district had to make their arrangements for treatment, though in some cases they received a small allowance or a refund of their subscriptions. The machinery for dealing with questions relating to the medical service is very much better and the widest publicity is now given to decisions in cases of serious breaches by practitioners of the terms of service.

127. The arrangements for the supply of drugs and appliances are also considerably in advance of pre-insurance days. The Act provides that "all proper and sufficient medicines" shall be available to insured persons as well as certain prescribed appliances. The appliances chiefly consist of dressings, but the list also includes certain other special items such as splints, even those of an expensive character, such as "Thomas's Splint," spinal jacket, etc. So far as drugs and medicines are concerned, there is no restriction as to what may be ordered, if requisite for the patient's treatment. It is true that a doctor must not prescribe extravagantly or excessively, but apart from this any drug or medicine—serums, vaccines, colloidal or proprietary preparations, oxygen, malt and oil, etc.—may be ordered by him.

128. An insurance practitioner is able to obtain a further opinion as to diagnosis or treatment by referring any case he may desire to the regional medical officer, and he may assist patients by referring them in suitable cases, to the local clinics for the treatment of tuberculosis or venereal diseases, or to the maternity centres.

CHAPTER III.—INDEX AND MEDICAL REGISTERS OF INSURANCE COMMITTEES.

THE NEED FOR INDEX AND MEDICAL REGISTERS.

129. The present arrangements for the administration of medical benefit are based upon the statutory rights conferred by the National Insurance Act, 1911. Every registered medical practitioner may claim to be included in the list of practitioners under agreement with an Insurance Committee for the attendance and treatment of insured persons, unless he has been removed from the list by the Minister of Health. The arrangements with practitioners must permit persons entitled to medical benefit to select any practitioner from the list and to obtain medical attendance and treatment from such practitioner if the latter consents; otherwise, they may be assigned to a practitioner by the Committee.

An Insurance Committee is accordingly precluded from the possibility of selecting a limited number of practitioners and of assigning to them the duty of attending and treating certain insured persons. It has therefore been necessary to set up two registers of those persons entitled to medical benefit, and these are known as the Index Register, and the Medical Register respectively. Their main purpose is to ensure that every Insurance Committee receives, for its area, and every practitioner, for himself, the due proportion of the money available for the provision of medical benefit.

THE FORM AND USE OF THE INDEX REGISTER.

130. The Index Register is compiled by the Insurance Committee from notifications received from

Approved Societies indicating their members entitled to medical benefit, or from the Ministry of Health in the case of deposit contributors and members of the Navy and Army Insurance Fund. Similarly, notifications are received in respect of persons who cease to be entitled to medical benefit.

131. The title to benefit is notified by the issue of an index slip bearing the name and address of the member, the membership number, the name of the society and branch (if any) and the date of entry into insurance. These index slips are sent to Insurance Committees through the Central Index Committee who note in their register the Committee to which the slip has been sent by them. The Insurance Committee on the receipt of the index slip, issue to the insured person a medical card, which is evidence to the practitioners on the list of title to medical treatment under the Committee's arrangements.

132. If an insured person does not join an Approved Society he is entitled to medical benefit from the Deposit Contributors Fund. Every insured person is thus entitled to medical benefit, and, if no index slip has been received, the Insurance Committee, on production of satisfactory evidence, may safely issue a temporary medical card which will be available until the insured person either joins an Approved Society or is definitely established as a deposit contributor.

MOVEMENTS IN THE INDEX REGISTER.

133. A record is made on the index slip of the name of the doctor by whom the insured person is accepted or to whom he has been assigned. The procedure, in the first instance, provides for the completion of the form of application and acceptance at Part A of the medical card. The record on the index slip must be altered every time the insured person changes his doctor for any reason, as he may do by merely completing Part B of the medical card and securing acceptance by a doctor. If the insured person has removed to the area of another Insurance Committee the index slip must be transferred. This is effected by the transmission of the first half of the medical card direct to the old Committee, and they send on the index slip through the Central Index Committee who note the transfer in their register.

134. It is estimated that 300,000 transfers of index slips between Insurance Committees occur during a year. This, however, represents but a fraction of the movement in the Index Registers of Insurance Committees during a year. There is a considerably larger number of insured persons who are transferred from the list of one doctor to that of another within the area of an Insurance Committee either owing to their removal or because they desire a change of doctor.

135. Index slips are also received for all persons entering or re-entering into insurance or transferring from one society or branch to another; and index slips must be removed when notifications are received, by means of orange slips, that the insured person has ceased to be entitled to medical benefit for any reason (e.g., ceasing to be insured, expulsion, death, emigration, etc.).

INDEX CLEARING SYSTEM.

136. In the initial stages index slips were issued by Approved Societies direct to the Insurance Committee responsible for the provision of medical benefit for the member. The cipher of the Insurance Committee was entered on the index slip, but not always correctly, and large numbers of index slips were transferred by the Insurance Committees receiving them to the appropriate Committee.

137. Removal slips were similarly issued in respect of insured persons. Many of them had trans-

ferred from one Insurance Committee area to another and the index slip was transferred to the new area, unless it had already been claimed upon the inclusion of the insured person in the list of a doctor at his new address. Removal slips were discontinued after a time and the insured person has since been deemed to reside in the area holding the index slip until he has selected a doctor in another area.

138. The same procedure was adopted by societies in sending direct orange slips in respect of insured persons who were suspended from medical benefit; reinstatement index slips upon the member resuming his title to medical benefit; and index slips in respect of members transferring from another society. Insurance Committees endeavoured to trace and cancel the previous slip but often without success, mainly owing to inaccurate entries on the slips, and difficulties in deciphering them. Occasionally, two or more index slips were issued in respect of the same member by the same or different societies, and often slips were not cancelled by the society where membership was ineffective.

139. There arose a steadily increasing inflation in the Index Registers of Insurance Committees as was shown by the count of the registers for the country exceeding the number of persons entitled to medical benefit, and there were doubts as to the degree of inflation being uniform. This was important as the distribution of the Central Medical Benefit Fund amongst Committees was based on the counts of these registers. Accordingly, a Central Clearing House was set up and the slips were collected, society by society, and collated in numerical order, and the internal inflation was substantially reduced.

During this process all slips issued by societies were sent to the clearance office through which are also transmitted slips passing between Insurance Committees. Both branches of the work—transmission and clearance—are now continued under the Central Index Committee.

The "second clearance" operations involve a comparison of the Index Registers of Insurance Committees, through the Central Register, with the membership registers of Approved Societies, and this work is still in progress in various forms. The Deposit Contributors and Navy and Army Insurance Fund Lists have been already cleared. The remaining inflation in the Index Registers is considerable and the experience of the clearance operations shows that it is unevenly distributed amongst Insurance Committee areas. Recently steps have been taken to expedite the work as it is recognised by all interested parties that the distribution of the Central Funds—in particular the Practitioners' Fund—must be reasonably safeguarded against the risk of inequalities of the areal "pools" and in the payments to insurance practitioners.

The Central Index Committee in receiving index slips and orange slips from Approved Societies, and in recording them and transmitting them to Insurance Committees, and in recording all movements of slips between Insurance Committees, is minimising the risk of new inflation. The Associations consider the machinery should be efficient, and that it will, as an essential function, ensure the prompt notification of all cases of cessation of title to medical benefit as well as of entry or re-entry into insurance in order that there may be the least possible inflation in the registers.

The Central Index Committee derives its income from the fund available for the administration expenses of Insurance Committees, and it includes amongst its members representatives of the Association and of Approved Societies.

140. At the last Census, no arrangements were made in England and Wales for ascertaining the distribution of the insured population, although this course was adopted in Scotland. This showed inflation in varying degrees, probably greater than in England and Wales, as no central clearance system

is in operation there. The effectiveness of the clearance system is to some extent impaired thereby, for it does not bring within its operations the whole insured population. It is suggested that the adoption of a uniform system should be considered.

It is also recommended that arrangements should be made at the next Census for the collection of information similar to that obtained in Scotland at the last Census showing the distribution of the insured population.

MEDICAL REGISTER.

141. The Insurance Committees, with two exceptions, having adopted the capitation system of remuneration for insurance practitioners, must necessarily maintain lists of the insured persons for whose treatment practitioners are individually responsible and in respect of whom they must be credited with their proper share of the Practitioners' Fund. These lists take the form of index slips, usually called medical slips, which are prepared by the Insurance Committee in respect of all insured persons accepted by or assigned to doctors; they are, collectively, known as the Medical Register.

142. The medical slips bear the name and address of the person, and particulars as to his title to benefit as a member of an Approved Society, deposit contributor, etc.; they indicate whether payments are due in respect of the supply of drugs and appliances on a capitation basis, and the steps taken in the transmission and collection of medical record envelopes. Originally, lists in a similar form were supplied to insurance practitioners, but these were discontinued when the system of medical record envelopes was introduced in 1921, since these now serve as the doctor's register.

In County areas, information for use in the distribution of the mileage funds is also recorded on the medical slips.

143. The normal procedure for notifying the acceptance of a patient is to send the medical card, which has been signed by the practitioner, after it has been presented to him duly completed by the insured person. Medical cards are issued to all insured persons as soon as the Committee receives the relative index slip, except in the considerable number of cases where they have been issued to the insured person on his application (on the form which may be obtained at any post office), or on his sending to the Committee a receipt, account, or notice of account given to him by an insurance practitioner if he failed to produce a medical card. These applications arise where the medical card has not been despatched, or has not been delivered, or where it may have been lost or destroyed, and in cases where the doctor has been notified that the person is disentitled to treatment.

144. At the same time as the medical slip is prepared the doctor's name is entered on the medical card, which is then returned to the insured person to be used as his voucher in obtaining treatment. The name of the doctor in every case is recorded on the relative slip in the Index Register, as well as subsequent changes for any reason, such as fresh choice of doctor, owing to change of address or otherwise, or change of method of treatment. On the first occasion a medical record envelope is prepared, but afterwards the medical record is collected from the insurance practitioner in whose list the insured person's name was previously included. The medical records are despatched to the appropriate doctors at short intervals.

145. The volume of work in connection with the issue of medical cards, the preparing and the keeping of the medical register, is of considerable, indeed of unexpected magnitude. The following records in respect of the year 1924, furnished by Insurance Committees for (a) a large County, (b) a large

County Borough and (c) a smaller County, may assist in this connection:—

—	(a)	(b)	(c)
Average number of insured persons entitled to medical benefit.	358,667	308,034	60,976
Average number on lists of insurance practitioners, Approved Institutions, or required or allowed to make their own arrangements.	311,225	275,452	53,524
Number of medical cards received.	44,384	43,557	11,717
Number of applications for medical cards received.	6,574	11,359	1,058
Number of temporary residents.	820	294	1,575
Number of medical cards issued or returned to insured persons.	79,370	91,868	22,723
Number of new medical records prepared.	24,994	29,610	5,407
Number of notices issued to insured persons on withdrawal of doctors.	17,651	8,516	2,870
Number of notices issued to persons on ceasing insurance.	12,060	14,342	2,202
Number of medical records recovered from doctors for transfer or deletion.	39,155	23,213	10,182
Number of doctor's slips prepared.	46,981	39,884	10,142
Number of insured persons changing doctor (by means of Part B. of Medical Card):—			
(a) Within the area ...	22,302	10,482	2,267
(b) From "foreign" areas.	6,276	3,465	2,468

TRANSFER OF PRACTICES.

146. The procedure adopted by Insurance Committees whenever an insurance medical practice is terminated or transferred, is designed to safeguard the right of the insured person to select the insurance practitioner by whom he wishes to be attended and treated. A notice is sent to every insured person when his name has been removed from the list of an insurance practitioner for any reason, and he is informed of his rights as to the selection of another practitioner or another method of treatment.

147. If the practice is transferred, and the Insurance Committee is informed that another insurance practitioner is willing to accept the patients, a statement to this effect is included in the notice. The insured person is told that unless he exercises his rights within a stated period (which has generally been reduced from 18 months to three months), he will be assigned to an insurance practitioner; a further notice is sent to him stating the name of the practitioner to whom it is proposed to assign him at the end of the month, if necessary. Originally, insured persons were notified that they had been transferred to the list of the successor, and that they were allowed 14 days in which to object to the transfer.

148. In view of the recent modifications in the regulations which permit an insured person to transfer from the list of one practitioner to the list of another by using his medical card at any time, the Association consider that a simpler procedure in connection with the transfer of practices is desirable, and recommend a reversion to the former arrangements with respect to notices to insured persons.

ALLOCATION SCHEMES AND PROCEDURES.

149. An insured person, as has already been stated, has the right to decide whether he will make application for acceptance by an insurance practitioner, for membership of an Approved Institution or for permission to make his own arrangements for obtaining treatment, unless he is one of those who are required to make their own arrangements.

An insured person who fails or neglects to select a method of treatment, or who has applied to an insurance practitioner, but has not been accepted by him, may be assigned to an insurance practitioner. For this and other purposes, the Insurance Committee and Panel Committee are jointly required to prepare a scheme, known as the "Allocation Scheme," under Article 15 of the Medical Benefit Regulations. The Scheme must provide for the appointment of a Sub-Committee on similar lines to the Medical Service Sub-Committee and, in addition to specifying the procedure for the assignment of insured persons to insurance practitioners, it must make provision for treatment pending acceptance or assignment of an insured person, and for emergency treatment. Restrictions may be imposed by it on the right of an insurance practitioner to require the removal of a patient from his list in such cases as are likely to involve hardship on the insured person owing to his condition of health.

The Allocation Scheme must also provide for a limit to be placed on the number of insured persons who may be included in the list of an insurance practitioner, subject to the maximum numbers in Article 15 (2) of the Regulations which may not be exceeded except in cases in which, owing to special circumstances, the Insurance Committee, with the approval of the Minister, otherwise permit. This matter has already been dealt with in paragraphs 59 to 62.

150. The usual procedure under the Allocation Schemes of Insurance Committees when a practitioner refuses to accept on his list a person who applies for treatment as an insured person is for him (a) to give temporary treatment, (b) to refer him to another practitioner and inform him that failing acceptance he may give notice to the Committee that he desires to be assigned to a practitioner, and (c) to inform the Committee of his action in the case. The Allocation Committee then assigns the insured person to such practitioner as it thinks fit. The procedure where assignment becomes necessary after the removal of the name of an insured person from the list of an insurance practitioner for any reason, is similar to that in the case of transfers of practices. (See paragraph 147.)

The Schemes usually make provision for emergency treatment by making it the duty of any practitioner who may be summoned and is available to give the insured person any necessary treatment, if neither the practitioner responsible for his treatment nor his deputy, whether summoned or not, is available for giving him any treatment immediately required owing to an accident or other sudden emergency.

The procedure to be adopted where the list of a practitioner exceeds the limit under the Allocation Scheme is for the numbers on the practitioner's list to be reviewed quarterly, and for the practitioner to take steps to reduce his list, and not to accept further insured persons until he has done so. If he has not taken suitable action within two months, the Allocation Sub-Committee select the names of the insured persons to be removed and the Insurance Committee notify them accordingly.

CHAPTER IV.—REGIONAL MEDICAL OFFICERS.

151. The regional medical officers were appointed by the Ministry in 1920, and particulars of their number of their duties have been given in the Ministry Statement (Appendix I., Section C., Paras. 170-5). In connection with their duties as medical referees attention is called to the number of cases in which sickness and disablement benefit is paid, and to the number of cases examined by them, and to the number declared to be not incapable of work; the latter number is a very small percentage of the total number in receipt of sickness and disablement benefits. Having regard to this fact, and to the length of time usually elapsing between the commencement of incapacity and the referee's examination, it may reasonably be inferred that the insurance practitioners are efficiently carrying out their medical certification duties.

152. The Association, having considered the duties of regional medical officers as consultants, and the extent to which consultation references are permitted, is of the opinion that there should be a considerable expansion of this branch of the Service. In the first place, consultations should be possible in the earlier stages of illness, and not be restricted, as they are at present, to cases in which certificates of incapacity have been issued for at least four weeks.

153. The regional medical officers also perform responsible duties in the inspection of medical records.

154. They have recently undertaken duties in the investigation of prescribing, and the Association has for some time held the view that their assistance should be available to Insurance Committees in connection with the consideration of reports on prescribing. It has noted the proposed arrangements under which the regional medical officers will be associated with the Insurance Committees and Panel Committees in connection with questions of alleged excessive prescribing, which will doubtless be such as to enable Insurance Committees to take full advantage of them.

155. The Association further considers that in entertaining applications from insurance practitioners for consent to the employment of assistants, and before deciding whether they should agree with the views of Local Medical Committees on questions as to range of medical service, Insurance Committees should be in a position to confer with the regional medical officers.

It would also urge, in the interest of the insurance medical service, that these officers should be brought into the closest relationship with Insurance Committees.

CHAPTER V.—DEPOSIT CONTRIBUTORS.

156. All insured persons who are unable or unwilling, or who fail within a certain period to become members of Approved Societies, as well as those who have ceased to be members, become deposit contributors under section 54 of the Act, and receive their benefits in accordance with the amount of their credit in the Deposit Contributors Fund, and when that credit is exhausted benefits are suspended. The arrangement for this special class of insured persons was of a temporary nature, and in the absence of a satisfactory alternative it continues. The individual accounts for deposit contributors are kept centrally, but all benefits are administered by Insurance Committees in accordance with their rules.

157. The number of deposit contributors was steadily declining until the outbreak of war, when the number began to increase, and it exceeded 400,000 in 1919. A rapid decline occurred during the next two years, and the number fell below 250,000, or to practically two per cent. of the insured; but during the next two years the number varied slightly and it may now be regarded as fairly constant. This cannot be said of the personnel: there is a steady stream of deposit contributors becoming members of Approved Societies after a usually short period of insurance, with only a small permanent section. Their distribution amongst Insurance Committees is uneven, but the various types are found in all areas. The proportion of deposit contributors on doctors' lists is considerably less than prevails amongst members of Approved Societies.

158. The expenditure on sickness benefit is at a lower rate than that obtaining amongst members of Approved Societies, and there are few payments of disablement benefit. This merely emphasises the serious position of the deposit contributors, whose benefits are suspended because the amount standing to their individual credit is exhausted, and whose title to medical benefit may even be suspended after a prolonged illness. It has been stated that deposit contributors as a class are not in need of insurance benefits, but this is contrary to the experience of Insurance Committees who find many claims for benefits are from persons belonging to an impoverished class, yet many of them, probably one-

fourth, cannot receive cash benefits in full. Although there is always a substantial balance in the Deposit Contributors Fund, it cannot be used for the individual deposit contributor who stands in need of benefits, and for this class the objects of the Insurance Scheme—the prevention and cure of sickness—are not achieved.

159. Insurance Committees and the Federated Associations have long recognised that the position of deposit contributors is unsatisfactory, and they have been led to this conclusion not only by the numbers of cases where the credit has been exhausted and the consequent—in some cases recurring—suspension from benefits, but by those cases in which, through insufficient credit, maternity benefit has not been paid in full.

160. Deposit contributors are subject to fresh waiting periods on re-entering insurance; and they cannot in any circumstances enjoy any of the additional benefits under the Act, or the advantages of the Prolongation of Insurance Act; these disadvantages should certainly be removed.

161. The Federated Associations are of opinion that deposit contributors should be placed on a sound insurance basis.

CHAPTER VI.—NAVY AND ARMY INSURANCE FUND.

162. The Navy and Army Insurance Fund under section 59 of the Act provides maternity benefit during service for men who are not members of Approved Societies. Under certain conditions it also provides benefits to men who after service in H.M. Forces may remain members of the Fund if they are unable, through health reasons, to obtain admission to an Approved Society. The Fund operates as an Approved Society in the administration of cash benefits, and payments are made on the recommendation of Insurance Committees who receive all claims from members of the Fund.

163. Unlike members of Approved Societies, however, members of the Navy and Army Insurance Fund have no right of appeal, and the Association would urge that some Court of Appeal be set up.

164. The membership of the Fund rapidly increased during the war and afterwards, until in January, 1920, the number, apart from serving men, was 70,000. Under the regulations many members have been required to take steps to join societies; those rejected on health grounds continue in membership, but those who failed to apply to societies have become deposit contributors. Last year there remained 30,000 on the registers of Insurance Committees, and these are practically all invalids. The claims for sickness and disablement benefits fall to be dealt with in large numbers; for the year 1923 the members received an average payment exceeding £1.

165. The Fund also provides medical benefit for uninsured men in receipt of a pension or allowance, and whose income from all sources does not exceed £160, and in determining this income allowances in respect of wives and other dependants are reckoned. The Association is of the opinion that this limit should be increased to £250 (which is the normal limit for non-manual workers to be insurable), and that the allowances for wives and other dependants should be excluded in determining the income.

CHAPTER VII.—SEAMEN'S NATIONAL INSURANCE SOCIETY.

166. The Seamen's National Insurance Society is a society specially set up under section 48 (4) of the 1911 Act, and continued by section 63 of the 1924 Act, for the benefit of insured persons in the mercantile marine, for whom there are special provisions relating to contributions and benefits.

167. Insured persons engaged in the sea service are entitled to medical benefit in the usual way while they are in Great Britain, but no provision is made under the Act while they are afloat, the shipowner being responsible for this provision. Many of them

who join other approved Societies, as they are permitted to do under the Act, receive medical benefit under the arrangements made by the Insurance Committees, but the medical benefit of those who elect to become members of the Seaman's National Insurance Society is administered by the Society instead of by Insurance Committees, but it is expressly laid down that nothing in the section should prevent the Society from agreeing with any Insurance Committee for the administration of medical benefit by the Committee to individual members of the Society.

168. In the early days of the insurance medical service there may have been some reason for separate arrangements, but in view of the modifications since made to meet the needs of temporary residents and travellers, and the development of the collective responsibility of insurance practitioners to provide treatment (including emergency treatment), the initial reasons no longer exist for the exceptional arrangements for members of this Society which do not extend to persons in the mercantile marine who join other Approved Societies.

169. The Association is of the opinion that members of this Society should now have the advantage of the arrangements made by Insurance Committees for medical benefit which would give the members an extended selection of doctor in any part of the country, remove the disadvantages of the present system (which include the difficulty often experienced in securing the services of a doctor) and further relieve Insurance Committees and doctors of unnecessary enquiries, and their members and the doctors from receiving and giving individual accounts. This would not only be a valuable simplification in the machinery, but would be beneficial to the insured persons themselves.

CHAPTER VIII.—EXEMPT PERSONS.

170. The number of persons who have applied for and now hold certificates of exemption in England and Wales is about 35,000, a small number in relation to the total insured population.

171. The fact that these persons are not required to make contributions themselves is due to their own initiative, but the employer's contribution must be paid. There seems to be no reason for any special provision to be made for enabling people making no personal contribution to the funds to derive financial benefit from the Act. Originally no benefits were provided for exempt persons, but at a later date medical benefit was granted in respect of their employers' contributions.

172. The extent to which these persons take advantage of the benefits provided is slight; for example: in one large industrial town in the north of England the total number of exempt persons is 884. This may be divided into two classes—(1) those who are required to make their own arrangements by reason of income limit—170; (2) those who do not come within that category—714. Of the first class 25 have in fact made their own arrangements, equal to 15 per cent. Of the second class 267 have in fact selected a doctor in the ordinary way, equal to 37 per cent.

173. The Federated Associations are of opinion that no special provision should be made for this class of person, but that sums payable on their account should be applied to other purposes.

If medical benefit is retained for this class, it is suggested that there should be no requirement with respect to their making their own arrangements for treatment on the ground of income.

CHAPTER IX.—OTHER POWERS AND DUTIES OF INSURANCE COMMITTEES.

STATUTORY PROVISIONS.

174. The principle duties, in the administration of medical benefit and of other benefits for deposit contributors and members of the Navy and Army Insurance Fund, have been dealt with, but Insurance Committees have other important powers and duties

under section 26, 50 and 107 of the National Health Insurance Act, 1924.

CONTRIBUTIONS TO HOSPITALS, ETC.

175. The powers of Insurance Committees under section 26 of the Act to make such subscriptions or donations as they think fit to hospitals, dispensaries and other charitable institutions have not been exercised to any considerable extent owing to lack of funds for the purpose, but occasional contributions have been made to hospitals, etc., with a view to securing preferential treatment for insured persons.

NURSING.

176. Insurance Committees are also empowered under the same section to make such subscriptions or donations as they may think fit for the support of district nurses, or to appoint nurses for the purpose of visiting and nursing insured persons. These powers have been more frequently exercised and substantial contributions have been made by Committees to Nursing Associations, or under Nursing Schemes. In three Insurance Committee areas, viz., Liverpool, Manchester, and Reading, schemes for the provision of a nursing service for insured persons are in actual operation, and contributions have been made by the Insurance Committees in support thereof. A model scheme was issued by the National Association in 1921, and many Insurance Committees endeavoured to bring about the establishment of local nursing schemes for the benefit of insured persons in their areas. Unfortunately, owing to the lack of funds available to them for this purpose, and to the difficulty in obtaining payments from Approved Societies under the same section, or under their schemes for additional benefits, these efforts were not attended with success, except in the three cases already mentioned.

HEALTH REPORTS, LECTURES, ETC.

177. The Government in promoting the National Insurance Bill of 1911 urged in its favour not only its insurance features and the provision made for the treatment of disease, but emphasised the provisions in the Bill for reducing sickness and disablement by removing their preventable causes. Great promises were held out of the improvement in the health of the community which would result if Parliament and the country accepted the Bill. Whatever may be said about the working of this scheme in the direction of insurance and treatment, the other promises have been unfulfilled.

178. Section 50 of the Act confers certain additional powers and duties upon Insurance Committees, which include the (a) making of reports as to the health of insured persons within the area, and (b) making provision for the giving of lectures and the publication of information on questions relating to health, and for that purpose of making arrangements with local education authorities, universities and other institutions.

This section was obviously based on the assumption that Insurance Committees would, as the result of the collective experience of thousands of general practitioners treating millions of the industrial population, possess a knowledge of the facts relating to the health of the community not possessed by any other Authority, central or local. Though the section gives no specific duty to the Committees in the matter of remedying evils, it does assume that they can assist in bringing to light what are the facts relating to health conditions, and in tracing the incidence of sickness and disablement to their source.

179. Section 107 goes further—it gives power to the Committees, amongst others, to penalise certain classes of persons and Authorities whose default has given rise to excessive sickness. Obviously, Parliament intended that Insurance Committees should be more than organisations for the administration of medical benefit. Each Committee owes a statutory duty to insured persons, and to the Approved Societies whose funds are wasted if avoidable sickness and disablement

are permitted, to concern itself not only with the routine work of administering benefit, but to regard itself as a Statutory Health Authority especially concerned with the maintenance of the health of the insured population in its area. This does not involve conflict with, but rather co-operation with other Local Health Authorities. The preventive features of the Bill, which were perhaps most emphasised, were those contained in section 107, dealing with excessive sickness. Whether it is due to the short period under normal circumstances which Committees had before the War, or to the War itself and the conditions arising therefrom, Committees were not able to exercise, as fully as they would have desired, their important powers and duties under this section.

180. The entrusting of those powers involves the imposing of responsibility upon Insurance Committees for their exercise. The fact that the enforcing of a Committee's claim under section 107 may be difficult, should not, in the opinion of the Association, deter Insurance Committees from examining the section and making such use of it as is possible for improving the health of insured persons, and, through them, of the community. The Association has expressed the opinion that these sections possess possibilities of work of the utmost national importance, and clearly impose statutory obligations upon Committees which are either workable or not. It considers that the collective experience of the Committees in the working of medical benefit should be reviewed, and that if the knowledge gained by Insurance Committees and Panel Committees were pooled, facts and data not in the possession of any Authority would be available as a basis for future action in the direction of health preservation and the prevention of sickness.

181. The Association in the early part of 1923 recommended Insurance Committees to confer with the Panel Committees on the subject, and report the results of their consultations, and to indicate the nature and extent of their activities under section 50 in making provision for the giving of lectures and the publication of information on questions relating to health. Many Insurance Committees—in particular, Coventry and Leicestershire—show a good record of work done, but, generally speaking, these powers and duties have not been exercised, mainly owing to financial considerations.

This work is mentioned by Sir George Newman, K.C.B., M.D., the Chief Medical Officer of the Ministry of Health in his Memorandum entitled "Public Education in Health." After referring to the educational work of Local Authorities and to various regulations, he urges that the law should be made clear as to the powers of Local Authorities to spend money on health propaganda. He then states:—

"Insurance Committees, although they have no power to raise rates, are entitled to expend upon educational work income assigned to them under the National Health Insurance Acts. For instance section 60 (1) (b) of the National Insurance Act, 1911, provides that the Insurance Committee of a county or a county borough shall in addition to other powers and duties conferred upon it, make such provision for the giving of lectures and the publication of information on questions relating to health as it thinks necessary or desirable. It may, for this purpose, also make arrangements with Local Education Authorities, with universities or with other educational institutions. Under these powers instruction has been given in subjects of general interest, such as the avoidance of minor ailments, the awakening of a civic sense of sanitation, and the importance of personal hygiene. For instance, the Leicestershire Insurance Committee have been constantly active in spreading information on health among insured persons in their area, emphasising in particular:—(a) the appalling total of unnecessary suffering and loss of life; (b) the need for its prevention and the ease with which it can be prevented; (c) the truth that each person's health is mainly in his own hands; and (d) the pleasure and power of perfect health. They claim that if propagandist work were effectually undertaken by Insurance Committees a

great deal of money now spent in respect of minor maladies would have been saved. A movement is now being initiated to impart knowledge in regard to the treatment of rheumatism and cancer. More important than any statutory power of Insurance Committees is the educational work naturally and properly performed by the insurance practitioner in the ordinary discharge of his duty to the patient. Unquestionably the direct educational work thus undertaken must far exceed in value anything within the power of the Insurance Committee."

182. The following methods have been adopted by Insurance Committees for bringing questions of health and hygiene to the notice of the public:—

- (a) Co-operation with Medical Officer of Health, Corporation, Education Authority, and Panel Committee.
- (b) Illustrated lectures on tuberculosis, infectious diseases, and other health matters, in public halls by special lecturers, supplemented by local medical practitioners and officials, and in co-operation with British Red Cross Society, the Federation of Women's Institutes, and other organisations.
- (c) Lectures in schools during school hours, and prizes to children for essays on health subjects.
- (d) Distribution of leaflets (*Health Maxims, A.B.C. of Hygiene, etc.*), to workpeople and scholars.
- (e) Display of large illustrated posters throughout town.
- (f) Issue of public notices in Press at regular intervals (including articles on health subjects).
- (g) Distribution of handbills from house to house.
- (h) Cards on Health Hints and circulars on cancer sent out with medical cards.
- (i) Health hints by means of rubber stamp on face of letters and back of envelopes by Insurance Committee and local firms.
- (j) Health maxims in form of book mark in use in public libraries.
- (k) Suggestion that Ministry of Health be asked through the National Association of Insurance Committees to transmit health leaflets, etc., with issue of contribution cards.
- (l) Films at cinemas.
- (m) Broadcasting.
- (n) Concentration of an Annual Health Week under special joint committee of representatives of Corporation, Insurance Committee, Friendly Societies, Trade Unions, etc.

Handbook of week's programme with articles by specialists.
 Publication of posters throughout town.
 Food and other exhibits.
 Special daily newspaper articles by medical practitioners and others.
 Films in cinemas.
 Lectures in factories, adult schools, friendly society, etc., meetings.
 Special meetings for mothers—Baby shows.
 Special "Health" services arranged by religious organisations, addressed in some cases by prominent medical men.

183. The Lancashire Insurance Committee appointed a special sub-committee to consider the question of sickness experience in a district within their area, and a copy of the report, dated 28th January, 1924, was sent to the Ministry of Health, the Lancashire County Council, and to certain Approved Societies.

The following extract may be given:—

"The Sub-Committee is of the opinion that there is overcrowding in the area, that sanitation is at its limit, that the sewage disposal works are inadequate in size, that the conservancy system, should be abolished, that the water supply is insufficient in the higher reaches, and that the sickness experience of the area is excessive."

In several other instances Insurance Committees have undertaken special investigations into health conditions existing within their areas, but owing to the inherent difficulties and short-comings of the sections little effective action has been possible.

184. The Association in January, 1919, in bringing this matter to the notice of the Insurance Commissioners, referred to the following paragraph in the Insurance Commissioners' Report for 1914-17, viz. :—

" 541. The War has greatly hampered the development of the preventive side of National Insurance, and, since 1914, Committees' activities in this direction have necessarily been of a sporadic nature, and somewhat restricted in their scope. The schemes adopted have comprised arrangements for lectures on health subjects, including questions of maternity and child welfare, for the distribution of leaflets, for lessons in cookery and food values, for the giving of prizes, for essays on matters relating to the preservation of health, and for the appointment of a health visitor."

185. The Minister of Health was approached by the Association in April, 1924, and the following extract from the letter addressed to him briefly sets out the position :—

" Insurance Committees were assured that they would not be prejudiced by the repeal of section 12 (2) (b) of the National Insurance Act, 1911, under which their General Purposes Funds received substantial sums (representing almost their whole income) and they anticipated that they would be recouped in accordance with the statement in the Ryan Committee's Report that their recommendation to abrogate the existing provision was made 'subject to its being found practicable to readjust the finances of Insurance Committees to meet the relatively small income from this source.' (See paragraph 291, page 55, of the further Report, 27th October, 1916.)

" The Association, satisfied that the interests of Insurance Committees were safeguarded, cordially supported the National Health Insurance Amendment Bill on its second reading in the House of Commons.

" Sir Edwin Cornwall, on the 4th December, 1917, gave an unqualified definite assurance that the loss caused to Insurance Committees by the provisions of clause 20 would be made good from other sources.

" The matter was again raised by a deputation from the Association to the Insurance Commissioners on the 30th August, 1918, when Sir Edwin Cornwall indicated that he was in the main in accord with the views of the Association, and in a letter, dated the 14th October, 1918, he stated that the cessation of this source of income would be taken into account year by year when the finances of Insurance Committees were under review.

" The Council also desire to refer to the provision in the Civil Service Supplementary Estimate, 1914-15, which was duly passed by Parliament. This Estimate included a sum not exceeding £20,000 to be applied to meet the cost of health lectures and the publication of information on questions of health, but the grants were withheld owing to the war.

" Insurance Committees have not so far been called upon to make any prescribed reports as to the health of insured persons or to furnish statistical and other returns under paragraph (a) of sub-section 1 of section 60. Neither have they been able to carry out adequately their duties under paragraph (b) in the matter of making provision for the giving of lectures and the publication of information on questions relating to health."

186. Representatives of the Association conferred with representatives of the British Science Guild in 1924, and a Memorandum on " Scientific Medicine and Preventive Medicine " was prepared and circulated amongst Insurance Committees, in which it was stated that in practice, up to the present, insurance

in this country has done little in the direction of preventive medicine. While it is true that the earlier treatment of sickness favoured by sickness insurance has a preventive value, this forms but a small part of the total possibilities of prevention of sickness. Insurance against sickness cannot be regarded as satisfactory so long as medical attendance on the worker remains separate from that on other members of the same family. Present arrangements need to be improved, and extensions of them so arranged, by the simultaneous adoption of scientific preventive measures, that the tax on family and national funds necessitated by insurance shall be reduced to its minimum amount. This can only be done by increased application of (a) personal hygiene, (b) preventive medicine and public health, (c) industrial hygiene, and by (d) systematic educational efforts to give practical effect to work directed to these ends.

It was further stated in the Memorandum that preventive medicine requires, in connection with the treatment of the sick, the investigation of statistical and other data supplied by medical practitioners with a view to the diminution or removal of the conditions favouring sickness, as well as wisely organised educational work among those eligible for treatment, with a view to the prevention of sickness, and that having regard to the terrible expense of sickness, action of this nature would secure valuable economic gains to the community.

187. The expenditure in carrying out the powers and duties under sections 50 and 107 is charged to the General Purposes Funds of Committees, and although the Insurance Committee Regulations, 1924, empower Committees, under article 57, to charge to the Administration Fund all sums transferred, with the approval of the Minister, from the Administration Fund to the General Purposes Fund, the latter Fund will not, it would appear, derive any additional income in this way which would assist in the development of the powers and duties of Committees under these sections.

188. The Federated Associations recommend a complete review of the position, and strongly urge the provision of adequate funds to enable Insurance Committees to develop thoroughly this part of their work.

CHAPTER X.—SANATORIUM BENEFIT.

189. Sanatorium benefit was administered by Insurance Committees until it ceased on the 1st May, 1921, after which date the domiciliary treatment of insured persons suffering from tuberculosis continued to be rendered by insurance practitioners as part of medical treatment, and the provision of institutional treatment for insured persons was merged in the provision for other persons undertaken by the Local Public Health Authorities.

190. When sanatorium benefit came into operation Insurance Committees were required to make arrangements to the satisfaction of the Insurance Commissioners under section 16 (1) of the 1911 Act with persons or Local Authorities (other than Poor Law Authorities) for the treatment of insured persons suffering from tuberculosis in sanatoria or other approved institutions, and with a view to providing treatment for such persons otherwise, e.g., at dispensaries. Insurance Committees entered into contracts with the County or County Borough Councils for their area, to whom the Government made capital grants together with maintenance grants equal to one half of their expenditure, over and above the amounts received from the Insurance Committee.

191. There is no doubt that the pressure exerted by Insurance Committees, and supported by the Government, heartily contributed to the rapid improvement and extension in the arrangements made by the County and County Borough Councils for the treatment of persons suffering from tuberculosis, which made it possible for them to be entrusted solely with this responsible duty, and for sanatorium benefit to cease to be provided out of National Health Insurance Funds.

192. The amount expended by Insurance Committees on sanatorium benefit exceeded five million pounds from insurance funds, and another million pounds from Exchequer grants and contributions from the Ministry of Pensions in respect of ex-service men. The number of insured persons recommended for sanatorium benefit was approximately 250,000, and recommendations were also made in respect of a large number of dependants of insured persons where Committees had extended this benefit to that class.

193. The activities of Insurance Committees were limited to the extent of the funds provided under the Act, admittedly inadequate for the purpose, but many County and County Borough Councils generously provided treatment for insured persons at a cost in excess of the contributions of Insurance Committees.

194. The administration of sanatorium benefit by Insurance Committees proved to be an important factor in dealing with the scourge of tuberculosis. The members of Insurance Committees regarded their duties in this matter to be of the utmost importance, and the benefit was thoroughly appreciated by insured persons, and not only those for whom it was necessary to recommend this benefit. The right to sanatorium treatment under the insurance scheme was highly valued, and to the insured person it had none of the objectionable features which appertain to treatment provided by charitable organisations or at the expense of the rates.

195. Another feature which made a strong personal appeal to the members of Insurance Committees was the provision of "extra nourishment" for insured persons in receipt of domiciliary treatment for tuberculosis. The applications for treatment were as a rule considered and dealt with by special sub-committees, and in many counties District Insurance Committees were entrusted with the preliminary examination of them. In making their recommendations Committees depended to a considerable extent upon the reports of their Medical Advisers, who were generally the Medical Officers of Health and Tuberculosis Medical Officers of the Council.

196. The sub-committees usually met monthly, and besides dealing with new applications, former recommendations were reviewed, and the period of institutional treatment was often extended on the advice of the medical adviser. Cases were individually considered, and the interest of the members in their work was evident from the regularity of their attendance at these meetings. Many soldiers and sailors were discharged during the war suffering from tuberculosis, and they were provided with treatment under the arrangements of Insurance Committees, and the cost of treatment was refunded by the Navy, Army, and Air Force Authorities, or by the Ministry of Pensions.

197. The progress of patients on their discharge from a sanatorium or hospital was closely watched by the Committee and the Medical Officers, and After-Care Committees were constituted for the purpose in many areas. The members made periodical visits to the patients at their homes to encourage the patients to take full advantage of the educational work of the sanatorium, and to ascertain whether suitable assistance could be rendered to the patients in the form of the provision of extra nourishment, assistance in obtaining suitable employment, or securing better "home conditions." Patients were often helped to secure improved housing accommodation and, in suitable cases, shelters were provided for them.

198. When sanatorium benefit came to an end there was a sense of keen disappointment amongst members of Insurance Committees. They felt that the same personal interest could not be taken in the individual cases, and they regretted the disappearance of the right on the part of the insured person to sanatorium benefit under a contributory scheme.

199. Although grants were made to the Councils of Counties and County Boroughs equivalent in amount to the sum derived from Insurance Funds, the Associa-

tion found it necessary to protest against their action, and the support given to it by the Ministry of Health, in charging insured persons for the treatment of tuberculosis. They noted with pleasure the Circulars Nos. 474 and 479 of the Ministry of Health, issued early in 1924, which announced increases in the Government grants, and impressed upon Local Authorities that no charge should be made unless they were satisfied that it could be made without detriment to the insured person's ability to provide adequate maintenance for himself and his dependants.

200. Insurance Committees in a number of areas still enjoy representation upon the Tuberculosis Committee of the County or County Borough Council, and they are usually represented on Tuberculosis Care Committees. The Association considers it desirable that this representation should be extended so that there may be adequate representation of every Insurance Committee.

201. The Federated Associations recommend that grants should be made by the Ministry of Health in aid of contributions made by Local Authorities towards the general expenditure of After-Care Committees under section 2 of the Public Health Tuberculosis Act, 1921, in addition to the grants now payable only in respect of the cost of the provision of clerical assistance and other administrative expenses.

CHAPTER XI.—ADMINISTRATION COSTS OF INSURANCE COMMITTEES.

STATUTORY PROVISIONS.

202. The statutory amount available to Insurance Committees (and Pricing Committees) for administration purposes is a sum not exceeding, in the aggregate, 6d. per insured person, together with the special contribution by Approved Societies towards the costs of the Central Index and Clearance work.

The previous arrangements have already been detailed in the Minister's statement, and need not be recapitulated.

DISTRIBUTION SCHEME.

203. The Central Administration Fund is distributed in the following manner:—A mean count of the index registers of insured persons other than deposit contributors and members of the Navy and Army Fund, as ascertained by the Distribution Committee, is taken. To this is added the numbers representing deposit contributors and members of the Navy and Army Insurance Fund, suitably "loaded" on account of the additional work which has to be performed by Insurance Committees. When the total units are thus obtained, there is first credited to all Committees a sum at a uniform rate per thousand units. Then there is added a special grant—an amount fixed by the Minister as being the sum which, taking into account any balance remaining in the Administration Fund, will be sufficient to meet the necessary requirements of the Committee for the year, after deducting the Committee's share of expenditure upon the Central Index Committee.

204. The distribution to Committees was originally on a uniform capitation basis, but it was soon found that this method lead to inequalities; the smallest Committees had an utterly insufficient income to meet their necessary expenses, while the larger Committees received a larger amount than was requisite for their needs.

DEFINITE AND ADEQUATE CREDITS.

205. On the whole, the present method would seem to work out equitably as between Committees, but there is considerable delay in notifying the amount available to Committees, with the result that dissatisfaction is often expressed, particularly in those cases in which a reduction of the amount anticipated has been made many months after the commencement of the financial year. For this reason it is suggested that definite and adequate credits should be available, and notified to Committees either before or at the begin-

ning of a financial year, the amount, if necessary, being a provisional sum, as in the case of medical benefit credits, with adjustment later on.

CONTROL OF EXPENDITURE.

206. The very closest supervision is maintained by the Ministry of Health over much of the expenditure by Committees; for example: all staff engaged and remuneration paid is subject to the specific approval of the Minister, as well as expenditure on office accommodation. In many cases the Minister fails to approve the recommendations of Committees as to the remuneration of their staff, the reason for declining to give sanction being the insufficiency of funds rather than the question of merit, of which no doubt, the Insurance Committee is the best judge.

A review of the staffing arrangements, with a view to effecting economies, has from time to time taken place, and particularly at the time of the Geddes Committee, when a special Departmental Committee, presided over by Mr. Leggett, was set up by the Minister of Health, upon which three Clerks to Insurance Committees were appointed, and they conducted a very exhaustive investigation into the matter.

It has been stated that the cost is now limited to a maximum of 6d. per head per insured person, but during recent years, owing to the altered values of money, the cost was in excess of this sum. As shown by the Statement submitted by the Ministry, the percentage of Insurance Committees' administration costs to the total income of the Scheme is only one per cent. (Q. 289), or, stated in another way, the total administration costs represent only 4½ per cent. of the amount expended on medical benefit. In arriving at this percentage, however, a sum of £30,000 is included in the income of Insurance Committees in respect of the special duties in connection with the Central Index Committee. Further, this method of comparing costs is not quite sound since it assumes that the only duties of Insurance Committees are in connection with the administration of medical benefit—their principal duty, it is true, but it overlooks the fact that these Committees are responsible for the administration of important matters relating to deposit contributors and members of the Navy, Army and Air Force Insurance Fund (including sickness, disablement and maternity benefits) and that they have other duties to perform, e.g., in connection with health propaganda.

MINOR PAYMENTS.

207. Apart from the expenditure upon staff and remuneration, printing, postages, etc., the latter of which is a particularly heavy item, the remaining expenses are nominal; the aggregate amount paid in respect of travelling expenses of members, or subsistence allowance in connection with attendances at meetings of the Committees and their Sub-Committees is small.

The Association considers that Committees should be empowered to pay the expenses of their representatives upon Local Authorities or Committees of Local Authorities in accordance with a satisfactory scheme.

SUPERANNUATION OF STAFF.

208. The Association is of opinion that the income available to Insurance and Pricing Committees for the purpose of administration should be sufficient to enable a satisfactory scheme of Superannuation upon a joint contributory basis to be set up for the staffs. At the present time the officers of Insurance Committees are practically the only persons engaged in work of a public character, certainly of a national character, who have no such provision, and since it has been held that they are not a Local Authority within the meaning of the Local Government and Other Officers' Superannuation Act, Committees are unable to take advantage of the powers to establish a voluntary scheme given by that measure.

GENERAL PURPOSES FUND.

209. In addition to the Administration Fund, Insurance Committees have a General Purposes Fund, which was until 1918 chiefly built up by sums representing sickness benefit due to insured persons, having no dependants, who had been afforded institutional treatment in respect of sanatorium benefit.

210. As previously stated, the Ryan Committee suggested the abolition of this provision, subject to its being found practicable to re-adjust the finances of Insurance Committees to meet the relatively small income from this source.

211. In fact, such loss has not been made good, and since the only fund available to Insurance Committees for the provision of lectures and for Health Propaganda generally, is the General Purposes Fund, the absence of the promised substituted provision has considerably restricted their activities in this direction, and under the recent regulations it would appear that the only income recently available to the fund, namely, bank interest, is to be largely diverted to other channels.

The Federated Associations accordingly recommend that adequate funds should be placed at the disposal of Insurance Committees to enable them to carry out their powers and duties in these matters.

CHAPTER XII.—TREATMENT BENEFITS.

NEED FOR COMPLETE MEDICAL AND ANCILLARY SERVICES.

212. The Association has from time to time considered communications from Insurance Committees and innumerable resolutions passed by them with regard to the limited scope of medical benefit and demanding better and more efficient medical and pharmaceutical services, and indeed a *complete* domiciliary service, comprising the services of doctor, dentist, pharmacist, nurse and midwife, supplemented by the services of medical and surgical consultants and specialists, diagnostic and treatment facilities, and adequate accommodation in hospitals and convalescent homes.

213. The experience of the first year of the administration of the National Insurance Act, 1911, and, in particular, the administration of medical and sanatorium benefits, shewed that although much had been secured, there were many problems to be dealt with and additional and extended services must be provided if the objects of the Act—the prevention and cure of sickness—were to be fulfilled. The system required to be supplemented by the provision of consultant and specialist treatment if disease was to be effectively combated; an adequate nursing service and sufficient hospital accommodation were urgent necessities; clinics and laboratories were indispensable.

GOVERNMENT GRANTS-IN-AID FOR SUPPLEMENTARY SERVICES.

214. The Government were soon convinced, and in July, 1914, submitted a supplementary estimate to Parliament which furnished substantial amounts to meet at least the requirements which clearly called for immediate attention. The sum of £50,000 was granted for the provision of Referee and Consultant Services and incidental matters. A similar amount was granted for the provision of specialist consultants and in aid of the equipment and maintenance of clinics for the use of insurance practitioners. There was a further grant of £100,000 to inaugurate a scheme of nursing, so that this necessary service might be provided by Insurance Committees. Pathological laboratories were also to be established, and a grant of £50,000 was made available for the purpose. The decision that these grants should be administered by the Insurance Committees was taken after very careful consideration.

215. The Council, in June, 1914, on the recommendation of the Medical Benefits Committee, passed the following resolutions:—

(1) That this Committee is of the opinion that amending Regulations should be made by the Insurance Commissioners so as to secure the provision by Insurance Committees of:—

- (a) such treatment in hospitals as appears to be needed by insured persons recommended for this by their doctor.
- (b) further facilities for modern means of exact diagnosis.
- (c) the services of trained nurses where recommended by the doctor in charge of the case, and
- (d) the provision of such further appliances as are shown to be needed.

(2) That in the opinion of this Committee any Schemes in connection with Medical Referees, outlined by the Chancellor of the Exchequer in his Budget statement, should be administered by Insurance Committees.

(3) That this Committee notes with satisfaction the statement of the Chancellor of the Exchequer that further financial assistance will be given to Insurance Committees for the purposes of providing health lectures and other educational work, and urges that the promised grants shall be made to Insurance Committees at an early date for that purpose.

216. A deputation from the English, Scottish, and Welsh Associations of Insurance Committees, arranged by the Federation Committee, was received by the Chancellor of the Exchequer, Right Hon. David Lloyd George, M.P., at the Treasury, on the 3rd July, 1914, when strong claims were put forward on behalf of Insurance Committees that these services should be provided by and through them, alongside of the medical and pharmaceutical services. It was satisfactory to know the principle was conceded that the provision of medical referees, specialist consultants, clinics, and a nursing service were integral parts of medical treatment, and that the whole scheme should be under one authority and control. The development of the main scheme of medical benefit on harmonious and efficient lines was made possible, and the danger of divided control averted.

217. The decision of the Government was quickly followed by a hurried decision to postpone action with regard to these grants, owing to the outbreak of War, and the uncertain situation arising in consequence. The Insurance Commissioners in their Report for 1914-17 referred to the Budget proposals of 1914 and the paragraphs relating to these grants (328-342) dealt lucidly with the objects to which they would, but for the outbreak of the War, have been devoted.

REPRESENTATIONS TO INSURANCE COMMISSIONERS.

218. The Association of Insurance Committees in January, 1919, shortly after the Armistice, approached the Insurance Commissioners on these matters in the following terms:—

(1) *Nursing.*

The utterly inadequate provision for nursing throughout the country has been brought into prominence in the administration of medical benefit, and the Association desires to urge upon the Insurance Commissioners that with the cessation of hostilities they should immediately resume the consideration of the question of the best manner of disbursing to Insurance Committees the grant for the provision of nursing, and the early promulgation of an efficient Scheme of Nursing to be established by Insurance Committees throughout the several areas, to be organised in the closest contact with, and under the direct supervision of the doctors attending the patients to be nursed, and in suitable co-operation with any analogous services under the Public Health Authorities in the different areas. Such provision is calculated to hasten the return of sick persons to health, and therefore to relieve the funds of Approved Societies.

(2) *Range of Medical Service.*

Insurance Committees, as a result of their experience during the past six years, are of the opinion that the range of medical service should be enlarged beyond that laid down in the Medical Benefit Regulations up to the high standard of "medical treatment and attendance" to which insured persons are entitled under section 8 of the 1911 Act. The limitation of the treatment of an insured person to "such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a general practitioner of ordinary competence and skill," has in many serious cases proved to be insufficient to secure the early and complete restoration to health of the patient, and has emphasised the necessity for the provision without further delay of the Specialist and Consultant Services for which a Grant-in-Aid was provided by the Government in its Supplementary Estimate on the 13th July, 1914.

(3) *Clinics.*

The Association welcomed the following statement in the Insurance Commissioners' Report for 1914-17 as to the provision of clinics:—

"It was proposed under this grant to make provision for encouraging the establishment and equipment by Panel Committees of clinics, for the use of doctors on the panel, in any area where a satisfactory scheme could be formulated, as there was evidence of an increasing desire among panel practitioners to bring this form of co-operative service within the reach of insured persons, and this desire was known to have resulted in at least one neighbourhood in the voluntary formulation of a scheme of this nature. . . ."

It was noted with satisfaction that the part of the grant allocated to clinics was to be applied in acquiring premises and in assisting in equipping those premises with the necessary apparatus.

The Association trusts that an early commencement will be made with the arrangements for the distribution of this grant as the demobilisation of doctors offers a most favourable opportunity for the establishment and equipment of clinics for the use of panel practitioners.

(4) *Medical Benefit for Dependants of Insured Persons.*

The extension of medical benefit to dependants of insured persons and to non-insured widows and orphans of deceased members of the Navy, Army, and Air Forces, has long been desired by the Association, and the time would now appear to have arrived when some active steps should be taken to this end by considering the best method of meeting the cost, and by negotiating with the medical profession as to the conditions of their service.

From the experience which Insurance Committees have gained during the administration of medical benefit up to the present time, they are strongly of opinion that it would be of advantage, not only to the insured population, but also to the medical profession, if some arrangements could be made whereby the treatment of the whole of the household of insured persons would be undertaken more or less on the same lines.

(5) *Dental Treatment.*

The necessity for adequate dental treatment is now thoroughly realised, and the enormous improvement in the provision of such treatment for men serving in the Navy, Army and Air Forces leads the Association to hope that this additional benefit under the 1911 Act may soon be in operation. Some provision has already been made for tuberculous persons and for members of certain Approved Societies, but arrangements extending to all insured persons should be made as soon as circumstances permit.

REPRESENTATIONS TO THE MINISTRY OF HEALTH.

219. The Association continued its efforts, and a resolution was passed at the Annual Meeting in October, 1920, welcoming the Report of the Consultative Council on Medical and Allied Services as an attempt to place the health services for the people on a sound and comprehensive basis. The Executive Council was empowered to consider the Report and to make such representations thereon as might appear desirable.

220. The Council, after long and careful consideration of the Report of the Consultative Council, in accordance with their instructions, passed the following resolutions, which were sent in May, 1921, to the Ministry of Health and to the Consultative Council:—

(1) *Domiciliary Service.*

"That this Association is of opinion that a complete 'Scheme' of domiciliary service (comprising the services of doctor, dentist, pharmacist, nurse, midwife, and health visitor), as outlined in Paragraphs 18-35 of the Report, is eminently desirable, and should be given effect to at the earliest possible date."

(2) *Voluntary Hospitals.*

"That this Association is of opinion that the position of the Voluntary Hospitals can best be met by means of a grant-in-aid for work carried out, and suggests that such a course be adopted, subject to the conditions attaching to the admission of patients being revised." Paragraphs 81-86.)

(3) *Institutional Accommodation.*

"That to secure increased institutional accommodation and to make possible a more suitable classification of patients, this Association supports the recommendation of the Medical and Allied Services Consultative Council for the immediate utilisation of Poor Law Infirmarys." (Paragraphs 46-59.)

(4) *Hospital Committee.*

"That to ensure the best use being made of all the hospital accommodation within an area, pending the creation of the new Local Health Authority, this Association is of opinion that provision should be made for the setting up of a provisional Committee in each area, consisting of representatives of every Authority engaged in health administration, and of the several hospitals within the area." (Paragraph 12.)

(5) *Adequacy of Hospital Accommodation.*

"That with a view to ascertaining the degree of adequacy of accommodation, this Association is of opinion that under the direction of the Ministry of Health a 'Hospital Survey' should be undertaken at an early date by the Committee of each area referred to in the preceding paragraph." (Paragraph 12.)

(6) *Nursing.*

"That the need of an adequate nursing service is urgent, and this Association suggests that the Committee referred to in paragraph (4) should, in conjunction with the Nursing Associations and Approved Societies operating within the area, prepare a Scheme for securing an adequate system of nursing for all sick persons for whom the doctor deems nursing to be necessary." (Paragraphs 29-32.)

221. At the Annual Meeting in October, 1923, these matters were again under discussion, and the following resolution was passed:—

"That this Association being of the opinion that it is eminently desirable

- (i) That medical benefit should be available for the dependants of insured persons;
- (ii) That the range of medical benefit should be extended so as to include maternity services;

reaffirms the previous decisions of the Association and the Executive Council thereon."

222. The Council have never ceased their advocacy of the early provision of these supplementary and additional services. In February, 1924, they communicated with the Ministry of Health on the subject of the necessity for the provision of further hospital accommodation, and recommended that a scheme should be prepared in accordance with the recommendations contained in the Interim Report of the Consultative Council on Medical and Allied Services; and later in the year the following resolution on the subject of additional benefits was sent to the Ministry:—

"That, having regard to the urgent need for the provision for all insured persons of those ancillary services which are recognised as being necessary as an essential part of the National Health Insurance Scheme, *e.g.*, nursing, specialist and consultant services, laboratory facilities, X-Ray examinations, etc., and for the further development of dental treatment, the Minister of Health be urged to take such need into consideration."

ALTERATIONS, EXTENSIONS, AND DEVELOPMENTS
RECOMMENDED.

223. The representatives of Insurance Committees attending the last Annual Meeting, held in October, 1924, decided respectfully to submit to the Royal Commission that the time had arrived when a complete medical service should be inaugurated for insured persons and their dependants, and that such medical service should include:—

- (a) Maternity services.
- (b) Less stringent conditions as affecting the rights of persons reaching the age of 70.
- (c) An extension of the present range of medical and surgical service so as to include the services of specialists and consultants.
- (d) The right of X-Ray examination.
- (e) Dental and ophthalmic treatment.
- (f) An adequate nursing service under a national scheme, available to every insured person.
- (g) The right to hospital and convalescent home accommodation and treatment.
- (h) The establishment of pathological laboratories for the provision of additional facilities for insurance practitioners, in respect both of diagnosis and treatment.

The matter was referred to the Executive Council for a report to be submitted to a special general meeting of the Association.

224. At the Special General Meeting referred to in the preceding paragraphs, and held on the 16th January, 1925, the Association approved the main outlines of this Statement, and instructed the Executive Council to arrange for the submission of these opinions to the Royal Commission, *viz.*:—

- (1) That the Association is of the opinion that medical benefits should be extended, and that treatment benefits should become primary benefits under the National Health Insurance Scheme, and
- (2) That the Association is convinced of the necessity for:—
 - (i) A complete domiciliary service, including such ancillary services as experience of Insurance Committees in administering medical benefit shews, *viz.*:—
 - (a) *Consultants and specialists*, in co-ordination with the general practitioner service.
 - (b) *Diagnostic and treatment facilities* (laboratories and clinics, X-Ray, etc.)
 - (c) *Nursing.*
 - (d) *Dental treatment.*
 - (e) *Ophthalmic treatment and appliances.*
 - (f) *Additional appliances.*
 - (g) *Maternity services* (including services of midwives).
 - (h) *Massage.*
 - (ii) The provision of hospital and convalescent home (in-patient) treatment.

(3) That the Association considers that medical benefit should be available, notwithstanding arrears of contribution due to unemployment, etc., or ceasing insurable employment before reaching the age of 70 after a certain period of insurance, especially in the case of blind persons, to whom special provisions apply.

(4) That the Association is further of the opinion that medical benefit should be provided for the dependants of insured persons.

(5) That the Association holds the view that all treatment benefits in the nature of medical benefit should be administered by and through Insured Committees.

The Association also considered the question of the priority which should be recommended in the event of its being found necessary for financial or other reasons to introduce these developments by stages instead of as a whole. The order in which they are presented above is the order of priority, if necessary, which the Association would prefer to be adopted.

NECESSITY FOR EXTENSION AND DEVELOPMENT.

225. At the present time the only medical service available, to which every insured person is entitled as of right, is what is known as "general practitioner" treatment, or the treatment that may be given by a general practitioner of ordinary professional competence and skill. It is generally admitted that such service is, in the interests of the health of insured persons, unduly limited and inadequate. For this reason there is a growing demand that medical benefit should be extended, and that certain "treatment" benefits should become available as "primary" benefits under the National Health Insurance Act. After full consideration, the Association is convinced of the necessity for a complete domiciliary service, as defined in the preceding paragraph, combined with the provision of institutional treatment in suitable cases.

226. The experience of Insurance Committees shows that innumerable enquiries are received by them from insured persons with regard to certain services other than those now provided under the arrangements of Insurance Committees. None of these services are at present available to all insured persons. The present position of these "treatment" benefits, having regard to the partial scope of the provision, and the fact that insured persons are contributing at a flat rate under a national scheme, cannot be regarded as satisfactory, and Insurance Committees from their experience in this respect recommend that these services should be made available to all insured persons, and not limited, as at present, to the members of those societies which can show disposable surpluses upon valuation.

227. Some of these additional benefits are in the nature of medical benefit, and under section 75 (5) of the 1924 Act it is provided that these shall be administered by and through Insurance Committees. The Association recognises that it would not be administratively easy for them to provide some of these services so long as they are not available to all, or the larger portion of the persons entitled to medical benefit. In order that advantage might be taken of the funds available for additional benefits, the Ministry, in lieu of providing for the making of arrangements by and through Insurance Committees, increased the list of additional benefits and made it within the power of Societies to deal with certain of them, either by making cash payments directly to express purpose of making arrangements for their provision. It was not possible, however, for Approved Societies to make any arrangements for providing these services, having regard to the statutory powers and duties of Insurance Committees with respect to the administration of "treatment" benefits in the nature of medical benefit.

228. Insurance Committees are in a position to make arrangements for the provision of the services ancillary to the medical and surgical services which they now provide. If a scheme had been made operative at the time of the valuation there is no doubt

that it would by this time have proved itself to be of great advantage to the insured population.

229. The recommendation of a complete domiciliary service calls for the extension of medical benefit so as to include the services mentioned in items (a), (b) (f) and (g) of paragraph 224 (2) (i) namely, consultants' and specialists' services; diagnostic and treatment facilities; additional appliances and maternity services.

CONSULTANTS AND SPECIALISTS.

230. The general practitioner service at present available to insured persons requires to be supplemented by practitioners who have acquired experience and skill in a particular direction. It is now the custom of general practitioners, and in the case of insurance practitioners their duty, to advise patients as to the steps to be taken in order to obtain special treatment or to seek other advice, or, as it is commonly termed, "second opinion." Insured persons are usually referred to hospitals for this special advice or treatment, since they are not in a position to take advantage of the services of consulting physicians and surgeons on their ordinary terms.

231. The Association considers that an efficient medical service for the insured demands that both classes of treatment should be made available to them under the National Health Insurance Scheme, and that suitable terms and conditions of service for consultants and specialists should be arranged so as to secure suitable co-ordination of these services with the general practitioner service.

DIAGNOSTIC AND TREATMENT FACILITIES.

232. The diagnostic and treatment facilities available to insurance practitioners are insufficient. At the present time, facilities are generally provided by local authorities in connection with the treatment of Tuberculosis and Venereal Disease. In some areas fairly adequate facilities in other respects are available, but in few instances have any arrangements been made under which insured practitioners are entitled to the services rendered by the laboratories, clinics, &c. The Association strongly urges improved facilities and recognises that provision for X-Ray examinations and treatment should be included.

ADDITIONAL APPLIANCES.

233. The appliances which may be ordered by an insurance practitioner are limited to those prescribed by regulation, and it not infrequently happens that the appliance which is considered necessary for a patient by his medical attendant cannot be ordered for him.

It is somewhat of an anomaly that an elastic bandage may be supplied but not the same elastic shaped as a knee-cap; that a spray for the throat may be ordered but not the atomiser or nasal douche to enable the medicament to reach the affected part; that lymph may be used to vaccinate a patient but a vaccination pad may not be supplied; that gauze and cotton wool tissue may be given but not the same material made into a pneumonia jacket; that eye drops or lotion may be ordered but no eye bath, eye dropper nor eye shade; that cotton wool and capsicum may be ordered separately but capsicum wool (cotton wool impregnated with capsicum) may not be supplied.

The Federated Associations, as stated in paragraph 101, recommend that arrangements should be made for the supply or, in appropriate circumstances, the loan of any appliances requisite in connection with medical treatment. These appliances should be available on the order of the practitioner in charge of the case, with sufficient safeguards against any excessive use.

But beyond the appliances requisite in connection with medical treatment there are cases where appliances would, if available, render the insured worker less liable to a claim for sickness or disablement benefit, and the Associations consider the provision of appliances of this type should continue to be possible under approved schemes for additional benefits.

MATERNITY SERVICES

234. The Federated Associations and the Insurance Committees have given much attention to the subject of the provision of maternity services.

The National Association at its annual meeting in October, 1918, decided in favour of the inclusion of maternity services within the range of medical benefit provided for insured persons and the extension thereof to the wives of insured persons.

The Council in bringing this matter to the notice of the Insurance Commissioners expressed the view that the restriction in the First Schedule to the Medical Benefit Regulations, 1913, excluding treatment in respect of a confinement from the scope of the agreement with panel practitioners, should be eliminated, and suggested that the services of certified midwives should be made available to insured persons and to the wives of insured persons under arrangements made by Insurance Committees.

It is, of course, understood that every practitioner under agreement with a Committee could not be expected to undertake maternity services, but the Associations are fully convinced that medical attention before, at and after confinement should be available in all cases, together with the provision of the services of certified midwives if desired. For this purpose separate lists of practitioners undertaking this service, and of midwives, should be compiled, and the fees to be paid for such services should be arranged centrally as in the case of remuneration for medical treatment. These services should be provided in addition to any cash payment that may be available by way of maternity benefit.

The Federated Associations strongly recommend the provision of maternity services as they consider them to be a necessary part of a complete domiciliary medical service.

TREATMENT BENEFITS AS PRIMARY BENEFITS.

235. The Federated Associations in recommending that treatment benefits should become primary benefits under the National Health Insurance Scheme, as stated in paragraph 224 have indicated their view that treatment benefits in the nature of medical benefit should be administered by and through Insurance Committees, as provided under sub-section 5 of section 75 of the National Health Insurance Act. They have also shown the order of priority which they prefer to be adopted if it is found impracticable, for financial or other reasons, to develop the scheme at a single stage to the desired extent.

The Associations recommend that the following treatment benefits be provided as being necessary for a complete domiciliary service, namely, Nursing, Dental treatment, Ophthalmic treatment and Massage. Of these, Nursing and Massage may be regarded as similar in type and the administration might be on parallel lines. Dental treatment and Ophthalmic treatment belong to another type and the administrative arrangements would be, broadly speaking, identical in method, not only in the provision of treatment, but also in the supply of dentures and optical appliances.

In the succeeding paragraphs Nursing and Dental treatment are discussed as representative of the two types.

NURSING.

236. In the course of the administration of medical, sickness and disablement benefits the fact has persistently emerged that insured persons have not been able to have the benefit of the skilled nursing necessary to supplement the medical attendance and treatment provided for them. As a result of this, the value of the medical treatment has been diminished and in many cases negated since the patient has been compelled to continue at or to return prematurely to work owing to economic circumstances; frequently, on the other hand, the illness of a patient has been unduly protracted with a corresponding increase in the amounts payable by way of sickness and disablement benefits.

Attention has been drawn (in paragraph 176) to the powers of Insurance Committees to make sub-

scriptions or donations for the support of district nurses or to appoint nurses, and reference has already been made (in paragraphs 216-217) to the Budget proposals of 1914, and to the Insurance Commissioners' Report for 1914-17, from which the following paragraph relating to nursing grants may here be quoted, viz. :—

" 341. It was decided, therefore, to make a Grant-in-Aid of £100,000 and, in view of the close connection which must exist between any nursing which was provided and the organised medical service of insured persons, it was decided that this grant should be administered by Insurance Committees, the primary object of the grant being to provide nursing for insured persons in their own homes, without precluding the possibility of a wider extension of the nursing service."

Insurance Committees have continued to press for a satisfactory nursing service for the insured since the matter was carefully considered at the annual meeting of the National Association in October, 1921, and the model scheme was circulated amongst Insurance Committees as a basis for local negotiations. In many areas there have been Conferences between representatives of Insurance and Panel Committees, Approved Societies and the Local Nursing Associations and, in some cases, of the Council for the County or County Borough.

For the identical reasons that the arrangements for medical benefit were entrusted to Insurance Committees, these are precisely the bodies best adapted to make the local arrangements for the provision of nursing for insured persons by and through the local Nursing Associations, and to assist in the extension of these Associations or the establishment of new ones where necessary in order that the service may be available to every insured person.

It is mainly in rural areas that there is inadequate or no provision for nursing, although in a few industrial districts the conditions are similar, but, happily, during the last four or five years there has been a steady increase in the formation of District Nursing Associations stimulated by the County Nursing Associations.

The Federated Associations are thoroughly convinced of the desirability of the provision of an adequate nursing service as a statutory benefit available to all insured persons entitled to medical benefit and they would willingly bring to bear in the administration of it the experience gained by them in the administration of medical benefit which has led them to the conclusion that nursing is a natural corollary to medical attendance and treatment.

DENTAL TREATMENT.

237. Dental treatment is at present available to less than one-half of the insured population, but only in few cases is the insured person entirely free from making a payment. This additional benefit is defined as "the payment of the whole or any part of the cost of dental treatment," and the payment in practice amounts to one-half, or less than one-half, of the cost. Again, the fact that dental treatment is not available to all insured persons leads to a considerable amount of correspondence, for not only are letters sent direct to the Ministry of Health, but many are received by Insurance Committees, who generally send a formal acknowledgment and pass on the letter to the Ministry or to one of its officers.

238. The attention of Insurance Committees was directed to the importance of dental treatment, if medical treatment were to be of real value to the patient, in the early days of the administration of sanatorium benefit, and there were many instances in which Insurance Committees found it necessary not only to provide dental treatment, but also to supply dentures for tuberculous patients, and to charge the cost to the Sanatorium Benefit Fund. Insurance Committees are firmly convinced of the necessity of providing all dental treatment which may be necessary on medical grounds for every insured person. Every Insurance Committee should be empowered to prepare a list of dentists, as in the case

of doctors and chemists, and questions arising would be dealt with by a Dental Service Sub-Committee, constituted similarly to the existing Services Sub-Committees. It should also be possible for insured persons who desire other services beyond those recommended by the Insurance Committee, to be able to obtain them on terms and conditions arranged by the Insurance Committee; this would necessitate a written statement being sent to the Committee by the dentist who proposed to undertake the work—a procedure similar to that applicable to insurance practitioners proposing to charge fees for services outside the scope of medical benefit.

239. Where additional services are given, payment might be made by the insured person, and an amount refunded to him by the Committee, as is done in the case of persons allowed or required to make their own arrangements for medical attendance and treatment; alternatively, the cost of the additional services might be paid by the insured person direct to the dentist, who would receive payment from the Insurance Committee in accordance with their arrangements for the treatment recommended by it. In any event, the Committee would require to be safeguarded against unreasonable expenditure, and it might accordingly be found desirable to arrange for the annual "pool" for dental treatment to be distributed under similar conditions to those which now apply to the Special Arrangements Fund.

HOSPITAL AND CONVALESCENT HOME TREATMENT.

240. The necessity for supplementing the complete domiciliary medical and ancillary services by suitable arrangements for the treatment of insured persons in hospitals and for their accommodation in convalescent homes scarcely requires to be stated. The present provision in all types of hospitals—voluntary hospitals, local authorities' hospitals and sanatoriums and poor law hospitals—is generally recognised to be quite inadequate to meet present-day requirements. The Federated Associations recommend that insured persons should be entitled in respect of payments from National Health Insurance Funds to residential treatment in hospitals and convalescent homes recommended for them under approved schemes.

EXTENSION TO DEPENDANTS OF INSURED PERSONS.

241. The Federated Associations in recommending the extension of medical benefit to the dependants of insured persons have in mind the satisfactory results which have attended the arrangements made for the insured themselves, and they are thoroughly convinced that the long-contemplated similar arrangements for dependants are much overdue.

It was by design and not by chance that the first additional benefit mentioned in the Fourth Schedule to the 1911 Act was medical benefit for dependants, and it was soon impressed upon Insurance Committees that this ought to be a primary benefit. The National Association soon after the Armistice approached the Government Department in the terms set up in paragraph 218 (4), not without hope that a proposal would be included in the 1920 Bill, although they were aware that there was a shortage of doctors due to the War, and that it would be some four or five years before the number could be sufficient.

The late Sir Robert Morant, then Chairman of the Insurance Commissioners, expressed his agreement with the policy of the Association in this matter, and the developments since that time, notably the formation of public medical services by the doctors themselves in many areas, have only strengthened the conviction of Insurance Committees and their earnest desire to see the realisation of this logical development of the insurance medical service.

REPRESENTATION ON INSURANCE COMMITTEES.

242. The provision of a nursing service and of dental treatment would require some slight modification in the constitution of the Insurance Committee, so as to include representatives of the nursing and dental professions. These might be appointed by the Minister of Health who now, as a rule,

appoints a chemist and one or more of the doctors included in the number forming at least ten per cent. of the membership of every Insurance Committee.

SUMMARY OF ALTERATIONS, EXTENSIONS AND DEVELOPMENTS RECOMMENDED.

243. The principal alterations, extensions and developments in medical benefit and other treatment benefits recommended by the Federated Associations have been briefly stated in paragraph 224.

The minor amendments which have been recommended in earlier paragraphs may conveniently be summarised as follows:—

Terms and Conditions of Service.

(1) That the Associations should be directly represented, on behalf of Insurance Committees, on any body or conference negotiating the terms and conditions of service and other arrangements connected with the administration of medical benefit. (Paragraph 31.)

Admission to the Medical List.

(2) That there should be similar powers of exclusion of medical practitioners from the medical list of Insurance Committees as exist in the case of chemists and also in the case of practitioners or chemists removed after enquiry from any medical list. (Paragraph 37.)

(3) That the admission of a medical practitioner to the medical list should be conditional upon surgery and waiting room accommodation, and the proposed arrangements for conduct of practice being satisfactory to the Insurance Committee. (Paragraphs 37 and 69.)

Medical Certification.

(4) That the issue of recommendations for treatment benefits by insurance practitioners to insured persons be no longer restricted to occasions on which a certificate of incapacity for work is given. (Paragraph 50.)

(5) That the system of medical certification be further simplified, and the form of voluntary certificate improved. (Paragraph 56.)

Medical Records.

(6) That arrangements be made for Insurance Committees to be in a position to take advantage of the information contained in the medical records kept by insurance practitioners and to undertake the compilation of statistics and the extraction of information as to the causes and incidence of sickness. (Paragraph 58.)

Limitation of Doctors' Lists.

(7) That an insurance practitioner should be permitted to exceed the maximum numerical limit within a reasonable margin, but not to go beyond a financial limit to be imposed. (Paragraph 62.)

Special Arrangements.

(8) That any savings in the Special Arrangements Fund or, alternatively, the General Medical Benefit Fund should be made available, if necessary, to meet abnormal claims upon the Special Arrangements Fund in any year or to meet certain expenses inadvertently incurred by insured persons in obtaining emergency treatment or drugs or appliances otherwise than from doctors or chemists on the lists of Insurance Committees. (Paragraph 86.)

Change of Method of Treatment.

(9) That members of approved institutions and persons making their own arrangements for medical treatment be given the same liberty to change their doctor or method of treatment at any time as exists for insured persons on the lists of insurance practitioners, instead of being restricted to giving notice before the 1st June or 1st December. (Paragraphs 70, 85 and 89.)

Approved Institutions.

(10) That complaints by members of approved institutions which are now dealt with under the Rules of the Institution should stand referred to the Medical Service Sub-Committee for investigation in the same way as all similar complaints of other insured persons. (Paragraph 88.)

(11) That the provisions as to Investigations, Disputes, Appeals, &c., contained in Parts V and VI of the Medical Benefit Regulations, 1924, in so far as they relate to witnesses and the awarding of costs, should be made applicable to Approved Institutions. (Paragraph 88.)

Additional Appliances.

(12) That the list of prescribed appliances should be increased and arrangements made for the supply or, in appropriate circumstances, the loan of any appliance requisite in connection with medical treatment. (Paragraphs 101 and 233.)

Breaches of Terms of Service.

(13) That the constitution of the Services Sub-Committees be revised with a view to the due discharge of their functions under all circumstances and to widening the field of selection to the office of Chairman. (Paragraphs 113 and 114.)

(14) That the Services Sub-Committees be given power to require witnesses to give evidence on oath in England and Wales as now obtains in Scotland. (Paragraph 120.)

(15) That where an insurance practitioner has (or is alleged to have) failed or neglected to comply with any of the terms of service the Insurance Committee should be consulted by the Ministry of Health, and afforded an opportunity of investigating the matter if necessary, through the Medical Service Sub-Committee, before any disciplinary action is taken by the Ministry. (Paragraph 124.)

(16) That penalties recommended by the Insurance Committees should not be varied by the Ministry without the Insurance Committee being afforded an opportunity of a hearing, or of making a statement of its views on the matter, a procedure now in operation in Scotland. (Paragraph 125.)

Index Register.

(17) That there should be a uniform system of clearance in connection with the Index Registers of Insurance Committees. (Paragraph 140.)

(18) That arrangements should be made at the next Census for the collection of information, as in Scotland at the last Census, showing the distribution of the insured population. (Paragraph 140.)

Transfer of Practices.

(19) That the arrangements in connection with the transfer of practices be simplified. (Paragraph 148.)

Regional Medical Officers.

(20) That the duties of regional medical officers as consultants be extended and that consultations should be possible in the earlier stages of illness, and not restricted to cases in which certificates of incapacity have been issued for at least four weeks. (Paragraphs 76 and 152.)

(21) That the services of regional medical officers should be made available to Insurance Committees to assist them in carrying out their duties in connection with prescribing reports, in approving the employment of assistants, and in dealing with questions as to the range of medical service and that, in the interest of the insurance medical services, these officers should be brought into the closest relationship with Insurance Committees. (Paragraphs 154 and 155.)

Deposit Contributors.

(22) That deposit contributors should be placed on a sound insurance basis. (Paragraph 161.)

Navy, Army, and Air Force Insurance Fund.

(23) That members of the Navy, Army and Air Force Insurance Fund should have the same right

of appeal as members of Approved Societies and that a Court of Appeal be set up for them. (Paragraph 163.)

(24) That the income limit for uninsured pensioners to be entitled to medical benefit should be increased from £160 to £250, the normal limit for non-manual workers, and that allowances, &c., should be excluded in assessing the amount of their income. (Paragraph 165.)

Seamen's National Insurance Society.

(25) That with a view to simplification of the machinery of medical benefit and in the interests of the members of the Seamen's National Insurance Society the members of this Society should be provided with medical benefit under the arrangements made by Insurance Committees for all other insured persons (including seamen who are members of Approved Societies). (Paragraph 169.)

Exempt Persons.

(26) That the special provisions under which Exempt Persons receive medical benefit should cease and the sums payable in respect of their employment should be applied to other purposes; but that if medical benefit is retained, there should be no requirement with respect to their making their own arrangements for treatment on the ground of income. (Paragraph 173.)

Tuberculosis and Tuberculosis Care Committees.

(27) That the representation of Insurance Committees upon the Tuberculosis Committees of the County or County Borough should be extended so that there may be adequate representation of every Insurance Committee. (Paragraph 200.)

(28) That grants should be made by the Ministry of Health in aid of contributions made by Local Authorities towards the general expenditure of After-Care Committees under section 2 of the Public Health Tuberculosis Act, 1921, in addition to the grants now payable only in respect of the cost of the provision of clerical assistance and other administrative expenses. (Paragraph 201.)

Administration Costs of Insurance Committees.

(29) That definite and adequate credits should be available and notified to Insurance Committees either before or at the beginning of a financial year. (Paragraph 205.)

(30) That Insurance Committees should be empowered to pay the expenses of their representatives upon Local Authorities or Committees of Local Authorities in accordance with a satisfactory Scheme. (Paragraph 207.)

(31) That the income available to Insurance and Pricing Committees for the purpose of administration should be sufficient to enable a satisfactory scheme of superannuation upon a joint contributory basis to be set up for the staffs. (Paragraph 208.)

(32) That adequate funds should be placed at the disposal of Insurance Committees to enable them to carry out their powers and duties under sections 50 and 107 of the National Health Insurance Act. (Paragraphs 188 and 211.)

244. As bearing on the last recommendation a statement as to the activities of Insurance Committees in England under section 50 of the National Health Insurance Act, 1924, and previously under section 60 of the 1911 Act, in relation to Health Propaganda, etc., is given below:—

PART I.—COUNTIES.

Insurance Committee and Particulars.

Cambridgeshire.

Films have been shown and lectures given.

*Insurance Committee and Particulars.**Cheshire.*

Sub-Committee appointed and taking steps in this connection.

Cornwall.

Education Authority was invited to co-operate with the doctors and the Insurance Committee.

Derbyshire.

Lectures given to students in all Secondary and Elementary Schools during Health Week by doctors, Health Visitors, etc. Literature distributed to schools, clergymen, Women's Institutes, Health Visitors, doctors and chemists. The arrangements were carried out in conjunction with the Local Education Authority.

Devonshire.

Leaflets supplied to the County Education Authority.

Dorsetshire.

Health Hints, etc., sent to insured persons with medical cards.

Durham.

Committee expended £50 on Health Lectures in conjunction with the Durham County Council. Arrangements made with Local Education Authority for issue of Leaflets and Health Notes to all schools in the County. Health propaganda work was suspended during the War and apart from co-operation with the County Council during Health Week, particularly in the schools, has not been resumed owing to uncertain and inadequate funds.

Essex.

Lectures were arranged for in various parts of the area in regard to tuberculosis and these resulted in the formation of Care Associations.

Hampshire.

Lectures arranged in several parts of Committee's area by joint arrangement with the County Council who share the expense.

Isle of Ely.

Leaflets issued.

Isle of Wight.

Leaflets issued to scholars by arrangement with Education Authorities.

Kent.

Co-operation of the County Medical Officer in the giving of lectures. Lectures on sanatorium benefit scheme and a week's caravan tour in the rural areas. Lectures on cancer by the County Medical Officer. Distribution to insurance practitioners of the monographs on various diseases issued by the Ministry of Health. A scheme for lectures on health subjects to school teachers or children in co-operation with the local education authorities is being discussed. Pamphlets on National Health Insurance on basis of pamphlet prepared by National Association of Insurance Committees, issued to schools.

Lancashire.

Lectures arranged.

Leicestershire.

This Insurance Committee submitted evidence on this subject direct to the Royal Commission.

Lincs. Kesteven.

Committee been in communication with the Education Committee relative to the distribution of literature.

Lincs. Lindsey.

Committee made a grant for the provision of Health lectures arranged by the Medical Officer of the County Council. The cost of lectures was approximately £60.

*Insurance Committee and Particulars.**Norfolk.*

280 Lectures delivered in County during this Winter Session through the joint co-operation of the Committee, the British Red Cross Society and Federation of Women's Institutes.

Northamptonshire.

Participation in Health Week. Have a scheme to provide and bear the expense of special lectures, cinema films, literature, advertising, Baby and Essay prizes. Have a Central Committee with representation by County Public Health and Education Committees, School Medical and Dental Officers, etc. Also District Committees to suit local conditions. Distribution of "Health Hint" cigarette cards, juvenile demonstrations. Local practitioners and officials supplement special list of lecturers.

Northumberland.

A scheme for lectures had just been completed at outbreak of War—some well-known men from various parts of the country had arranged to speak. Literature was distributed—"Rules of Health"—all over the County up to the beginning of War in 1914. Arrangements were made with the Education Authority for the distribution of pamphlets on Health to all schools in 1913 and 1914.

Nottinghamshire.

A film dealing with tuberculosis has been shown at cinemas in the area. Lectures on the prevention of consumption have been given. Literature has been distributed amongst insured persons through large employers of labour in the area. Arrangements with Education Authority are at present under discussion.

Rutlandshire.

Doctors lecture in the schools and individual members of Insurance Committee give small prizes for essays. Semi-public lectures given in two large centres, the cost being defrayed by the Education Committee. Articles in local Press; issue of skeleton lessons to headmasters of schools and Sunday Schools. Appeal to clergy to give an annual Health Sermon. Operations handicapped through lack of funds. 3,500 Health Leaflets distributed in October, 1924. Health Hints issued with all medical cards, etc., and schools. Clergy, Doctors, etc., circularised in connection with Health Weeks. Arrangements made with Education Authority for Leaflet No. 1 to be issued to the elder school children.

Somerset.

Leaflets issued to the older scholars of the Elementary Schools throughout the County of Somerset.

Staffordshire.

Lectures were given in 1916 and 1917 in connection with tuberculosis.

Surrey.

Circulation of N.A.I.C. Leaflets.

Sussex, East.

Before the War lectures given in various parts of the County by means of caravan, illustrated by lantern lectures, Tuberculosis Exhibitions held at schools and recognised by the Education Authority as part of the school curriculum, lectures arranged at cinemas, use of posters and handbills. A few lectures held since the War, but the Committee felt that the results achieved were probably hardly commensurate with the expense involved, and since 1920 in view of the

Insurance Committee and Particulars.

shortage of funds, although the matter has been considered from time to time, nothing has been done.

Surrey, West.

Publication of Health articles.

Warwickshire.

Health lectures, illustrated by slides and films, have been given to school children during school hours in cinemas. Sets of Healthgrams, on varied tinted paper, Health-hint cards (in the form of "cigarette card") and post cards bearing healthgrams, so arranged as to be usable for correspondence, have been distributed to school children at the elementary schools, cinemas after lectures and otherwise. Posters containing health maxims have been displayed at railway stations in the county. Leaflets (supplied by the County Medical Officer of Health) and circulars (issued by the Ministry of Health) on cancer have been delivered to the doctors on the panel. Health maxims have been printed on the back of medical card envelopes. The Committee have had the co-operation of the Medical Officers of Health and Directors of Education in the arranging of lectures and distribution of literature in the schools.

Wiltshire.

Lectures illustrated by lantern slides given throughout the county in 1914. County Council and County Education Authority co-operated.

Worcestershire.

Lectures on tuberculosis arranged in 1918. 15,000 Health Week circulars were issued to elementary schools last October. Health Maxims printed on medical card envelopes. Arrangements made with Education Authority for teachers to give lectures during Health Week.

Yorks., E. Riding.

Arrangements made with Education Authority for distribution of leaflets.

Yorks., N. Riding.

Arrangements made with Education Authority for distribution of N.A.I.C. leaflets.

Yorks., W. Riding.

National Health Week arranged in conjunction with County Council and Panel Committee including addresses in schools by medical practitioners and head teachers. Health Cards distributed to pupils. Co-operation of Ministers of Religion. Lectures by Tuberculosis Officers during the winter. Health posters sent to schools. Competition among school children for short composition in verse or prose on health subjects, with book prizes given. Cost of health propaganda work approximately £200 for each of the two years, this cost being defrayed by the County Council and the Insurance Committee.

PART II.—COUNTY BOROUGHES.

*Insurance Committee and Particulars.**Barrow.*

Co-operated with Town Council during Health Week. Lessons given in Elementary Schools by teachers.

Bath.

Films shown from time to time. Lectures in conjunction with the Association for the Prevention of Tuberculosis given in various parts of the City.

*Insurance Committee and Particulars.**Birkenhead.*

During winter months lectures given by Local Authorities. Circulars and Leaflet No. 1 (Revised) distributed by Insurance Committee to large firms, departments and to public generally. Arrangements with Education Authority pending.

Birmingham.

Lectures given by insurance practitioners to the insured persons on their lists. Arrangements for addresses on health subjects to be given at early morning schools, P.S.A.'s, Adult Bible Classes, etc. Leaflets prepared for despatch with Committee's correspondence, medical cards, etc., also for distribution by Approved Societies.

Blackburn.

Insurance Committee have representatives on Local Publicity Committee on Health. Activities directed by Medical Officer of Health and pamphlets issued. Publicity Committee is representative of all the public bodies in Blackburn.

Blackpool.

Offered to collaborate with Corporation. Leaflet by Medical Officer of Health on Cancer to be issued to work people in Corporation Departments and issued as a public notice in the Press at quarterly intervals.

Bolton.

Arrangements with Local Health Authority.

Bootle.

"Health Hints" are periodically distributed with medical cards.

Bournemouth.

Issued pamphlets prepared by Joint Propaganda Committee.

Bradford.

Special leaflets issued by Insurance Committee giving information for parents and children on health and distributed through local Education Authority.

Brighton.

Held one or two lectures.

Bristol.

Films shown in connection with sanatorium benefit in conjunction with the Health Committee.

Burton-on-Trent.

Leaflets issued by N.A.I.C. sent to and accepted by the Local Education Authority for issue to children on leaving school.

Bury.

Five attempts have been made in past 2½ years, but lack of financial means has always prohibited further progress. No local authority support. Education Authority has been approached.

Coventry.

Co-operates with Corporation in the distribution of literature. Prepared and distributed to every house in the area a handbill and drew public attention by large illustrated posters. Last year prepared and issued in Press weekly for 23 weeks articles dealing with the diagnosis and treatment of various common ailments. In 1924 Committee prepared a report on local conditions and matters affecting the health of insured persons in the Borough in which the

Insurance Committee and Particulars.

Committee again emphasised the need for improved housing; the provision of synthetic sunlight treatment and additional institutional accommodation for tuberculous persons, health propaganda and the setting up of a Public Laboratory. In all these cases the results of the Committee's representations have been most gratifying.

Croydon.

Lectures on health subjects in 1914, 1917 and 1920 at 8 different centres in the Borough. Distribution of literature to the older children in the schools. Assistance of Local Medical and Panel Committees and of individual practitioners sought in the direction of securing better facilities for diagnosis and treatment of cancer. Reports on local conditions and matters affecting the health of insured persons in the Borough prepared in 1924 presented to the Ministry and to the Town Council. Following these Reports considerable progress made by the Town Council in several important directions, *e.g.*, inspections of houses of the working-classes for evidence of over-crowding, improvements in the local Tuberculosis Scheme, establishment of a public laboratory in the town.

Darlington.

Committee regret they cannot undertake Health Propaganda owing to lack of funds.

Dudley.

Public Meetings held on Tuberculosis. Health Lectures in schools. Committee desire greater powers under sections 61 and 63 of National Insurance Act, 1911, and grants to carry out same.

East Ham.

Leaflets on Health matters are extensively issued by the Committee and arrangements are in force, in conjunction with the Libraries Committee, for the issue of book-marks bearing health hints with Library Books. Blotters bearing health hints are issued to all children and students attending schools and continuation classes.

Gateshead.

Consideration has been given on many occasions to health propaganda but owing to the depleted state of Committee's General Purposes Fund, they have been unable to engage in this work.

Gloucester.

Lectures held 1913 to 1916.

Great Yarmouth.

Owing to lack of funds the Committee has not been in a position to undertake any special work regarding Health Propaganda.

Grimsby.

Committee have no available funds for health propaganda work.

Halifax.

A film, "The story of John McNeil," (loaned by the National Association for the Prevention of Tuberculosis) was shown in four of the local Picture Houses in 1917. Illustrated lectures were given on Tuberculosis in 1916 and 1917. Cards bearing health maxims issued with all medical cards, and to all school children in the borough. Lecture given to the teachers under the Local Authority in 1917.

Hastings.

Owing to lack of funds no work undertaken.

*Insurance Committee and Particulars.**Hull.*

Distributed circulars and supplied information to Local Education Committees for use of teachers and special lessons to children.

Liverpool.

A special Joint Committee consisting of members of the Insurance Committee and City Council was formed in 1914 for the purpose of Health Propaganda, but the outbreak of War prevented this object being given effect to. Since that date, apart from the distribution of certain literature, little has been done, though a special Committee has been formed consisting of representatives of the Insurance Committee, the Health Committee of the City Council and the Local Education Authority and the Liverpool Local Medical and Panel Committee, with a view to arrangements again being made.

Leicester.

Concentrates on annual "Health Week." Has a combined Committee of Corporation, Insurance Committee, Trades Union organisations, a local "Health Society," etc. 20,000 handbooks of Week's programme and articles by Specialists. Propaganda by means of illuminated tramcar; publication of posters all over the town, films in all cinemas; special newspaper articles by medical men and others—one daily. Lectures in factories; adult schools; trade union and friendly society meetings; to school children in school hours; special meeting for mothers; prominent medical men occupy pulpits on the Sunday commencing Health Week; etc., etc. The Insurance Committee undertakes the cost of producing the posters, etc. (Cost this year, £50.)

Manchester.

Leaflets issued. The subject is under the consideration of a Joint Committee of representatives of Insurance and Panel Committees.

Middlesbrough.

Lectures given on three occasions. Literature has been distributed on two occasions. Correspondence with Education Authority *re* hygienic instruction in schools.

Norwich.

No funds available.

Plymouth.

Pure Milk Lecture in connection with sanatorium benefit.

Portsmouth.

Lectures held on tuberculosis. Literature issued in regard to cancer and N.H.I. generally. Arrangements with Education Authority with regard to issue of N.H.I Circulars.

Reading.

Lectures have been arranged on several occasions. Last year the Insurance Committee suggested a Health Week and in close co-operation with the Town Council this was held with most gratifying results. Leaflets have been issued with medical cards. Arrangements made with the Education Authority for issue to elder children of N.A.I.C. Leaflet and for lessons by teachers.

Rotherham.

No work undertaken owing to lack of funds.

St. Helens.

Co-operation with Corporation Health and Education Committees in organisation of Health Week. Card of "Health Hints" distributed to

Insurance Committee and Particulars.

school children. Hints stamped by means of rubber stamps on face of letters sent out by local firms. Prizes given for Essays by school children. Baby shows at various clinics, etc., churches etc., requested to hold special Health Services during Health Week. Exhibition of special film taken locally showing the work incidental to Maternity and Child Welfare. Suitable pictorial card giving health hints issued. These cards were issued to school children through the Education Authority. Committee is handicapped in regard to Health Propaganda owing to lack of appropriate income.

Sheffield.

Lectures given in the area during the past 3 years under the Joint auspices of the Committee, Joint Hospitals Council and the Sheffield Education Committee.

Smethwick.

Exhibition of lantern slides at local cinemas giving suitable health hints. Lectures given in conjunction with the National Association for the Prevention of Tuberculosis. Committee issued to insured persons leaflets dealing with "seasonal" ailments; also issuing a book entitled "Preservation of Health" compiled by the Medical Officer of Health. Arrangements made with Education Authority for lectures in schools.

Southampton.

Issued 20,000 leaflets to school children during Education Week, 1924.

Wakefield.

Co-operated for lectures and literature with Wakefield Council of Social Service.

Walsall.

Lectures on tuberculosis given at Town Hall and in the Schools. Arrangements made with Education Authority for distribution of literature in the Schools. Prizes have been awarded to school children for essays on subjects relating to health.

West Bromwich.

In June, 1915, the Committee arranged for a Tuberculosis Exhibition to be held in West Bromwich for one week. Lectures on tuberculosis, prevention and after care, were given in various parts of the town, and illustrated by means of lantern slides. Dr. Jacobs of Leeds lectured to the school children in the upper standards. A quantity of literature (e.g. handbills, posters, etc.) relating to health was printed and circulated throughout the town. In October,

Insurance Committee and Particulars.

1923, and also in October, 1924, the Insurance Committee co-operated with other Local Authorities in successfully promoting a "Health Week" in West Bromwich. Since July, 1923, a small printed slip calling attention to different "Health Maxims" has been enclosed with every medical card issued by the Committee.

West Ham.

Lectures by medical practitioners and Sanitary Inspectors in 1913 on "health in the home," "how to keep the house healthy however poor," "tuberculosis: prevention and cure." Cost of 12 lectures £55 2s. 5d. Lectures well attended. Similar lectures in 1919. Proposal to hold a health week in 1921 dropped as no funds were available. Distribution of health leaflets from 1922 onwards. Health sermons in churches and chapels on one Sunday in 1922. Health talks to adolescent persons in various parts of the Borough in 1924. Mass meeting lectures on sunlight and health, illustrated by lantern views. 60,000 "health hints" book-markers circulated in books issued by the public libraries. In 1925 10 lectures on health subjects and 10 lectures on National Health Insurance to persons between 16 and 18 years of age attending the five Juvenile Unemployment Centres in the Borough. Nasal hygiene hints distributed on cards. Committee proposes to continue health propaganda and Insurance education so long as the limited funds at their disposal will permit.

West Hartlepool.

Have offered to co-operate with Local Health Committee.

Wigan.

In conjunction with the Local Health Authorities, Lantern Lectures on tuberculosis have been given. Leaflets supplied to Director of Education who arranged for distribution and appropriate lessons.

Worcestershire.

Grant of £25 from the General Purposes Fund to assist the City Council in holding a "Health Week."

York.

No real action in this respect has been taken by the Committee at the present, mainly owing to lack of funds. Offer of assistance to the Public Health Committee for the purpose of inaugurating Health Weeks has been accepted.

April, 1925.

20, New Elvet,
Durham,

28th February, 1925.

APPENDIX XXXVII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE SCOTTISH ASSOCIATION OF INSURANCE COMMITTEES, BY MR. WILLIAM MARCHBANK MARSHALL, *Solicitor*, CLERK TO THE COUNTY OF LANARK INSURANCE COMMITTEE, AND HON. SECRETARY TO THE SCOTTISH ASSOCIATION OF INSURANCE COMMITTEES. See Minutes of Evidence of the Twenty-Third Day, Questions 13,143 to 13,208.

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NOTE.

Broadly speaking the functions of Insurance Committees in Scotland are the same as in England. There are, however, specialities in Scotland which have resulted in variation in subsidiary matters.

This Statement is to be regarded as supplementary to the Statement presented to the Commission by the Federation Committee of the three Associations of Insurance Committees in England, Scotland and Wales.

CHAPTER I.—INSURANCE COMMITTEES.

ESTABLISHMENT OF INSURANCE COMMITTEES.

1. There are 54 Insurance Committees in Scotland, 31 being County Insurance Committees and 23 Burgh Insurance Committees. In Kinross and Clackmannan and in Moray and Nairn, the counties are combined for National Insurance purposes, but otherwise each county is a separate unit of administration. All burghs containing a population of 20,000 and upwards, according to the Census of 1911, are also administered by separate Insurance Committees, but

the two burghs of Dumfries and Maxwellton, which are contiguous, are combined for the purposes of the Act. Each of these burghs is a separate Public Health Authority. There are over 300 Public Health Authorities in Scotland, but of these the District Committees and smaller Burghs, which are Public Health Authorities within their respective areas, are not represented directly on the Insurance Committee.

2. There are approximately 1,650,000 insured persons in Scotland and the distribution varies widely in the respective areas. Over 44 per cent. of the insured persons in Scotland are resident in the City of Glasgow and the three contiguous counties of Lanark, Ayr and Renfrew. On the other hand the counties of Sutherland, Caithness, and Ross and Cromarty, with an area of over 6,000 square miles, contain rather under 22,000 insured persons, less than can be found in the towns of Greenock or Paisley. Owing to the extent of the areas involved, it would, however, be quite impracticable for administrative purposes to insist on further combination between counties. Any slight saving in central administration would be much more than counterbalanced by increased cost in travelling, while the local office would lose touch with large parts of the area of administration.

3. In addition to the 54 Committees referred to there has been constituted under section 59 (5) of the 1911 Act a combination of all Insurance Committees in Scotland for the purpose of establishing a Central Bureau for pricing and checking chemists' accounts for the supply of drugs and appliances to insured persons. This Central Bureau is established in Glasgow, and the staff scrutinise and check all prescriptions issued by medical practitioners to insured persons in Scotland. This Bureau has proved successful, and its increasing utility is shown by the fact that, apart from National Health Insurance, it is being taken advantage of by an increasing number of Local Authorities and others whose prescriptions are checked and priced by the Bureau on terms agreed upon.

CONSTITUTION OF INSURANCE COMMITTEES.

4. Insurance Committees were established in the summer of 1912 and have now been in existence for over 12 years. Under normal circumstances, it should have been possible by this time to appreciate the true value of these Committees, but it is doubtful whether the experience gained is as yet sufficient to estimate their present and potential value in the working of the scheme. During the first two years, the scheme of National Insurance being novel, the whole machinery of administration had to be created. In addition National Insurance itself was the centre of an embittered political controversy to which there was added, in the case of the Insurance Committees, difficulties with the medical profession which in the early days were acute. The European War, which supervened, causing the absence on national service of large numbers of medical practitioners and official staff, made it necessary for Committees to limit their activities to keeping the machinery already created running with comparative smoothness. The post War period brought with it fresh problems and further difficulties. It would be somewhat unfair, therefore, to suggest, as might reasonably have been done had the period been normal, that 12 years of the administration of medical benefit by Insurance Committees is a sufficient period in which to estimate the value or point to the defects of the system.

5. The membership of the Insurance Committee varies. It numbers thirty in the case of seventeen of the smaller counties and the number increases to a maximum of eighty in the case of the City of Glasgow. Three-fifths of the membership represent insured persons and are appointed either directly by Societies having a large membership in the area, or indirectly by delegates appointed by the remaining Societies at a meeting specially called for the purpose. One-fifth of the members are appointed by the County or Town Council. A number of medical practitioners varying with the size of the Committee are appointed by the Local Medical Committee and the Local Authority, and the remaining members of the Committee are appointed by the Scottish Board of Health. By negotiation one-tenth of the members are medical practitioners. The appointments by the Board comprise medical practitioners, chemists, employers, and representative public men and women. A certain definite representation of women is secured. The Association is of opinion that a statutory provision should be made to secure a definite representation of employers on each Committee.

6. The Committee, therefore, when constituted, represents primarily insured persons with a strong representation from the County or Town Council, a fair representation of medical practitioners, a chemist and other interested parties. While in the early years of administration there was at times a difficulty in reconciling what appeared to be opposing interests, of late years this feeling has almost, if not entirely, disappeared and the general experience of Insurance Committees is that there is a genuine desire on the part of all members, by their attendance at meetings and their interest in the work, to improve the efficiency of the service and the whole working of the National Insurance system:

7. The attendance of members at meetings is good, exceptionally good in the case of Burgh Committees, and quite fair in the case of County Committees where meetings involve a considerable sacrifice of time on the part of members. The interest taken by members in the proceedings is also good, but the feeling is frequently expressed that there is little power of initiative, and that further duties should be entrusted to Committees.

8. As is general among the larger Local Authorities, the main duties of the Committees are entrusted to sub-committees. Each Insurance Committee is required to appoint a Finance Sub-Committee and an Allocation Sub-Committee, and generally does appoint other sub-committees, e.g., a Medical Benefit Sub-Committee. In county areas the Insurance Committee follows the practice of the County Council and meets only three or four times a year. In the Burghs the Committees meet as a rule bi-monthly, or even monthly. The sub-committees meet when required. In many areas the Finance Committee meets monthly, in some quarterly. The attendance of members at sub-committee meetings is good.

9. In addition to these sub-committees there are also the Services Sub-Committees, consisting of Medical Service Sub-Committee, Pharmaceutical Service Sub-Committee, and Joint Services Sub-Committee. These particular sub-committees deal with complaints against the medical or pharmaceutical services, and are constituted in a particular way, containing representatives of insured persons, doctors and chemists. These Services Sub-Committees act in a semi-judicial capacity, and it is the general experience that all complaints brought forward are considered with the greatest care and impartiality and with a desire to do complete justice as between the parties. The number of really serious cases dealt with is remarkably small.

POWERS AND DUTIES OF INSURANCE COMMITTEES.

10. The powers and duties of Insurance Committees are fully detailed in the Statements submitted to the Commission by the Ministry of Health

and the Scottish Board of Health. As there indicated, the Insurance Committee is mainly concerned with the administration of medical benefit, but in addition it administers all benefits falling to deposit contributors and members of the Navy and Army Fund. Further powers and duties are conferred upon Insurance Committees by sections 60 and 63 of the original Act.

11. Insurance Committees originally dealt with sanatorium benefit, but this particular benefit was abolished in December, 1920, special powers being given to Local Health Authorities in this connection.

12. In Scotland only ten clerks to Committees are whole time officials. The income for administration in most cases is not sufficient, even if it were desirable, to appoint a whole time staff. In some cases certain members of the staff are whole time engaged on Insurance Committee work, in other cases the clerk is allowed a fixed sum, out of which he provides office accommodation and clerical staff. Many of the clerks to Committees have other appointments and a substantial number are qualified legal practitioners. The Scottish Association of Insurance Committees is of opinion that the work done by officials of Insurance Committees has been efficient and economical.

SCOTTISH ASSOCIATION OF INSURANCE COMMITTEES.

13. The Scottish Association of Insurance Committees was formed at a meeting held early in 1913. The objects of the Association as stated in the Constitution are:—(1) to confer on questions of administration committed to Insurance Committees by the National Insurance Act, 1911, and Acts explaining and amending the same, and to take such steps as may from time to time appear desirable to secure efficiency and standardisation of methods and forms (2) to promote the interests of Insurance Committees as they may be affected either by legislation or by the administration of Government Departments, and (3) to take such action as may be necessary in relation to or in connection with any other subjects in which Insurance Committees in general may be interested.

14. Every Insurance Committee in Scotland is affiliated to the Association. Each year a Conference of the Association is held at some suitable town in Scotland, the place of meeting being changed annually. These Conferences are invariably attended by representatives from every Committee and result in discussions mainly on the National Insurance system as administered by Insurance Committees. Reports are submitted and considered, resolutions passed, and an address given to the delegates on some aspect of public health. The executive work of the Association is carried out by an Executive Committee, 16 in number. This Committee is constituted by the election of six representatives from County Committees and six from Burgh Committees, together with the President, Vice-President, Immediate Past President, and the Secretary. This Committee meets quarterly with occasional special meetings. A considerable body of correspondence from Committees is dealt with at these meetings. Occasionally action has been taken in connection with Parliamentary Bills. During the course of the year a large body of correspondence is dealt with by the Secretary to the Association. In addition to these duties the Association is frequently consulted by the Board, and on numerous occasions has submitted to the Board by deputation, suggestions for alteration in the Regulations and Orders under which the scheme of National Health Insurance is carried on.

15. The Association has issued various pamphlets and leaflets, and these have been circulated to Committees.

16. Further, the Association has endeavoured to simplify the working of the Scheme. Within recent years it has standardised a prescription book for

Scotland and arranged for the printing in bulk of all prescription forms required by Insurance Committees throughout the country. This has resulted in a considerable saving, especially to the smaller Committees. In these and similar matters, and by the dissemination of information of common interest, the Association has proved of great value to Committees, and on questions of general principle a convenient link between them and the Central Authority.

17. The Association is linked up with the Associations in England and Wales by means of a Federation Committee. All documents are exchanged and a representative regularly attends meetings of the Federation Committee in London.

CHAPTER II.—MEDICAL BENEFIT.

STATUTORY PROVISIONS RELATING TO MEDICAL BENEFIT.

18. Medical benefit is defined in the original Act as "Medical treatment and attendance including the provision of proper and sufficient medicines and such medical and surgical appliances as may be prescribed by regulations to be made by the Insurance Commissioners." So far as medical treatment is concerned this is now defined in the Medical Benefit Regulations (Scotland), 1924, as "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." There is, further, a limitation under which the practitioner is not required to give treatment in respect of a confinement, and an extension in the case of an emergency when the practitioner is required to render whatever services are necessary, having regard to the circumstances, in the best interest of the patient. The original intention when the Bill was projected was apparently to continue and extend the arrangements whereby Friendly Societies could appoint doctors in accordance with the practice observed in the past, but in deference to Parliamentary opposition the Local Health Committee, now the Insurance Committee, was constituted. In any event the working out of the scheme must have revealed the necessity for local administration. Had the scheme as projected been carried in Parliament it would have been hopeless to administer medical benefit. The decision to permit to the insured person free choice of doctor rendered it quite impossible to work the system except through a central authority in each administrative area. Where the patients of a doctor might be members of 50 different societies it would be unreasonable to expect the doctor to make separate arrangements with each society. The system as established by the Act has resulted in a very large number of societies being represented in areas by a very limited number of members. When Insurance Committees were re-elected in 1921 there were in the County of Lanark members of 251 societies, and of these 184 had each less than 50 members resident in the County, and 67 had only one member each within the area. At the date of the election in 1924 there were similarly in the County of Lanark members of 233 societies, and of these 165 had each less than 50 members resident in the County, and 46 had only one member each within the area. Of the societies represented in the County of Lanark in 1921, 38 were no longer represented in the area, and in 1924 20 societies were represented which had formerly no members within the County area. This feature is common to Committee administration throughout the whole of Scotland.

19. The Act of 1911 contemplated under section 15 (6) that the Insurance Committee should negotiate with each society and adjust the cost of medical benefit, the question to be ultimately settled failing agreement by the Insurance Commissioners. For reasons which have been indicated this procedure would have been impracticable, but in any event the doctors and chemists insisted upon the rates to be paid for their respective services being adjusted nationally and this has operated since the commencement of the Act. Insurance Committees have no voice in the negotiations, but the Association is in-

variably consulted by the Board when any question of the kind is under consideration.

MEDICAL TREATMENT IN PRE-INSURANCE DAYS.

20. It was generally assumed in Parliament during the discussions on the National Insurance Bill that a very large proportion of the working population obtained medical attendance and treatment under the arrangements made by the Friendly Societies. The number of members of Friendly Societies in Scotland as shown by the Report for 1911 issued by the Registrar of Friendly Societies was 496,702, but this included many who were members of more than one society, and also a large number whose membership did not carry with it any right to medical treatment. It is, accordingly, impossible to estimate the actual number of workers for whom medical attendance and treatment was provided under the Friendly Society system. In many of the public works and colliery districts medical attendance was provided on the contract system by a deduction of 3d. per week, or some similar sum from each workman employed. For this sum the works' doctor undertook to provide treatment and drugs both to the workman and to his dependants.

21. Further, the Poor Law Commission Report showed that in Scotland probably to a much greater degree than in England there was great reluctance on the part of the poor to consult the Poor Law Medical Officers, and the terms and conditions of the appointment of these Officers showed indeed that it was not contemplated that their services would be in any great demand. Thus by far the greater part of the population in Scotland obtained medical treatment as private patients, and calling in the doctor involved a financial burden which was not readily faced. The out-patient departments of Voluntary Hospitals and the free Dispensaries supplied large numbers of the poorer classes in our large towns with medical aid. It was estimated that in Edinburgh, in 1901, 29 per cent., or between one in three and one in four of the population, received free, or virtually free, medical treatment in a year, and a similar state of matters existed in Glasgow, Aberdeen and Dundee. The work of these out-patient departments was rapidly increasing, and it is undoubted that the charitable provision made by these establishments was greatly and increasingly abused by persons well able to pay for treatment. On the other hand the lack of medical attendance in the Highlands and Islands was alarming, and there the position was becoming increasingly serious. In not a few areas the number of uncertified deaths was over 50 per cent. of the whole, and rose in some districts as high as 70 per cent. Large numbers of the sick went untended. Though not paupers they were too poor to engage a doctor who might require on each visit to travel many miles over moor and hill.

22. The need on the part of the working classes generally for medical treatment was thus only to a limited extent met by the arrangements made through the Friendly Societies and the Works' Contract system. The scheme adopted by the Friendly Societies in Scotland usually provided for treatment by a local doctor to the members resident within a radius of two or three miles at a fixed annual fee for each member varying from 2s. 6d. to about 4s., but rarely if ever exceeding the latter figure. In the districts where the works' system prevailed the Friendly Societies were usually well supported, and the worker might be paying for medical attendance both to the Friendly Society and through the work. But there were many defects. There was no free choice of doctor, and in general sickness claims were only admitted by the society when certified by the branch doctor. While the same cannot fairly be stated about the Works' Contract system, there can be no doubt that the payments by Friendly Societies were quite inadequate to secure a satisfactory service. Here and there were signs of unrest. In various industrial centres the medical men combined and endeavoured to secure better terms from the societies. In two cases in Scotland where both parties were obstinate Medical Associations were established by the Combined Friendly Societies, who had no diffi-

culty in securing the services of a doctor to undertake responsibility for the entire membership. On the other hand, in many industrial areas there had been some disturbance of the Works' Contract system as a result of the growing demand of the workers for free choice of doctor.

MEDICAL TREATMENT NOW AVAILABLE.

23. The Act confers by section 15 (2) (b) a right on the part of any duly qualified medical practitioner who is desirous of being included in the medical list of being so included, but where the Board, after enquiry, are satisfied that his continuance on the list would be prejudicial to the efficiency of the medical service to the insured, they may remove his name from the list. At first each medical practitioner desirous of being placed on the list required to sign an agreement with the Committee detailing the terms and conditions of service. It is now, however, the practice that the doctor should sign a simple application to be placed on the list and agreeing to accept the terms of service contained in the first schedule to the Medical Benefit Regulations.

24. So far as Scotland is concerned, the great majority of doctors in general practice have entered the service with the appropriate Committee or Committees covering the area of their respective practices. There are approximately 2,175 general practitioners in Scotland and of these 1,790 are engaged in insurance practice. About 70 of these medical practitioners are women. In the majority of committee areas every general practitioner, without exception, is on the medical list. In the larger centres there are a certain number of practitioners who have always limited themselves to middle or upper class practice, and many of these have declined to come on the list, although some have done so, limiting their panel to the employees of their private patients. Further, in these larger centres there are a certain number of consultants and semi-consultants to whom the panel could not possibly be remunerative. Otherwise, with few exceptions, the whole of the medical profession in Scotland in general practice are on the lists of the Committees, and their services are available to such of the insured as may care to place themselves under their care.

25. In one or two areas some little difficulty was experienced in the early years but this has long since disappeared.

26. A certain amount of criticism has been directed to what appears to be a limitation of treatment as defined in the terms of service, and it is even suggested that the medical profession limit their treatment unduly. This is not borne out by the experience of Insurance Committees. Under the regulations if a medical practitioner considers a service to be outwith the terms of his contract he is entitled to place the matter before the Local Medical Committee and Insurance Committee for their decision. Failing agreement by these two Committees the question in dispute is settled by referees appointed by the Board. During the past twelve years there have been about fifty cases of this kind, more than half of these having arisen in the cities of Glasgow and Edinburgh. In only two cases did the Committees fail to reach agreement. In the great majority of areas no question of this kind has ever been raised and notwithstanding the provisions of the contract it is the view of the Association that the vast majority of medical practitioners place no limitation on the service they are able to render to their insured patients. It is probable that in the larger centres advantage is taken of the services available to the working population at the hospitals and dispensaries, but it must be kept in view that better class patients in these areas would avail themselves in similar circumstances of the services of the specialist rather than limit their treatment to that of the general practitioner. Insurance Committees report that the Local Medical Committees take a broad and indeed a generous view of the duties of the doctor to his patient under the Insurance contract. Throughout a very large part of Scotland the services of specialists and consultants are not available, and the general practitioner is providing for the insured population the same

standard of professional skill as is offered to his better class patients. The number of complaints involving failure to attend and provide treatment, which have been considered by the appropriate Sub-Committees, is negligible, numbering only 30 in four years.

SICKNESS CERTIFICATES.

27. In considering complaints with regard to the issue of sickness certificates the Association desires to emphasise the enormous numbers of these certificates which pass without question. Having regard to the amount expended in Scotland in sickness and disablement benefit there must be roughly two and a half million certificates issued by medical practitioners throughout the year. The complaints considered by the Services Sub-Committees during four years, of the wrongous or careless issue of sickness certificates number 51, during which period there would be issued approximately ten million certificates. The Association suggest that these figures show that in the vast majority of cases there is little or no reason for complaint. Insurance Committees can only deal with any question of laxity from information supplied by the Approved Society, and deal without hesitation with properly substantiated complaints. It is the opinion of the Association that, broadly speaking, the system is working smoothly and well. It is not unreasonable to expect a certain amount of negligence and carelessness among the very large personnel of the Insurance Medical Service, and having regard to the magnitude of the Scheme, the Association regards the limited number of substantiated complaints with a certain degree of satisfaction.

28. The Committees recognise that the sickness certificate is the sole means adopted by societies in general for proving incapacity and that great care is necessary to prevent looseness or carelessness which may result in a heavy burden on the funds. While societies at times allege that there is carelessness on the part of the medical practitioner, the Committees have also experienced a counter-charge by the medical profession, that notwithstanding all their instructions to the contrary, certain agents of societies insist on certificates being dated for a particular day in each week, and notwithstanding that they have power to do so, decline to pay beyond the date of the certificate.

29. A further source of friction is the position with regard to final certificates. The doctor is definitely forbidden to issue a final certificate after an insured person has returned to work, and complains that in such cases societies frequently decline to pay sickness benefit for the last few days of illness. There is also the difficult question as to what is incapacity for work. The Act does not provide payment of sickness benefit during partial incapacity and the medical practitioner has frequently a difficulty in interpreting his duty in such a case.

MEDICAL RECORDS.

30. Medical Records are issued by Insurance Committees to the doctors, and in addition to their primary purpose they serve as a list of the patients of the practitioner. In the case of removal, death, or suspension from benefit, the record is recovered by the Committee from the practitioner. There is a steady stream of record cards being received and issued in and from the offices of the Insurance Committee. The general experience is that records are returned from the doctors with a reasonable measure of punctuality, but that difficulty is found with a limited number of doctors, resulting in considerable correspondence. In most areas this difficulty is said to be decreasing as doctors become more and more familiar with the requirements. The medical record is admittedly valuable where properly kept, but many practitioners do not sufficiently appreciate the importance of keeping these records properly. The professional nature of the record makes inspection somewhat difficult, but to ensure the proper keeping and ultimate value of the record the Association suggests that the District Medical Officers should on occasion inspect the records of a proportion of the doctors and ascertain whether these are being kept with a fair degree of accuracy.

31. At the close of each year the doctor requires to complete a card for every patient to whom a sickness certificate has been issued, and these are forwarded in bulk to the Scottish Board of Health. So far no purpose appears to have been served by the compilation and collection of these cards. The Association suggests that these cards might usefully be scrutinised by the Committees to assist in the fulfilment of their duties under sections 60 and 63 of the original Act.

SIZE OF PANEL LISTS.

32. The maximum number of insured persons for whom a doctor, without assistance, can be responsible, must not exceed 2,500, but quite a number of Committees have fixed a lower figure of 1,500 or 2,000. An increase is usually permitted in the case of partnerships or when a permanent assistant is engaged. Attention is directed to the table submitted by the Scottish Board of Health, from which it appears that two-thirds of the doctors in the County areas have panels under 500 and only one-third have panels of over that number, while in Burghs only one-third of the doctors have panels of less than 500 and two-thirds have panels over that number. The Association is of opinion that no further reduction is called for under existing circumstances, and in any event should not be general, but applied to particular cases and under special circumstances.

33. The value of free choice of doctor is highly appreciated by the public, and there would be general resentment at a further limitation which would compel considerable sections of the insured population to place themselves under a doctor of second choice.

34. It is not the experience of Committees that complaints are more frequent among the patients of doctors with large lists than among those under the charge of doctors with moderate lists.

35. It is suggested that any further limit should not be one of numbers but should be financial, so that a medical practitioner who so desires, might be permitted to take upon his list patients whom he particularly desired to have under his care.

EMPLOYMENT OF ASSISTANTS, &c.

36. The medical practitioner is required to obtain the consent of the Committee to the employment of an assistant, and, with the consent of the Board, may employ more than one. The practice of employing assistants does not appear to be increasing although in the opinion of the Association it is an undoubted advantage to the insured population as well as to the practitioner and the assistant. The Association suggests that it is desirable that the medical graduate should have some experience of general practice under a more experienced practitioner and that, broadly speaking, it would be of advantage to provide that a medical practitioner should not be admitted to the medical list unless and until he has had some experience either of general practice or post graduate hospital work.

SURGERY AND WAITING ROOM ACCOMMODATION.

37. The report obtained from Committees by the Association show that, generally speaking, the surgery and waiting room accommodation provided in medical practices in Scotland is adequate.

38. In Scotland for the most part, the surgery is attached to the dwelling house of the doctor. When the surgery forms part of the business premises of the chemist Committees have endeavoured, with a proper regard for the convenience of the insured patients, to discourage a practice which, to some extent, affects the right of free choice of chemist. There have been a few complaints as to the accommodation provided, usually with respect to waiting room facilities, but these appear to have been remedied through the action of Committees. The lock-up surgery is almost entirely confined to the industrial districts in the West of Scotland. These appear to number 450, and of these 353 are found in the City of Glasgow. In such cases Committees have taken action to secure that in the absence of the doctor suitable arrangements are made.

39. In the earlier years there were a few isolated cases of differentiation in the treatment of insured

and private patients. These have now disappeared and Committees report that to-day there is not even a suspicion of differentiation in treatment.

CHARGING OF FEES.

40. The cases where doctors have improperly charged fees to insured persons cannot be many. Although the number of cases brought to the notice of Committees is not conclusive on the question the Association believe that insured persons are now fairly cognisant of their rights under the Act and that if this practice were not very infrequent the attention of Committees would have been directed to the matter before this. In the few cases dealt with appropriate action has been taken.

41. The Terms of Service for Insurance Practitioners provide, with regard to the charging of fees, that in a case where a person claims treatment as an insured person, but cannot produce evidence of his title to benefit, or where the evidence of his title to benefit is in doubt, an insurance practitioner may demand and accept from the applicant a reasonable fee for treatment rendered including payment for any drugs or appliances supplied, provided that he renders the applicant an account or gives a receipt on a special form. The insured person may apply to the Insurance Committee within 14 days and if the Committee is satisfied that he was eligible to receive treatment from the practitioner the Committee may recover the fee from the practitioner by deduction from his remuneration or otherwise and repay to the applicant the amount of the fee. The Association has ascertained that this provision is seldom used. Many Committees report that so far no advantage has as yet been taken by any doctor of the provisions, and the number of cases where panel doctors have rendered accounts or charged fees under this arrangement must be exceedingly small. The Association is informed that the usual practice appears to be for a practitioner to give whatever treatment is necessary and either advise the insured person to obtain a medical card from the Insurance Committee or to communicate with the Committee himself with a view to establishing the title to benefit of his patient. Applications by insured persons are made from time to time to Insurance Committees to secure the withdrawal of doctors' accounts or the repayment of fees. In nearly all these cases inquiry shows that nothing was said at the time of consultation as to the patient being an insured person, and only after an account has been rendered, or after the fee has been paid, is any attempt made to establish a title to benefit. Where in such cases it appears that the applicant was entitled to medical treatment, and was not on the list of another practitioner in the area, it has generally been found sufficient to advise the doctor that the account must be cancelled or to inform him that the fee would be deducted from the remuneration. As a rule the fee paid is refunded by the doctor to the Insurance Committee for repayment to the insured.

DISTRICT MEDICAL OFFICERS.

42. Although informal consultations are occasionally held between the officials of Committees and the District Medical Officers there is no link between Committees and this service. The Association is of opinion that it would be of advantage to the service if the District Medical Officers were brought into direct relationship with Insurance Committees and made available for consultation in appropriate matters. It was hoped that these medical officers might be able to meet the demand among medical practitioners for a second opinion in suitable cases, but their limited number and the extent of their duties as medical referees has rendered it impossible for them to undertake these duties to any appreciable extent. The Association suggests that an increase in the number of officers is called for to provide that their time should not be entirely devoted to referee work.

MILEAGE GRANT.

43. The Association has on various occasions directed its attention to the position of the country doctor. His case is peculiar. He has not derived

the same advantage from the provisions of the Insurance Act as the doctor in a populous centre, yet it is the doctor in the single practice area whose presence is most necessary to the success of the whole scheme. The drawbacks of medical practice in country districts, in the main the higher ratio of expense and the limited opportunities of increasing what may be a very moderate income, render it on occasion a matter of difficulty to maintain a satisfactory service.

44. The provisions of the Insurance Act, and the great improvement in travelling facilities as a result of the almost universal use of the motor car by the country doctors have, however, greatly improved the medical service in the rural districts. The uncertified deaths in Scotland have dropped by more than a half and the County Committees agree that the medical facilities now available may in general be regarded as adequate. The following reports from County Committees may be of interest:—

Perthshire.

There has been very little difficulty in this County in obtaining the services of doctors in single practice areas. At one time there was difficulty in getting a resident doctor for Kinloch Rannoch, which is 17 miles from Aberfeldy and 22 miles from Pitlochry. For a period of about three months there was no resident doctor, and special arrangements had to be made with a doctor in Pitlochry to visit Kinloch Rannoch regularly for consultation, and also to visit specially when required. There is a very small population in the district. With the assistance now given from the Highlands and Islands Medical Service Board the difficulty should not again arise. There was also for a short period a difficulty in Blackford, but there is now a doctor resident there. It may be said that the County is adequately served with doctors. The greater use of motor cars, and the substantial Mileage Grant have been of great benefit to rural doctors, and the Committee would emphasise the absolute necessity for continuing the substantial payment for mileage in rural areas.

Aberdeenshire.

Very little difficulty has been experienced except in case of Braemar where there is recurring difficulty owing to the small number on the panel, and the nature of the practice. Changes of doctor here have been frequent, and much difficulty and delay usually experienced in securing a new doctor.

Ayrshire.

There has been difficulty in two rural areas, as follows:—

Ailsa Craig with an insured population of 40, which is an island situated 10 miles from the coast, is within the Committee's area, and considerable difficulty has been experienced from time to time in making arrangements for medical treatment. Arrangements are made with one practitioner on the mainland, and a system of signals by bonfires and carrier pigeons arranged, so that the doctor may know when he is to visit the island. A boat-hirer is paid at a fixed rate per voyage for taking the doctor to the island, but this does not cover any voyage which the contractor cannot undertake on account of rough weather. In these circumstances the Committee requires to pay for the use of the Lifeboat. This has happened on one occasion.

It might be mentioned also that in one rural area the doctors at one time who were resident in other rural areas some miles distant, declined to attend the insured persons in the first mentioned area unless they were paid on an attendance basis. An arrangement was ultimately made for this, with the proviso that the total accounts were not to exceed the amount which would have been paid on a capitation basis, taking the number of insured persons as the number on the list of the doctor who had last practised in that particular village. This special arrangement was carried on for some years and was only discontinued on 1st July last.

Inverness-shire.

The type of doctor in the Western and Islands portion of the County of Inverness has improved, which

is largely the result of the passing of the Insurance Act. The income from the capitation fees has helped to provide a better class of practitioner. There is, on the whole, a much higher standard of medical attendance in the West Coast. Difficulty has been experienced in getting satisfactory doctors to remain in the West and Islands portion of the County. In the Parish of Strath there have been 19 doctors in 21 years. The present doctor has been in practice there for three years, the longest period a doctor has remained in the Parish.

45. A decline in the number of urban doctors, while regrettable, could be met, but the disappearance or the retiral from insurance practice of doctors in single practice areas would create at once an insurmountable difficulty. The country doctor has usually less, sometimes much less, than 500 insured persons on his list, and the expense and time involved in attending these persons scattered over a wide countryside is considerable. In addition there are other difficulties experienced which render practice in such an area much less attractive than practice in the towns. The insured person has free choice and even in what is known as a single practice area insured persons sometimes choose the services of a medical practitioner who is outside that area. To meet the expenses of the country doctor a Mileage Grant is provided, which is distributed by the Board to Committees, and distributed again among the country doctors by the Insurance Committee after consultation with the Panel Committee.

46. The Association is not satisfied that the Mileage Grant for Scotland is sufficient having regard to the wide area involved, the physical difficulties of the country, and the scattered nature of many of the practices. Further particulars with regard to the position of the country practices are at present being ascertained, but the Association suggests that the position of the country doctor should be specially considered in any adjustment of remuneration. While no objection is offered to the basis of distribution of the Mileage Fund among Committees it is necessary that the present practice of distribution jointly by the Insurance Committee and Panel Committee should be continued. The circumstances of medical practice vary. The number of insured persons in two practices may be similar, the actual distance of the insured from the doctors' surgeries may be the same, and yet the distribution of the patients and the nature of the practice may be such as to create an injustice if both practices are treated on the same basis. A small village containing 100 insured persons may be comparatively easily reached but the same number of insured persons scattered over moor or hill may involve an extraordinary amount of labour and attention. These considerations are taken into account by the Committees in the distribution of monies, and their local knowledge enables this to be done with a substantial measure of justice.

SPECIAL ARRANGEMENTS.

47. The number of persons in Scotland who are permitted or are required to make special arrangements for medical treatment is small numbering only 6,240. Of this number the great majority are resident in Institutions where it is the desire of the Managers that the resident medical officers should provide the necessary treatment to members of the staff. Approximately only 978 are other cases. In 24 areas there are no cases of this kind. In eight areas one person only has so made application and been permitted. If simplification is desired the Association suggests that as an adequate medical service is available in every area this specialty should now disappear. Arrangements could be made in the case of the Institutions whereby the resident medical officer would be permitted to confine himself entirely to the residents in the Institution while the other individuals should be required to make a choice from the medical list of the Committee.

COMPLAINTS.

48. The constitution, powers and duties of the various Service Sub-Committees have been fully explained. Occasionally letters or messages are received

from insured persons which are not so much in the nature of complaints as of enquiry as to their rights. There is also a certain proportion of cases where a message to the medical practitioner or an explanation to the insured person removes any grievance. Definite complaints are few in number.

49. It is the belief of the Association that the conspicuous absence of complaints is largely due to the unofficial activities of Insurance Committees and their officers. The Insurance Committee Clerk is generally in fairly close touch with the practitioners practising in his Committee's area. While forming no part strictly of his administrative duties as specified in Statutes and in Regulations, many unrecorded services are rendered by the Insurance Committee Clerk in the direction of eliminating causes of dispeace between panel doctor and panel patient. The practitioner is persuaded to accept the view that the credit of the service is of more importance than the gratification of his technical rights. The patient is persuaded to extend consideration to his doctor and to appreciate his occasional difficulties. The Association is confident that the services of Insurance Committee Clerks in this connection are greatly appreciated by insurance practitioners and by insured persons alike. Members of Insurance Committees have frequent opportunities of bringing to the notice of the Clerk cases which appear to call for his intervention, and these opportunities are largely utilised. These are matters of which no record is kept. They figure in no statistics of Insurance Committee administration, but their value to the efficiency and smooth-running of the panel system should not be overlooked or under-estimated.

50. The meetings of the Medical Service Sub-Committee are usually well attended. While in the early years there may have been an inclination on the part of sections of the Sub-Committee to take a somewhat partial view of the matters under consideration this is seldom now apparent. The passage of time and the lessons of experience have resulted in a much improved standard of impartiality. The general experience of Committees is that complaints are fairly and properly considered by these Sub-Committees, and that every endeavour is made to secure justice to both parties. While no actual cases of difficulty have been submitted, several Committees suggest that the payment of expenses to witnesses would assist in the elucidation of complaints and that the expense involved to an insured person sometimes prohibits him pursuing what he would otherwise regard as a substantial case for consideration by the Committee.

51. These views apply with equal force to the Pharmaceutical Service Sub-Committee and the Joint Services Sub-Committee, but the occasions for meetings of these Sub-Committees have hitherto been few in number.

DRUGS AND APPLIANCES.

52. By section 15 (5) of the Insurance Act, the Insurance Committee is required to make provision for the supply to insured persons of proper and sufficient drugs and medicines and such appliances as may be prescribed, all in accordance with regulations made by the Commissioners. As indicated in the Statement submitted by the Board a tariff of drugs was framed and rates of payments adjusted by negotiation between the Scottish Insurance Commissioners and the Pharmaceutical Standing Committee (Scotland). From time to time there have been alterations in the rates, and annually the whole question is considered at a joint meeting between representatives of the Board, the Pharmaceutical Standing Committee (Scotland), and the Scottish Association of Insurance Committees.

53. In general the dispensing of medicines is done by chemists, but in rural areas, where a service of chemists is not available, doctors are required to dispense for their patients, and are paid at a capitation rate equal to the average cost per insured person of the drugs supplied by chemists in the area. The number of chemists under contract with the Committees has shown a steady increase. There are about 1,250 chemists, with in all about 1,400 shops under contract with the Insurance Committees in Scotland.

54. A certain amount of ill-founded criticism has been directed towards the provisions of the Act with regard to the supply of drugs, but it is clear that the insured person is entitled to all and any drugs reasonably necessary for treatment. The drug tariff is not exhaustive but illustrative, and drugs not included may be ordered by the doctor and charged against the Drug Fund. Repeatedly prescriptions have been dispensed involving heavy expenditure on the Fund, and no question based upon cost alone has been or could have been raised as to the propriety of the charge. Vaccines, sera, and insulin are regularly prescribed. For the year ended June, 1924, the cost of the insulin provided for insured person in Scotland amounted to £2,650 8s. 1d.

55. The capitation fee provided to meet the cost of drugs and appliances has varied from time to time, and since January, 1924, has been at the rate of 1s. 8½d. per head. At the end of 1923 the unexpended balances in the Drug Funds of the Scottish Committees amounted to £112,973. During 1924 there was a startling rise in the expenditure which has caused some anxiety, and is at present the subject of investigation.

56. The need for checking prescriptions was realised at an early date and, as indicated in the Statement submitted by the Board, a Drug Accounts Committee for Scotland was constituted under sections 59 (5) and 80 of the National Insurance Act, for the purpose of scrutinising the accounts furnished to Committees, and furnishing statistical and other returns and reports with reference to the accounts. The Drug Accounts Committee consists of fourteen members, ten representing insured persons, two the medical profession, and two the pharmaceutical profession. The Committee established a Central Checking Bureau in Glasgow, under the superintendence of a qualified pharmacist, and since early 1915 all prescriptions issued in Scotland to insured persons have been scrutinised and checked at this Bureau.

57. In addition to scrutinising and checking prescriptions, very excellent work is done by the Bureau in the way of providing statistical returns showing the incidence of prescribing in the several areas, the cost per insured person, and the cost for each patient on the several doctors' lists. These statistical returns are supplied to each Insurance Committee, and copies furnished to the local Panel Committee and the local Pharmaceutical Committee, to aid in the control of the Drug Fund and assist in the elimination of extravagance. The experience of the past ten years has shown that without supervision, and if necessary, action, the wastage in the Drug Fund which would ensue would be quite indefensible. Extraordinary differences both in frequency and cost exist in the methods of prescribing of doctors practising in the same area. Apart from errors or carelessness, unnecessary demands upon the Drug Fund are, in the main, due either to the prescribing of unnecessarily expensive drugs when equally efficient but much more economical substitutes are available, the unnecessary and extravagant use of flavouring agents, and the prescribing of excessive quantities. Together with the drain upon the fund due to these causes, the Association is of opinion that the increasing demands upon the Drug Fund of recent years are due to other causes which cannot be similarly controlled. The feeling among insured persons that the medicines supplied under the National Insurance Scheme are of an inferior quality has practically disappeared, and the undoubted fact that insured persons are now going at a much earlier stage of illness to consult with the doctor has had its effect. In addition, the periodic waves of influenza, coupled with, or perhaps attributable to, the weather conditions during the past year or two, have been unfavourable to the maintenance of a normal health standard.

58. The Central Checking Bureau has proved distinctly successful, and increasing use is being made of it by Local Health Authorities and others. The cost of the Bureau is borne in equal proportions by the Insurance, Panel, and Pharmaceutical Committees, and has ranged between three and four per cent. of the value of the prescriptions scrutinised.

59. The Association has suggested that there might be prepared by a competent authority a Hand-book of Hints on Economic Prescribing. Such a Hand-book might be issued by Insurance Committees to insurance practitioners. It would be of probable advantage to all and of certain advantage to practitioners who come upon Panel Lists with little or no previous experience of general practice. The Association is proceeding, in co-operation with the British Medical Association Insurance Acts Sub-Committee (Scotland), to frame a Hand-book on the lines suggested.

60. The Association believes that, without in any way impairing efficiency, considerable economies in the supply of drugs to insured persons might be effected. They do not suggest any drastic alteration in the present method of entrusting to Panel Committees the duty of checking excessive prescribing; but they feel bound to express the opinion that in many areas the functions of Panel Committees are being allowed to remain dormant. The machinery is there but it is not active. They have suggested that steps be taken to systematise the procedure of Panel Committees, and that the Central Authority insist upon such systematised procedure being followed. In several areas the prescribing of practitioners, whose drug costs are in excess of normal, is regularly analysed and reported upon by or on behalf of the Panel Committee. This procedure is the exception rather than the rule. If the exception were to become the rule, as the Medical Benefit Regulations contemplate, the Drug Fund would, in the opinion of the Association, be placed upon a sounder financial footing. The Association is proceeding in co-operation with the British Medical Association Insurance Acts Sub-Committee (Scotland) to frame systematised procedure for Panel Committees.

61. The Association suggests that from time to time, as means are available, consideration should be given to the extension of the list of Appliances. In particular Committees generally are of opinion that such appliances as Throat Brushes, Eye Baths, and Nasal Douches should be added, as being necessary for the proper application of the remedies prescribed by the doctor.

62. The Association has recently directed its attention to the matter of the testing of medicines and appliances supplied by panel chemists to insured persons. Insurance Committees have been advised by the Association to request their respective areal Local Authorities to include the testing of dispensing in their administration of the Food and Drugs Acts. There is no evidence before the Association to show that Panel Chemists are acting without due regard to their responsibilities. On the contrary, there is every reason to believe that the dispensing of medicines to insured persons in Scotland is of a high professional standard. The Association is, however, of opinion that the proper discharge of the administrative duties of Insurance Committees demands that they should see put into operation a systematic testing of the supply of medicines and appliances by panel chemists to insured persons.

CHAPTER III.—INDEX AND MEDICAL REGISTERS OF INSURANCE COMMITTEES.

INDEX REGISTER.

63. Each Insurance Committee requires to keep a register of all insured persons presumed to be within the area. This Register is in the form of cards containing the appropriate information filed under the names of the societies of which the insured persons are members. The Index Register is the basis of the Committee's operations. The method of proceeding is, shortly, as follows:—In the case of a new entrant the Society forwards an Index Slip to the appropriate Committee. The Committee forwards a medical card to the individual who takes it to the doctor of his choice. It is there completed and forwarded to the Insurance Committee when the name is placed upon the doctor's list and the medical card returned to the insured person. On the other hand, when a person already insured has removed from the area of his original residence to

another Insurance Committee area he is presumed to take his medical card to a new doctor, who completes it and forwards it to the Committee. The Committee applies to the former Committee for the Index Slip and the Medical Record appropriate to the individual. The Medical Record, which should be in the possession of the original doctor, fails to be recovered by the Committee from that doctor with the object ultimately of reaching the doctor chosen in the new area. There are often considerable delays on the part of the society, the doctor, or the insured person, and these involve a considerable amount of routine work to Committees, an experience which is fairly uniform throughout the country. Further, the medical card is frequently lost or destroyed and applications require to be made through the doctor or directly to the Committee for the issue of a new card. The following statement shows the actual number of changes for the year 1924 in several Committee areas in Scotland.

Insurance Committee.	Index Slips Received.	Orange Slips Received.	Removals to other Areas.
Lanark County ...	13,422	5,480	3,012
Aberdeen Burgh ...	6,464	3,500	900
Dundee Burgh ...	9,300	7,000	1,600
Edinburgh Burgh ...	19,727	12,185	3,360
Glasgow Burgh ...	55,536	26,092	5,754

64. The constant flow of population and the changes in personnel on the part of the insured involve steady and systematic work to Committee officials.

65. It is notorious that there is considerable inflation in the registers of Committees, and the Association will welcome all reasonable measures to reduce this inflation to reasonable dimensions. It is of opinion that systematic action jointly by Societies and Committees would remove a very large proportion of the existing inflation, but is convinced that under no scheme will it be possible to have at any time an absolutely correct record of the insured in any area. The flow of population and the constant changes through death, emigration, marriage, etc., coupled with the extraordinary difficulties and delays experienced by societies in recovering contribution cards from their members, render it almost impossible to secure more than approximate accuracy; but so long as inflation is relatively on the same basis among all the Insurance areas substantial justice results to all parties interested.

MEDICAL REGISTER.

66. A subsidiary register kept by Committees is entitled the Medical Register, and contains indexed under the name of the appropriate doctor the names of all insured persons who are on doctors' lists. The following statement shows the number of additions to and removals from doctors' lists in several Committee areas in Scotland during the year 1924:—

Insurance Committee.	Additions.	Removals.
Lanark County ...	14,639	10,479
Aberdeen Burgh ...	8,126	6,998
Ayr County ...	9,498	6,348
Dundee Burgh ...	14,800	12,650
Edinburgh Burgh ...	13,601	8,109
Glasgow Burgh ...	64,638	44,228

67. It has been indicated that the issue and re-issue of medical cards involves a very considerable amount of routine work which is inevitable so long as the system of free choice of doctor is continued. Until the commencement of 1924 the insured were only permitted to change their doctor at fixed intervals, and on the average the number of changes annually would be about two per cent. of the medical register. Since 1st January, 1924, the insured have been permitted to change at any time. This per-

mission has naturally increased the number of changes. For the six largest Committees in Scotland, containing a total number of 850,000 insured, there were during 1924 28,024 changes. It is the opinion of the Association that as the insured become more conscious of their rights in this connection the present percentage will increase but not to any considerable extent.

68. The Insurance Committee is also required to carry through certain arrangements in connection with the transfer of medical practices so as to ensure that the rights of the insured are sufficiently protected at such times. It is the ordinary practice of the doctors, in the case of such transfers, to consult with the Clerk to the Committee so as to secure that the arrangements made are likely to obtain the approval of the Committee.

CHAPTER IV.—DEPOSIT CONTRIBUTORS.

69. Insurance Committees in Scotland are required to deal with all benefits receivable by deposit contributors. The number in Scotland has varied considerably. At the inception of the Act it was approximately 36,600. The number increased rapidly as a result of war and post war conditions but has since fallen substantially and stood at 21,000 for 1923, a number which does not appear likely to be substantially reduced. A considerable amount of work of a routine nature is associated with the administration of these benefits. The proportion of deposit contributors who definitely choose a doctor is approximately 55 per cent., much less than in the case of members of Approved Societies.

70. With regard to sickness benefit, the attention of the Association has been directed to the number of claims disallowed on account of the balance of contributions standing at the credit of contributors having become exhausted. In 15 Committee areas with more than 14,000 deposit contributors 4150 claims for sickness benefit, representing approximately 1504 claimants, were made during the year 1924. Of these 1504 claimants 457 ceased to draw benefit through previous payments having exhausted the moneys at their credit.

71. The expenditure on financial benefits is much less than in the case of members of Approved Societies, but that is doubtless due to the system which gives nothing of the nature of real insurance to a deposit contributor. In any case of serious sickness a deposit contributor soon exhausts all the funds standing at his credit, and thereafter receives only medical benefit in respect of his contributions. The Association is of opinion that the present position is unsatisfactory and that something of a more permanent nature should be created, if this can be done on a sound insurance basis.

72. The Association is strongly of opinion that the deposit contributor class should be abolished, but the question of what should be done with these insured persons is not free from difficulty. There are two suggestions: (1) that they should be allocated to existing Approved Societies, and (2) that a separate society should be formed which would enable the members to receive the usual medical benefits and minimum cash benefits. As between the alternative proposals opinion seems to be sharply divided. The objection to the first suggestion is based mainly on the ground that it is impossible to allocate fairly among societies, many of whom by their constitution restrict their membership to certain definite classes, and to the alternative suggestion the objection urged is that a new society constituted as proposed might compete unfairly with existing societies. The Association has discussed the matter and is of opinion that it is beyond its province to make a recommendation in favour of either. The interest of Insurance Committees is mainly confined to securing that this class should have the benefit of real insurance, medical and cash benefits, and that the particular means by which this may be secured is one for determination by the Authorities in consultation with Approved Societies and any other interested bodies.

CHAPTER V.—NAVY AND ARMY FUND.

73. There are certain duties in connection with members of the Navy and Army Fund performed by Insured Committees. These are principally the provision of medical benefit to members of the Fund, both insured and non-insured, and the examination and certification of claims for sickness and maternity benefit. During the war and for some time after its close the membership of the Fund increased very rapidly. The past year or two, however, has witnessed a large diminution in membership through death, emigration, transfers to Approved Societies and ceasing insurable employment. The attention of the Association has been directed to the position of uninsured men in receipt of a pension or allowance and who are entitled to medical benefit from the Fund in respect that the total income from all sources does not exceed £160 per annum. In determining this income allowances in respect of wives and other dependants are included. The Association is of opinion that this limit should be increased to £250, the normal insurable limit for non-manual workers.

CHAPTER VI.—SEAMEN'S NATIONAL INSURANCE SOCIETY.

74. The Association agrees with the view of the English Association of Insurance Committees that in the interests of all concerned the speciality applicable to members of this Society should cease.

CHAPTER VII.—EXEMPT PERSONS.

75. The number of persons in Scotland who applied for and were permitted to be exempt numbered approximately 11,000 at the inception of the Act. The number has declined, and for the year 1923 it stood at 4866. These persons, although making no contribution personally and outwith the Act by their own choice, were in 1913 granted medical benefit in respect of their employer's contribution. The number who actually apply to be placed on the list of doctors varies but on the average does not exceed 50 per cent.

76. The Association is of opinion that no reason exists for permitting the continuance of this system. If, however, the Commission should think otherwise the Association suggests that it is improper that a class of persons exempt from the operation of the Act by their own choice and making no personal contribution to the funds should be permitted to derive financial benefit from the operation of the Act. It is suggested that such persons, if permitted to be exempt, should receive no benefit but that the sums payable on their account should be applied for other purposes indicated later.

CHAPTER VIII.—SANATORIUM BENEFIT.

77. While the administration of sanatorium benefit by Insurance Committees is mainly of historical interest, it should not be forgotten, that it marked a pronounced advance in the fight against tuberculosis. Undoubtedly sanatorium benefit was one of the most popular features of the National Insurance Act. The insured had the right to sanatorium treatment, not merely, or principally, in the interests of the Public Health, but as a direct contributor to a national scheme, aiming at the improvement of the national health, through curative measures applied to the individual. The objectionable feeling that he was an object of charity, or a charge upon the rates, was removed.

78. The funds provided under the Act were admittedly inadequate for the purpose, and in consequence the activities of Committees were hampered, but, within the ambit of their powers, and to the extent of the institutional facilities available, Committees dealt faithfully, sympathetically, and enthusiastically with the work entrusted to them. It may be noted that, as a result of the Insurance Act and the operations of Insurance Committees, the sanatorium accommodation throughout the country was substantially increased. Domiciliary treatment was provided in many cases. This included medica-

treatment, including medicines, and in addition what were known as "extra medical comforts," such as milk, eggs, butter, &c., to the value of 7s. 6d. weekly.

79. Seventeen Committees succeeded in making arrangements with Local Authorities—either under section 17 of the 1911 Act, or by special agreement—for the extension of the benefit to the dependants of insured persons. One Local Authority indeed entrusted the Insurance Committee with the consideration and disposal of all applications for treatment received by them.

80. Applications for treatment were as a rule considered and dealt with by a special sub-committee, which being for the most part composed of representatives of Approved Societies, was in close touch with the insured population, and frequently acquainted with the individual applicants. The treatment recommended depended largely on the report by the committee's medical advisor.

81. These sub-committees met each month to deal with new applications, and to consider reports, regularly obtained, as to the progress of patients undergoing treatment. Extension of treatment was freely given, where suggested by the Medical Officer. Generally speaking, the course of each case was minutely followed. One of the features of the Sanatorium Benefit Sub-Committee was the regularity of the attendance of its members, and the keenness they evinced in their work.

82. During and immediately after the war considerable numbers of soldiers and sailors were discharged, suffering from tuberculosis. These cases were referred by the Army authorities to Insurance Committees for treatment, the whole cost of treatment being defrayed by the Ministry of Pensions.

83. In a number of areas After-Care Committees were constituted, whose members, in a friendly and unofficial way, periodically visited ex-patients at their homes, to ensure, as far as practicable, that they were carrying out the instructions given in regard to home treatment. Where a further course of treatment appeared to be advisable, patients were instructed that they should send in another application to the Committee.

84. Another method adopted for the purpose of keeping in touch with patients who had received treatment, was by the issue periodically of questionnaires, the replies to which served to indicate whether or not improvement in health had been maintained.

85. The withdrawal in December, 1920, of sanatorium benefit as a National Health Insurance benefit, was a source of keen disappointment to Committee members, who felt that the same personal interest could not be shown in each case, and believed it undesirable that patients should be made to feel that they were being treated at the expense of the rates, instead of on a contributory basis.

CHAPTER IX.—OTHER POWERS OF INSURANCE COMMITTEES.

86. The powers of Committees under section 60 of the original Act to give lectures and publish information on questions relating to health have been used to a considerable extent. The Insurance Committee is able to secure the sympathetic assistance of the general practitioners and through the various societies can count upon the co-operation of local friendly society and other officials. One Committee has for several winters arranged a series of health lectures in smaller villages and hamlets. In addition this Committee arranged a scheme for prizes to school children for essays on Health, and made arrangements through the Education Authority for the instruction of youths in their rights and duties under the Insurance Acts. Many other Committees also provided lectures, but all have been seriously handicapped by the insufficiency of funds. Certain moneys were available in the earlier years of the Act for the general purposes of the Committee, but this source of supply ended in 1918. Promises were made at various times that grants were likely to be

secured to assist Committees in this connection, but these have not yet materialised.

87. The Association is of opinion that all Committees should arrange at suitable times short lectures to young persons entering insurance on their rights and obligations under the Insurance Acts.

88. The Association is very strongly of opinion that Committees, if they had the necessary funds, would be able to undertake and carry out much useful propaganda work of the nature indicated.

89. A very important purpose served by the Committee is that it provides a local office and officials available for consultation by the insured persons, doctors, and chemists in the area. The officials are familiar with local conditions. They are in close touch with the medical and pharmaceutical professions, and in large measure with the principal societies operating within the area. A very large number of enquiries of all kinds are made at the offices of Committees by insured persons in difficulty. The great majority of these cases are adjusted either by friendly advice or assistance in matters of minor difficulties. Frequently if the question is one with the medical profession a personal communication with the doctor concerned clears away a misunderstanding which has caused difficulty as between the doctor and his patient. The assistance of Committee members is frequently enlisted either by the insured person or by the Committee official and generally the work of the Committee has resulted in smoothing the wheels of administration. The number of such enquiries is naturally greater in the cities than in the country areas. In Glasgow approximately from 900 to 1000 persons call weekly at the offices of the Committee during busy times, the numbers falling in the summer months. In Lanarkshire the number of callers is approximately 50 to 60 per week. The majority of these deal with lost medical cards or questions as to the right of the insured person to medical benefit, but a substantial proportion refer to other difficulties connected with the Act. In county areas generally speaking the correspondence is considerably greater than in the burghs, and by letter or telephone, and the assistance of members of Committee, the County Committees keep in close touch with the administration throughout the area.

CHAPTER X.—COST OF ADMINISTRATION.

90. When Insurance Committees were first constituted it was clearly a matter of some difficulty to estimate the income necessary for the better performance of the duties entrusted to them. In consequence there has been considerable variation from time to time in the funds provided, and also in the ratio of distribution among Committees. At a very early stage it was apparent that the smaller Committees, more particularly in the rural and Highland Counties, would find it quite impossible to carry through the duties entrusted to them on funds provided on the simple basis of numbers of insured resident in the area. The Association, after a thorough investigation, submitted a statement of the case to the responsible Minister and were successful in securing an addition and re-arrangement which materially improved the position of affairs. There have been various subsequent alterations and re-arrangements, all as detailed in the Statement submitted to the Commission by the Minister and the Scottish Board of Health. The present cost of Insurance Committees is roughly about 6½d. per insured person, and the Association is of opinion that under the present Scheme no further reduction in expenditure can reasonably be anticipated. The need for economy in the public service has all along been appreciated by Committees who while anxious to improve the smooth working of the machine have been equally solicitous to avoid any suspicion of extravagance. It is questionable as to whether the present income is sufficient in the more sparsely populated areas to secure and maintain a satisfactory standard of service. There are many complaints from the smaller Committees that their activities are hampered as the result of increasing stringency in the Administration Fund.

CHAPTER XI.—ALTERATIONS, EXTENSIONS AND DEVELOPMENTS.

91. The Association is of opinion that an increase in the present rate of contribution is not, under existing circumstances, desirable or expedient. It would be resented by both employers and employed. The present contribution should be sufficient to provide additional services of a kind which might greatly improve the range of medical service provided for the insured. When the Act was projected the statistics of sickness available were limited and the Actuary responsible necessarily required to exercise extreme caution. There are now, however, twelve years of reliable statistics of sickness among the insured available to the Government, and the valuation returns so far as ascertained show that the margin of safety has been so substantial that the Insurance Fund could well stand additional charges. The Association believes that the surplus funds are unreasonably high, having regard to the liability experienced by the generality of societies for the primary benefits. The Association, therefore, suggests that the Government Actuary should be required to ascertain from the statistics available what is the margin reasonably available for other and additional benefits, and that if the view of the Association is well founded, additional medical benefits of the nature and in the order tabulated should be provided for the whole insured population. The Association is of opinion that the service should first be expanded for the insured population on the following lines—

1. Dental Benefit.
2. Nursing.
3. Optical Treatment and Appliances.
4. Additional Appliances.
5. Consultants' and Specialist Treatment.
6. Maternity Services.

and that if and when funds are available for the purpose medical benefit should be extended to the dependants of the insured.

92. The Association is definitely of opinion that treatment benefits of the nature of medical benefit should be administered by and through Insurance Committees. It might, however, be desirable that the proportion of representatives on Insurance Committees appointed by the Board of Health should contain parties interested in these additional benefits, e.g., dental and nursing representatives. The Association would refer to the Supplementary Grants made by Parliament in 1914 under which certain of these services were, after very careful consideration, definitely approved of.

CHAPTER XII.—SUMMARY OF MINOR AMENDMENTS.

93. The Association submits for consideration the following Minor Amendments to the Scheme.

(1) Admission to Medical List.

It should be a necessary condition of the admission of an insurance practitioner to the Medical List that he satisfies the Insurance Committee that he has had a period of practical experience either in general practice or on the staff of a hospital or similar institution.

(2) Sickness Certification.

An insurance practitioner is now required to make a recommendation for dental or other treatment only when he issues a certificate of incapacity for work and has been informed by the Approved Society that under its scheme of additional benefits, payments may be made.

Provision should be made for recommendations to be given irrespective of the insured person's capacity for work.

(3) Medical Records.

Arrangements should be made for Insurance Committees to take advantage of the information con-

tained in summary cards completed by insurance practitioners, and to undertake the compilation of statistics and the extraction of information therefrom as to the causes and incidence of sickness.

(4) Limitation of Doctors' Lists.

The present limitation of lists by numbers may prevent acceptance of patients by the family doctor. He should be permitted to exceed the maximum numerical limit within a reasonable margin, but not go beyond a fixed financial limit.

(5) Special Arrangements.

Where an Insurance Committee satisfies the Scottish Board of Health that there is an adequate medical service, it should be relieved of the necessity for allowing or requiring any insured person to make his own arrangements for medical attendance and treatment.

(6) Appliances.

The Association recommends that the list of prescribed appliances should be increased and that arrangements be made for the supply of any appliances requisite in connection with medical treatment.

Arrangements should be made for lending expensive appliances in appropriate circumstances.

(7) District Medical Officers.

The services of District Medical Officers should be made available to Insurance Committees to assist them in carrying out their duties in connection with prescribing reports, in approving the employment of assistants, and in dealing with questions as to the range of medical service, etc.

They should be empowered to ascertain, by periodical inspections, whether the medical records in the hands of insurance practitioners are being kept with reasonable care.

To enable these duties to be properly undertaken and in addition to provide a second opinion in suitable cases where requested by the insurance practitioners, it would be necessary to provide for an increase in the number of these officers.

(8) Deposit Contributors.

The position of deposit contributors is unsatisfactory; many are frequently "in and out" of benefit; protracted illness or unemployment exhausts credit; maternity benefit is often reduced or not available through insufficient credit; there are fresh waiting periods on re-entering insurance.

Deposit contributors should be placed on a sound insurance basis.

(9) Navy and Army Insurance Fund.

The income limit for uninsured pensioners should be increased from £100 to £250, the normal limit for non-manual workers, and allowances, etc., should be excluded in assessing the amount of income.

(10) Seamen's National Insurance Society.

The initial reasons no longer exist for exceptional arrangements in the case of this Society (they do not extend to persons in the Mercantile Marine who join other societies, even if membership is restricted to the same class). The modifications in the panel system to meet the requirements of temporary residents and travellers now meet the case.

This would be beneficial to the insured persons and a valuable simplification in machinery.

(11) Exempt Persons.

As previously indicated the Association is definitely of opinion that this speciality should cease but that in any event no benefit should be provided when no contribution has been made and when the person concerned is outwith the Act by his own choice. In the latter event the payments made in respect of this class should be applied towards the general purposes of the Committees.

APPENDIX XXXVIII.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE ASSOCIATION OF WELSH INSURANCE COMMITTEES BY MR. FREDERICK LLEWELLYN JONES, B.A., LL.B. (LOND.) CHAIRMAN OF THE FLINTSHIRE INSURANCE COMMITTEE.

See Minutes of Evidence of the Twenty-Third Day, Questions 13,209 to 13,270.

1. Mr. Frederick Llewellyn Jones is the Chairman of the Flintshire Insurance Committee, and has acted as such Chairman since the establishment of the Committee in 1912. He was the first President of the Association of Welsh Insurance Committees which was formed in 1914, and has been a member of the Association since then. He has also been since the year 1914 one of the representatives of the Welsh Association on the Federation of English, Welsh and Scottish Insurance Committees, and is this year President of the Federation. He was a member of the Welsh and Joint Advisory Committees under the National Insurance Act, 1911, and is now a member of the Welsh Consultative Health Council (Ministry of Health).

2. There are 17 Insurance Committees in Wales and Monmouthshire, and, with the exception of Breconshire Insurance Committee, which has for the past two years withdrawn from the Association, they are all members of the Association.

3. The following 'heads' of evidence have been submitted to the constituent Committees of the Association, all of which give general support thereto.

POWERS AND DUTIES OF INSURANCE COMMITTEES.

4. This Association is of opinion that the administration of sanatorium benefit should have continued to be vested in the Insurance Committee, and not in the County Council. The Association is of opinion that insured persons should be entitled to full treatment and travelling expenses to and from sanatoria without cost to them, and favours the formation of an independent committee to deal with any complaints made by an insured person with regard to sanatorium treatment.

HEALTH LECTURES AND EDUCATIONAL WORK.

5.—(1) The Ministry should give Insurance Committees a lead as to carrying out section 60 (1) (a) of the principal Act, dealing with reports on the health of insured persons.

(2) Adequate funds should be made available to enable all Insurance Committees to develop their powers and duties under section 60 (1) (b) of the principal Act, dealing with health lectures and propaganda, which work could be best carried out by co-operation with education and other local authorities.

(3) Powers should be given to Insurance Committees by which the provisions of section 63 (1) of the principal Act might be made operative.

BETTER AND MORE EFFICIENT MEDICAL AND PHARMACEUTICAL SERVICE.

6.—(1) The constituent Committees of the Association were asked whether insured persons in their respective areas have been found to experience difficulty in obtaining medical certificates owing to their living at a distance from the doctor's surgery, and whether the procedure followed by the medical practitioners in such cases indicated a full appreciation of the provisions of paragraph 9 (4) First Schedule Medical Benefit Regulations 1924 and clause 8 of the Medical Certification Rules. It has been ascertained that no complaints have been received under this head.

(2) The existing maxima numbers on the lists of panel practitioners should substantially be reduced, regard being had to the nature of the area served.

(3) The Association, having regard to the experience of the Insurance Committees for the Counties of Glamorgan and Monmouth respectively in the administration of institutions formed under sections 15 (4) and 15 (3) of the principal Act, without committing itself to an expression of approval or disapproval think it advisable that evidence be given before the Commission by Mr. H. Eynon Lewis and that the Commission be invited to consider the advisability or otherwise of a suggestion that Insurance Committees be empowered to consider and approve applications for the formation of new institutions under section 15 (4) of the principal Act and that the Medical Benefit Regulations should provide for the investigation by the Insurance Committees of complaints made by insured persons on the lists of institutions, and that the rules of institutions be amended accordingly.

(4) The suggestion that additional services should be established, e.g. consultations and specialised treatment, laboratories, &c., that panel practitioners should have duties in connection therewith, that they should be encouraged to associate themselves with the work thereof, and that they should have the right, if possessing the necessary qualifications, of being appointed to give service in the same way as a consultant or specialist, has been considered by the Association.

The Association, however, while expressing general approval of the establishment of such services, appreciates the difficulty of making any detailed recommendations. The Association understands that the Swansea Borough Insurance Committee have had before them certain recommendations made by Dr. A. F. Bladden, of Swansea General Hospital, and suggests that, Dr. Bladden might be asked by that Committee to submit his scheme to the Royal Commission.

MEDICAL REFERREES.

7. Provision should be made whereby regional medical officers can be consulted by insurance practitioners at any time during the illness of a patient instead of such consultations being restricted to cases in which the insured person has been certified as incapable of work for at least four weeks continuously.

HOSPITALS.

8. Hospital accommodation should be adequate to the requirements of the whole of the insured population.

CONVALESCENT HOMES

9. Convalescent homes should be provided and utilised as adjuncts to hospitals or otherwise.

NURSING.

10. The Minister of Health is urged to include domiciliary nursing as an integral part of the medical benefit of insured persons. (In the opinion of the Association this matter is of very great importance.)

DENTAL TREATMENT.

11. Dental treatment should be provided as one of the benefits under the Act.

ADDITIONAL APPLIANCES.

12. Insured persons should be entitled to obtain free of cost all medical appliances recommended by panel practitioners.

EXTENSION OF MEDICAL BENEFIT TO DEPENDANTS.

13. Provision should be made through Insurance Committees of medical benefit for the wives and dependants of insured persons, and that the range of medical benefit should be extended so as to include maternity services.

INCOME LIMIT FOR UNINSURED INVALIDED EX-SERVICE MEN.

14. The income limit for uninsured invalided ex-Service men should be increased to £250.

STANDARD OF DRUGS AND APPLIANCES AND TESTING OF SAME.

15. Funds should be made available for the testing and analysis by Insurance Committees of drugs, etc., dispensed to insured persons.

16. Clause 4 (3) of the Third Schedule to the Medical Benefit Regulations, 1920, should be amended so as to make it clear that drugs and appliances ordered under a name for which a standard appears in the British Pharmacopœia and the British Pharmacopœia Codex or the supplements thereto, should be in accordance with such standard.

FREE CHOICE AND TRANSFER OF DOCTOR.

17. Members of Institutions and Organisations should have the same freedom of transfer as insured persons on the lists of medical practitioners.

MEDICAL RECORDS.

18. Medical practitioners should be required to continue to keep and furnish records of their attendance on and treatment of insured persons.

EXCESSIVE PRESCRIBING.

19. Insurance Committees should be asked to report on this matter particularly with regard to high frequency where such exists.

SERVICES SUB-COMMITTEES.

20. Revision of the regulations relating to Services Sub-Committees is desirable, and such Sub-Committees should have power to compel the attendance of any practitioner or other person who may be concerned in a complaint, as statements are often made which are incapable of proof or otherwise without the attendance and evidence of persons concerned.

NON-PERFORMANCE OR BREACH OF DUTY.

21. As the Insurance Committee is the Authority administering medical benefit with whom a practi-

tioner enters into agreement, and to which he is primarily responsible, correspondence with regard to non-performance by a doctor of his duties under the terms of service should be undertaken with the Insurance Committee, and no penalty should be imposed on the doctor for any breach of such terms of service until the alleged offence has been investigated by the Medical Service Sub-Committee.

PENSION ADMINISTRATION.

22. The Minister of Health is urged to confer with the Minister of Pensions for the purpose of devising some method of co-ordinating the work of the medical branches of the Ministry of Pensions with the medical service provided by insurance practitioners under the National Insurance Acts.

SUPERANNUATION.

23. Insurance Committee Officers should be brought within the scope of the Local Government Officers Superannuation Act.

WHOLE TIME MEDICAL SERVICE

24. The Association disagrees with the proposal put forward by the National Conference of Friendly Societies for a whole time National Medical Service.

ADDITIONAL BENEFITS.

25. Ophthalmic treatment should be included in benefits.

GENERAL NOTES.

26. It is not advisable that any health functions at present vested in Insurance Committees should devolve upon County and County Borough Councils or Committees thereof, as such bodies are already overburdened with work.

27. Emphasis should be laid before the Commission upon the effective work of Insurance Committees in the past in the administration of medical benefit, the benefits of the Navy and Army Fund and deposit contributors.

28. The administration of medical benefit by Insurance Committees commands the highest respect and appreciation of insurance practitioners, pharmacists and the insured population. Owing to the nature of their administrative machinery and organisation, Insurance Committees are capable of dealing with greatly extended responsibilities under any enlarged scheme of medical and allied services. A revision of the basis of membership so as to secure a wider representation of interested bodies would be welcomed and would assist in securing local co-ordination.

APPENDIX XXXIX.

STATEMENT OF EVIDENCE SUBMITTED ON BEHALF OF THE GLAMORGAN COUNTY INSURANCE COMMITTEE BY MR. HENRY EYNON LEWIS, CLERK TO THE COMMITTEE.

See Minutes of Evidence of the Twenty-Third Day, Questions 13,271 to 13,369.

1. Mr. Henry Eynon Lewis is a member of the Association of Welsh Insurance Committees since its inception, Vice-Chairman of the Welsh Central Index Committee, member of the Welsh Joint Insurance (Pricing) Committee and Clerk to the Insurance Committee for the County of Glamorgan since August 1912.

2. The witness has been authorised by the Association of Welsh Insurance Committees to give evidence with regard to—

- (1) Institutions approved under section 15(4) of the National Insurance Act, 1911, and
- (2) Collective own arrangement organisations approved under section 15(3) of the same Act.

INSTITUTIONS APPROVED UNDER SECTION 15(4).

3. With regard to Institutions approved under section 15(4) of the National Insurance Act, 1911, the section referred to as follows:—

The regulations made for the purposes of this section shall provide that, in the case of persons who are entitled to receive medical treatment and attendance under any system or through any institution existing on the sixteenth day of December, nineteen hundred and eleven, and approved by the Insurance Committee and the Minister, medical treatment and attendance so received may be treated as, or as part of, their medical benefit under this Act, and may provide for the committee contributing towards the expenses thereof the whole or any part of the sums which would be contributed in the case of persons who have made their own arrangements under the last preceding subsection, but the regulations shall secure that no person shall be deprived of his right of selecting, if he desires so to do, in accordance with the foregoing provisions of this section, the duly qualified medical practitioner by whom he wishes to be attended and treated.

4. Institutions approved under this section are generally in connection with large works such as collieries, iron, steel and tinsplate works, and arrange to provide treatment to the insured persons employed thereat and to their dependants.

5. Payment of capitation fees is made by the Insurance Committee to the approved Institution in respect of insured persons whose names are included in the List of that Institution.

6. Payment is only made by the Insurance Committee of the full capitation fee on the production of a certificate from the Institution showing that that amount has been expended by the Institution on the provision of medical benefit to its insured members, and for this purpose the proportion relating to insured members is calculated as three-sevenths of the total expenditure on medical benefit.

7. The credit of the Institution for the year is arrived at as follows:—

- (1) The amount determined to have been expended by the Institution on the provision of medical treatment and attendance to insured members; or
- (2) the yearly capitation fee in respect of the average number of insured persons whose names are included in the Institution's list:

whichever shall be the less.

8. This system of payment precludes Institutions from participating in any "pool."

9. No payment is made to an Institution in respect of any of the expensive drugs referred to in the Appendix to the Distribution Scheme—the Treasury is relieved of that liability. A panel practitioner in addition to the capitation fee for drugs in respect of dispensing patients receives payment on the basis of the Drug Tariff for any drugs and appliances mentioned in the Appendix to the Distribution Scheme as approved by the Minister. The Drug Fund being subsidised by the Treasury necessitates the Treasury being liable for the more expensive drugs, etc., supplied to insured persons who obtain their medical treatment and attendance from an insurance practitioner.

10. A deduction, ranging from 1½d. to 4d. in the pound is being made from the earnings of insured

persons and paid over to the Management Committee of the Institution.

11. An insured person whose name is included in the list of a practitioner may transfer to the list of another practitioner at any time, but transfer to or from the list of an approved Institution cannot be effected except at the 1st January and 1st July in any year, and then applications for such transfers must be received by the Insurance Committee before the 1st June or 1st December as the case may be.

12. Each Approved Institution is required to submit, in addition to Form 97 I.C., copies of the audited statement of accounts and balance sheet yearly.

13. Additional benefits are provided free of charge to patients by some Approved Institutions. The following examples may be given of Institutions operating in Glamorgan:—

- Dental surgeon's services.
- Maternity service.
- Nursing by hospital trained nurses.
- Provision of ambulance car.
- Payment of railway fares of patients to hospitals and contributions to hospitals and convalescent homes.
- Major and minor operations.
- Artificial limbs.
- Appliances other than those included in the Second Schedule to the Medical Benefit Regulations.

14. The following Institutions have been approved in the area under section 15 (4) of the National Insurance Act, 1911:—

Name of Institution.	Period of Approval.
Brynamman and District Workmen's Medical Society ...	1913.
Pentre Colliery Systems ...	1913.
Gelli Colliery Medical Fund ...	1913
Tynybedw Colliery System ...	1913
Bwlfa Ddu Colliery System ...	1913.
Gilfach Goch Medical Aid fund	1913.
Parc and Dare System ...	1913.
Mardy Colliery Poundage Scheme	1913.
Cwmtwrch and District Medical Aid Society ...	1913-15.
Abergwynfi Colliery Medical Aid Fund ...	1913-15.
Pwllgwaun Workmen's Doctors Fund ...	1913-15.
Newbridge Works Doctors Fund	1913-15.
Post Office Medical System ...	1913-20.
Garw Ocean Medical Institution	1913-21.
Cwmavon Tinsplate Workers' Medical Institution ...	1913-present time.
Ferndale Workmen's Doctors Fund ...	1913-present time.
*Garw Valley Medical Aid Society ...	1913-present time.
Ocean (Western) Colliery Medical Aid Society ...	1913-present time.
Ogmore Valley Medical Aid Society ...	1913-present time.
Pontlottyn Workmen's Medical Fund ...	1913-present time.
Rhymney Workmen's Medical Aid Fund ...	1913-present time.
Wyndham Colliery Medical Aid Society ...	1913-present time.

* This institution was approved under section 15 (3) from 1914 to 1922 inclusive.

15. The following Institutions have received approval in the area for 1924 under section 15 (4) of the National Insurance Act, 1911:—

Name of Institution.	Mean No. on List for 1924.
Cwmavon Tinplate Workers' Medical Institution	244
Ferndale Workmen's Doctors Fund ...	475½
Garw Valley Medical Aid Society ...	3640½
Ocean (Western) Colliery Medical Aid Society	1128½
Ogmore Valley Medical Aid Society ...	678½
Pontllynn Workmen's Medical Fund...	583½
Rhymney Workmen's Medical Aid Fund	119½
Wyndham Colliery Medical Aid Society	906½

RECOMMENDATIONS.

16. The Insurance Committee for the County of Glamorgan recommend:—

- (1) that Insurance Committees be empowered to consider and approve of applications for the formation of new Institutions under section 15 (4) of the National Insurance Act, 1911, and section 24 (4) of the National Health Insurance Act, 1924, and
- (2) that the Medical Benefit Regulations should provide for investigation by the Insurance Committee of complaints made by insured persons on the lists of Institutions and that the rules of Institutions be amended accordingly.

17. The recommendation referred to in paragraph 16 (1) above was considered by the Association of Welsh Insurance Committees, but in view of the fact that such Institutions exist in only one other Committee area in Wales, the majority of the members were not in a position to express a definite opinion on the matter and resolved:—

"That the Commission be invited to consider the advisability or otherwise of a suggestion that Insurance Committees be empowered to consider and approve applications for the formation of new Institutions under section 15 (4) of the principal Act and that the Medical Benefit Regulations should provide for the investigations by the Insurance Committees of complaints made by insured persons on the Lists of Institutions and that the Rules of Institutions be amended accordingly."

COLLECTIVE OWN ARRANGEMENT ORGANISATIONS.

18. Collective Own Arrangement Organisations are bodies providing medical treatment and attendance and are approved by the Insurance Committee under section 15 (3) of the National Insurance Act, 1911, for the purpose of making their own arrangements collectively for providing and obtaining medical benefit.

19. Such organisations are mostly in connection with large works and employ their own medical practitioners and provide treatment similar to that provided by Institutions.

20. Quite a number of applications have been made to the Insurance Committee for the County of Glamorgan for approval of Collective Own Arrangement Organisations, but that for various reasons the approval has not been given in all cases.

21. The method adopted in forming some, if not most of these organisations, appears to have been the formation of a committee connected with certain work or works. This committee would convene a meeting or meetings of a number of the employees. A number of the employees would apply at the works' office to have the doctor's poundage money (which usually ranges between 1½d. and 4d. in the pound) retained for the committee, which committee would engage a medical practitioner. The name of the practitioner engaged would then be placed on the Medical List, and at the usual transferring time—mid or

end of the year—most of the insured persons who had applied to have their poundage money retained for the local committee would apply to the Insurance Committee to have their names placed on the list of the practitioner appointed by the local committee. In the meantime application would have been made to the Insurance Committee for approval under section 15 (3) of the National Insurance Act, 1911. In cases where the Insurance Committee refused approval these Organisations sooner or later become defunct.

22. The income of these Organisations is derived in much the same way as Institutions approved under section 15 (4) of the National Insurance Act, 1911.

23. Payment by the Insurance Committee to these Organisations is on the basis of the capitation fee for medical treatment and drugs on the average number on the list of the Organisation for the year. This payment is not, as in the case of Institutions, conditional on that amount being expended by the Organisation on the provision of medical treatment and attendance to the insured persons on the list of the Organisation.

24. The Insurance Committee require that each Organisation shall furnish a statement of accounts and balance-sheet annually and that the same shall have been certified by a chartered accountant, incorporated accountant, or a person certified as a public auditor under the Friendly Societies Act, 1896.

25. Insured persons whose names are included in the list of an Organisation cannot receive medical treatment as temporary residents under the Committee's arrangements but the Organisation which receives the capitation fee for an insured person pays the account of any practitioner for treatment rendered during any temporary absence from home.

26. Additional benefits, similar to the additional benefits, provided by Institutions are also provided by some Organisations.

27. The medical practitioners connected with five of these Organisations in the area, committed such breaches of their terms of service as to cause the Insurance Committee, after the necessary investigation, to make representations to the Minister that the continuance of their names on the Medical List would be prejudicial to the efficiency of the medical service of the insured, with the result that three of the names were removed from the Medical List by order of the Minister.

28. The great scarcity of practitioners during the War made it often difficult for the committees managing Organisations approved under section 15 (3) to obtain the services of the practitioners they would desire to appoint.

29. Further the ban placed on these Organisations by the British Medical Association materially added to the difficulties of the Management Committees thereof to appoint the practitioners they would otherwise have been able to secure.

30. The following Organisations have been approved by the Committee:—

Name of Organisation.	Period of Approval.
Senghenydd & Aber Valley Co-operative Medical Aid Society	1913-14.
Bargoed & District Medical Aid Society	1914.
Gorseinon & District Medical Aid Society	1913-15.
Mountain Ash Workmen's Medical Association ...	1913-16.
Briton Ferry Workmen's & General Institution for Medical & Surgical Treatment	1913-31/12/21.
Ely Valley Medical Aid Society	1/7/21-31/12/21.

Name of Organisation.	Period of Approval.
Ynysybwl & District Medical Aid Society	1/7/21-31/3/22.
Gilfach Goch Workmen's & Examiners' Medical Scheme	1/10/18-31/12/22.
Windsor Colliery Medical Aid Society	1/7/21-31/3/23.
Llwynypia Workmen's & Officials Medical Aid Society	1913-present time.
Neath & District Medical Aid Association	1913-present time.
Mardy & District Workmen's Medical Aid Society	1/1/21-present time.

31. The following Organisations have been approved by the Insurance Committee under section 15(3) for the year 1924, namely:—

Name of Organisation.	Mean No. on List for 1924.
Llwynypia Workmen's & Officials Medical Aid Society	4327½
Neath & District Medical Aid Association	2464½
Mardy & District Workmen's Medical Aid Society	912

32. Generally speaking, the services rendered by the staffs connected with the three Organisations now approved under section 15(3) may be considered satisfactory, while in some cases they are able to supply to insured members benefits in addition to those provided under the National Health Insurance Acts.

33. As an instance of the additional benefits the Llwynypia Workmen's & Officials Medical Aid Society provide the following:—

Dental treatment on recommendation of one of their medical officers by arrangement with two dentists, one at Tonypany and the other at Pentre.

Nursing by hospital trained nurses.

Weekly contributions made by members to local hospital which includes the provision of ambulance.

Payment of railway fares of members to convalescent homes or hospitals at a distance.

Practically all minor and major operations performed by the members of the medical staff engaged.

Most appliances are supplied on recommendation by the chief medical officer of the staff.

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